STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155094	A. Building B. Wing	05/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
St Mary Healthcare Center	2201 Cason St Lafayette, IN 47904

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44598 Based on observation, interview and record review, the facility failed to ensure residents were served their meals together, staff were seated while eating with the residents, and a resident was able to complete their meal before being removed from the dining room for 1 of 2 dining rooms reviewed for dignity. (the legacy dining room) Findings include: 1. During an observation, on 5/14/25 at 12:00 p.m., the residents were seated in the legacy dining room. CNA 15 took a resident's meal ticket, gave the ticket to Dining Assistant 12, and he prepared the resident's plate. The CNAs passed out plates to residents seated at different tables randomly until all residents were served. During an interview, on 5/14/25 at 11:54 a.m., CNA 11 indicated Dining Assistant 12 told her to take a resident's meal ticket and pass the food out in the order of the tickets. CNA 11 told Dining Assistant 12 they should serve one table at a time. During an interview, on 5/14/25 at 12:12 p.m., Activity Associate 13 indicated normally the trays were passed out one table at a time until all the residents had received their food. During an interview, on 5/14/25 at 12:26 p.m., Dining Assistant 12 indicated he was told to serve the residents by meal tickets and not one table at a time. 2. During an observation, on 5/14/25 at 12:24 p.m., CNA 11 was standing next to a table in the dining room talking with two residents. CNA 11 had a small bowl in her left hand and a fork in her right hand eating out of the bowl. During an interview, on 5/14/25 at 12:27 p.m., CNA 11 indicated she needed to sit down and not eat standing next to the residents. During an interview, on 5/14/25 at 1:15 p.m., the Director of Nursing (DON) indicated the staff should not stand and eat out of a bowl in the dining room. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview, on 5/15/25 at 3:03 p.m., the DON indicated the Legacy dining room was served family style and the staff were encouraged to eat with the residents. CNAs needed to sit down with the residents at the table and not stand. 52643 3. During an observation, on 5/12/25 at 12:06 p.m., Resident 58 was in his wheelchair in the legacy dining room and had just finished a bowl of soup. The hospice CNA entered the dining room and approached the resident. The resident was waiting for the main course when the hospice CNA pulled the resident away from his table. The hospice CNA was observed pushing the resident out of the dining room before he finished his meal and had told the resident she was going to give him a shower. During an observation, on 5/12/25 at 12:21 p.m., the hospice CNA returned the resident to the dining room. The resident was wearing clean clothes, and his hair was wet. The dining staff had served the other residents, and the hospice CNA had to retrieve the resident's food from the kitchen. During an interview, on 5/15/25 at 9:43 a.m., CNA 2 indicated showers were usually given before or after breakfast on the day shift. The showers were not to be given during mealtimes. During an interview, on 5/15/25 at 9:55 a.m., the DON indicated residents would be given showers during mealtime only in an extreme situation. A shower could be given when a resident was incontinent and covered with bowel movement. A hospice visit note, dated 5/12/25, indicated the hospice CNA provided activities of daily living (ADL) for Resident 58 from 12:04 p.m. to 12:38 p.m., and a shower was given. A current facility policy, titled Guidelines for Meal Service, dated as revised 5/22/18 and received from the DON on 5/14/25 at 12:22 p.m., indicated .To provide residents with a choice of food, dining times and fine dining experience .Lunch is generally served around noon .During meal service, staff members will make efforts to serve all the residents seated together at the same time. This is not always possible due to various reasons A current facility policy, titled Resident Rights-Life Enrichment, dated as revised 4/14/25 and received from the Executive Director on 5/12/25 at 10:40 a.m., indicated .The purpose of this policy is to ensure that the rights of each resident are consistently preserved and respected in the provision of Life Enrichment services. Special care must be taken to uphold and safeguard these rights while delivering programs that enhance the quality of life for residents .Residents' dignity and privacy will be respected during individual and group programs A current facility policy, titled Legacy Family Style Dining Standards, dated as revised 11/7/18 and received from the Clinical Support Nurse on 5/15/25 at 3:30 p.m., indicated .Serve residents from the LEFT, following the THS Standards: Each dish or meal item is owned by the team member throughout the meal service to ensure everyone is offered the items, and to ensure the dish/bowl is refilled and served again when requested .Approach each resident and offer the assigned item to each resident, using a verbal prompt .After everyone at the table is served, move to the next table to repeat the process until every resident has been served .Eat with residents and carry on pleasant conversation: Place a small amount of food on a COLORED plate and sit among the residents, at the corner of table (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.1-3(t)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 52091 Based on interview and record review, the facility failed to ensure a do not resuscitate (DNR) order was updated when received for 1 of 1 resident reviewed for advanced directives. (Resident 21) The deficient practice was corrected on 4/28/25, prior to the start of the survey, and therefore was past noncompliance. Findings include: The clinical record for Resident 21 was reviewed on 5/16/25 at 11:34 a.m. The diagnoses included, but were not limited to, adult failure to thrive, heart failure, coronary artery disease, hypertension, Parkinson's disease, type 2 diabetes, obesity, schizophrenia, iron deficiency anemia, and hypothyroidism. A physician's order dated 3/25/25 indicated full code status. A State of Indiana Out of Hospital Do Not Resuscitate Declaration and Order form indicated the resident was to be a DNR. The form was signed by the resident representative and witness on 4/1/25. The form was signed by the physician on 4/14/25. A physician's order, dated 4/22/25, indicated DNR code status. During an interview, on 5/19/25 at 10:19 a.m., LPN 10 indicated that when she received a signed DNR order, she entered the order and scanned the form into the resident's electronic chart. During an interview, on 5/19/25 at 12:13 p.m., the DON indicated once the form was completed, it was uploaded into the residents' chart and the orders were updated to match the form. The DON indicated there were times the form was uploaded into the chart and the orders did not get updated. She began an audit with a plan of correction in April. A current facility policy, titled Guidelines for Advanced Directives, dated 9/26/24 and received from the Clinical Support Nurse on 5/16/25 at 2:25 p.m., indicated .Advanced Directives will be reviewed with resident and/or resident representative .The resident or representative will advise .regarding wishes for end of life directives and code status .The nursing staff will confirm the desired code status and obtain an order from the physician The deficient practice was corrected by 4/28/25, after the facility implemented a systemic plan which included audits and conducting staff training on advanced directives. 3.1-4(f)(5)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 52091 Based on record review and interview, the facility failed to ensure the residents were issued SNF ABN's (Skilled Nursing Facility Advance Beneficiary Notice of Non-coverage) for 2 of 3 residents reviewed for beneficiary notification. (Resident 1 and 20) The deficient practice was corrected on 2/13/25, prior to the start of the survey, and therefore was past noncompliance. Findings include: 1. Resident 1 started on Medicare Part A services on 11/3/24. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The last covered day of Part A Service was 12/13/24. There was no SNF ABN or NOMNC provided to Resident 1. 2. Resident 20 started on Medicare Part A services on 10/22/24. The facility initiated the discharge from Medicare Part A services when benefit days were not exhausted. The last covered day of Part A Service was 12/23/24. There was no SNF ABN or NOMNC provided to Resident 20. During an interview, on 5/15/25 at 11:22 a.m., the DON (Director of Nursing) indicated the beneficiary notices were not being completed prior to February this year and a plan of correction was now in place. A current facility policy, titled NOMNC Completion SOP, reviewed on 10/24/22 and provided by the Clinical Support on 5/19/25 10:00 a.m., indicated .For residents receiving therapy under Medicare Part A, social services will issue NOMNC prior to therapy discharge. If the resident has Medicare days remaining and is staying at the campus after therapy discharge social services will the SNF ABN form in addition to the NOMNC The deficient practice was corrected by 2/13/25, after the facility implemented a systemic plan which included audits and conducting staff training on following the standard operating procedure for completing NOMNCs. 3.1-4(f)(3)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 50956 Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS) assessment was correctly coded for 1 of 1 resident reviewed for resident assessments. (Resident 49) Findings include: The clinical record for Resident 49 was reviewed on 5/14/25 at 3:56 p.m. The diagnoses included, but were not limited to, schizophrenia, bipolar disorder, and cognitive communication deficit. A Preadmission Screening and Resident Review (PASARR), dated 12/18/24, indicated the resident did not have any known recent or current mental health conditions. An admission minimum data set (MDS) assessment, dated 12/24/24, indicated the resident did not have a diagnosis of schizophrenia. A resident information sheet, last reviewed by the physician on 3/13/25, indicated the resident had a diagnosis of schizophrenia and bipolar disorder. A significant change in status MDS assessment, dated 3/26/25, indicated Resident 49 had a diagnosis of schizophrenia. Resident 49's physician's orders did not include any antipsychotic medications for the treatment of schizophrenia or bipolar disorder. During an interview, on 5/16/25 at 2:00 p.m., the Director of Nursing (DON) indicated Resident 49 did not have a schizophrenia or bipolar diagnosis, but his roommate did. During an interview, on 5/19/25 at 11:09 a.m., the DON indicated the incorrect diagnoses had been removed from Resident 49's chart. During an interview, on 5/19/25 at 11:11 a.m., the MDS Coordinator indicated that the schizophrenia and bipolar disorder diagnoses were inputted incorrectly onto the MDS assessment. They should not have been listed. During an interview, on 5/19/25 at 12:27 p.m., the MDS corporate support indicated the facility did not have an MDS policy. They followed the RAI (resident assessment instrument) guidelines. 3.1-31(c)(1) 3.1-31(i)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 52643 Based on interview and record review, the facility failed to ensure vital signs and neurological assessments were documented for 1 of 1 resident reviewed for assessments. (Resident 70) The deficient practice was corrected on 5/10/25, prior to the start of the survey, and therefore was past noncompliance. Findings include: The clinical record for Resident 70 was reviewed on 5/15/25 at 1:37 p.m. The diagnoses included, but were not limited to, hypertension, chronic kidney disease, type 2 diabetes mellitus, and retention of urine, A facility event and incident report, dated 12/13/24 at 6:41 p.m., indicated the resident had an unwitnessed fall. The report did not include documentation for the 72-hour follow-up vital signs or neurological assessments. A facility event and incident report, dated 4/1/25 at 10:20 a.m., indicated the resident had an unwitnessed fall. The report did not include documentation for the 72-hour follow-up vital signs or neurological assessments. During an interview, on 5/15/25 at 9:48 a.m., the Director of Nursing (DON) indicated neurological assessments were not initiated on 4/1/25. The nurse took the first set of vital signs and did not initiate the documentation needed to complete the required documentation. During an interview, on 5/19/25 at 11:33 a.m., the DON indicated documentation for the unwitnessed fall on 4/1/25 was not started. The nurse was new and did not initiate the required records. The unwitnessed fall, dated 12/13/24, did not have documentation of the 72-hour vital signs. During an interview, on 5/19/22 at 11:30 a.m., LPN 14 indicated that when a resident had an unwitnessed fall the resident would be assessed for injuries. Vital signs and neurological assessments would be completed every shift for 72 hours. The nurse would chart the information in the residents' Electric Health Records (EHR) During an interview, on 5/19/25 at 3:25 p.m., the DON indicated the facility had no further documentation to provide. A facility falls management program guideline indicated the nursing staff would monitor and document the continued resident response and effectiveness of interventions for 72 hours. The neurological assessments would be completed and documented on the fall event form. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A current facility policy, titled Fall Management Program Guideline, dated as reviewed 12/17/24 and received from the DON on 5/19/25 at 11:45 a.m., indicated .The attending physician or medical director in the absence of the attending physician and the responsible party should be notified .Any orders received from the physician should be noted and carried out .Nursing staff will monitor and document continued resident response and effectiveness of interventions for 72 hours .communicate Interventions during shift report A current facility policy, titled Guidelines for Neurological Checks, dated as reviewed 12/17/24 and received from the DON on 5/15/25 at 10:30 a.m., indicated .To evaluate the level of consciousness, evaluate pupil response, motor function, and vital signs that may alert staff for potential for head injury or seizure activity . Neuro-checks for 24 hours should be completed within the Fall Event Form .Obtain vital signs with each assessment A current facility policy, titled Quick Guide to Matrix Documentation Guidelines, dated as revised on 2/20/18 and received from the DON on 5/19/25 at 11:45 a.m., indicated .Post event .progress notes, vital signs q shift for 72 hours The deficient practice was corrected by 5/10/25, after the facility implemented a systemic plan which included audits, conducting staff education for falls and neuro checks. 3.1-37(a)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 50956 Based on interview and record review, the facility failed to ensure a resident's diagnoses in the medical record were accurate and correct for 1 of 1 resident reviewed for documentation. (Residents 49) Findings include: The clinical record for Resident 49 was reviewed on 5/14/25 at 3:56 p.m. The diagnoses included, but were not limited to, schizophrenia, bipolar disorder, and cognitive communication deficit. A facility resident information sheet, last reviewed by the physician on 3/13/25, indicated the resident had a diagnosis of schizophrenia and bipolar disorder. The physician's orders did not include any antipsychotic medications for the treatment of schizophrenia or bipolar disorder. During an interview, on 5/16/25 at 2:00 p.m., the Director of Nursing (DON) indicated Resident 49 did not have schizophrenia or a bipolar diagnosis. During an interview, on 5/19/25 at 11:09 a.m., the DON indicated the incorrect diagnoses were incorrect and should not have been listed on the diagnoses list. Upon exit, the facility was unable to provide an accurate records policy. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 52091 Based on interview and record review, the facility failed to ensure the policy and procedure related to administering two (2) step Mantoux skin tests for tuberculosis were followed for 4 of 5 employees reviewed for infection control. (QMA 6, QMA 7, CNA 8 and CNA 9) Findings include: 1. A facility tuberculin testing for employees' form, dated 9/25/24, indicated QMA 6 was given the first step tuberculosis (TB) test on 9/25/24 and was read on 9/28/24. The second step was given on 10/10/24 and read on 10/12/24. There was no documentation indicating the time the first and second step tests were read. 2. A facility tuberculin testing for employees' form, dated 8/14/24, indicated QMA 7 was given the first step TB test on 8/14/24 and was read on 8/16/24. The second step was given on 8/30/24 and read on 9/1/24. There was no documentation indicating the time the first and second step test was read. 3. A facility tuberculin testing for employees' form, dated 1/19/25, indicated CNA 8 was given the first step TB test on 1/19/25 and was read on 1/21/25. The second step was given on 2/1/25 and read on 2/3/25. There was no documentation indicating the time the first and second step test was read. 4. A facility tuberculin testing for employees' form, dated 11/8/24, indicated CNA 9 was given the second step TB test on 11/18/24 and was read on 11/20/24. There was no documentation indicating the time the second step test was read. During an interview, on 5/19/25 at 10:28 a.m., LPN 10 indicated when a TB test was administered all the information including the lot number, date, time, and initials should be documented. The test would be read in 48-72 hours. It would be the same process when reading the test. A current facility policy, titled Mantoux Test Procedure, dated as reviewed on 12/16/24 and provided by the DON on 5/19/25 at 9:49 a.m., indicated .Record administration of Mantoux Test (date, time .) .Read the Mantoux Test results in 48-72 hours 3.1-18(e)