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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155094 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 03/31/2026 |
| NAME OF PROVIDER OR SUPPLIER St Mary Healthcare Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2201 Cason St Lafayette, IN 47904 | |
| For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) | | |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p> | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on observation, interview and record review, the facility failed to ensure the food preparation area did not contain employee drinks and frozen food was sealed in 1 of 1 kitchen reviewed. This deficient practice had the potential to affect 65 of 65 residents who received food from the kitchen. Findings include: During the kitchen observation, on 3/24/26 at 9:36 a.m., with the Dietary Manager, the following were observed: a. The food preparation counter had two unopened cans of energy drinks and a white cup with a lid and straw stored next to a jar of peanut butter and loaf of bread. b. On the second shelf in the walk-in freezer, there was a large opened plastic bag containing one skinless chicken breast. The chicken breast had a small amount of ice buildup on the upper left corner. c. On the second shelf in the walk-in freezer, there was a large cardboard box of skinless chicken breasts. The chicken was left in an untied plastic bag, and the cardboard lid was left wide open. During an interview, on 3/24/26 at 9:45 a.m., the Dietary Manager indicated the drinks belonged to the staff and staff were not supposed to store any food or drinks in the food preparation area. During an interview, on 3/24/26 at 10:19 p.m., the Dietary Manager indicated the clear package of one skinless chicken breast was open and had ice on the edges of the chicken breast. The box of opened chicken should have been tied and not opened to air. During an interview, on 3/25/26 at 11:15 p.m. Dietary Staff 5 indicated staff should never leave their personal drinks or food in the kitchen. A current facility policy, titled Culinary Services, reviewed on 7/10/25 and received from the Executive Director 3/25/26 at 1:59 p.m., indicated .Food and supplies shall be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance. All foods in the freezer are wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. Items are labeled and dated. 410 IAC (Indiana Administrative Code) 3.1-21(i)(3)</p> | | |

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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a physician's orders were followed, a medication was administered according to the ordered parameters, and to obtain an admission weight for 3 of 3 residents reviewed for quality of care. (Resident 6, 17 and 44) Findings Include: 1. The clinical record for Resident 6 was reviewed on 3/25/26 at 10:59 a.m. The diagnoses included, but were not limited to, hypotension, vitamin deficiency, acute kidney failure, and iron deficiency anemia. A care plan, dated 3/19/26, indicated the resident had a potential for cardiovascular distress related to the diagnosis of hypotension. Interventions included, but were not limited to, administer medications as ordered. A physician's order, dated 3/11/26, indicated to administer midodrine (a medication for low blood pressure) 5 milligrams (mg), four times a day, and to hold the medication for a systolic blood pressure greater than 110. A medication administration record (MAR), dated 3/11/26 through 3/25/26, indicated midodrine was administered outside of the hold parameters on the following dates: On 3/12/26 at 4:00 p.m., with a systolic blood pressure of 167. On 3/15/26 at 4:00 a.m., with a systolic blood pressure of 129. On 3/17/26 at 8:00 a.m., with a systolic blood pressure of 112. On 3/23/26 at 12:00 p.m., with a systolic blood pressure of 114. On 3/24/26 at 4:00 a.m., with a systolic blood pressure of 111. On 3/25/26 at 8:00 a.m., with a systolic blood pressure of 127. A MAR, dated 3/11/26 through 3/25/26, indicated midodrine was held when it should have been administered on the following dates: On 3/11/26 at 12:00 p.m., with a systolic blood pressure of 102. On 3/11/26 at 4:00 p.m., with a systolic blood pressure of 110. On 3/12/26 at 8:00 a.m., with a systolic blood pressure of 101. On 3/12/26 at 12:00 p.m., with a systolic blood pressure of 101. On 3/16/26 at 4:00 a.m., with a systolic blood pressure of 104. On 3/17/26 at 4:00 p.m., with a systolic blood pressure of 109. On 3/18/26 at 4:00 a.m., with a systolic blood pressure of 100. On 3/18/26 at 8:00 a.m., with a systolic blood pressure of 104. On 3/18/26 at 12:00 p.m., with a systolic blood pressure of 104. On 3/18/26 at 4:00 p.m., with a systolic blood pressure of 102. On 3/19/26 at 8:00 a.m., with a systolic blood pressure of 105. On 3/19/26 at 12:00 p.m., with a systolic blood pressure of 108. On 3/19/26 at 4:00 p.m., with a systolic blood pressure of 101. On 3/22/26 at 4:00 a.m., with a systolic blood pressure of 105. On 3/23/26 at 4:00 a.m., with a systolic blood pressure of 106. On 3/23/26 at 8:00 a.m., with a systolic blood pressure of 106. During an interview, on 3/25/26 at 11:21 a.m., the Director of Nursing (DON) indicated medications should not be administered or held out of parameters. During an interview, on 3/25/26 at 11:32 a.m., LPN 2 indicated on the MAR, the nurse's initials would be in parenthesis if the medication was not given and a note would appear below with the reason it was held. Medications should not be administered outside of parameters. 2. The clinical record for Resident 17 was reviewed on 3/25/26 at 11:44 a.m. The diagnoses included, but were not limited to, diastolic (congestive) heart failure, dementia, type 2 diabetes mellitus, and anxiety disorder. A physician's order, dated 7/31/25, indicated an admission order was placed for a one-time weight with an end date of 7/31/25. There was no admission weight found during the clinical record review. During an interview, on 3/25/26 at 11:23 a.m., the Director of Nursing (DON) indicated the first weight for Resident 17 was obtained on 8/5/25. No other weight was documented prior to 8/5/25. 3. The clinical record for Resident 44 was reviewed on 3/25/26 at 10:53 a.m. The diagnoses included, but were not limited to, cellulitis of the right lower limb, pulmonary fibrosis, dementia, diabetes mellitus, and hypertension. The resident was admitted on [DATE] and the admission weight was not obtained until 1/23/26. During an interview, on 3/25/26 at 10:35 a.m., the Clinical Support Nurse indicated the policy did not specify when to obtain an admission weight. The weight in the computer was charted three days after the resident was admitted to the facility. During an interview, on 3/25/26 at 11:29 a.m., LPN 2 indicated admission weights were to be obtained at the time of admission. During an interview, on 3/25/26 at 11:39 a.m., LPN 3 indicated she would obtain admission weights on the day of admission before the end of her shift. During an interview, on 3/25/26 at 11:41 a.m., QMA 4 (continued on next page)</p> | | |

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| <p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>indicated an admission weight needed to be obtained within 24 hours of the resident's arrival. One of the first tasks she would complete with a new resident would be to obtain their weight. A current facility policy, titled Medication Administration General Guidelines, dated as revised on 11/2018 and received from the Executive Director on 3/24/26 at 1:59 p.m., indicated .Medications are administered as prescribed.FIVE RIGHTS - Right resident, right drug, right dose, right route and right time.A current facility policy, titled Guidelines for Weight Tracking, dated as reviewed on 5/22/18 and received from the Clinical Support Nurse on 3/24/26 at 1:59 p.m., indicated .Guidelines for Weight Tracking.Residents will have their weight taken and recorded upon admission to establish a baseline.410 IAC (Indiana Administrative Code) 3.1-37(a)</p> |