PRINTED: 10/25/2024
FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES				OMB NO. 0938-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155825	B. WING		09/20/2024	
	PROVIDER OR SUPPLIED		2345 V	ADDRESS, CITY, STATE, ZIP COD V 86TH ST NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
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F 0000	REGULATORT OF	K ESC IDENTIFTING INFORMATION	IAG		DATE	_
Bldg. 00	Licensure Survey. Residential Licensure Survey dates: Septe 2024.  Facility number: 00 Provider number: 1 AIM number: 1002  Census Bed Type: SNF/NF: 20 Residential: 13 Total: 33  Census Payor Type Medicare: 1 Medicaid: 16 Other: 3 Total: 20  These deficiencies accordance with 41	ember 16, 17, 18, 19 and 20, 00389 55825 88920	F 0000	This Plan of Correction constitute written allegation of compliance for the deficiencie cited. However, the submission the Plan of Correction is not a admission that a deficiency exor that one is cited correctly. The Plan of Correction is submitted meet the requirements establish by state and federal law. St. Augustine Home for the Aged desires this Plan of Correction be considered the facility's allegation of compliance. Compliance is effective Octob 21, 2024.  We respectfully request a desireview of our Plan of Corrections.	s on of n kists This d to shed	
F 0578 SS=D Bldg. 00	483.10(c)(6)(8)(g) Request/Refuse/I Dir Based on interview failed to ensure a re obtained and accura	and record review, the facility esident's code status was ately documented in the	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	n	ļ

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 10/10/2024

Page 1 of 16

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 disclosable

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.

Steven M. Still, MPA

Event ID: L6PB11 Facility ID: 000389 If continuation sheet

Administrator

10/25/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST ST AUGUSTINE HOME FOR THE AGED INDIANAPOLIS, IN 46260 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Finding includes: corrected and completed with an executed Physician Orders for The clinical record for Resident 171 was reviewed Scope of Treatment (POST) form on 9/16/24 at 2:58 p.m. The diagnoses included, on September 17, 2024. (See but were not limited to, hypertension, severe F578 POST form-Redacted) protein-calorie malnutrition, hemorrhage from respiratory passages, and anemia. How other residents having the potential to be affected by the Resident 171 was admitted to the facility on same deficient practice will be 9/5/24. identified and what corrective action(s) will be taken. A document, titled "Long-Term Care Patient An audit of all resident charts was Summary," with post-acute care discharge performed on October 8, 2024. No instructions, dated 8/2/24, indicated Resident 171 corrections to any additional did not have advanced directives. charts were indicated. (See F578 Advanced Directive A document, titled "Indiana Physician Orders for Audit-Redacted) Scope of Treatment (POST)," was prepared on 8/21/2024. The designation of the resident's What measures will be put into preferences related to, attempt resuscitation/CPR, place and what systemic or do not attempt resuscitation/DNR was left changes will be made to ensure that the deficient practice does not recur. A code status was not documented on the face Staff responsible for the acquisition of POST forms and /or advanced directives will be There was no order addressing code status found in-serviced on October 17, 2024. in the record. as to policy and procedure. (See F578 Advanced Directive A baseline care plan meeting, completed on In-Service Syllabus) 9/10/24, lacked documentation to show a discussion was had with the resident or resident How the corrective action(s) representative regarding code status preferences. will be monitored to ensure the deficient practice will not A code status preference was not documented in recur, i.e. what quality the care plan for Resident 171. assurance program will be put

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Event ID:

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

L6PB11

Facility ID: 000389

into place.

Each new admission will be

audited by the Social Services

Director, or her designee, using

If continuation sheet

Page 2 of 16

10/25/2024 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST INDIANAPOLIS, IN 46260 ST AUGUSTINE HOME FOR THE AGED (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE clinical record within 24 hours after being the audit tool (See F578 Advanced admitted. If a code status was not present in the Directive Audit Tool). Results of clinical record, staff would treat the resident as a the admission audit will be full code and would perform CPR. presented to, and reviewed by, the QAPI committee at its monthly During an interview, on 9/16/24 at 3:06 p.m., the meeting. The Social Worker is Director of Nursing (DON) indicated Resident 171 responsible to maintain did not have a code status documented in his compliance. clinical record. The DON was not aware if the resident's preferences was to attempt By what date the systemic resuscitation/CPR, or do not attempt changes for each deficiency resuscitation/DNR due to it was left blank on the will be complete. POST form. Residents were seen by the physician October 21, 2024 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

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Resident's desires...."

3.1-4(f)(4)(A)(ii) 3.1-4(f)(5)

"...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

Event ID:

L6PB11

Facility ID: 000389

If continuation sheet

Page 3 of 16

DEPARTMENT OF HEALTH AND HUMAN SERVIC	ES
CENTERS FOR MEDICARE & MEDICAID SERVICE	S

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPLETED	
		155825	B. WI	NG	·	09/20/	2024
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP COD		
					V 86TH ST		
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(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
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							BITTE
F 0684	483.25						
SS=D	Quality of Care						
Bldg. 00							
	Based on interview	and record review, the facility	F 06	584	What corrective action(s) wil	l	10/21/2024
	failed to ensure a res	sident was assessed and			be accomplished for those		
	treated for constipat	tion, to ensure a resident was			residents found to have been	1	
	assessed for complic	cations of congestive heart			affected by the deficient		
	_	the physician of weight gains			practice?		
		cian's ordered parameters for			The facility policies for bowel		
		ewed for quality of care.			protocol, weight protocol, and	care	
	(Resident 12, 18 and				plan updating have been revie		
	(resident 12, 10 dit	u 11)			and updated.	wcu	
	Einding ingludge.				I	·	
	Finding includes:				The facility will in-service nursi	-	
	1 701 11 1	10 7 11 110			staff, including CNAs, QMAs, a		
		rd for Resident 12 was reviewed			nurses regarding the revised b	owel	
	_	o.m. The diagnoses included,			protocol to make sure proper		
		I to, chronic respiratory failure			documentation of BM's is done		
	with hypoxia, asthm	na, and constipation.			every shift. Nurses and QMA's	will	
					be in-serviced on monitoring		
		nt documentation indicated			"alerts" in our electronic health	1	
	the resident had not	had a bowel movement from			record system (PCC) daily for	any	
	8/27/24 to 8/31/24 (	(5 days).			resident who is not documente	ed	
					as having a BM in 3 days, and		
	There was no abdon	ninal assessment noted in the			nurses' assessment for		
	record.				constipation will also be review	ved	
					as part of the in-service. (See		
	A physician's order,	initiated on 8/31/23, indicated			F684, F690, F695, F880 In-Se	rvice	
	"BOWEL CONST	ΓΙΡΑΤΙΟΝ PROTOCOL: do not			Syllabus)		
	go				As part of the in-service, Nurse	es,	
	more than 2 days wi	ithout a bowel movement, take			CNAs and QMAs will be educa		
	Miralax 17 grams in	1 8 ounces of fluids as needed			on the weight protocol including	ıg	
	for constipation"				rechecking of weights and	-	
	•				physician notification of losses	or	
	A physician's order.	initiated on 6/21/24, indicated			gains. Nurses will be re-traine		
		of Miralax 17 grams in the			assessment of lung sounds,		
	morning for constip	_			presence or absence of edema	a.	
	201 001001				physician notification, chest pa	•	
	A physician's order	initiated on 4/19/24, indicated			present or absent, and		
		sate Sodium 8.6-50 milligram			documentation of all actions ta	ıken	
	_	constipation twice a day.			by the nursing staff. (See		
	aoret as necueu 101	consupution twice a day.			by the hursing stall. (See		

PRINTED: 10/25/2024

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC						RM APPROVED B NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	III TIPI E C	ONSTRUCTION	(X3) DATE	
	OF CORRECTION	IDENTIFICATION NUMBER	ľ	UILDING	00	COMPL	
THILD TEAT	or condition	155825	B. W		<u></u>	09/20/	
		100020	J			00/20/	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
OT 41101	LICTINE LICIAE EO	THE AGED			V 86TH ST		
STAUG	USTINE HOME FOR	R THE AGED		INDIAN	NAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					In-Service Syllabus)		
	A physician's order,	, initiated on 4/19/24, indicated					
	to give Senna-Docu	sate Sodium 8.6-50 milligrams			MDS Coordinator reviewed fa	cility	
	daily for constipation	on.			policy regarding the updating	of	
					care plans to be current with e	each	
	A care plan, initiate	ed on 3/30/22, indicated the			resident's status, including		
	resident had a poter	ntial for constipation related to			physician orders and condition	า	
	decreased mobility	and medications. Interventions			changes. (See F684 Care Pla	n	
	included, but were i	not limited to, administer stool			Audit-Redacted)		
	softener/ laxative as	s ordered, monitor for			,		
	symptoms of consti	pation such as abdominal			How other residents having	the	
		domen and bowel sounds,			potential to be affected by th		
	and administer as n	eeded medications (to promote			same deficient practice will l		
	a bowel movement)	after three days.			identified and what correctiv	е	
					action(s) will be taken?		
	During an interview	y, on 9/20/24 at 8:45 a.m., RN 1			The bowel protocol has been		
	indicated bowel mo	vements were to be charted by			reviewed and revised for all		
	the CNA. The nurse	e would talk with the resident			residents.		
	and ask when they l	last had a bowel movement. If					
	no bowel movemen	t after three days, then the			The weight protocol has been		
	bowel assessment w	vas to be done and charted in			reviewed and revised for all		
	the notes. If the resi	dent had an order for			residents.		
	medication the nurs	e was to administer the					
	medication. If there	was no order, the nurse would			Charge nurses have reviewed	all	
	contact the physicia	n.			residents to make sure that th	ey	
					meet the revised bowel protoc	ol	
	During an interview	y, on 9/20/24 at 3:55 p.m., the			including resident #12. This re	view	
	Director of Nursing	indicated she was not able to			and any action taken because	of	
	find documentation	of a bowel movement from			the revised bowel protocol is		
	8/27/24 to 8/31/24 d	or an assessment which was			documented in each resident's	S	
	completed. The staf	f should ask the resident if			medical record.		
	they have had a boy	vel movement (if not					
	documented) and th	en follow the facility bowel			What measures will be put in	ito	
	movement protocol	. The protocol consisted of			place and what systemic		
	increasing fluids an	d assessing the bowel sounds.			changes will be made to		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

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

L6PB11

Facility ID: 000389

protocol:

ensure that the deficient

practice does not recur.

All residents will now be monitored

as indicated in the revised bowel

If continuation sheet

Page 5 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST INDIANAPOLIS, IN 46260 ST AUGUSTINE HOME FOR THE AGED (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE chronic kidney disease. May have 8oz prune juice daily as needed for no BM for 24 hours, The documented weights indicated the resident unless contraindicated. weighed 165.3 pounds on 9/2/24 and 170.4 pounds May have Miralax 17gm daily as on 9/3/24 which indicated a gain of 5.1 pounds in needed for no BM for 48 hours. a 24-hour period. unless contraindicated or is already routinely receiving this There was no assessment of the lung sounds, medication. edema, or chest pain found in the record. There May have Dulcolax suppository was no documentation the weight was rechecked daily as needed for no BM for 72 for accuracy and there was no note to indicate the hours, unless contraindicated. In physician had been informed of the weight gain. addition, the nurses' assessment of the resident and the physician's A physician's order, dated 5/31/24, indicated to notification will be documented in weigh the resident daily in the morning and to the medical record. report to the physician a weight gain of greater Audits of staff compliance with the than three pounds in 24 hours or five pounds in a bowel protocol will be done at week for a diagnosis of congestive heart failure. least 3 times a week for the first month, weekly for the next month, A physician's order, initiated 7/4/24, indicated to and then monthly for the 3rd encourage a fluid restriction of 1500 milliliters (ml) month. The audit reports will be daily for chronic heart failure. reviewed by the DON, Staff Development nurse or designee for A current care plan, revised on 12/4/23, indicated any needed follow up. (See F684 the resident was at risk for complications due to QA Audit Tool 2024-Bowel) The congestive heart failure, atrial fibrillation and results of resident audits and the hypertension. She would be free of complications need for any further staff and have clear lung sounds and the heart rate and re-education will be discussed rhythm would be within normal limits. with nurses as indicated. Interventions included, but were not limited to, Audits of staff compliance with the monitor for difficulty breathing, weight gain, edema and chest pain, contact the physician as weight protocol will be done at indicated, and weight monitoring as ordered. least 3 times a week for the first month, weekly for the next month, A current care plan, revised on 8/7/24, indicated and then monthly for the 3rd the resident was at risk for dehydration related to month. The audit reports will be diuretic therapy, edema, hypertension, congestive reviewed by the DON, Staff heart, and a history of hyponatremia (low sodium Development nurse or designee for levels) with a fluid restriction. Interventions any needed follow-up. (See QA Audit Tool 2024-Weights) The included, but were not limited to, monitor weights

CENTERS FOR MEDICARE & MEDICAID SERVICES X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED

155825 B. WING 09/20/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST

ST AUGUSTINE HOME FOR THE AGED			INDIANAPOLIS, IN 46260		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	as ordered and consult the physician as indicated.		results of resident audits and the		
			need for any further staff		
	During an interview, on 9/20/24 at 8:45 a.m., RN 6		re-education will be discussed		
	indicated residents with a diagnosis of congestive		with nurses as indicated.		
	heart failure (CHF) should have their oxygen				
	saturation levels assessed per physician's order.		If a resident is identified as not		
	Daily weights were to be completed, and the		being followed up as per the bowel		
	physician notified if there was a weight gain. A		protocol or physician orders, the		
	respiratory assessment was to be done, a reweigh		DON or Staff Development nurse		
	of the resident, and check the resident for edema		will attend to the resident's care		
	and skin turgor. An SBAR (a type of assessment		first. Once that has occurred, the		
	to relay information to the physician) should be		DON, Staff Development nurse or		
	completed. If after notifying the physician there		designee will review the bowel		
	were new orders, carry out the orders and		protocol with the staff involved.		
	continue to monitor the resident.3. The clinical		Future noncompliance with the		
	record for Resident 11 was reviewed on 9/17/24 at		protocol will be addressed with		
	2:41 p.m. The diagnoses included, but were not		individual counseling/ discipline as		
	limited to, unspecified dementia, hyperlipidemia,		per facility policy.		
	age related osteoporosis, and unspecified		If a resident is identified as not		
	atherosclerosis of native arteries of bilateral legs.		being followed up as per the		
			weight protocol or physician		
	A physician's order, with a start date of 7/1/24,		orders, the DON, Staff		
	indicated if a gain or loss of 4 pounds since the		Development nurse or designee		
	last weight, then weigh 4 days consecutively and		will attend to the resident's care		
	notify provider if the gain or loss was valid.		first. Once that has occurred, the		
			DON/Staff Development nurse or		
	A vitals log indicated the following weights:		designee will review the weight		
	On 7/1/2024, the weight was 157.0 pounds.		protocol with the staff involved.		
	On 8/1/2024, the weight was 156.7 pounds.		Future noncompliance with the		
	On 9/1/2024, the weight was 161.5 pounds.		protocol will be addressed with		
			individual counseling/ discipline as		
	On 9/1/24, the resident gained 4.8 pounds		per facility policy.		
	compared to the last weight.		How the corrective action(s)		
			will be monitored to ensure the		
	There was no documentation in the record to		deficient practice will not		
	indicate the resident had been weighed for 4 days		recur, i.e. what quality		
	after the weight gain or notification to the		assurance program will be put		
	provider of the gain had occurred.		into place.		
			The DON or designee will bring the		
	During an interview, on 9/19/24 at 3:07 p.m., the		results of the audits for		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L6PB11

Facility ID: 000389

If continuation sheet Page 7 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 09/20/2024 155825 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2345 W 86TH ST INDIANAPOLIS, IN 46260 ST AUGUSTINE HOME FOR THE AGED (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Director of Nursing (DON) indicated she did not compliance of the bowel protocol see documentation to indicate the resident was and weight protocol along with the weighed for those 4 days per the order. planned schedule for doing the audits to the monthly QAPI During an interview, on 9/20/24 at 10:52 a.m., the committee meeting for review and DON indicated the expectation was staff would further recommendations. At the follow the physician's orders and if they had any end of the audit schedule, the questions, they would call the physician. committee members may decide that regular reporting of the bowel A current facility policy, titled "WEIGHT, LOSS protocol or weight compliance is OR GAIN," dated as revised in 8/2018 and no longer needed. The DON is received from the Director of Nursing on 9/20/24 responsible for assuring at 11:10 a.m., indicated "...A Resident with weight compliance. gain should be assessed and monitored for signs By what date the systemic and symptoms of Congestive Heart Failure...." changes for each deficiency will be complete. A current facility policy, titled "Weights, October 21, 2024 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.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L6PB11

Facility ID: 000389

If continuation sheet

Page 8 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURV		SURVEY					
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TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE
	3.1-37(a)						
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Income Based on interview failed to ensure urinordered by the physreviewed for catheter Finding includes:  The clinical records on 9/17/24 at 3:33 put were not limited brain injury from in heart failure, and chappoxia (a condition oxygen in the blood A care plan, initiate resident had an indubladder obstruction interventions include monitor and documfacility policy.  A physician's order, to record urinary out The Medication and August 2024, was and documentation on the evening shift on on August 21st, and	d on 4/27/23, indicated the welling catheter related to and urinary retention. The led, but were not limited to, ent urinary output per the , initiated on 4/6/23, indicated	F 00	590	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  The facility will in-service nurs staff, including CNAs, QMAs, Nurses regarding the facility p for care of residents with Fole catheters and documentation catheter output. (See F684, F695, F880 In-Service Syllabuthe facility policy regarding the updating of care plans to be current with each resident's status, including physician ord and condition changes. The M Coordinator will create an audit tool regarding review of care plans.  How other residents having a 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.	ing and olicy y of 690, us) ew e lers IDS it the e oe e	10/21/2024
	indicated urinary ou	y, on 9/20/24 at 8:45 a.m., RN 1 atput was to be documented Administration Record.			All residents who have a Foley catheter have been checked a are current with output documentation.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L6PB11

Facility ID: 000389

If continuation sheet Page 9 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

	T OF DEFICIENCIES DF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155825	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 09/20/2024
	ROVIDER OR SUPPLIER JSTINE HOME FOR		2345	r address, city, state, zip cod W 86TH ST NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	OUTPUT," dated as received from the In 9/20/24 at 4:40 p.m adequate hydration and to assist in their by using I & O (intarecords are kept on	plicy, titled "INTAKE AND is last revised in 01/2024 and infection Preventionist on, indicated "To ensure levels of certain Residents rassessment and management aske and output) recordI&O Residents with the athetersrecord output from		What measures will be put in place and what systemic changes will be made to ensure that the deficient practice does not recur.  Audits of staff compliance with Foley catheter will be done at least 3 times a week for the firmonth, weekly for the next more and then monthly for the 3rd month. The audit reports will be reviewed by the DON, Staff Development nurse or design any needed follow up. The resof resident audits and the need any further staff re-education be discussed with nurses as indicated. (F690 QA Audit To 2024-catheter output)  If a resident with a Foley cath is identified as not being follow up as per physician orders or per care plan interventions, the DON, Staff Development nurse designee will attend to the resident's care first. Once that occurred, the DON, Staff Development nurse or design will review the Foley catheter policy with the staff involved. Future noncompliance with the protocol will be addressed with individual counseling/ disciplinger facility policy.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e. what quality assurance program will be protocol will be program will be protocol will be assurance program will be protocol will be assurance program will be protocol.	h a rst onth, be leee for sults ed for will ool eter wed as ne se or t has leee lee th ne as

PRINTED: 10/25/2024

	OF HEALTH AND HUN						RM APPROVED
	R MEDICARE & MEDIC		(3/2) 1.6	III TIDI E CC	NICTRICTION		B NO. 0938-039
	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00  B. WING		COMPL	
		155825	B. W.	ING		09/20/	2024
NAME OF I	DROVIDED OD GUDDI IED			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER			2345 W	/ 86TH ST		
ST AUG	JSTINE HOME FOR	R THE AGED		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					into place. The DON or designee will bring results of the audits for compliance of Foley catheter and documentation of output a with the planned schedule for doing the audits to the monthl QAPI committee meeting for review and further recommendations. At the end the audit schedule, the commitmembers may decide that regreporting of the Foley catheter audit is no longer needed. Eventhough written audits may not continue, the processes in plate to monitor compliance will continue. The DON is responsifor assuring compliance.  By what date the systemic changes for each deficiency will be complete. October 21, 2024	care along  y  of ittee ular en  ce sible	
F 0695 SS=D Bldg. 00	Based on observation review, the facility was dated for the date	eostomy Care and on, interview and record failed to ensure oxygen tubing ny it was changed for 3 of 3 for respiratory care. (Residents	F 00	595	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	n	10/21/2024

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

1. During an observation, on 9/17/24 at 9:35 a.m.,

oxygen at two (2) liters per minute through a nasal

Resident 18 was observed in a recliner in her

room. She was found to be using supplemental

cannula. The oxygen line did not have a date to

L6PB11

Facility ID: 000389

If continuation sheet

in-service nursing staff, including

care of residents with respiratory

regarding the facility policy for

equipment, including oxygen

CNAs, QMAs, and nurses

Page 11 of 16

CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155825	B. WI	ING		09/20/	/2024
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
					V 86TH ST		
ST AUG	USTINE HOME FO	R THE AGED		INDIAN	IAPOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
TAG	· ·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
	<u> </u>	gen tubing had been changed.			tubing. (F684, F690, F695, F8	80	Dille
	show when the oxy	gen tubing had been changed.			In-Service Syllabus)	00	
	The clinical record	for Resident 18 was reviewed			The MDS Coordinator will revi	ow to	
		p.m. The diagnoses included,			ensure care plan interventions		
		d to, cerebral ischemia (acute			completed as part of the resid		
		npaired blood flow to the brain),			care, and that the resident's c		
		nronic respiratory failure with			reflects the care plan.	ai C	
		on which occurs from lack of			How other residents having	the	
	oxygen in the blood				potential to be affected by th		
	oxygen in the blood	.,.			same deficient practice will be		
	A physician's order	, initiated on 7/11/24, indicated			identified and what correctiv		
		at two (2) liters per minute via			action(s) will be taken?	<del>C</del>	
		hronic respiratory failure with			All residents who have oxyger	•	
	hypoxia.	monic respiratory failure with			tubing have been checked for		
	пурохіа.				_		
	2 During on observ	vation, on 9/16/24 at 10:33 a.m.,			compliance in changing and d	aurig	
		in sitting up in her room. She			the oxygen tubing per facility		
	_	ng supplemental oxygen at			policy.		
		inute through a nasal cannula.			What magazines will be put in	***	
		d not have a date to show when			What measures will be put in	ito	
	the oxygen tubing h				place and what systemic		
	the oxygen tubing i	iad been changed.			changes will be made to ensure that the deficient		
	The eliminal record	for Resident 12 was reviewed					
		p.m. The diagnoses included,			practice does not recur.		
	_	d to, chronic respiratory failure			Audits of staff compliance for	looot	
		na, and chronic obstructive			oxygen tubing will be done at 3 times a week for the first mo		
	1 **						
	pulmonary disease	(COPD).			weekly for the next month, and		
	A physician's ander	, initiated on 3/12/23, indicated			then monthly for the 3rd month		
		the oxygen tubing and storage			The audit reports will be review		
	_				by the DON, Staff Developme		
	bags every evening	siiit oii Tuesuay.			nurse and charge nurses for a	•	
	A core plan mari	d on 5/20/24 indicated the			needed follow up. The results		
	_	d on 5/29/24, indicated the			resident audits and the need f		
	resident had a poter				any further staff re-education		
	_	to COPD, asthma, chronic			be discussed as indicated. (S		
		with hypoxia, pulmonary			F695 QA Audit Tool 2024-oxy	gen	
		c heart failure. She required			tubing)		
	supplemental oxyge	en.			l., ., ., ., ., ., ., ., ., ., ., ., ., .		
	1				How the corrective action(s)		İ

3. During an observation, on 9/16/24 at 12:19 p.m.,

will be monitored to ensure the

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	1	JILDING	00	COMPL	
		155825	B. W	ING	_	09/20/	/2024
	PROVIDER OR SUPPLIEI			2345 W	ADDRESS, CITY, STATE, ZIP COD / 86TH ST APOLIS, IN 46260		
31 AUG		R THE AGED		INDIAN	APOLIS, IN 40200		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	DATE
		in a high back wheelchair in			deficient practice will not		
	_	was found to be using			recur, i.e. what quality		
		en at two (2) liters per minute			assurance program will be p	ut	
		nula. The oxygen line did not when the oxygen tubing had			into place.	41	
	been changed.	when the oxygen tubing had			The DON or designee will brir results of the audits for	ig ine	
	seen enungen				compliance in changing oxyge	en	
	The clinical record	for Resident 10 was reviewed			tubing along with the planned		
		2 p.m. The diagnoses included,			schedule for doing the audits	to	
		d to, hypoxemia, heart failure,			the monthly QAPI committee		
		ep apnea (a sleep disorder			meeting for review and further		
	which occurs when the upper airway partially or completely collapses during sleep, interrupting the audit schedule, the committee						
	breathing).				members may decide that reg reporting of the oxygen tubing		
	A physician's order	r, initiated on 8/5/20, indicated			audit is no longer needed. Eve		
		se oxygen at two liters per			though written audits may not		
	minute.				continue, the processes in pla		
					to monitor compliance will		
	_	d on 9/4/24, indicated the			continue. The DON is respons	sible	
		applemental oxygen to maintain			for assuring compliance.		
	adequate oxygenati	on.			By what date the systemic		
	During on interview	v, on 9/17/24 at 2:27 p.m., the			changes for each deficiency		
	1	g indicated the oxygen tubing			will be complete. October 21, 2024		
	_	weekly, and the tubing should			October 21, 2024		
	_	date it was changed.					
		olicy, titled "OXYGENATOR,"					
		d in 8/18 and received from RN					
		46 a.m., indicated "Nasal					
	changed weekly'	and humidifier must be					
	changed weekly						
	3.1-47(a)(6)						
F 0880	483.80(a)(1)(2)(4)	)(e)(f)					
SS=D	Infection Preventi						
Bldg. 00							
	Based on interview	and record review, the facility	$\mathbf{F}$ 0	የደበ	What corrective action(s) will	il.	10/21/2024

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			URVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
		155825	B. W	'ING		09/20/2	2024
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	8	2345 W 86TH ST				
ST AUGL	JSTINE HOME FOR	R THE AGED	INDIANAPOLIS, IN 46260				
			1		,	I	075°
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		e use of antibiotics including			be accomplished for those		
	the use of standardized tools for the appropriateness of antibiotics prescribed for 1 of 5 residents reviewed for unnecessary medications.				residents found to have been	n	
					affected by the deficient practice?		
	(Resident 11)	ioi unnecessary medications.			The facility policy has been		
	(Resident 11)				updated to reflect its efforts at		
	Finding includes:				tracking and analyzing the use		
	1 manig merades.				antibiotics for the residents. The		
	The clinical record	for Resident 11 was reviewed			Antibiotic Stewardship program	1	
		o.m. The diagnoses included,			will use McGeers Criteria to		
	-	I to vitamin D deficiency,			assess antibiotics for		
		steoarthritis, and age-related			appropriateness of use. Track	ina	
	osteoporosis.				of illness and antibiotic use for	-	
	•				residents will be done by the		
	A physician's order	, with a start date of 7/23/24,			Infection Preventionist or		
	indicated the reside	nt took Keflex (an antibiotic)			designee.		
	oral capsule 250 mi	lligrams (mg).			The Infection Preventionist or	DON	
					will in-service nurses regardin	g the	
	During an interview	y, on 9/20/24 at 3:27 p.m., the			facility policy for antibiotic		
	-	(DON) indicated their			stewardship using the McGee	rs	
		acking for antibiotics. She was			Criteria. (See F684, F690, F69	95,	
		dy who did surveillance using			F880 In-Service Syllabus)		
		(surveillance definitions used			How other residents having	I	
	-	s) in the facility. The nurses			potential to be affected by th		
		gns and symptoms to the			same deficient practice will be		
	physician but did no	ot use a specific protocol.			identified and what correctiv	e	
	and t				action(s) will be taken?		
		mentation of a surveillance			The facility has set up a syste		
	tool used for the res	sident.			keep the Infection Preventioni	St	
	A assessment in 11	ilad !! A mtilaiati - Ct 1 1 '			updated for residents using	.	
		eled "Antibiotic Stewardship			antibiotics. This will allow her		
		2024 and received from the			track antibiotic use and measu	ire it	
		3:45 p.m., indicated "Infection dinates all antibiotic			against McGeers Criteria.  She will track resident antibiot	io	
	•	es, maintains documentation,			use on a format that lists each		
	and serves as a reso					1 dS	
		ses participate in the program			it occurs.		
		of residents and following			What measures will be put in	nto	
	-	shed by the program. 4. The			place and what systemic		
	-	ntibiotic use protocols and a			changes will be made to		
	F-05 IIIOIGG05 GI	and procesors und u	1		I SHALLED THE DO HIGGO LO		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L6PB11

Facility ID: 000389

If continuation sheet Page 14 of 16

EPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTERS FOR MEDICARE & MEDICAID SERVICES						
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>	COMPLETED			

NAME OF	PROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, STATE, ZIP COD	
	USTINE HOME FOF			V 86TH ST NAPOLIS, IN 46260	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE
		ntibiotic useThe facility uses		ensure that the deficient	
	_ ·	Surveillance Definitions,		practice does not recur.	
	`	teria, or other surveillance		The DON and Infection	
	_	tionsDocumentation related		Preventionist will meet at least	
	· ·	aintained by the Infection		weekly to review resident illness	
		ding, but not limited		requiring antibiotic use.	
	toassessment form	-		Documentation of the antibiotics	
		sdata collection forms for		use and McGeers assessment wil	.
		ess, and outcome measures"		also be reviewed. Any concerns	
	, p	, <del></del>		on antibiotic overuse for residents	.
	A current policy, tit	led "Infection Prevention and		will be discussed with the Medical	
		dated 1/2024 and received from		Director. Documentation of the	
		4 at 3:45 p.m., indicated "The		physician's response will be	
		icipate in surveillance through		placed with the antibiotic	
	^	ents and reporting changes in		stewardship material for that	
		dents' physician's and		month.	
		per protocol for notification of			
		se reporting of communicable		How the corrective action(s)	
		onsAntibiotic use protocols		will be monitored to ensure the	
		nitor antibiotic use will be		deficient practice will not	
		t of the antibiotic stewardship		recur, i.e. what quality	
		Pection preventionist, with		assurance program will be put	
		Director of Nursing, serves as		into place.	
	the leader of the ant			The DON or Infection Preventionis	st
	program"	•		will bring the results of the	
				antibiotic stewardship tracking for	
	3.1-18(b)(1)(A)			residents to the monthly QAPI	
	3.1-18(b)(1)(B)			committee meeting for review and	ı
	3.1-18(b)(1)(C)			further recommendations. Regula	
				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.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L6PB11

Facility ID: 000389

If continuation sheet Page 15 of 16

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2024 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE SURVEY COMPLETED	
		155825	B. WI	NG		09/20/	/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 2345 W 86TH ST			
ST AUGL	JSTINE HOME FOF	R THE AGED	INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY S	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
					October 21, 2024		
R 0000							
Bldg. 00							
	This visit was for a State Residential Licensure		R 0000		This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, the submission of		
	Survey. This visit included a Recertification and State Licensure Survey.						
	Survey dates: September 16, 17, 18, 19 and 20, 2024						
					the Plan of Correction is not an		
	2024				admission that a deficiency exists or that one is cited correctly. This		
	Facility number: 000389  Plan of Correction is submitted to meet the requirements established				d to		
	Residential Census:	13			by state and federal law. St. Augustine Home for the Aged		
	St Augustine Home	for the Aged was found to be			desires this Plan of Correction to be considered the facility's		
	•	410 IAC 16.2-5 in regard to the					
	State Residential Li				allegation of compliance.		
					Compliance is effective Octob	per	
	•	completed on September 30,			21, 2024.		
	2024.				We respectfully request a desk		
					review of our Plan of Correcti	on.	

State Form Event ID: L6PB11 Facility ID: 000389 If continuation sheet Page 16 of 16