STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. BUILDING 00 B. WING	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00440491 and IN00438928. Complaint IN00440491-No deficiencies related to the allegations are cited. Complaint IN00438928-No deficiencies related to the allegations are cited. Survey dates: August 13, 14, 15, 16 and 19, 2024 Facility number: 000535 Provider number: 155604 AIM number: 100267250 Census Bed Type: SNF/NF: 75 Total: 75 Census Payor Type: Medicare: 5 Medicaid: 46 Other: 24 Total: 75 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on August 21, 2024.	F 0000	This Plan of Correction is submitted under Federal and State regulations and status applicable to long term care providers. This Plan of Correction does not constitute an admission of liability on the part of the facility and such liability is hereby denied. The submission of the plan does not constitute agreement by the facility that the surveyor's findings or conclusions are accurate, that the findings constitute a deficiency, or that the scope and severity regarding any of the deficiencies are cited correctly. Please accept this plan as out credible allegation of compliance.	
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Nicole Hardy	RN	09/03/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, interview and record review, the facility failed to ensure a resident was seated at a table with the height adjusted to accommodate the resident's needs for 1 of 1 resident reviewed for accommodation of needs. (Resident 3) Finding includes: During an observation, on 8/13/24 at 12:10 p.m., Resident 3 was sitting at the end of a long table with other residents who required assistance to eat. She was resting her head on the table during the meal. During an observation, on 8/15/24 at 11:56 a.m., Resident 3 was sitting in the dining room at a long table with other residents who were being assisted with meals. The table was at the level of the resident's chin. She was feeding herself. Her head was leaning to the left and forward. She had a clothing protector on, and a CNA was sitting next to the resident. During an observation, on 8/16/24 at 11:44 a.m., the resident was sitting at the long dining room table with other residents who required assistance with meals. Her chin was at the level of the table. She was leaning forward and looking down. She was not interacting with others. The clinical record for Resident 3 was reviewed on 8/15/24 at 10:28 a.m. The diagnoses included, but were not limited to, mild cognitive impairment of uncertain or unknown etiology, bipolar disorder, mild depression, and adjustment disorder with	F 0558	Facility has provided resident 3 with a shorter dining table that is at the appropriate height for her on 08/17/24 by Administrator. Residents with shorter stature while sitting in chair or wheelchair have the potential to be affected determined on 8/28/24 by Occupational Therapist. OT screened residents and did not find any resident requiring a change in table height. Currently no other residents are being seen on OT case-load for posture/positioning trials. Nursing and Dietary staff in-serviced by OT or designee on proper table height on 9/3/24. Therapy Director or designee in-serviced OT's and COTA's on documentation requirements to include notation of trialing table height for residents on 8/28/24. OT will complete observation/audits of 5 residents at mealtime in the dining room weekly x 4 weeks; monthly x 3 months, then on a quarterly basis based on MDS schedule to establish new work flow. Therapy Director or designee to audit OT documentation requirements weekly x 4; monthly x 3; quarterly x3. Results of on-going audits will be submitted to QAPI Committee for review and recommendations.	09/13/2024

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	anxiety. A physician's order, dated 7/16/24, indicated occupational therapy (OT) was to evaluate and treat as indicated. OT was to treat the resident for 25 visits in 8 weeks addressing activities of daily living (ADL) retraining, therapeutic activity, therapeutic exercises, and resident/caregiver education. An OT progress note, dated 8/1/24 to 8/13/24, indicated the resident was being seen for active range of motion (AROM) for neck, shoulder, elbow and hand joints to encourage upright sitting, and retraining safety awareness education. On 8/13/24, a note indicated the therapist consulted with the dining room staff and daughter to try a lower dining table. The resident was able to reach food at the time and would continue to monitor. During an interview, on 8/16/24 at 11:53 a.m., RN 6 indicated there was one adjustable table and pointed to the table in the middle, near the half wall, where a patient and another staff member were sitting. During an interview, on 8/16/24 at 12:05 p.m., the Director of Nursing (DON) indicated the resident had been sitting at a lower table before, but the resident was moved due to therapy wanting the resident to improve her posture. A review of the resident's therapy notes did not indicate to seat the resident at a dining table which came to the level of her chin. A current facility policy, titled "Resident Rights and Responsibilities," dated as last reviewed 5/2022 and received from DON on 8/19/24 at 10:01			

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	a.m., indicated " ...You have the right to be treated with respect and dignity, including the right to...reside and receive services in the facility with reasonable accommodations of your needs and preferences ...." 3.1-3(v)(1)			
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the			

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	resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed.			
	Based on observation, interview and record review, the facility failed to ensure a resident's functional limitation in range of motion was included in the comprehensive care plan for 1 of 2 residents reviewed for mobility. (Resident 53) Finding includes: During an observation, on 8/13/24 at 2:01 p.m., Resident 53 had contractures of the fingers on both hands. The clinical record for Resident 53 was reviewed on 8/15/24 at 12:15 p.m. The diagnoses included, but were not limited to, myoclonus (sudden, involuntary muscle jerks, shakes or spasm), polyosteoarthritis (arthritis affecting five or more joints at once), and right shoulder pain. An occupational therapy (OT) service note, dated 4/17/24, indicated both resident's hands had minimum to moderate arthritis deformities but were	F 0656	Resident 53's care plan has been updated to include functional limitation in range of motion of upper extremities which included resident's hands from arthritis on 8/15/24 and 8/28/24 by DON. Residents with functional limitation in range of motion have the potential to be affected determined by MDS Coordinator on 8/28/24. Identified resident's care plans have been reviewed and updated to reflect parts of the body affected by arthritis or cause of limitation. Comprehensive Care Plan Policy updated to ensure inclusion of parts of body with functional limitation in range of motion. Care plan team in-serviced on revised policy by DON on 9/4/24. MDS Coordinator or designee to audit that functional limitations of	09/13/2024

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	functional with maximum difficulty. A Minimum Data Set (MDS) assessment, dated 4/23/24, indicated the resident had a functional limitation in range of motion of her upper extremities which could include, the shoulders, elbows, wrists and hands. A care plan, initiated 4/16/24, indicated the resident had polyosteoarthritis. The care plan did not include the parts of the body affected by arthritis. During an interview, on 8/19/24 at 3:08 p.m., the Assistant Director of Nursing (ADON) indicated the occupational therapist note showed the resident had arthritic changes in her hands. A current policy, titled "Care plan, Comprehensive," dated as last reviewed on 7/2021 and received from the Administrator on 8/20/24 at 11:47 a.m., indicated "...The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS...Each resident's comprehensive care plan is designed to describe...Identified problem areas...Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change...The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans...After each assessment, including both the comprehensive and quarterly review assessments..." 3.1-35(a)		residents are included in the comprehensive care plan weekly based on the MDS schedule x 4 weeks; monthly x 3; quarterly x 3. Results of on-going audits will be submitted to QAPI Committee for review and recommendations.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care			

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	Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview and record review, the facility failed to ensure a resident's bruising was documented as being assessed and monitored and to ensure out of range glucometer readings were reported to the physician as ordered for 3 of 3 residents reviewed for quality of care. (Resident 124, 15 and 12) Findings include: 1. During an observation, on 8/13/24 at 1:43 p.m., Resident 124 had purple bruising on the left side of her face on her cheek. The bruising was the size of two 50 cent pieces put together. The clinical record for Resident 124 was reviewed on 8/13/24 at 1:43 p.m. The diagnoses included, but were not limited to, vascular dementia with other behavioral disturbance, severe major depressive disorder with psychotic symptoms, generalized anxiety disorder, and chronic obstructive pulmonary disease. A care plan, dated 7/18/24, indicated the resident had a potential for impaired skin integrity due to her poor physical condition, limited mobility, dementia, and incontinence. The goal included the resident would be free of injury. The interventions included, but were not limited to, provide skin hygiene every shift and report skin concerns to the nurse and physician.	F 0684	Resident 124 left cheek bruised area assessed (including size, appearance, origin of bruising, date of first identified, and healing process) on 8/16/24, 8/23/24, and 8/29/24 by DON. MD and resident representative updated on bruising on 8/16/24. Resident 12's and 15's accuchecks for August 2024 reviewed. MD notified of all blood sugars below or above call parameters by DON for resident 12 on 8/13/24 and Unit Manager for resident 15 on 8/13/24. Residents who have accucheck orders with call parameters have the potential of being affected determined by DON on 8/16/24. Identified resident's accuchecks for August 2024 reviewed and notifications were appropriate. Residents currently with bruising have the potential to be affected as determined by ADON on 8/19/24. Identified residents assessed by DON or designee. Assessment and documentation completed (including size, appearance, cause of bruising, date of first identified, and healing process). MD and resident	09/13/2024

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	A progress note, dated 7/21/24 at 7:10 p.m., indicated the nurse was notified the resident was observed on the floor. The resident was sitting on the floor next to the bed. The resident stated she had rolled over. The resident had a hematoma and bruising to the left forehead and no other injuries were noted. The progress note did not include bruising to the left side of the resident's cheek. A progress note, dated 7/24/24, indicated the resident was noted to be sitting upright in front of the closet door to her room with her knees drawn up and her arms wrapped around them. The resident had bloody drainage from the left side of her head above the ear. There was a small laceration 1.2 centimeters long, 0.1 centimeters in depth, and 0.2 centimeters in width. A physician's order, dated 7/24/24, indicated to monitor a left forehead hematoma each shift for signs of infection. An interdisciplinary team (IDT) progress note, dated 7/25/24, indicated the resident was reviewed in the safety committee. The resident declined an interview to gather more information about the fall. The fall appeared to have happened while the resident was attempting to get in the closet. The IDT note did not include any information about the bruising on the resident's face. A Fall QS (every shift) documentation, dated 7/28/24, indicated the resident's hematoma was starting to resolve and bruising was noted down the side of the resident's face from the hematoma.		representative updated on bruising if indicated. Physician Notification Policy revised for blood glucose notification. Accucheck orders amended to include prompt for nursing in supplementary documentation to include MD notification. Weekly and QS Non-Pressure Skin Assessment revised to include date of first identified, origin of bruise, size, appearance, and healing process. Nursing staff in-serviced by DON on 9/3/24 regarding revision on Physician Notification Policy, new supplementary documentation prompt for accuchecks, and revised Weekly and QS Non-Pressure Skin Assessment. DON or designee will complete daily audits on accuchecks with call parameters to ensure appropriate notification have been completed x 2 weeks; followed by weekly x 4 weeks; monthly x 3 months; quarterly x 3 quarters. DON or designee to complete audit of residents with bruising assessments for accuracy and completion weekly x 4; monthly x 3; quarterly x 3. Results of on-going audits will be submitted to QAPI Committee for review and recommendations.	

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	The documentation did not include where the hematoma was located or the size of the bruising. A skin assessment, dated 7/31/24, indicated the resident's forehead hematoma had resolved. The resident had bruising on the left side of her cheek. The skin assessment did not include any measurements of the bruising or how much of the cheek was bruised. An occupational therapy daily note, dated 8/1/24, indicated the resident had a bruised left forehead and face. The therapy note did not include the size of the bruising or measurements of the area. A skin assessment, dated 8/16/24, indicated the resident had a left cheek bruise 3.3 centimeters in length and 4 centimeters in width. The area was dark purple in the center and the surrounding area had reddish hues on the edges. The skin assessment did not include how the bruising to the left side of the cheek occurred or the date the bruising was first located. During an interview, on 8/19/24 at 3:10 p.m., the Assistant Director of Nursing (ADON) indicated the resident had a fall on 7/21/24 and had bruising to the left forehead. The resident fell on 7/23/24 and had an abrasion to her ear. The resident was also on Xarelto (a blood thinner) and prednisone (for inflammation) during the time of the falls. Her healing was delayed due to the medications. The documentation did not show the bruising was being followed.2. The clinical record for Resident 12 was reviewed on 8/15/24 at 9:56 a.m. The diagnoses included, but were not limited to,			

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	diabetes mellitus, respiratory failure, chronic pulmonary edema, cognitive communication deficit, major depressive disorder, anxiety disorder, end stage renal disease, and hypertension. A physician's order, dated 8/3/24, indicated to obtain an Accu check (test used to estimate blood sugar levels) before meals and at bedtime. Call the physician if the blood sugar level was less than 60 or greater than 490. A Medication Administration Record (MAR), dated August 2024, indicated the following: a. On 8/3/24 at 8:00 p.m., the blood glucose level was 56. b. On 8/5/24 at 6:00 a.m., the blood glucose level was 51. c. On 8/5/24 at 4:00 p.m., the blood glucose level was 53. d. On 8/5/24 at 8:00 p.m., the blood glucose level was 51. e. On 8/7/24 at 4:00 p.m., the blood glucose level was 52. f. On 8/9/24 at 6:00 a.m., the blood glucose level was 56. g. On 8/11/24 at 6:00 a.m., the blood glucose level was 49. A care plan, dated 6/17/24 and last revised 8/12/24, indicated the resident had diabetes mellitus (DM). The interventions included, but were not limited to, monitor blood sugars and to notify the physician of results as ordered. There was no documentation, from 8/1/24 to 8/17/24, to indicate the physician was notified of the blood glucose levels less than 60. During an interview, on 8/15/24 at 2:37, the DON			

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	indicated it was her expectation the staff would follow the physician's order. When the blood glucose fell within the call range, the physician should be notified. The nurses should follow the physician's order. 3. The clinical record for Resident 15 was reviewed on 8/15/24 at 9:52 a.m. The diagnoses included, but were not limited to, diabetes mellitus, dementia, anxiety disorder, and cognitive communication deficit. A care plan, dated as revised 7/3/24, indicated the resident had diabetes mellitus (DM). The interventions included, but were not limited to, monitor blood sugars and to notify the physician of results as ordered and to monitor for hyperglycemia (high blood glucose level). A physician's order, dated 8/13/24, indicated to get an Accu-check before meals and at bedtime. Notify the physician for a blood sugar less than 60 or greater than 400. A Medication Administration Record (MAR), dated August 2024, indicated the following: a. On 8/7/24 at 6:00 p.m., the blood glucose level was 452. b. On 8/14/24 at 6:00 p.m., the blood glucose level was 454. There was no documentation, from 8/1/24 to 8/17/24, to indicate the physician was notified of the blood glucose levels out of range. During an interview, on 8/15/24 at 4:11 p.m., the DON indicated there was no documentation the physician was notified of the high blood glucose levels.A current policy, titled "Physician Notification, Change in Condition," dated as last			

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	reviewed on 8/2021 and received from the DON on 8/15/24 at 4:00 p.m., indicated "...To ensure that significant changes in resident status are based on the assessments which are to be documented in the medical record and medical care problems are communicated to the attending physician in a timely, thorough manner...When contacting physicians, the nurse should attempt to have the following information available...change in vital signs outside physician ordered parameters, general guidelines or normal parameters for the resident...Blood sugar >300 or <60... Laboratory values...Any of the following abnormal reports unless otherwise directed by physician...Any of the following abnormal reports unless otherwise directed by physician...Glucose >300 or <60 in a diabetic on oral hypoglycemic medication, insulin or <60 for any resident (diabetic or non-diabetic)...." A current policy, titled "Skin Condition Assessment," dated as last reviewed on 10/2022 and received from the DON on 8/19/24 at 3:15 p.m., indicated "...Each resident will be observed for skin concerns daily during care and on the assigned bath day by nursing staff. Any concerns will be reported to the charge nurse who will assess the area and document accordingly...Skin observations that should be reported include...bruises... A separate skin report will be completed for each identified skin problem area...Previous measurements will be reviewed..." 3.1-37(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic			

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	155604	A. BUILDING 00 B. WING	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY REHAB AND NURSING CENTER	1205 N 14TH ST LAFAYETTE, IN 47904

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, interview and record review, the facility failed to ensure a staff member followed the policy and procedure when verifying the gastrostomy tube (g-tube) placement prior to medication administration for 1 of 1 resident reviewed for a gastrostomy tube. (Resident 9) Finding includes: During a medication administration observation, on 8/16/24 at 1:50 p.m., Registered Nurse (RN) 4 placed 60 milliliters (ml) of water into a piston and attached it to the resident's g-tube. RN 4 then pushed the 60 ml of water into the tube and pulled back on the syringe. She then indicated there was no tube feeding (residual). During an interview, on 8/19/24 at 12:45 p.m., RN 4 indicated she pushed the water into the g-tube first and then pulled back on the syringe. This	F 0693	Resident 9's g-tube placement verified by checking residual. Tube in place and flushes easily. RN 4 educated on proper procedure on 8/16/24 by ADON. Currently facility does not have any other residents with g-tubes. Nursing staff in-serviced on protocol for g-tube placement verification by DON on 9/3/24. Competency check offs for nursing staff on procedure for g-tube placement by DON or designee on 9/3/24. Nursing competency check off for g-tube placement will be included in orientation process. DON or designee will observe medication administration with placement verification of g-tube 2x/weekly x 4 weeks; monthly x	09/13/2024

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	was how she checked for the residual and did not know what the facility policy indicated. A current policy, titled "Enteral Tube Medication Administration," not dated and received from the Director of Nursing on 8/16/24 at 2:21 p.m., indicated "...With gloves on, check for proper tube placement by checking stomach contents (residual). Never check placement with water. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100ml...." 3.1-44(a)(1)		3; quarterly x 3. Results of on-going audits will be submitted to QAPI Committee for review and recommendations.	
F 0919 SS=E Bldg. 00	483.90(g)(1)(2) Resident Call System §483.90(g) Resident Call System The facility must be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from- §483.90(g)(1) Each resident's bedside; and §483.90(g)(2) Toilet and bathing facilities. Based on observation, interview and record review, the facility failed to ensure all areas of the wireless call system were functioning properly for 5 of 5 halls reviewed for the call system. (Hall A, B, C, D and E) Finding includes: During a resident council meeting, on 8/15/24 at 2:03 p.m., Resident 56 indicated the call light notifications would go to the staff phones. The residents could not tell if the call request had been received since there was no light which turned on. Sometimes during the night, it would take a long	F 0919	Hallways A, B, C, D, E call light system functioning properly. Verified by Administrator on 8/16/24. Reeducation completed to address concerns voiced during staff interviews for RN 2, 3 and 4 on 8/16/24 by DON. Label with passcode placed on iPads for all users on 8/16/24 by Administrator. All residents have the potential to be affected by call light system. Monitors placed at centralized staff work area (both nurse's stations) on 8/27/24 by	09/13/2024

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	time for her roommate's call light to get answered. Resident 56 would then call the nurses desk and the staff would respond to the request for help. During an observation, on 8/16/24 at 11:18 a.m., Registered Nurse (RN) 2 indicated the call system was new and the old call lights in the hallway no longer worked. If a resident activated a call light, the staff would get notification on their phone. The phone would make a noise or vibrate. The call light was tested in Room 143. RN 2 pressed the resident's call light button. RN 2 then turned up the volume on her phone and the phone made a ding sound. During an observation, on 8/16/24 at 11:26 a.m., RN 3 indicated she used her own phone for the call lights. The phone was in her pocket and was turned off. RN 3 turned on her phone and turned up the volume. During an interview, on 8/15/24 at 2:40 p.m., the Director of Nursing (DON) indicated the facility installed a new call light system. The residents could not see or hear the call lights and thought the lights did not work. The facility provided the residents with bells to ring. During an interview, on 8/16/24 at 11:18 a.m., RN 2 indicated the nurses, Certified Nursing Assistants (CNA), and the management team carried phones. The only way they were notified of a call lights were by their own phones or the staff could get a facility phone at the front desk. RN 2 indicated the staff could also check on an iPad (electronic device) on each hall. RN 2 opened the iPad screen and did not know the password to access the call light system. During an interview, on 8/16/24 at 11:28 a.m., RN 4 indicated the CNAs answered the call lights and		Administrator. Monitors will provide visual and audible alerts to staff of call lights. In addition, staff will continue to use iPads, facility phones, and personal phones for visual and audible notifications of call lights. Revision of Call Light Policy and Procedure for placement of monitors. All staff in-serviced on new devices and Call Light Policy and Procedure on 8/31/24 by DON. New employees will receive training on Call Light Policy and Procedure. Administrator or designee will complete audits of call light system including 10 random testing of call lights, 5 staff interviews on knowledge of call light system, and 5 residents resident interviews for any concerns regarding call lights weekly x 4; monthly x 3; quarterly x 3 quarters. Results of on-going audits will be submitted to QAPI Committee for review and recommendations.	

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	"she did other things". During an interview, on 8/16/24 at 11:36 a.m., the DON indicated anyone could answer a call light. She did not know what staff took the phones from the desk. A current policy, titled "Call Lights," dated as revised 6/2024 and received from the Director of Nursing on 8/19/24 at 9:59 a.m., indicated "...All personnel, unless otherwise directed by the Administrator or designee, must always be vigilant and aware of call lights. The notify app will be downloaded to the device being utilized for alerts. This would include personal phones, facility phones, and iPads. The call light button or pad will be accessible to the resident while in their bed or other sleeping accommodations, and/or while sitting in a chair in the resident's room...Answer all call lights promptly, regardless of the resident assignment...At the beginning of the shift, staff will log in to the Notifync app on their device. Scroll to username. Enter 6-digit PIN. Set your zone located under "profile" or wheel symbol in right lower corner. Go to "alerts" or lightning symbol in left lower corner. When the resident activates the call light within their living area, the device being used will receive an alert and the room number will appear on the device. It will appear as a red alert. Note what area the alert is coming from i.e. bed A, bed B, bathroom then Hit the green "take" button on the device...In the event of system or power failure: Each resident will be provided with a bell to ring manually. For those residents unable to utilize a bell, frequent and periodic rounds will be conducted...." 3.1-19(u)			