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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	08/16/2019

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. Survey dates: August 12, 13, 14, 15, & 16, 2019. Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 145 SNF: 24 NCC: 2 Total: 171 Census Payor Type: Medicare: 20 Medicaid: 101 Other: 50 Total: 171 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/20/19.	F 0000	F000 St. Anthony Home (“the provider”) submits this Plan of Correction (“POC”) in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1)are relied upon to adversely influence or serve as a basis, in any way, for the selection and/or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services (“CMS”), the state of Indiana or any other entity; or (2) to serve, in any way to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is 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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			Evidence and should be inadmissible in any proceeding on that basis.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.			

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	§483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation and interview, the facility failed to ensure each resident's dignity was maintained related to an exposed urinary catheter bag for 1 of 4 resident reviewed for dignity. (Resident 158) Finding includes: On 8/12/19 at 12:43 p.m., Resident 158 was observed in her room in bed. There was a catheter bag with urine in it hanging from the bed frame and visible from the hallway. On 8/14/19 at 10:13 a.m., the resident was observed in bed. There was a catheter bag with urine in it hanging from the bed frame and visible from the hallway. The resident's record was reviewed on 8/14/19 at 9:35 a.m. Diagnoses included, but were not limited to, bladder retention and pressure ulcers of the sacrum. The resident was cognitively intact. Interview with the Director of Nursing on 8/14/19 at 11:30 a.m., indicated catheter bags should be inside a dignity bag. 3.1-3(t)	F 0550	F550: The Facility is requesting desk compliance 1:1 Regarding resident #158, no adverse reactions were noted related to the exposure of the urinary catheter bag while in bed. 1:2 Residents with catheters will be reviewed to ensure that their dignity bags are utilized to promote quality of life as well as proper placement which includes not being visible from the hallway when the dignity bag is not in use. 1:3 The Director of Staff Development/designee will re-in-serviced staff on the purpose of the dignity bags as well as the placement of urinary drainage bags to prevent them from being viewed from the hallway when the dignity bag is not in use. The Unit Manager/designee will audit five (5) residents with catheters weekly per unit for the next six (6) months to assure that the urinary drainage bag is placed to prevent visibility from the hallway or placed in a dignity bag.(attachment 1 of 2)	09/13/2019

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			1:4 The DON/designee will report findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. img width="104" height="3" src="file:///C:/Users/Bmagerl/AppData/Local/Temp/msohtmlclip1/01/clip_image001.png" >1:5 Systemic changes will be completed by 09-13-2019.	
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 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 and interview, the facility failed to ensure a resident's needs were met related to a call light out of reach for 1 of 1 residents observed for accommodation of needs. (Resident 158) Finding includes: On 8/13/19 at 10:30 a.m., Resident 158 was observed lying in his bed. His call light cord appeared under his back, the call light button was not visible as he was laying on it. The resident was not able to get the call light out from under him upon request.	F 0558	F 558: The Facility is requesting desk compliance 1:1 Regarding resident #158, the call light was placed within reach with no adverse reactions noted. 1:2: The Unit Manager/designee completed an audit on all residents to ensure their call light was within reach with any deficiencies corrected at that time.	09/13/2019

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	On 8/15/19 at 9:55 a.m., the resident was observed in bed. The call light was hanging on the bed frame behind him, where he was not able to reach it. During an interview on 8/15/19 at 10:05 a.m. with LPN 3, she indicated the resident was physically able to use the call light to summon assistance and the call light was out of reach at that time. The resident's record was reviewed on 8/13/19 at 2:43 p.m. Diagnoses included, but were not limited to, Parkinson's disease, and ulcers to both feet. A 14-day Minimum Data Set Admission assessment, dated 7/22/19, indicated he had some cognitive impairment and required extensive assistance for bed mobility. 3.1-3(v)(2)		1:3 The Director of Staff Development /designee re-in-serviced staff on ensuring that all call lights are placed within reach at all times. The Unit Manager/designee will assess five (5) residents call light placement weekly per unit on all shifts to ensure the call light is within reach for six (6) months. (attachment #1of 2) 1:4 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 09-13-2019.	
F 0604 SS=D Bldg. 00	483.10(e)(1); 483.12(a)(2) Right to be Free from Physical Restraints §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).			

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	§483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.			
	Based on observation, record review, and interview, the facility failed to ensure a resident was free from physical restraints related to not releasing a restraint during meal times and every 2 hours for 3 of 3 residents reviewed for restraints. (Residents 52, 109, & 120) Findings include: 1. On 8/12/19 at 12:48 p.m., Resident 52 was observed sitting in her wheelchair at a table eating lunch. The resident had a seat belt restraint attached to the wheelchair in front of her waist. On 8/15/19 at 11:57 a.m., Resident 52 was observed sitting in her wheelchair at a table eating lunch. A staff member was sitting with the resident assisting her with her lunch. The seat	F 0604	F 604: The Facility is requesting desk compliance 1:1 Regarding residents #52, #109, & #120 no adverse reactions were noted from the staff not releasing their seat belt restraints every 2 hours & during mealtimes. 1:2 Interim nursing manager immediately addressed the staff regarding this practice. All residents with restraints were assessed to ensure	09/13/2019

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	belt restraint was attached to the wheelchair in front of her waist. Record review for Resident 52 was completed on 8/14/19 at 2:19 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, dementia, anxiety, and depression. The Annual Minimum Data Set (MDS) assessment, dated 5/21/19, indicated the resident was cognitively impaired. The resident required an extensive 1 person assist for transfers, dressing, and personal hygiene. A restraint was used daily. A Care Plan indicated the resident had a trunk restraint (alarming seat belt) which was used daily in her chair or out of bed. An intervention included to remove the restraint when the resident was at supervised activities. The August 2019 Physician's Order Summary indicated an order for a self releasing seat belt. The belt should be released every 2 hours and during meals. Interview with CNA 1 on 8/15/19 at 12:01 p.m., indicated the resident was supposed to have her seatbelt off when eating. She unhooked the resident's seat belt at that time. Interview with Interim Unit Manager 1 on 8/15/19 at 2:21 p.m., indicated staff should have released the resident's restraint at meal times. 2. On 8/12/19 at 12:49 p.m., Resident 109 was observed sitting in a Broda wheelchair having lunch. A staff member was assisting the resident with eating. A seatbelt restraint was observed fastened around the resident's waist.		physician orders related to their restraint were followed and any deficiencies corrected at that time. 1:3 The Director of Staff Development/designee re-in-serviced nursing staff on the policy and procedure for residents with restraints to ensure interventions/release schedules is followed. The Unit Manager/designee will assess all residents with restraints weekly per unit on all shifts to ensure interventions/release schedules are followed for six (6) months. (Attachment #1 of 2) 1:4 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 09-13-2019.	

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On 8/15/19 at 11:54 a.m., Resident 109 was observed sitting in a Broda wheelchair having lunch. A staff member was assisting the resident with eating. A seatbelt restraint was observed fastened around the resident's waist.

Record review for Resident 109 was completed on 8/15/19 at 9:23 a.m. Diagnoses included, but were not limited to, anemia, dementia, anxiety, depression, and dementia.

The Significant Change Minimum Data Set (MDS) assessment, dated 7/2/19, indicated the resident was cognitively impaired. The resident required extensive assist for bed mobility, transfers, toilet use, dressing, and personal hygiene. A trunk restraint was used daily.

A Care Plan indicated the resident had a seat belt while in wheelchair related to poor safety awareness secondary to delusions, hallucinations and auditory disturbances secondary to dementia. An intervention included to release the belt every 2 hours and for meals.

The August 2019 Physician's Order Summary indicated an order for a self releasing belt. The belt should be released every 2 hours and during meals.

Interview with QMA 1 on 8/15/19 at 12:02 p.m., indicated the resident's restraint should be removed at meal times.

Interview with Interim Unit Manager 1 on 8/15/19 at 2:21 p.m., indicated staff should have released the resident's restraint at meal times.3. During a continuous observation on 8/12/19 from 10:20 a.m. to 12:49 p.m. Resident 120 was observed seated in

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her wheel chair in the unit dining room. An alarming self release seat belt was in place across her lap. The resident was served lunch during this time. The seat belt was not released at any time during this observation.

On 8/15/19 at 12:33 p.m. the resident was observed seated in her wheel chair eating lunch. The alarming self release seat belt was in place across her lap. The seat belt was not released during the meal.

Resident 120's record was reviewed on 8/14/19 at 1:37 p.m. Diagnoses included, but were not limited to, dementia with behavioral disturbance, hypertension, and anxiety disorder.

A Significant Change Minimum Data Set (MDS) assessment, dated 6/22/19, indicated a trunk restraint was used daily and there was no impairment in range of motion to the upper or lower extremities.

A Physician's Order, dated 6/20/19, indicated "alarm self releasing seat belt. Release every 2 hours and during meals."

A Care Plan for the alarming self release seat belt indicated the resident was unable to release the belt on command. The interventions included, "...check hourly and release restraint every 2 hours and during meals to provide position change and or activity unless contraindicated..."

Interview with Interim Unit Manager 1 on 8/15/19 at 2:22 p.m. indicated the seat belt should have been released every 2 hours and during meal times.

A facility policy, titled "Restraints (Physical)",

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	received from Interim Unit Manager 1 as current, indicated, "...10. Place the resident in a supervised area and check frequently; remove resident restraint every two hours for personal care..." 3.1-3(w)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on observation, record review, and interview, the facility failed to ensure the necessary care and services for activities of daily living (ADLs) were provided to a dependent resident related to unclean and untrimmed fingernails for 1 of 2 residents reviewed for activities of daily living. (Resident 9) Finding includes: On 8/12/19 at 12:23 p.m., Resident 9 was observed sitting in a wheelchair eating lunch. The resident's fingernails were long with debris underneath. On 8/15/19 at 11:30 a.m., Resident 9 was observed sitting at a table getting ready to eat lunch. The resident's fingernails were long with debris underneath. LPN 9 was observed wiping the resident's hands. The resident's fingernails still was observed to have debris underneath. Record review for Resident 9 was completed on 8/15/19 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, dementia,	F 0677	F677: The Facility is requesting desk compliance 1:1: Regarding resident #9 her fingernails were cleaned by the nursing staff. 1:2: The Unit Manager/designee assessed all residents to ensure ADL's were completed evidenced by completed personal daily care tasks which includes bathing, nail care, dressing, oral hygiene, grooming, toileting, eating, & drinking. Any deficiencies were corrected at that time. 1:3 The Director of Staff Development/designee re-in-serviced the nursing staff on	09/13/2019

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	anxiety, and depression. The Significant Change Minimum Data Set (MDS) assessment, dated 7/30/19, indicated the resident was cognitively impaired. The resident required an extensive assist of 1 person for eating and personal hygiene. A Care Plan indicated the resident required extensive assist with bed mobility, transfers, toilet use, and a limited assist with eating due to the diagnosis of dementia and right hemiparesis (weakness on one side of the body). An intervention included to keep the resident's nails well trimmed and clean. The Shower Skin Check Sheet indicated the resident had a shower on 8/12/19 at night. There was a box on the sheet that was not checked that the resident's fingernails were groomed. Interview with LPN 9 on 8/15/19 at 2:10 p.m., indicated the staff should have noticed the resident's fingernails were long and dirty when they completed resident care. CNAs were supposed to do nail care on shower days. If they noticed they were dirty in between shower days, then they should have cleaned them. She had cleaned the residents hands earlier and did notice the resident's fingernails were long with debris underneath them but she did not clean under her fingernails. A policy titled, "Nail Care", received as current from the facility on 8/15/19, indicated, "...Fingernails and toenails will be cleaned and trimmed on bath day weekly except for diabetics or circulatory impaired individuals. Nails will also be cleaned and trimmed daily as needed after AM or HS care...."		the importance of completing of all personal daily care tasks. The Unit Manager/designee will assess five (5) residents weekly per unit on all shifts to ensure proper personal care has been performed for six (6) months. (attachment #1of 2) 1:4 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 09-13-2019.	

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	3.1-38(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care 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, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 2 of 4 residents reviewed for non-pressure related skin conditions. (Residents 52 & 68) Findings include: 1. On 8/12/19 at 12:05 p.m., Resident 52 was observed sitting in a wheelchair in the hallway. A dark purple discoloration was observed to the resident's right shin area. On 8/14/19 at 3:00 p.m., Resident 52 was observed sitting in her wheelchair in the hallway. A large dark purple discoloration was still observed to the resident's right shin area. Record review for Resident 52 was completed on 8/14/19 at 2:19 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, dementia, anxiety, and depression.	F 0684	F684: The Facility is requesting Desk Compliance 1.1: The Interim Unit Manager completed a head to toe assessment of residents #52 and #68. An incident report was completed for each resident on the identified areas. Skin sheets and care plans were also completed. The Physician and the family were both notified of the findings for each identified resident. No adverse reactions noted. 1:2 The Unit Manager / designee completed head to toe assessments on all residents to ensure identification and notification of discolorations had been	09/13/2019

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	The Annual Minimum Data Set (MDS) assessment, dated 5/21/19, indicated the resident was cognitively impaired. The resident required an extensive 1 person assist for transfers, dressing, and personal hygiene. The record lacked any documentation the resident's discoloration had been assessed or monitored. Interview with LPN 8 and Interim Unit Manager 1 on 8/14/19 at 3:24 p.m., indicated they were unaware about the resident's discoloration on her shin. They would have to look to see if the area had been assessed. Follow up interview with Interim Unit Manager 1 on 8/15/19 at 9:24 a.m., indicated she was unable to find any documentation the resident's discoloration had been assessed or monitored. Staff should have noticed the discoloration. 2. On 8/13/19 at 10:37 a.m., Resident 68 was observed sitting in a wheelchair in her room. The resident had a dark purple discoloration to the top of her right hand. On 8/14/19 at 8:57 a.m., Resident 68 was observed sitting in a wheelchair in her room. The resident had a dark purple discoloration to the top of her right hand. Record review for Resident 68 was completed on 8/13/19 at 3:07 p.m. Diagnoses included, but were not limited to, anemia, heart failure, hypertension, diabetes mellitus, and dementia. The Significant Change MDS assessment, dated 6/13/19, indicated the resident was cognitively impaired. The resident required extensive assist		met with any deficiencies corrected at that time. 1:3 The Director of Staff Development / designee re-in-serviced nursing staff on the proper procedure to follow regarding identification of a discoloration/skin condition, actions to take when a discoloration/skin condition is noted, as well as proper notification and monitoring of the area. The Unit Managers / designees will assess five (5) residents per unit weekly for six (6) months to ensure discolorations/skin conditions have been identified and documented per policy. (attachment#1 of 2) 1:4 The DON / designee will report audit findings completed by the Unit Manager/designee to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance.	

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	for dressing and personal hygiene. The record lacked any documentation the resident's discoloration had been assessed or monitored. Interview with LPN 7 on 8/14/19 at 9:44 a.m., indicated the resident had gotten a skin tear recently to her hand. The discoloration should have been documented but had not been. Interview with Unit Manager 4 on 8/14/19 at 9:57 a.m., indicated she had not seen the area on the resident's hand since the skin tear occurred. The bruising should have been documented and measured weekly until the area was healed. There was no documentation the bruising had been assessed or monitored. 3.1-37(a)		1:5 Systemic changes will be completed by 09-13-2019.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic 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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake			

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	to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to provide acceptable parameters of nutrition related to not providing adaptive equipment for a resident's drinks for 1 of 4 residents reviewed for nutrition. (Resident 52) Finding includes: On 8/15/19 at 10:09 a.m., Resident 52 was observed sitting in her wheelchair at a table. A staff member had given the resident a snack of crackers and a cup of water. There was no lid on the cup of water. On 8/15/19 at 12:05 p.m., Resident 52 was observed sitting in her wheelchair at a table. Staff brought resident her lunch tray and drinks. There were no lids on the drinks. Record review for Resident 52 was completed on 8/14/19 at 2:19 p.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, dementia, anxiety, and depression. The Annual Minimum Data Set (MDS) assessment, dated 5/21/19, indicated the resident was cognitively impaired. The resident required limited assist for eating. A Care Plan indicated the resident was at risk for altered eating patterns. An intervention included beverages be placed in cups with lids. A Nutrition Assessment, dated 5/24/19, indicated the resident was to have cups with lids to prevent	F 0692	F 692: The Facility is requesting desk compliance 1:1 Regarding resident #52, no adverse reactions were noted. 1:2 The Interim Unit Manager immediately addressed staff regarding adaptive feeding equipment & reported concern to Dining Service Manager. 1:3 The Director of Staff Development/designee re-in-serviced staff regarding the necessity to notify the dietary department for any resident needing adaptive equipment, location of identified equipment, storage of identified equipment, cleaning procedure as well as ensuring adaptive equipment is available at all meals. The Unit Manager/designee will audit five (5) resident trays weekly per unit at various meals times for six (6) months to ensure	09/13/2019

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	spillage. Interview with CNA 1 on 8/15/19 at 12:30 p.m., indicated she was unsure if the resident was supposed to have lids on her cups. She then looked at the resident's meal ticket and it indicated the resident was supposed to have cups with lids. She then proceeded to look for a cup with a lid in the assisted dining area on the unit. She found one cup and one lid. She poured one of the resident's drinks into the cup with the lid. The resident still had two other drinks which did not have lids. Interview with Interim Unit Manager 1 on 8/15/19 at 2:21 p.m., indicated if the resident was supposed to have adaptive dietary equipment, then staff should make sure that the resident had it at all meal times. A policy titled, "Adaptive Feeding Equipment", received as current from the facility on 8/15/19, indicated, "...5. The dietary department should be notified of residents needing adaptive equipment; the equipment is stored and maintained in the dietary department. Appropriate utensils should be placed on the resident's food tray, at each meal, and returned to the dietary department, on the food tray, for sanitization...." 3.1-46(a)(1)		adaptive equipment is present for resident's with a physician's order. (attachment #1 of 2) 1:4 The DON/designee will report findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 09-13-2019.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning,			

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	is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart.			
	Based on observation, interview and record review, the facility failed to ensure a resident received respiratory care in accordance with the individualized plan of care related to incorrect delivery of oxygen for 1 of 10 resident's reviewed for oxygen use. (Resident 107) Finding includes: On 8/12/19 at 11:38 p.m., Resident 107 was observed seated in her room with her oxygen being delivered via nasal cannula. The oxygen tubing was observed to be bent at the attachment site to the water bottle in a manner that occluded the flow of oxygen. The nurse was notified at that time. On 8/13/19 at 11:30 a.m., the resident was observed seated in her room with her oxygen on, however the oxygen concentrator was not turned on, so she was not receiving any oxygen. LPN 6 was notified at that time. On 8/13/19 at 12:00 p.m., the resident's oxygen concentrator was observed to be on and delivering oxygen at 3 liters/ per minute. During an interview with LPN 6 on 8/13/19 at 12:05 p.m., she indicated the resident was on 2 liters / per minute of oxygen and the current setting was incorrect. Review of the resident's record was completed on 8/13/19 at 11:14 a.m. Diagnoses included, but were not limited to, dementia and chronic	F 0695	F695: The Facility is requesting desk compliance 1:1 Regarding resident #107, no adverse reactions were noted upon assessment. 1:2: The Unit Manager/designee completed an audit on all residents with physician orders for oxygen to ensure that the equipment was functioning properly & that the oxygen was at the correct flow rate matching the physician orders. 1:3: The Director of Staff Development/designee re-in-serviced licensed staff as well as QMAS regarding proper functioning oxygen equipment and correct physician ordered flow rate. The Unit Manager/designee will assess five (5) residents weekly per unit on various shifts for proper functioning oxygen equipment and correct physician ordered flow rate.(attachment #1 of 2) 1:4 The DON/designee will report audit findings to the QAPI committee monthly for	09/13/2019

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	obstructive pulmonary disease (COPD), for which she required supplemental oxygen. A Physicians Order, dated 5/2/19, indicated oxygen at 2 liters/ per minute. 3.1-47(a)(6)		six (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 09-13-2019.	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing			

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	dose can be readily detected. Based on observation, interview and record review, the facility failed to ensure stored medications were properly labeled related to over the counter medications not labeled for residents in 2 of 5 medications carts and 1 of 4 medication rooms observed. (Medication Carts 3c and 3a, and Medication Room 2b) Findings include: 1. During an observation of the 3c medication cart with LPN 3 on 8/16/19 at 12:10 p.m., a bottle of Sleep Support oral spray, a bottle of Tylenol and a bottle of Advanced Relief eye drops were observed to be in residents' medication drawers without instruction labels. 2. During an observation of the 3a medication cart with LPN 4 on 8/16/19 at 12:35 p.m., a box of Debrox ear drops was observed in a resident's drawer without an instruction label attached. 3. During an observation in the 2b medication room with LPN 6 on 8/16/19 at 1:00 p.m., the treatment cart had Nystat powder, Venelex ointment and Vitamin A & D ointment in residents' drawers without instruction labels. During an interview with the Director of Nursing on 8/16/19 at 2:05 p.m., she indicated all medications, including over the counter, should have the same information on the labels. The policy titled, "Medication from Resident's Home/ Family and Outside Pharmacy Vendors", dated 7/1/02, was received from the Director of Nursing on 8/16/19 at 2:55 p.m. The policy indicated, "The medication must be labeled appropriately with name, medication, dose,	F 0761	F761: The Facility is requesting desk compliance 1:1 No adverse reaction were noted from improper labeled over the counter medications. 1:2: The Unit Manager/designee audited medication carts to assure all over the counter medication was accurately labeled with any deficiencies corrected at that time. 1:3 The Director of Staff Development/designee re-in-serviced licensed staff & QMAS on labeling for over the counter medication as well as prescription medication stored in the Facility medication carts. Unit Managers/designee will audit five (5) resident medications weekly per unit that are stored in the Facility medication carts to ensure proper labeling of over the counter medication & prescription medication for six (6) months. (attachment #2 of 2) 1:4 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor the data presented for any trends &	09/13/2019

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	instructions, Physician, date dispensed and date expired." 3.1-25(o)		determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 9-13-2019	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:			

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	(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of			

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	its IPCP and update their program, as necessary. Based on observation, record review, and interview the facility failed to maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment related to not dating oxygen tubing and humidifiers, reusing single use urinary catheter irrigation kits, and a CNA touching food and nonfood items without proper sanitizing or washing of hands during a meal service. This had the potential to affect 7 of 33 residents whose rooms were randomly observed and 14 residents who ate in the 3D Dining Room. (Residents 86, 159, 272, 70, 124, 58, and 125, Dining Room 3D) Findings include: 1. During an observation on 8/12/19 at 9:33 a.m., Resident 86's oxygen tubing and humidifier were not dated. During an observation on 8/13/19 at 3:00 p.m., Resident 86's oxygen tubing and humidifier were not dated. Resident 86's record was reviewed on 8/13/19 at 2:49 p.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease-difficulty breathing), hypertension (high blood pressure), diabetes mellitus and irregular heart rhythm. The current Physician Order Summary indicated to change the oxygen tubing and humidifier weekly. Interview with Unit Manager 3 on 8/13/19 at 3:07 p.m., indicated the oxygen tubing should be dated on a piece of tape attached to the tubing. The humidifier and oxygen tubing should be changed	F 0880	F880 The Facility is requesting desk compliance 1:1 No adverse reaction noted from not labeling and dating oxygen tubing and humidifier bottles that were changed weekly for residents: #86, #159, #272, #124, #70, #58 and #125. No adverse reactions noted from open irrigation kits at bedside for resident #124. Open irrigation kits removed immediately. No adverse reaction noted from a staff member touching food & nonfood items without proper sanitizing or washing her hands during meal service. 1:2 The Unit Manager/designee completed a chart audit which indicated that oxygen tubing and humidifier bottles had been changed and charted as such in the resident record. The Oxygen administration policy was updated to include labeling of oxygen tubing and humidifier bottles when changed weekly. The Unit	09/13/2019

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	together weekly. 2. During an observation on 8/12/19 at 10:04 a.m., Resident 159's oxygen tubing and humidifier were not dated. During an observation on 8/13/19 at 3:01 p.m., Resident 159's oxygen tubing and humidifier were not dated. Resident 159's record was reviewed on 8/12/19 at 2:52 p.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease-difficulty breathing), diabetes mellitus, and end stage renal (kidney) disease. The current Physician Order Summary indicated to change the oxygen tubing and humidifier weekly. Interview with Unit Manager 3 on 8/13/19 at 3:07 p.m., indicated the oxygen tubing should be dated on a piece of tape attached to the tubing. The humidifier and oxygen tubing should be changed together weekly. 3. During an observation on 8/12/19 at 2:47 p.m., Resident 272's oxygen tubing was not dated. During an observation on 8/13/19 at 9:27 a.m., Resident 272's oxygen tubing was not dated. During an observation on 8/13/19 at 3:03 p.m., Resident 272's oxygen tubing was not dated. Resident 272's record was reviewed on 8/13/19 at 2:54 p.m. Diagnoses included, but were not limited to, COPD (Chronic Obstructive Pulmonary Disease-difficulty breathing). The current Physician Order Summary indicated to		Manager/designee immediately addressed staff related to following physician order when irrigating urinary catheters and removal of equipment after each treatment. Unit Manager/designee addressed hand washing/use of hand sanitizer with identified staff. 1:3 The Director of Staff Development/designee re-in-serviced nursing staff on updated Oxygen Administration policy ensuring all tubing and humidifier bottles are labeled per policy & documented in resident record. The Director of Staff Development/designee re-in-serviced nursing staff in regards to the catheter irrigation policy which included properly disposing of equipment following catheter care. The Unit Managers/designee will assess five (5) residents as well as resident records weekly per unit on all shifts to ensure oxygen therapy is intact, placed on the correct flow rate per physician's order, documented as completed, & labeled	

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	change the oxygen tubing weekly. Interview with Unit Manager 3 on 8/13/19 at 3:07 p.m., indicated the oxygen tubing should be dated on a piece of tape attached to the tubing. The humidifier and oxygen tubing should be changed together weekly.4. On 8/12/19 at 10:26 a.m., and 8/13/19 at 3:35 p.m., Resident 124 was observed in her room and seated in bed. The oxygen humidification bottle connected to the oxygen concentrator was not dated. The resident received oxygen nighty at bedtime. An interview with RN 2 8/13/19 at 3:38 p.m. indicated the oxygen tubing and set up was changed on Sundays and there was currently no date indicated on the oxygen tubing or humidification bottle. An interview with Unit Manager (UM) 2 on 8/14/19 at 9:45 a.m. indicated the date on the humidification bottle was back dated to 8/11/19 and there was no date on the oxygen tubing. The record for Resident was reviewed on 8/14/19 at 1:20 p.m. diagnoses included, but were not limited to atrial fibrillation (irregular heartbeat), coronary artery disease (narrowed blood vessels), hypertension (elevated blood pressure), and heart failure. 5. On 8/12/19 at 11:08 a.m., Resident 70 was observed lying in bed and wearing nasal cannula connected to wall oxygen without a date on the oxygen tubing. On 8/13/19 at 8:40 a.m. and 3:16 p.m., the resident was observed seated in wheelchair with a nasal cannula connected to portable oxygen without a date on the oxygen tubing.		per policy for six (6) months. The Unit Managers/designee will audit all residents requiring urinary catheter irrigation to ensure all supplies/kits are discarded after a single use five (5) times weekly for six (6) months. (Attachment #2 of 2) The Director of Staff Development/designee re-in-serviced staff on the handwashing policy when passing resident trays & while serving in the dining rooms. Unit manager/designee will observe three (3) staff handwashing techniques weekly for six (6) months. (attachment #2 of 2) 1:4 The DON/designee will report audit findings to the QAPI committee monthly for six (6) months. The QAPI committee will monitor data presented for any trends and determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 9-13-2019.	

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ST ANTHONY HOME - CROWN POINT	203 FRANCISCAN DR CROWN POINT, IN 46307

(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

The record for Resident was reviewed on 8/14/19 at 1:20 p.m. diagnoses included, but were not limited to bradycardia (slow heart rate), anemia (low red blood cells), atrial fibrillation, coronary artery disease, hypertension, and congestive heart failure.

An interview with RN 3, 8/13/19 at 3:34 p.m. indicated the oxygen tubing should be dated every time it was changed and they were typically changed on Sundays. The resident's current oxygen tubing was not dated.

The current Physician's Order Summary, dated 7/22/19, indicated oxygen at 2 liters per minute as needed. Another order, dated 7/8/19, indicated change oxygen tubing weekly.

6. On 8/12/19 at 2:55 p.m., 8/13/19 at 2:00 p.m. and 8/13/19 at 3:13 p.m., Resident 58 was seated in her recliner chair with a nasal cannula in place without a date on the oxygen tubing.

The record for Resident was reviewed on 8/14/19 at 1:20 p.m. diagnoses included, but were not limited to atrial fibrillation, hypertension, cardiomegaly, and atherosclerotic heart disease.

An interview with RN 1 on 8/13/19 at 3:32 p.m. indicated the oxygen tubing and set up should be changed on Sundays and there was no date indicated on the oxygen tubing.

7. On 08/12/19 at 3:08 p.m., Resident 125 was observed seated in bed with a nasal cannula connected to an oxygen concentrator and no date on the humidified water bottle or nasal cannula tubing. On 8/13/19 at 8:48 a.m., the resident was observed seated in the dining room with a nasal

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cannula in place and no date on the oxygen tubing.

The record for Resident was reviewed on 8/14/19 at 1:20 p.m. Diagnoses included, but were not limited to hypertension, depression, seizure disorder, and stroke.

An interview with RN 2 on 8/13/19 at 3:38 p.m. indicated the oxygen tubing and set up was changed on Sundays and there was no date indicated on the oxygen tubing or humidification bottle.

An interview with UM 2 on 8/14/19 at 9:45 a.m. indicated the date on the humidification bottle was back dated to 8/11/19 and there was no date on the oxygen tubing.

The current Physician's Order Summary, dated 12/30/17, indicated oxygen at 2 liters per minute and another order dated 12/31/17 indicated to change oxygen tubing and humidifier weekly.

The current Care Plan, dated 10/17/18, indicated to change oxygen tubing and humidification bottle weekly and as needed.

The "Oxygen Administration" policy, provided by UM 3 on 8/14/19 at 3:45 p.m., indicated "....d. Change equipment (humidification bottle, mask, and tubing) every 7 days...."

8. On 8/12/19 at 1:19 p.m., during an observation of Resident 124's room, there were three opened irrigation kits observed sitting on the desk.

On 8/14/19 at 9:34 a.m., there were irrigation kits dated 8/11/19 in the drawer.

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On 8/16/19 at 12:24 p.m., an irrigation kit and normal saline bottle dated 8/11/19 were observed on top of the desk.

The record for the resident was reviewed on 8/16/19 at 12:20 p.m. diagnoses included, but were not limited to neuromuscular dysfunction of bladder (bladder dysfunction), atrial fibrillation, coronary artery disease, hypertension, and congestive heart failure

An interview with RN 2 on 8/13/19 at 3:38 p.m. indicated the irrigation kits were being used for urinary catheter irrigation (flushing a urinary catheter). He also indicated the irrigation kits should not be out in the open as they were.

An interview with UM 2 on 8/14/19 at 9:45 a.m. indicated the irrigation kits for catheters should be single use only.

An interview with LPN 5 on 8/16/19 at 12:25 p.m. indicated the kits should have been disposed of after use and a new kit used for each irrigation.

Interview with UM 3 on 8/16/19 at 12:30 p.m. indicated the resident was supposed to receive catheter irrigation twice daily and the nurse was supposed to use a new irrigation kit with each irrigation.

The current Physician's Order Summary, dated 7/12/19, indicated to flush Foley catheter daily with 100 milliliters, twice daily starting 7/13/19.

The current Care Plan, dated 9/27/18, indicated Foley catheter care every shift per facility policy.

The "Catheter Irrigation" policy, provided by the Administrator on 8/14/19 at 12:45 p.m., indicated

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"....Catheters should be irrigated by a license nurse using sterile technique...."

9. On 8/12/19 at 12:25 p.m., CNA 2 removed food which fell from a resident's mouth from his clothing protector and wiped the resident's mouth. She proceeded to get another lunch tray and did not perform hand hygiene. At 12:32 p.m. CNA 2 touched her nose and continued to passed a room tray without performing hand hygiene.

An interview with CNA 2 on 8/12/19 at 12:40 p.m., indicated she was supposed to use hand sanitizer in between resident assistance and when touching her face.

An interview with UM 2 on 8/12/19 at 12:44 p.m., indicated staff are supposed to use proper hand hygiene while serving the residents.

The "Hand Hygiene" policy, provided by UM 2 on 8/12/19 at 1:11 p.m., indicated either antimicrobial soap and water or alcohol based hand rub must be used between resident contacts, and after sneezing, coughing, and/or blowing or wiping the nose.

3.1-18(a)
3.1-18(b)(1)