STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	09/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00240323. This visit was in conjunction with the Recertification and State Licensure Survey and with the Investigation of Complaints IN00238074 and IN00238390. Complaint IN00240323 - Substantiated. Federal/State deficiencies related to the allegations are cited at F314 and F323. Complaint IN00238074 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F312, and F465. Complaint IN00238390 - Substantiated. Federal/State deficiencies related to the allegations are cited at F250, F312, F323, and F465. Survey dates: September 11, 12, 13, 14, 15, and 18, 2017 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census bed type:	F 0000	F000 St. Anthony Home (“the provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1)are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (“CMS”), the state of Indiana or any other entity; or (2) to serve, in any way to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	SNF/NF: 147 SNF: 13 NCC: 2 Total: 162 Census payor type: Medicare: 17 Medicaid: 98 Other: 47 Total: 162 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/21/17.		Evidence and should be inadmissible in any proceeding on that basis.	
F 0314 SS=D Bldg. 00	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of			

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	practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services, related to hi-protein supplements to assist in wound healing not provided to the resident as ordered by the Physician, for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Finding includes: During an observation on 09/11/17 at 12:40 p.m., Resident B was sitting in the dining room. The lunch meal consisted of pureed cod and corn. During an observation on 09/13/17 at 8:30 a.m.,8:30 a.m., the Unit Manager was feeding the resident breakfast in her room. The resident remained in bed. The breakfast consisted of cranberry juice, coffee, and regular peaches, puree pancakes and sausage. There was no yogurt on the breakfast tray. During an interview at 8:40 a.m. on 9/13/17, the Unit Manager indicated there was no yogurt on the breakfast tray. An Observation of wound care with the	F 0314	F314 Request desk compliance 1:1 Regarding Resident "B", both tray card and order were reviewed to ensure that they were consistent with what was being served. No adverse reaction noted. 1:2 Audit completed to assess resident's with wounds and/or open areas to ensure that interventions are in place as ordered to promote wound healing. 1:3 Dietary manager/designee re-inserviced staff related to highlighting the tray ticket for any ordered hi protein supplement and importance of placing ordered supplements on the resident's tray. DON/designee will assess and monitor that pressure ulcer interventions are in place as ordered. Dietary manager/designee will audit five(5) high risk trays each week for six(6)weeks, then ten(10) trays monthly for total of six(6) months. DON/designee will audit five(5) residents with ordered wound interventions each week for six(6) weeks, then ten (10) residents with wound interventions monthly for total of six(6) months.	10/16/2017

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	Wound Nurse and Unit Manager on 09/13/17 at 8:45 a.m. to 9:25 a.m., indicated there was an unstageable deep tissue injury (purple pressure areas on the skin, damage to the tissue cannot be confirmed due to slough or eschar) on the right heel, stage 2 (partial thickness loss) on the right ischium, and an unstageable pressure ulcer on the coccyx, which had tunneling (deeper area into the tissue). Resident B's record was reviewed on 09/12/17 at 12:10 p.m. Diagnoses included, but were not limited to, repeated falls and Alzheimer's disease. A care plan, dated 9/27/16, indicted a risk for pressure ulcers due to decreased mobility, poor safety awareness, on 8/11/17 a blister blood filled right outer heel noted, 8/24/17 a coccyx wound noted, and 08/31/17 upon readmission from the hospital a right ischium and left ischium wound (healed) 9/12/17, was added to the care plan problem. The interventions included dietary consult. A Dietary Consult Note, dated 8/15/17 at 11:05 a.m., indicated the resident had a pressure area and was receiving fortified pudding with lunch and recommended yogurt with breakfast and ice cream with dinner.		1:4 The dietary manager/designee as well as DON/designee will report findings to the QAPI committee monthly for six(6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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	A Physician's Order, dated 09/01/17, indicated to resume yogurt with breakfast, fortified mashed potatoes with lunch, and ice cream with dinner for wound healing. This Federal Tag relates to complaint IN00240323. 3.1-40(a)(2)			
F 0323 SS=D Bldg. 00	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct			

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	installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. Based on observation, record review, and interview, the facility failed to ensure a resident received adequate assistive devices to prevent accidents, related to interventions to assist in fall prevention were not in use as ordered by the Physician, for 1 of 3 residents reviewed for falls. (Resident B) Finding includes: Resident B was observed on 09/12/17 at 2:45 p.m. sitting in her room in a Broda chair (High back/reclining wheelchair). There was no personal alarm observed on the chair. During an observation on 09/13/17 at 9 a.m. with the Unit Manager and Wound Nurse present, the resident was lying in bed and a safety alarm was not located on	F 0323	1:1 regarding resident B, the safety alarms were applied & no injuries were noted. 1:2: Unit Managers/designee completed an audit on all residents with fall interventions to ensure they were intact with any deficiencies corrected at that time. 1:3 Director of Staff Development /designee re-inserviced nursing staff on ensuring all fall prevention interventions are in place per the care plan/care card. The Unit Manager/designee will assess 5 residents per unit per week on all shifts with fall interventions to ensure compliance for 6 months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for 6 months.	10/16/2017

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	the bed. The Unit Manager acknowledged there was no safety alarm on the bed. Resident B's record was reviewed on 09/12/17 at 12:10 p.m. Diagnoses included, but were not limited to, repeated falls and Alzheimer's disease. A Fall Risk Assessment, dated 06/22/17, indicated a high risk for falls. A Quarterly Minimum Data Set (MDS) assessment, dated 06/13/17, indicated severely impaired cognition, extensive assistance of two for bed mobility, extensive assistance of one for transfers, and not steady without help for standing, walking, and moving on and off toilet. A care plan, dated 09/27/16, indicated a fall risk due to history of falls. The interventions included, safety alarms when in bed and in a chair. Physician's Orders, dated 07/29/16, indicated sensor alarm when in bed and sensor pad when up in wheelchair or chair. This Federal Tag relates to Complaints IN00240323 and IN00238390. 3.1-45(a)(2)		The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 10/16/17	

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