STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	09/18/2015

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit was in conjunction with the Investigation of Complaint IN00182447. Survey dates: September 14, 15, 16, 17, and 18, 2015. Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF: 23 SNF/NF: 145 NCC: 3 Total: 171 Census Payor Type: Medicare: 20 Medicaid: 110 Other: 41 Total: 171 NCC Sample: 1 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	St. Anthony Home – Crown Point ("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 Evidence and should be inadmissible in any proceeding on	

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

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

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			that basis.	
	Quality review completed by 26143, on September 25, 2015.			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on interview and record review, the facility failed to follow the plan of care related to laboratory testing completed as ordered for 1 of 25 residents whose plan of care was reviewed. (Residents #257) Finding includes: The record for Resident #257 was reviewed on 9/17/15 at 9:06 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and diabetic neuropathy. Review of a Physician's Order, dated 5/26/15, indicated laboratory orders for a "BMP (basic metabolic profile, electrolytes) and CBC (complete blood count) in a week on 6/2/15 and HgbA1C	F 0282	1.Regarding resident #257, on that date the Physician was notified by the Unit Manager / designee regarding the HgbA1C lab and new order obtained for HgbA1C to be drawn with no adverse reactions noted. The nurse identified received documented 1:1 re-inservicing. 2.Unit Managers / designees reviewed resident plans of care and physician orders to ensure completion with any deficiencies noted corrected at that time. 3.The Director of Staff Development (DSD) / designee re-inserviced the licensed staff regarding the proper procedures to follow	10/18/2015

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	(hemoglobin A1C, a blood test for diabetes management) in 3 months." There was lack of documentation in the record to indicate the HgbA1C test had been completed as ordered. The resident had a current care plan for diabetes. The Nursing interventions included, but were not limited to, labs as ordered. Interview with the DON (Director of Nursing) on 9/18/15 at 1:11 p.m. indicated the HgbA1C was not completed as ordered and had been missed. 3.1-35(g)(2)		after a laboratory testing order has been obtained, and the need to follow all plans of care and physician orders. In addition to weekly audits reviewed in clinical stand up meetings that include review of physician order compliance, Unit Mangers / designees will audit five (5) residents per unit weekly for eight (8) weeks, then ten (10) residents per unit monthly for seven (7) months who have physician orders to ensure they are completed. 4.The DON / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning October 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 10/18/15.	
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest			

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	practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.			
	Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services related to the monitoring and assessment of bruises for 1 of 3 residents reviewed for non pressure related skin conditions of the 7 residents who met the criteria for non pressure related skin conditions. (Resident #196) Finding includes: On 9/14/15 at 2:35 p.m., Resident #196 was observed to have a deep purple discoloration on the right hand between the first and second knuckles. On 9/16/15 at 11:07 a.m., Resident #196 was observed to have a deep purple discoloration on the right hand between the first and second knuckles. The resident indicated she had probably bumped her hand on something. Record review for Resident # 196 was completed on 9/16/15 at 11:13 a.m. The residents diagnoses included, but were not limited to, anemia, hypertension, dementia, anxiety, and depression.	F 0309	1.Regarding resident #196, on that date the Unit Manager completed a head to toe assessment. An incident report was completed on the identified area to the right hand between the first and second knuckles. Skin sheets and a care plan were also completed. The Physician and the family were both notified of the findings. No adverse reactions noted. 2.Unit Managers / designees completed head to toe assessments on all residents to ensure identification and notification of discolorations had been met with any deficiencies corrected at that time. 3.DSD / designee re-inserviced nursing staff on the proper procedure to follow regarding identification of a discoloration, actions when a discoloration is noted, as well as proper notification and monitoring of the area. The Unit Managers / designees will assess five (5) residents per	10/18/2015

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	The Quarterly Minimum Data Set (MDS) assessment completed on 7/17/15 indicated the resident had a BIMS (Brief Interview of Mental Status) score of 6 which indicated the resident was cognitively impaired. The assessment indicated the resident needed total assistance of 1 person for bed mobility; extensive assistance of 1 person for transfers, walking, locomotion, dressing, toileting, and personal hygiene; limited assistance of 1 person for eating and physical help of 1 person for bathing. A care plan dated 4/4/15, indicated the resident was at risk for pressure ulcers, had fragile skin and bruised easily. Nursing interventions included to do skin checks twice weekly with bathing. Review of a Skin Check Sheet completed on 9/16/15, indicated the resident received a shower and had her nails trimmed. The sheet indicated the resident did not have any skin integrity problems. The sheet was signed by CNA #1 and LPN #1. Interview with CNA #1 on 9/16/15 at 11:42 a.m., indicated she had given the resident a shower on 9/16/15 but did not notice any bruising or discolorations. Interview with LPN #1 on 9/16/15 at		unit weekly for eight (8) weeks, then ten (10) residents per unit monthly for seven (7) months to ensure discolorations have been identified and documented per policy. 4.The DON / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning October 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 10/18/15.	

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	11:49 a.m., indicated the resident received a shower on 9/16/15. During the shower she did a skin assessment of Resident # 196 and did not notice the resident to have any bruising or discolorations. Interview with Unit Manager #1 on 9/16/15 at 11:59 a.m., indicated the nurse and the CNA should have observed the discoloration on the resident's hand when the resident had received her shower. The discoloration should have been written on the Skin Check Sheet and a Non-Pressure Skin Condition Report should have been filled out. A follow up interview with Unit Manager #1 on on 9/16/15 at 3:35 p.m., indicated the shower sheet dated 9/16/15 indicated the discoloration to the resident's hand was added after it was brought to staffs attention. A "Skin Check Sheets Policy & Procedure", received as current from the Unit Manager #1 on 9/16/15 at 3:43 p.m. indicated "...Policy: It is the policy of the facility to have the CNAs complete a skin assessment sheet on bath days. The CNA is to report any skin concerns to the licensed nurse"...Procedure: 2. Nursing staff (CNAs and nurses) will assess skin integrity during bathing. 3. The nurse will			

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	complete the Skin Check Sheet weekly...." 3.1-37(a)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on record review and interview, the facility failed to ensure each resident was free from unnecessary medications related to a laboratory test not completed as ordered for 1 of 5 residents reviewed for unnecessary medications. (Residents	F 0329	1.Regarding resident #257, on that date the Physician was notified by the Unit Manager / designee regarding the HgbA1C lab and new order obtained for HgbA1C to be drawn with no adverse reactions noted.	10/18/2015

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	#257) Finding includes: The record for Resident #257 was reviewed on 9/17/15 at 9:06 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus type II, hypertension, and diabetic neuropathy. Review of the September 2015 Physician Order Summary indicated an order for Humalog (insulin) subcutaneous four times daily per sliding scale (insulin to be given based on blood sugar result). Review of a Physician's Order, dated 5/26/15, indicated laboratory orders for a "BMP (basic metabolic profile, electrolytes) and CBC (complete blood count) in a week on 6/2/15 and HgbA1C (hemoglobin A1C, a blood test for diabetes management) in 3 months." There was lack of documentation in the record to indicate the HgbA1C test had been completed as ordered. Interview with the DON (Director of Nursing) on 9/18/15 at 1:11 p.m. indicated the HgbA1C was not completed as ordered had been missed. 3.1-48(a)(6)		2.Unit Manager / designee reviewed residents requiring an A1C laboratory testing to ensure completion with any deficiencies corrected at that time. 3.The Director of Staff Development (DSD) / designee re-inserviced the licensed staff regarding the proper procedures to follow after a laboratory testing order has been obtained. Unit Mangers / designees will audit five (5) residents per unit weekly for eight (8) weeks, then ten (10) residents per unit monthly for seven (7) months who have laboratory testing orders to ensure they are completed. 4.The DON / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning October 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 10/18/15.	

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F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to distribute food under sanitary conditions, related to food transported uncovered, staff touching non food and food items without changing gloves, and improper sanitation of a food thermometer for 2 of 2 meals observed of 3 dining areas observed (2A Dining Room, 2B Dining Room, and 2D Dining Room) Findings include: 1. During an observation of the lunch meal in the 2B Dining Room on 9/14/15 at 11:53 a.m., the following was observed: Dining Service Aide (DSA) #1 entered the dining room, did not wash her hands or use hand sanitizer, put gloves on, took food pans out of the food cart, and set the pans of food in the steam table. DSA #1 then took the food temperatures and	F 0371	1.Regarding DSA #1, the associate was immediately re-inserviced upon identification regarding proper handwashing and glove usage, and covering of food during transport. Regarding DSA #2, the associate was immediately re-inserviced upon identification regarding proper food temperature testing method and sanitation practices. Any remaining food identified was disposed of. 2.The Dining Services Director / designees made rounds of all dining rooms with any other deficiencies noted corrected at that time. There were no adverse / negative outcomes noted to any residents. 3.The Dining Services Director / Director of Staff	10/18/2015

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	began serving the food. DSA #1 served each resident's biscuit with her gloved hand. DSA #1 poured drinks from the cold cart, walked across the room to get clean dishes from the dish cart, and touched the handle of the dessert cart multiple times in between serving the biscuits with her gloved hand. DSA #1 was not observed to wash her hands, use alcohol gel, or change her gloves after touching the non food items. 2. During an observation of the lunch meal in the 2A Dining Room on 9/14/15 at 12:52 p.m., the following was observed: DSA #1 was observed pushing the dessert cart down the hall toward the 2A dining room. An uncovered pan of biscuits was observed on the top shelf of the cart. A tray of yellow cake with the plastic wrap half off was observed on the second shelf of the cart. The tray of yellow cake had been set inside the bin of clean utensils that was also uncovered. DSA #1 entered the dining room, did not wash her hands or use hand sanitizer, put gloves on, walked across the room to get dishes off of the dish cart, took food pans out of the food cart, and set the pans of food in the steam table. DSA #1 then		Development / designee re-inserviced dining staff regarding proper handwashing and glove usage, proper procedure for covering food during transport, and proper food temperature testing method and sanitation practices. The Dining Services Director / designee will perform rounds eighteen (18) times weekly for three (3) months and then nine (9) times weekly for six (6) months to ensure compliance with same. 4.The Dining Services Director / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning October 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 10/18/15.	

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	began serving the food. DSA #1 served jello from the cold cart, served one plate of food from the steam table, put a biscuit on the plate using her gloved hand, opened the refrigerator on the cold cart and poured a cup of apple juice and a cup of milk and closed the refrigerator. DSA #1 then served another plate from the steam table, put a biscuit on the plate using her gloved hand, opened the refrigerator on the cold cart and poured a cup of milk, closed the refrigerator, got a loaf of bread from the dessert cart, removed two slices of bread with her gloved hand, and served a piece of chicken from the steam table. DSA #1 continued to serve each resident's biscuit with her gloved hand. DSA #1 poured drinks from the cold cart, walked across the room to get clean dishes from the dish cart, and touched the handle of the dessert cart multiple times in between serving the biscuits with her gloved hand. DSA #1 was not observed to wash her hands, use alcohol gel, or change her gloves after touching the non food items. Interview with DSA #1 on 9/14/15 at 1:32 p.m. indicated if she had used her			

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	gloved hand to serve bread because she had run out of utensils. She further indicated if she touched any non food item she should have changed her gloves before returning to serving the food. She indicated she had not changed her gloves during dining service. Interview with the Food Service District Manager and the Dining Experience Manager on 9/16/15 at 10:30 a.m. indicated DSA #1 was a new employee and they would inservice her. They further indicated staff should not be touching any food with their hands and should have used a utensil. The Food Service District Manager indicated there was a lack of handwashing sinks in the dining areas so their policy was to use alcohol gel. She further indicated DSA #1 should have used alcohol gel. They indicated all food should have been covered when transported down the hallway. A facility policy, titled, "Safety and Sanitation Glove Usage", dated 11/18/13, and received as current from the Food Service District Manager, indicated, "...Single use gloves shall be used for only ONE task, and then discarded...Single use gloves should ALWAYS be changed when moving from one task to another...Always wash			

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	and dry hands before and after gloving...Proper Steps to Gloving -Wash and sanitize hands before gloving...Remove gloves when:...- touching soiled food contact areas... -moving from food prep to food service... -after handling non-food items such as garbage bags or chemicals -leaving food prep area..." A facility policy, titled, "China/Food Storage & Transportation to the Wings", dated 8/31/15, and received as current from the Food Service District Manager, indicated, "...11.) All food items are to be covered with film and/or foil at all time during transport a. Kitchen to Wings b. Wing to Wing c. Wing to Kitchen d. Trays to Rooms. 12.) Film, foil, or lids should be used. If the film or foil has been punctured-it needs to be replaced before transporting..." 3. During a lunch service observation on 9/17/15 at 12:04 PM for food temperatures before serving on unit 2D, DSA (Dining Service Aide) #2 received the heated cart from the kitchen and transferred the food pans to the steam table in the unit dining room. He then donned clean gloves and began to test food temperatures without first cleaning off the temperature probe. DSA #2 continued to test the temperature of each food, wiping off the temperature probe			

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	with a napkin between foods. He indicated at that time he did not usually use a napkin, the kitchen "usually sends up wipes to use." On 9/17/2015 at 12:18 PM, the Food Service District Manager witnessed DSA #2 using a napkin to wipe off the temperature probe between foods and subsequently brought probe wipes to the unit and told DSA #2 he should be using those to clean off the temperature probe between foods. A policy titled "Safety & Sanitation. Food Temperature and Taste" was provided by the Director of Dining Services on 9/18/15 at 8:30 a.m. and deemed as current. The policy indicated, ".... Methods/ How To/ Procedure: ... Food temperatures should be taken using a calibrated (or digital) stem thermometer. Before probing any product the thermometer should be sanitized with an alcohol swab ...." 3.1-21(i)(2) 3.1-21(i)(3)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an			

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	155214	A. BUILDING 00 B. WING	09/18/2015

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	Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review, and interview, the facility failed to provide a sanitary environment to help prevent the development and transmission of disease	F 0441	1.Regarding the residents in the two identified rooms on the second floor, on that date the Unit Managers / designees discarded the bed pans and	10/18/2015

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	and infection related to improperly stored bedpans and bath basins on 1 of 3 floors in the facility. (2nd floor) Findings include: During the environmental tour on 9/18/15 at 9:45 a.m. through 10:45 a.m., with the Environmental Manager, Plant Operations Assistant, Director of Plant Operations, ADON (Assistant Director of Nursing) and the Administrator present, the following was observed: 1. Room #210 had two uncovered bath basins stored on the side of the bathtub. 2. Room #222 had an uncovered bedpan stored inside the bathtub on top of a wheelchair cushion and next to a dirty glove and used plastic cup. During the observations the facility staff acknowledged the above findings. A facility policy, dated 05/10, titled, "Bedpan", received as current from the ADON on 9/18/15, indicated, "...Return the bedpan to storage..." 3.1-18(b)(1)		bath basins that were uncovered and replaced with new bed pans and bath basins. Bed pans and bath basins were placed into a plastic bag for storage. 2.The Unit Managers / designees audited all resident rooms to ensure no other bed pans or bath basins were improperly stored with no other deficiencies were noted at that time. 3.The DSD / designee re-inserviced nursing staff regarding the policy / procedure for proper storage of bed pans and bath basins (storing in plastic bags). The Unit Managers / designees will round five (5) resident rooms per unit weekly for eight (8) weeks, then ten (10) resident rooms per unit monthly for seven (7) months to ensure proper storage of bed pans and bath basins. 4.The DON / designee will report audit findings to the QAPI committee monthly for nine (9) months beginning October 2015. The QAPI committee will monitor the data presented for any trends	

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			and determine if further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 10/18/15.	
F 0465 SS=E Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to maintain an environment that was safe, clean, and in a state of good repair, related to marred and gouged walls and doors, peeling and sharp edges on a door skin(protector), a broken call light push button, a loose bathroom call light box, bubbled wall plaster, a gouged toilet seat, and cracked floor tile, for 3 of 3 floors. (First, Second and Third) Findings include: An Environmental Tour was conducted on 9/18/15 from 9:45 - 10:45 a.m. with the Environmental Manager, Plant Operations Assistant, Director of Plant Operations, ADON (Assistant Director of Nursing) and Administrator (for part of the tour). The following was observed: 1. First Floor	F 0465	1.All areas noted on first, second and third floors were addressed / repaired on 9/18/15 after completion of environmental tour. 2.Director of Plant Operations / designees audited resident doors for sharp corners / marring / gouges with any identified issues repaired at that time; room floor tiles with no other deficiencies noted; room walls for holes / bubbled or peeling plaster / marring with any deficiencies noted corrected at that time; room towel bar sets with no other deficiencies noted; resident call lights with no other deficiencies noted; and resident toilet seats with no other deficiencies noted; all by	10/18/2015

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	a. Room 108: The door skin (protector) for the inner bathroom door was falling off and had potentially sharp corners. One resident resided in this room. 2. Second Floor a. Room 212: There was a cracked floor tile by the bathroom entrance and the inner bathroom door was gouged. One resident resided in this room. b. Room 222: There was a hole in the wall behind the door above the baseboard. One resident resided in this room. c. Room 230: There was only one end cap of a towel bar set remaining attached to the wall behind the toilet. One resident resided in this room. d. Room 233: The room call button was missing the button cover. One resident resided in this room. e. Room 243: The plaster all around the window in the bathroom was bubbled and peeling. One resident resided in this room. f. Room 296: The entry wall on the right side of the room door was marred. 3. Third floor		9/21/15. 3.Director of Plant Operations / designee re-inserviced Plant Operations staff on requirements for maintaining a safe, functional, sanitary, and comfortable environment for residents, staff and the public as they relate to the above, and the need to address issues promptly. Other departments also re-inserviced on same by DSD / designee, including method of communication of issues to Plant Operations Department. Director of Plant Operations initiated order of additional doors skins to enhance and prolong the safety, integrity and appearance of additional resident doors. Director of Plant Operations / designee will round five (5) resident rooms per wing weekly for eight (8) weeks, then ten (10) resident rooms per wing monthly for seven (7) months to ensure compliance in all above areas. 4.The Director of Plant Operations / designees will report audit findings to the	

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	a. Room 333: The toilet seat had multiple gouges. One resident resided in this room. b. Room 336: There were gouges in the inner bathroom door. One resident resided in this room. c. Room 338: The call light box in the bathroom was loose from the wall. One resident resided in this room. d. Room 377: The outer bathroom door was marred. One resident resided in this room. At the time of the tour, the facility staff acknowledged the above findings. 3.1-19(f)		QAPI committee monthly for nine (9) months beginning October 2015. The QAPI committee will monitor the data presented for any trends and determine if further monitoring / action is necessary for continued compliance. 5.Systemic changes will be completed by 10/18/15.	