STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155825	A. BUILDING 00 B. WING	09/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: September 16, 17, 18, 19 and 20, 2024. Facility number: 000389 Provider number: 155825 AIM number: 100288920 Census Bed Type: SNF/NF: 20 Residential: 13 Total: 33 Census Payor Type: Medicare: 1 Medicaid: 16 Other: 3 Total: 20 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on September 30, 2024.	F 0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective October 21, 2024. We respectfully request a desk review of our Plan of Correction.	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g)(12)(i)-(v) Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir Based on interview and record review, the facility failed to ensure a resident's code status was obtained and accurately documented in the clinical record for 1 of 1 resident reviewed for advanced directives. (Resident 171)	F 0578	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident 171's medical chart was	10/21/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Steven M. Still, MPA	Administrator	10/10/2024

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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	Finding includes: The clinical record for Resident 171 was reviewed on 9/16/24 at 2:58 p.m. The diagnoses included, but were not limited to, hypertension, severe protein-calorie malnutrition, hemorrhage from respiratory passages, and anemia. Resident 171 was admitted to the facility on 9/5/24. A document, titled "Long-Term Care Patient Summary," with post-acute care discharge instructions, dated 8/2/24, indicated Resident 171 did not have advanced directives. A document, titled "Indiana Physician Orders for Scope of Treatment (POST)," was prepared on 8/21/2024. The designation of the resident's preferences related to, attempt resuscitation/CPR, or do not attempt resuscitation/DNR was left blank. A code status was not documented on the face sheet. There was no order addressing code status found in the record. A baseline care plan meeting, completed on 9/10/24, lacked documentation to show a discussion was had with the resident or resident representative regarding code status preferences. A code status preference was not documented in the care plan for Resident 171. During an interview, on 9/16/24 at 3:00 p.m., RN 3 indicated a newly admitted resident should have a code status preference documented in their		corrected and completed with an executed Physician Orders for Scope of Treatment (POST) form on September 17, 2024. (See F578 POST form-Redacted) **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.** An audit of all resident charts was performed on October 8, 2024. No corrections to any additional charts were indicated. (See F578 Advanced Directive Audit-Redacted) **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Staff responsible for the acquisition of POST forms and /or advanced directives will be in-serviced on October 17, 2024, as to policy and procedure. (See F578 Advanced Directive In-Service Syllabus) **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place.** Each new admission will be audited by the Social Services Director, or her designee, using	

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	clinical record within 24 hours after being admitted. If a code status was not present in the clinical record, staff would treat the resident as a full code and would perform CPR. During an interview, on 9/16/24 at 3:06 p.m., the Director of Nursing (DON) indicated Resident 171 did not have a code status documented in his clinical record. The DON was not aware if the resident's preferences was to attempt resuscitation/CPR, or do not attempt resuscitation/DNR due to it was left blank on the POST form. Residents were seen by the physician within 72 hours after admission and a code status would then be documented in the clinical record. The POST form in the clinical record was from Resident 171's previous place of residence. During an interview, on 9/17/24 at 3:05 p.m., the DON indicated the Social Service Director (SSD) had seen the original POST form for Resident 171 in the clinical record and did not initiate the code status process upon admission. A current policy, titled "Advance Directive," dated as last revised 8/2017 and received from the DON on 9/22/24 at 11:18 a.m., indicated "...Document on admission, that Advance Directives exist and place a copy of the Advance Directives in the Resident Medical Record...As Advance Directive are completed or modified, a current copy is kept within the Medical/Nursing Chart...Assist with communication of the Advance Directives, as necessary, to physician, Home staff, hospital staff, Resident, Resident Representative and Family according to Resident's desires...." 3.1-4(f)(4)(A)(ii) 3.1-4(f)(5)		the audit tool (See F578 Advanced Directive Audit Tool). Results of the admission audit will be presented to, and reviewed by, the QAPI committee at its monthly meeting. The Social Worker is responsible to maintain compliance. **By what date the systemic changes for each deficiency will be complete.** October 21, 2024	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on interview and record review, the facility failed to ensure a resident was assessed and treated for constipation, to ensure a resident was assessed for complications of congestive heart failure and to notify the physician of weight gains outside of the physician's ordered parameters for 3 of 3 residents reviewed for quality of care. (Resident 12, 18 and 11) Finding includes: 1. The clinical record for Resident 12 was reviewed on 9/17/24 at 2:31 p.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, asthma, and constipation. The bowel movement documentation indicated the resident had not had a bowel movement from 8/27/24 to 8/31/24 (5 days). There was no abdominal assessment noted in the record. A physician's order, initiated on 8/31/23, indicated "...BOWEL CONSTIPATION PROTOCOL: do not go more than 2 days without a bowel movement, take Miralax 17 grams in 8 ounces of fluids as needed for constipation...." A physician's order, initiated on 6/21/24, indicated to give half a scoop of Miralax 17 grams in the morning for constipation. A physician's order, initiated on 4/19/24, indicated to give Senna-Docusate Sodium 8.6-50 milligram tablet as needed for constipation twice a day.	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility policies for bowel protocol, weight protocol, and care plan updating have been reviewed and updated. The facility will in-service nursing staff, including CNAs, QMAs, and nurses regarding the revised bowel protocol to make sure proper documentation of BM's is done every shift. Nurses and QMA's will be in-serviced on monitoring "alerts" in our electronic health record system (PCC) daily for any resident who is not documented as having a BM in 3 days, and nurses' assessment for constipation will also be reviewed as part of the in-service. (See F684, F690, F695, F880 In-Service Syllabus) As part of the in-service, Nurses, CNAs and QMAs will be educated on the weight protocol including rechecking of weights and physician notification of losses or gains. Nurses will be re-trained on assessment of lung sounds, presence or absence of edema, physician notification, chest pain present or absent, and documentation of all actions taken by the nursing staff. (See	10/21/2024

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	A physician's order, initiated on 4/19/24, indicated to give Senna-Docusate Sodium 8.6-50 milligrams daily for constipation. A care plan, initiated on 3/30/22, indicated the resident had a potential for constipation related to decreased mobility and medications. Interventions included, but were not limited to, administer stool softener/ laxative as ordered, monitor for symptoms of constipation such as abdominal pain, a distended abdomen and bowel sounds, and administer as needed medications (to promote a bowel movement) after three days. During an interview, on 9/20/24 at 8:45 a.m., RN 1 indicated bowel movements were to be charted by the CNA. The nurse would talk with the resident and ask when they last had a bowel movement. If no bowel movement after three days, then the bowel assessment was to be done and charted in the notes. If the resident had an order for medication the nurse was to administer the medication. If there was no order, the nurse would contact the physician. During an interview, on 9/20/24 at 3:55 p.m., the Director of Nursing indicated she was not able to find documentation of a bowel movement from 8/27/24 to 8/31/24 or an assessment which was completed. The staff should ask the resident if they have had a bowel movement (if not documented) and then follow the facility bowel movement protocol. The protocol consisted of increasing fluids and assessing the bowel sounds. 2. The clinical record for Resident 18 was reviewed on 9/17/24 at 3:33 p.m. The diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure with hypoxia, and		In-Service Syllabus) MDS Coordinator reviewed facility policy regarding the updating of care plans to be current with each resident's status, including physician orders and condition changes. (See F684 Care Plan Audit-Redacted) **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The bowel protocol has been reviewed and revised for all residents. The weight protocol has been reviewed and revised for all residents. Charge nurses have reviewed all residents to make sure that they meet the revised bowel protocol including resident #12. This review and any action taken because of the revised bowel protocol is documented in each resident's medical record. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** All residents will now be monitored as indicated in the revised bowel protocol:	

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	chronic kidney disease. The documented weights indicated the resident weighed 165.3 pounds on 9/2/24 and 170.4 pounds on 9/3/24 which indicated a gain of 5.1 pounds in a 24-hour period. There was no assessment of the lung sounds, edema, or chest pain found in the record. There was no documentation the weight was rechecked for accuracy and there was no note to indicate the physician had been informed of the weight gain. A physician's order, dated 5/31/24, indicated to weigh the resident daily in the morning and to report to the physician a weight gain of greater than three pounds in 24 hours or five pounds in a week for a diagnosis of congestive heart failure. A physician's order, initiated 7/4/24, indicated to encourage a fluid restriction of 1500 milliliters (ml) daily for chronic heart failure. A current care plan, revised on 12/4/23, indicated the resident was at risk for complications due to congestive heart failure, atrial fibrillation and hypertension. She would be free of complications and have clear lung sounds and the heart rate and rhythm would be within normal limits. Interventions included, but were not limited to, monitor for difficulty breathing, weight gain, edema and chest pain, contact the physician as indicated, and weight monitoring as ordered. A current care plan, revised on 8/7/24, indicated the resident was at risk for dehydration related to diuretic therapy, edema, hypertension, congestive heart, and a history of hyponatremia (low sodium levels) with a fluid restriction. Interventions included, but were not limited to, monitor weights		May have 8oz prune juice daily as needed for no BM for 24 hours, unless contraindicated. May have Miralax 17gm daily as needed for no BM for 48 hours, unless contraindicated or is already routinely receiving this medication. May have Dulcolax suppository daily as needed for no BM for 72 hours, unless contraindicated. In addition, the nurses' assessment of the resident and the physician's notification will be documented in the medical record. Audits of staff compliance with the bowel protocol will be done at least 3 times a week for the first month, weekly for the next month, and then monthly for the 3rd month. The audit reports will be reviewed by the DON, Staff Development nurse or designee for any needed follow up. (See F684 QA Audit Tool 2024-Bowel) The results of resident audits and the need for any further staff re-education will be discussed with nurses as indicated. Audits of staff compliance with the weight protocol will be done at least 3 times a week for the first month, weekly for the next month, and then monthly for the 3rd month. The audit reports will be reviewed by the DON, Staff Development nurse or designee for any needed follow-up. (See QA Audit Tool 2024-Weights) The	

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	as ordered and consult the physician as indicated. During an interview, on 9/20/24 at 8:45 a.m., RN 6 indicated residents with a diagnosis of congestive heart failure (CHF) should have their oxygen saturation levels assessed per physician's order. Daily weights were to be completed, and the physician notified if there was a weight gain. A respiratory assessment was to be done, a reweigh of the resident, and check the resident for edema and skin turgor. An SBAR (a type of assessment to relay information to the physician) should be completed. If after notifying the physician there were new orders, carry out the orders and continue to monitor the resident.3. The clinical record for Resident 11 was reviewed on 9/17/24 at 2:41 p.m. The diagnoses included, but were not limited to, unspecified dementia, hyperlipidemia, age related osteoporosis, and unspecified atherosclerosis of native arteries of bilateral legs. A physician's order, with a start date of 7/1/24, indicated if a gain or loss of 4 pounds since the last weight, then weigh 4 days consecutively and notify provider if the gain or loss was valid. A vitals log indicated the following weights: On 7/1/2024, the weight was 157.0 pounds. On 8/1/2024, the weight was 156.7 pounds. On 9/1/2024, the weight was 161.5 pounds. On 9/1/24, the resident gained 4.8 pounds compared to the last weight. There was no documentation in the record to indicate the resident had been weighed for 4 days after the weight gain or notification to the provider of the gain had occurred. During an interview, on 9/19/24 at 3:07 p.m., the		results of resident audits and the need for any further staff re-education will be discussed with nurses as indicated. If a resident is identified as not being followed up as per the bowel protocol or physician orders, the DON or Staff Development nurse will attend to the resident's care first. Once that has occurred, the DON, Staff Development nurse or designee will review the bowel protocol with the staff involved. Future noncompliance with the protocol will be addressed with individual counseling/ discipline as per facility policy. If a resident is identified as not being followed up as per the weight protocol or physician orders, the DON, Staff Development nurse or designee will attend to the resident's care first. Once that has occurred, the DON/Staff Development nurse or designee will review the weight protocol with the staff involved. Future noncompliance with the protocol will be addressed with individual counseling/ discipline as per facility policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into plac**e. The DON or designee will bring the results of the audits for	

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	Director of Nursing (DON) indicated she did not see documentation to indicate the resident was weighed for those 4 days per the order. During an interview, on 9/20/24 at 10:52 a.m., the DON indicated the expectation was staff would follow the physician's orders and if they had any questions, they would call the physician. A current facility policy, titled "WEIGHT, LOSS OR GAIN," dated as revised in 8/2018 and received from the Director of Nursing on 9/20/24 at 11:10 a.m., indicated "...A Resident with weight gain should be assessed and monitored for signs and symptoms of Congestive Heart Failure...." A current facility policy, titled "Weights, Techniques," dated as revised 8/2018 and received from the Director of Nursing on 9/20/24 at 11:11 a.m., indicated "...Residents with a three to five (3-5) lb. loss or gain are reported to the nurse, Supervisor of Director of Nursing...." A current facility policy, titled "Congestive Heart Failure," dated as reviewed 1/2023 and received from the Director of Nursing on 9/19/24 at 2:24 p.m., indicated "...In the event of any symptoms of CHF (Congestive Heart Failure) of a Resident, the Physician, Resident Representative, Family will be notified by the Charge Nurse under whose supervision the Resident has been delegated, immediately...Common symptoms are...Weight gain...." A current facility policy, titled "BOWEL AND BLADDER PROGRAM SCHEDULE," was received from the Director of Nursing on 9/20/24 at 11:11 a.m. The policy did not address a bowel protocol.		compliance of the bowel protocol and weight protocol along with the planned schedule for doing the audits to the monthly QAPI committee meeting for review and further recommendations. At the end of the audit schedule, the committee members may decide that regular reporting of the bowel protocol or weight compliance is no longer needed. The DON is responsible for assuring compliance. **By what date the systemic changes for each deficiency will be complete.** October 21, 2024	

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F 0690 SS=D Bldg. 00	3.1-37(a) 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on interview and record review, the facility failed to ensure urinary output was monitored as ordered by the physician for 1 of 1 resident reviewed for catheter care. (Resident 18) Finding includes: The clinical record for Resident 18 was reviewed on 9/17/24 at 3:33 p.m. The diagnoses included, but were not limited to, cerebral ischemia (acute brain injury from impaired blood flow to the brain), heart failure, and chronic respiratory failure with hypoxia (a condition which occurs from lack of oxygen in the blood). A care plan, initiated on 4/27/23, indicated the resident had an indwelling catheter related to bladder obstruction and urinary retention. The interventions included, but were not limited to, monitor and document urinary output per the facility policy. A physician's order, initiated on 4/6/23, indicated to record urinary output every shift. The Medication and Treatment Record, for August 2024, was missing urinary output documentation on the night shift for August 1st, the evening shift on August 18th, the night shift on August 21st, and the day shift on August 27th. During an interview, on 9/20/24 at 8:45 a.m., RN 1 indicated urinary output was to be documented on the Medication Administration Record.	F 0690	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility will in-service nursing staff, including CNAs, QMAs, and Nurses regarding the facility policy for care of residents with Foley catheters and documentation of catheter output. (See F684, F690, F695, F880 In-Service Syllabus) The MDS Coordinator will review the facility policy regarding the updating of care plans to be current with each resident's status, including physician orders and condition changes. The MDS Coordinator will create an audit tool regarding review of care plans. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** Nurses will be responsible for documenting urinary output information every shift while residents have a Foley catheter. All residents who have a Foley catheter have been checked and are current with output documentation.	10/21/2024

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	A current facility policy, titled "...INTAKE AND OUTPUT," dated as last revised in 01/2024 and received from the Infection Preventionist on 9/20/24 at 4:40 p.m., indicated "...To ensure adequate hydration levels of certain Residents and to assist in their assessment and management by using I & O (intake and output) record...I&O records are kept on Residents with the following...Foley catheters...record output from catheters...." 3.1-41(a)(2)		**What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Audits of staff compliance with a Foley catheter will be done at least 3 times a week for the first month, weekly for the next month, and then monthly for the 3rd month. The audit reports will be reviewed by the DON, Staff Development nurse or designee for any needed follow up. The results of resident audits and the need for any further staff re-education will be discussed with nurses as indicated. (F690 QA Audit Tool 2024-catheter output) If a resident with a Foley catheter is identified as not being followed up as per physician orders or as per care plan interventions, the DON, Staff Development nurse or designee will attend to the resident's care first. Once that has occurred, the DON, Staff Development nurse or designee will review the Foley catheter policy with the staff involved. Future noncompliance with the protocol will be addressed with individual counseling/ discipline as per facility policy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put**	

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			into place. The DON or designee will bring the results of the audits for compliance of Foley catheter care and documentation of output along with the planned schedule for doing the audits to the monthly QAPI committee meeting for review and further recommendations. At the end of the audit schedule, the committee members may decide that regular reporting of the Foley catheter audit is no longer needed. Even though written audits may not continue, the processes in place to monitor compliance will continue. The DON is responsible for assuring compliance. **By what date the systemic changes for each deficiency will be complete.** October 21, 2024	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated for the day it was changed for 3 of 3 residents reviewed for respiratory care. (Residents 18, 12 and 10) Findings include: 1. During an observation, on 9/17/24 at 9:35 a.m., Resident 18 was observed in a recliner in her room. She was found to be using supplemental oxygen at two (2) liters per minute through a nasal cannula. The oxygen line did not have a date to	F 0695	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The facility policy has been updated to include the care of oxygen tubing. The facility will in-service nursing staff, including CNAs, QMAs, and nurses regarding the facility policy for care of residents with respiratory equipment, including oxygen	10/21/2024

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	155825	A. BUILDING 00 B. WING	09/20/2024

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ST AUGUSTINE HOME FOR THE AGED	2345 W 86TH ST INDIANAPOLIS, IN 46260

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	show when the oxygen tubing had been changed. The clinical record for Resident 18 was reviewed on 9/17/24 at 3:33 p.m. The diagnoses included, but were not limited to, cerebral ischemia (acute brain injury from impaired blood flow to the brain), heart failure, and chronic respiratory failure with hypoxia (a condition which occurs from lack of oxygen in the blood). A physician's order, initiated on 7/11/24, indicated to provide oxygen at two (2) liters per minute via nasal cannula for chronic respiratory failure with hypoxia. 2. During an observation, on 9/16/24 at 10:33 a.m., Resident 12 was up in sitting up in her room. She was found to be using supplemental oxygen at two (2) liters per minute through a nasal cannula. The oxygen line did not have a date to show when the oxygen tubing had been changed. The clinical record for Resident 12 was reviewed on 9/17/24 at 2:31 p.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, asthma, and chronic obstructive pulmonary disease (COPD). A physician's order, initiated on 3/12/23, indicated to change and date the oxygen tubing and storage bags every evening shift on Tuesday. A care plan, revised on 5/29/24, indicated the resident had a potential for respiratory complications due to COPD, asthma, chronic respiratory failure with hypoxia, pulmonary fibrosis, and chronic heart failure. She required supplemental oxygen. 3. During an observation, on 9/16/24 at 12:19 p.m.,		tubing. (F684, F690, F695, F880 In-Service Syllabus) The MDS Coordinator will review to ensure care plan interventions are completed as part of the resident's care, and that the resident's care reflects the care plan. **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** All residents who have oxygen tubing have been checked for compliance in changing and dating the oxygen tubing per facility policy. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur.** Audits of staff compliance for oxygen tubing will be done at least 3 times a week for the first month, weekly for the next month, and then monthly for the 3rd month. The audit reports will be reviewed by the DON, Staff Development nurse and charge nurses for any needed follow up. The results of resident audits and the need for any further staff re-education will be discussed as indicated. (See F695 QA Audit Tool 2024-oxygen tubing) **How the corrective action(s) will be monitored to ensure the**	

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	Resident 10 was up in a high back wheelchair in the dining area. He was found to be using supplemental oxygen at two (2) liters per minute through a nasal cannula. The oxygen line did not have a date to show when the oxygen tubing had been changed. The clinical record for Resident 10 was reviewed on 9/20/24 at 12:02 p.m. The diagnoses included, but were not limited to, hypoxemia, heart failure, and obstructive sleep apnea (a sleep disorder which occurs when the upper airway partially or completely collapses during sleep, interrupting breathing). A physician's order, initiated on 8/5/20, indicated the resident may use oxygen at two liters per minute. A care plan, revised on 9/4/24, indicated the resident required supplemental oxygen to maintain adequate oxygenation. During an interview, on 9/17/24 at 2:27 p.m., the Director of Nursing indicated the oxygen tubing should be changed weekly, and the tubing should be labeled with the date it was changed. A current facility policy, titled "OXYGENATOR," dated as last revised in 8/18 and received from RN 1 on 9/18/24 at 10:46 a.m., indicated "...Nasal cannula/face mask and humidifier must be changed weekly...." 3.1-47(a)(6)		**deficient practice will not recur, i.e. what quality assurance program will be put into plac**e. The DON or designee will bring the results of the audits for compliance in changing oxygen tubing along with the planned schedule for doing the audits to the monthly QAPI committee meeting for review and further recommendations. At the end of the audit schedule, the committee members may decide that regular reporting of the oxygen tubing audit is no longer needed. Even though written audits may not continue, the processes in place to monitor compliance will continue. The DON is responsible for assuring compliance. **By what date the systemic changes for each deficiency will be complete.** October 21, 2024	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on interview and record review, the facility	F 0880	**What corrective action(s) will**	10/21/2024

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	failed to monitor the use of antibiotics including the use of standardized tools for the appropriateness of antibiotics prescribed for 1 of 5 residents reviewed for unnecessary medications. (Resident 11) Finding includes: The clinical record for Resident 11 was reviewed on 9/17/24 at 2:41 p.m. The diagnoses included, but were not limited to vitamin D deficiency, hypertension, polyosteoarthritis, and age-related osteoporosis. A physician's order, with a start date of 7/23/24, indicated the resident took Keflex (an antibiotic) oral capsule 250 milligrams (mg). During an interview, on 9/20/24 at 3:27 p.m., the Director of Nursing (DON) indicated their physician did the tracking for antibiotics. She was not aware of anybody who did surveillance using the McGeer criteria (surveillance definitions used to identify infections) in the facility. The nurses would report the signs and symptoms to the physician but did not use a specific protocol. There was no documentation of a surveillance tool used for the resident. A current policy, titled "Antibiotic Stewardship Program," dated 1/2024 and received from the DON on 9/20/24 at 3:45 p.m., indicated "...Infection preventionist - coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff...Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. 4. The program includes antibiotic use protocols and a		**be accomplished for those residents found to have been affected by the deficient practice?** The facility policy has been updated to reflect its efforts at tracking and analyzing the use of antibiotics for the residents. The Antibiotic Stewardship program will use McGeers Criteria to assess antibiotics for appropriateness of use. Tracking of illness and antibiotic use for residents will be done by the Infection Preventionist or designee. The Infection Preventionist or DON will in-service nurses regarding the facility policy for antibiotic stewardship using the McGeers Criteria. (See F684, F690, F695, F880 In-Service Syllabus) **How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken?** The facility has set up a system to keep the Infection Preventionist updated for residents using antibiotics. This will allow her to track antibiotic use and measure it against McGeers Criteria. She will track resident antibiotic use on a format that lists each as it occurs. **What measures will be put into place and what systemic changes will be made to**	

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	system to monitor antibiotic use...The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections...Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to...assessment forms...antibiotic use protocols/algorithms...data collection forms for antibiotic use, process, and outcome measures...." A current policy, titled "Infection Prevention and Control Program," dated 1/2024 and received from the DON on 9/20/24 at 3:45 p.m., indicated "...The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physician's and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections...Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. C. The infection preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program...." 3.1-18(b)(1)(A) 3.1-18(b)(1)(B) 3.1-18(b)(1)(C)		**ensure that the deficient practice does not recur.** The DON and Infection Preventionist will meet at least weekly to review resident illness requiring antibiotic use. Documentation of the antibiotics use and McGeers assessment will also be reviewed. Any concerns on antibiotic overuse for residents will be discussed with the Medical Director. Documentation of the physician's response will be placed with the antibiotic stewardship material for that month. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into plac**e. The DON or Infection Preventionist will bring the results of the antibiotic stewardship tracking for residents to the monthly QAPI committee meeting for review and further recommendations. Regular reporting of infection control issues will occur each month with recommendations by the QAPI committee to be implemented by the Infection Preventionist. She will report the results of those recommendations at the following month's meeting. **By what date the systemic changes for each deficiency will be complete.**	

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: September 16, 17, 18, 19 and 20, 2024 Facility number: 000389 Residential Census: 13 St Augustine Home for the Aged was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality review was completed on September 30, 2024.	R 0000	October 21, 2024 This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of the Plan of Correction is not an admission that a deficiency exists or that one is cited correctly. This Plan of Correction is submitted to meet the requirements established by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction to be considered the facility's allegation of compliance. Compliance is effective October 21, 2024. We respectfully request a desk review of our Plan of Correction.	