STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. Building B. Wing	05/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anthony	203 Franciscan Dr Crown Point, IN 46307

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)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 45666 Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for self-administration of medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 111) Finding includes: On 5/14/24 at 9:21 a.m., Resident 111 was observed in her room in bed. There was a medication cup noted with multiple pills in it on the table next to her. The resident indicated the nurses always had left her morning medications for her to take after she had eaten her breakfast. Resident 111's record was reviewed on 5/15/24 at 1:22 p.m. Diagnoses included, but were not limited to, dementia, heart disease, and anxiety disorder. A Significant Change Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was cognitively intact for daily decision making. She had taken antidepressants, anticoagulants, diuretics, and opioid medications in the last 7 day look back period. An Interdisciplinary Team (IDT) note, dated 5/14/2024 at 9:18 a.m., indicated the IDT met to review the resident and determined the resident was able to self-administer prescribed medications prepared by the nurse or QMA. The medications to be self-administered were furosemide 40 milligrams (mg) everyday, l-methylfolate 15 mg daily, levothyroxine 75 micrograms daily, macrobid 100 mg twice daily until complete, memantine 5 mg daily, norco 5-325 mg every four hours as needed (PRN), potassium 10 milliequivalents daily, pregabalin 200 mg twice daily, rivastingmine 1.5 mg twice daily, senna docusate 8.6 mg every 12 hours PRN, sumatriptan 100 mg every 2 hours PRN, tobramycin 1 drop in both eyes until complete. There were no physician orders for self-administration of the medications. During an interview on 5/16/24 at 11:09 a.m., the Administrator indicated there should have been an order to self administer the medications. 3.1-11(a)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/20/2024
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32582 Based on record review and interview, the facility failed to notify the family/representative of a significant weight loss, a weight loss, and a new order for a nutritional supplement for 2 of 7 residents reviewed for nutrition. (Residents 59 and 143) Findings include: 1. Resident 59's record was reviewed on 5/14/24 at 2:42 p.m. Diagnoses included, but were not limited to, Lewy body dementia, psychotic disorder, depressive disorder and diabetes mellitus. The resident resided on the locked dementia unit. The Quarterly Minimum Data Set (MDS) assessment, dated 3/29/24, indicated the resident had severe cognitive impairment and required limited staff assistance for bed mobility and transfers, and could eat independently after set up. The Current Physician Orders indicated the resident was on a regular diet. There were no nutritional supplements or fortified food ordered. The resident's weights were as follows: 2/5/24: 232 pounds (lbs) 2/11/24: 230 lbs 2/18/24: 218 lbs 2/25/24: 217 lbs 3/6/24: 217 lbs This was a weight loss of 15 lbs, 5%, in one month. There was no documentation the family had been notified. A Quarterly Nutrition Review, dated 3/29/24, indicated the resident had a significant weight loss of 5% in 30 days. The resident did not receive snacks, supplements or fortified food. The resident's weight had been stable since 2/18. The resident's intake of food and fluid was estimated to meet needs at the time. There were no new nutritional recommendations at the time. The resident's continued weights were as follows: 4/2/24: 220 lbs (+3 lbs) 5/3/24: 203 lbs (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	5/7/24: 203 lbs (reweigh) This was an additional weight loss of 14 pounds, for a total weight loss of 29 pounds, 12.5%, since her admission on 2/5/24. There was no documentation the family had been notified. During an interview on 5/17/24 at 12:52 p.m., a family member indicated she had been notified yesterday, 5/16/24, of the current 17 pound weight loss. She had not been notified of additional weight losses. She was unaware of the significant weight loss that occurred from 2/5/24-3/6/24. During an interview on 5/17/24, the Director of Nursing indicated there was no documentation the family had been notified of the initial significant weight loss. 2. Resident 143's record was reviewed on 5/17/24 at 1:55 p.m. Diagnoses included, but were not limited to, Alzheimer's dementia, iron deficiency, and chronic lymphocytic leukemia. The Quarterly MDS assessment, dated 3/11/24, indicated the resident had significant cognitive impairment, required limited assistance with bed mobility and transfers, and could eat independently after set up. The resident's weights were as follows: 11/1/23: 124 lbs 3/6/24: 116 lbs This was an eight pound, 6.45% loss, in four months. There was no documentation the family had been notified. A Physician's Order, dated 3/23/24, indicated to give a health shake with breakfast daily for weight loss. There was no documentation the family had been notified of the new order. During an interview with a family member on 5/20/24 at 1:03 p.m., she indicated her mother was not on a special diet and had not lost any weight that she was aware of. She indicated she was not aware of the eight pound weight loss or new order for health shake daily. During an interview with the Administrator on 5/20/24 at 3:00 p.m., she indicated there was no documentation the family had been notified. The policy, Resident Weight Monitoring, indicated, .The resident's physician and family/guardian will notified of any verified significant weight change . 3.1-5(a)(3)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 32788 Based on observation and interview, the facility failed to ensure a clean and homelike environment related to stained and dirty bed linens for 1 of 35 residents reviewed for a homelike environment. (Resident B) Finding includes: On 5/14/24 at 10:03 a.m., Resident B was observed lying in bed with his eyes closed. There was a dark reddish-brown stain on the bottom sheet next to where his left forearm was resting. His pillowcase also had a large brown stain along the end of it. On 5/15/24 at 10:42 a.m., Resident B was observed lying in bed with his eyes closed. The stains remained to the bottom sheet and the pillowcase. On 5/15/24 at 10:58 a.m., a CNA exited the room after providing care to Resident B. Resident B was now sitting up in his wheelchair in his room. His bed had been made, however, the stains remained to the bottom sheet and the pillowcase. During an interview with the Administrator on 5/15/24 at 11:11 a.m., she indicated the linens were probably already stained when they were put on the bed. She then changed the linens. This citation relates to Complaint IN00431905. 3.1-19(f)(5) 3.1-19(g)(4)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. 32582 Based on observation, record review, and interview, the facility failed to ensure dependent residents received the activities of daily living (ADL) care needed related to showers not given as scheduled, facial hair unshaven, and soiled sheets on a resident's bed for 5 of 8 residents reviewed for ADL care. (Residents 76, 121, 52, C, and 45) Findings include: 1. On 5/13/24 at 2:53 p.m., Resident 76 was observed lying in his bed. His hair appeared greasy and there was visible white debris observed. His beard had visible food debris. On 5/14/24 at 9:11 a.m., the resident was observed lying in bed. His hair was greasy with white debris observed. The resident's record was reviewed on 5/15/24 at 12:50 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular accident, diabetes mellitus and vascular dementia. The Annual Minimum Data Set assessment, dated 2/8/24, indicated the resident had moderate cognitive impairment and required extensive assistance for bed mobility and toileting. The current ADL Care Plan indicated the resident needed total assistance for bathing/showering due to activity intolerance, hemiplegia, and physical debility. The shower book indicated he was to receive a shower twice weekly on Wednesday and Saturday. Shower sheets for the past 30 days were reviewed as follows: 4/20/24: bed bath 5/1/24: bed bath 5/4/24: bed bath 5/11/24: bed bath 5/15/24: bed bath There were no documented showers, bed baths, or refusals for 4/24, 4/27 or 5/8/24. During an interview on 5/15/24 at 2:26 p.m., CNA 8 indicated if a resident refused a shower, then a bed bath was offered. If they refused the bed bath, a refusal form should be completed and the nurse was to be notified. During an interview on 5/16/24 at 11:15 a.m., the Director of Nursing indicated there were no additional shower sheets available. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. During an interview on 5/13/24 at 11:17 a.m., Resident 121 indicated he was not getting showers twice weekly as scheduled. The residents record was reviewed on 5/16/24 at 11:45 a.m. Diagnoses included, but were not limited to, congestive heart failure, unspecified dementia, and diabetes mellitus. The Annual MDS assessment, dated 3/15/24, indicated he was cognitively intact and required extensive assistance for bed mobility and limited assistance for toileting and transfers. The current ADL Care Plan indicated he needed total assistance with bathing/showering related to activity intolerance and dementia. The shower book indicated he was to receive a shower twice weekly on Monday and Thursday. Shower sheets for the past 30 days were reviewed as follows: 4/24/24: shower 4/29/24: shower 5/2/24: shower 5/9/24: shower There were no documented showers, bed baths, or refusals for 4/18, 4/22, 5/6 or 5/13. During an interview on 5/16/24 at 11:15 a.m., the Director of Nursing indicated there were no additional shower sheets available. 32664 3. On 5/14/24 at 10:17 a.m., Resident 52 was observed lying in bed. The resident had long facial hair observed to her chin. The resident indicated the staff would sometimes shave her and was unsure the last time she was shaved. On 5/15/24 at 11:09 a.m., Resident 52 was observed lying in bed. The resident was still observed with long facial hair to her chin. The record review for Resident 52 was completed on 5/15/24 at 11:10 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, heart failure, hypertension, diabetes mellitus, dementia, and stroke. The Quarterly Minimum Data Set (MDS) assessment, dated 4/29/24, indicated the resident was cognitively intact. The resident was dependent for bathing, transfers and mobility. The resident required substantial/maximal assistance for personal hygiene. A Care Plan, dated 1/27/24 and revised 1/30/24, indicated the resident needed assistance with activities of daily living. An intervention included the resident needed an extensive assistance x 1 person for personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/15/24 at 2:04 p.m., CNA 2 indicated the resident was given 1 shower a week and 1 bed bath a week. She was to be shaved weekly with her bathing or when her facial hair was observed. CNA 2 had given the resident a bed bath the day before and did not shave the resident, but she should have shaved her. 45666 4. On 5/14/24 at 9:39 a.m., Resident C was observed in bed wearing only a t-shirt and appeared disheveled. He had no brief on and the linens under him were soiled. On 5/14/24 at 10:16 a.m., Resident C was observed in bed wearing only a t-shirt. He had no brief on and the linens under him were soiled. Resident C's record was reviewed on 5/14/24 at 2:16 p.m. Diagnoses included, but were not limited to peripheral vascular disease and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was severely cognitively impaired. He was dependent on staff for toileting hygiene and required substantial/maximal assistance for personal hygiene and shower/bathing. A Care Plan, dated 4/1/24, indicated the resident needed assistance with activities of daily living. Interventions included, but not limited to, the resident required extensive assistance for toilet use. The Shower Sheets from April and May 2024 indicated the resident had refused on 4/13/24, received a shower on 4/15/24, refused on 4/27/24, and received a shower on 4/28/24. There was nothing further documented. During an interview on 5/16/24 at 10:02 a.m., the Administrator had no further information to provide. 5. During an interview on 5/13/24 at 11:34 a.m., Resident 45 indicated she was not receiving showers twice a week. Resident 45's record was reviewed on 5/16/24 at 1:13 p.m. Diagnoses included, but were not limited to, schizoaffective disorder, anxiety disorder, and bipolar disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/24, indicated the resident was moderately cognitively impaired for daily decision making. She required substantial/maximal assistance for showering. A Care Plan, dated 9/22/23, indicated the resident needed assistance with activities of daily living. Interventions included, but were not limited to, the resident required extensive assistance with showering and had fluctuations in needs and provide additional staff assistance as needed. The Shower Sheets were reviewed for April and May 2024 and indicated the resident received a shower on 4/5/24, 4/9/24, 4/16/24, 4/19/24, 4/23/24, 5/7/24, and 5/14/24. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/20/24 at 2:37 p.m., the Director of Nursing had no further information to provide. This citation relates to Complaint IN00431905. 3.1-38(a)(3)(D) 3.1-38(b)(2)

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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. 32788 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 3 of 7 residents reviewed for non-pressure related skin conditions. (Residents B, 66, and 10) Findings include: 1. On 5/14/24 at 10:03 a.m., Resident B was observed lying in bed with his eyes closed. He had 2 scabbed areas to his right forearm and multiple purple discolorations to his left forearm. On 5/15/24 at 10:42 a.m., Resident B was observed lying in bed with his eyes closed. The scabbed areas and discolorations remained to his arms. Record review for Resident B was completed on 5/15/24 at 3:50 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia with behavioral disturbance, and chronic kidney disease. The Significant Change Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was cognitively impaired and required substantial/maximal assist with upper body dressing. A current Care Plan, updated 3/11/24, indicated the resident was at risk for skin breakdown. An intervention included, skin inspection weekly and as needed, document and notify md of abnormal findings . The most recent Weekly Nursing Summary, dated 4/25/24, indicated there were no current skin issues. During an interview on 5/15/24 at 3:10 p.m., the Director of Nursing (DON) indicated the Wound Nurse would assess the resident's skin. No further information was provided. 2. On 5/13/24 at 10:49 a.m., Resident 66 was observed seated in her Broda chair in her room. There were dark purple discolorations to the tops of both hands. On 5/15/24 at 10:04 a.m., Resident 66 was observed seated in her Broda chair in her room. The dark purple discolorations remained to the tops of both hands. Record review for Resident 66 was completed on 5/16/24 at 1:41 p.m. Diagnoses included, but were not limited to, hypertension, dementia with psychotic disturbance, and hyperlipidemia. The Quarterly Minimum Data Set (MDS) assessment, dated 4/5/24, indicated the resident was cognitively impaired. She was dependent on staff for upper body dressing and received antiplatelet medications. (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 Care Plan, updated 4/8/24, indicated the resident was at risk for increased bruising or bleeding due to aspirin therapy. An intervention included, observe for signs of abnormal bleeding such as increased frequency of bruising, increased size of bruises .document abnormal findings and notify MD . The Medication Administration Record (MAR), dated 5/2024, indicated the resident had received aspirin daily. The most recent Weekly Nursing Summary, dated 5/4/24, indicated there were no current skin issues. During an interview on 5/16/24 at 11:13 a.m., the Administrator was made aware of the skin discolorations. No further information was provided. 45666 3. On 5/13/24 at 2:32 p.m., Resident 10 was sitting in a wheelchair in his room. He had scattered discolorations noted to bilateral lower legs, a splotchy reddened area on his neck, and his right arm was red and swollen. He indicated he had lotion to put on his lower legs, but could not reach it himself. He was unsure what happened with his neck and his right arm was swollen. Resident 10's record was reviewed on 5/14/24 at 3:01 p.m. Diagnoses included, but were not limited to, congestive heart failure, respiratory failure, and cellulitis of the right upper limb. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident was severely cognitively impaired for daily decision making. There was no documentation related to the discolorations noted to the bilateral shins or reddened area on the neck in the record. During an interview on 5/16/24 at 3:15 p.m., the Wound Nurse indicated the resident had never had a rash on his neck that she was aware of, but he occasionally had heat rashes. She was not aware of the discolorations to the lower extremities. 3.1-37(a)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. 32582 Based on observation, record review, and interview, the facility failed to ensure a resident received the assistive device needed to maintain vision related to broken glasses not addressed in a timely manner, for 1 of 2 residents reviewed for vision/hearing. (Resident 76) Finding includes: On 5/13/24 at 2:53 p.m., 5/14/24 at 9:11 a.m., and 5/15/24 at 1:20 p.m., Resident 76 was observed lying in his bed. There was a pair of glasses with one of the arms broken off sitting on the overbed table. The resident indicated he used them for reading. The resident's record was reviewed on 5/15/24 at 12:50 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular accident, diabetes mellitus, and vascular dementia. The Annual Minimum Data Set assessment, dated 2/8/24, indicated the resident had moderate cognitive impairment and required extensive assistance for bed mobility and toileting. There was no documentation in the record related to the broken glasses or optometry appointments. During an interview on 5/16/24 at 9:47 a.m., CNA 1 indicated the glasses had been broken for several days. She did not know if the nurse or Unit Manager had been notified of the broken glasses because she had been off work for a couple days. The glasses had been broken before and the Social Service Director (SSD) took care of it. During an interview on 5/16/24 at 9:55 a.m., the SSD indicated she had not been notified the glasses were broken but would look into it. 3.1-39(a)(b)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing for pressure ulcers, related to ensuring a wound treatment and offloading boots were in place for 2 of 8 residents reviewed for pressure ulcers. (Residents D and E) Findings include: 1. The closed record for Resident D was reviewed on 5/16/24 at 2:52 p.m. Diagnoses included, but were not limited to, anemia, dementia with mood disturbance, and atrial fibrillation. The resident was admitted to the facility on [DATE] and discharged on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 2/13/24, indicated the resident was cognitively impaired, had no unhealed pressure ulcers, and was at risk for pressure ulcers. A Care Plan, dated 3/19/24, indicated the resident had a pressure ulcer to the left hip. An intervention included, wound treatments as ordered. The Skilled Care Nursing Documentation form, dated 3/18/24, indicated there were no current skin issues. A Pressure Ulcer Note, dated 3/19/24 at 3:03 p.m., indicated the resident had a newly acquired stage 3 pressure ulcer to her left trochanter (hip). This was the first observation of the area, and it measured 0.7 cm (centimeters) x (by) 0.9 cm x 0.1 cm. A Skin and Wound Note by the Wound Nurse Practitioner (NP), dated 3/19/24 at 3:14 p.m., indicated the resident had MASD (moisture associated skin damage) to the left buttock that was healed and had a new pressure injury to the left hip. The left hip area measured 0.7 cm x 0.9 cm x 0.1 cm and was a stage 3. The treatment recommendation for the left hip was, .1. Cleanse with wound cleanser. 2. apply medical grade honey to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN [as needed] . The Pressure Ulcer Weekly Observation, dated 3/26/24, indicated the left trochanter pressure area measured 0.6 cm x 0.9 cm x 0.1 cm and was a stage 3. The area was improving, and treatment orders were in place. A Skin and Wound Note by the Wound NP, dated 3/26/24 at 12:48 p.m., indicated the left hip stage 3 area measured 0.6 cm x 0.9 cm x 0.1 cm and was healing. The treatment recommendation for the left hip was, .1. Cleanse with wound cleanser. 2. apply medical grade honey to base of the wound. 3. secure with Bordered gauze. 4. change Daily, and PRN [as needed] . The Physician's Orders Summary, dated 3/2024, lacked any treatment orders for the left hip area. There was an order, dated 2/20/24, for silver sulfadiazine/miconazole/triamcinolone cream mixture to the left buttock every shift. This order was discontinued on 3/20/24 and a new order for the same treatment was put in as a preventative treatment to the left buttock starting 3/20/24. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Saint Anthony		STREET ADDRESS, CITY, STATE, ZIP CODE: 203 Franciscan Dr, Crown Point, IN 46307	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Medication Administration Record (MAR), dated 3/2024, lacked documentation of any treatment to the left hip area at any time. During an interview with the Wound Nurse and the Director of Nursing (DON) on 5/17/24 at 9:45 a.m., the Wound Nurse indicated she had made a data entry error and had written left buttock instead of left hip in the treatment order on 3/20/24. She had disagreed with the Wound NP's recommendation for the medical honey treatment to the left hip and continued with the same treatment they had used to the left buttock area previously. She had not documented this. The Wound NP had seen the resident the following week and indicated the wound was healing. 2. On 5/13/24 at 10:47 a.m., Resident E was observed sitting in his Broda chair in his room. The pressure offloading boots were not observed in place to his feet. Two pressure offloading boots were observed on the floor behind his recliner. On 5/13/24 at 10:03 a.m., Resident E was observed sitting in his Broda chair in his room. The pressure offloading boots were not observed in place to his feet. Two pressure offloading boots were observed on the floor behind his recliner. Record review for Resident E was completed on 5/15/24 at 10:34 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, type 2 diabetes mellitus, and anemia. The Significant Change Minimum Data Set (MDS) assessment, dated 2/29/24, indicated the resident had 2 unstageable pressure ulcers and one suspected deep tissue injury. A current Care Plan indicated the resident was at risk for skin breakdown. The interventions included, preventative skin care as ordered. A Wound Nurse Practitioner Note, dated 3/5/24, indicated the deep tissue injury (DTI) to the right heel had resolved. A Physician's Order, dated 3/6/24, indicated bilateral heel offloading boots/float heels as tolerated every shift for preventative. A Physician's Order, dated 2/8/24, indicated to assist resident to elevate heels off the bed with boots every shift for preventative. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 5/2024, indicated the offloading boots had been signed off every shift. During an interview with the DON on 5/15/24 at 3:10 p.m., she was made aware the resident's offloading boots had not been in place. She indicated the order was written to wear the boots as tolerated and the resident may not like to wear them or kick them off. She was unable to provide any documentation the resident had refused to wear the boots or was not tolerating them. This citation relates to Complaint IN00431905. 3.1-40(a)(2)

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F 0688

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.

32582

Based on observation, record review, and interview, the facility failed to ensure a resident's positioning was maintained related to hand splints not applied as ordered, for 3 of 4 residents reviewed for positioning/mobility. (Residents 76, 10 and 125)

Findings include:

1. On 5/13/24 at 2:53 p.m., Resident 76 was observed lying in his bed. His left hand was contracted and there was no splint in place.

On 5/15/24 at 1:20 p.m., the resident was observed lying in bed. His left hand was contracted and there was no splint in place. The resident indicated he used to wear a splint, but was told he didn't need to wear it anymore. He was unable to open his left hand.

The resident's record was reviewed on 5/15/24 at 12:50 a.m. Diagnoses included, but were not limited to, hemiplegia (one sided paralysis) and hemiparesis (one sided weakness) following a cerebral vascular accident, diabetes mellitus and vascular dementia.

The Annual Minimum Data Set assessment, dated 2/8/24, indicated the resident had moderate cognitive impairment and required extensive assistance for bed mobility and toileting.

A Physician's Order, dated 2/6/24, indicated the resident was to wear a left resting hand splint 6-8 hours daily as tolerated to promote anatomical alignment and prevent contracture.

The April and May 2024 Treatment Administration Record (TAR) did not have the splint order, so there was no documentation if it was applied or refused.

During an interview on 5/15/24 at 2:17 p.m., LPN 1 indicated she did not know if the resident was supposed to wear a splint or not.

During an interview on 5/15/24 at 3:05 p.m., the Director of Nursing provided a copy of the physician's order for the splint and a care card that indicated the resident was to wear a left hand splint as tolerated. She was unaware the treatment was not showing up on the TAR. No additional information was provided.

45666

2. On 5/13/24 at 2:32 p.m., Resident 10 was sitting in a wheelchair in his room. His right forearm was resting on the armrest of the wheelchair and noted to be red and swollen. He was not wearing any splinting device.

On 5/15/24 at 10:21 a.m., Resident 10 was noted in a wheelchair in his room. His right forearm was resting in his lap with no splinting device.

(continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 9:32 a.m., Resident 10 was noted in a wheelchair in his room with his right forearm resting in his lap with no splinting device. Resident 10's record was reviewed on 5/14/24 at 3:01 p.m. Diagnoses included, but were not limited to, congestive heart failure, respiratory failure, and cellulitis of the right upper limb. The Quarterly Minimum Data Set (MDS) assessment, dated 5/8/24, indicated the resident was severely cognitively impaired for daily decision making. A Care Plan, dated 3/7/24, indicated the resident needed assistance with activities of daily living. Interventions included, but were not limited to, right hand brace per Physician's Orders. A Physician's Order, dated 5/1/24, indicated right hand splint, circulation checks every shift. During an interview on 5/20/24 at 2:37 p.m., the Director of Nursing had no further information to provide. 3. During an interview on 5/13/24 at 2:55 p.m., Resident 125 indicated his left hand was contracted. He wore a splint at one time, but staff had not assisted with putting it on in a long time. They never look at my hand any more, not even for nail care. On 5/15/24 at 11:12 a.m., Resident 125 was observed in his bed with no splinting device to his left hand. Resident 125's record was reviewed on 5/16/24 at 9:43 a.m. Diagnoses included, but were not limited to type 2 diabetes mellitus and heart failure. The Admission Minimum Data Set (MDS) assessment, dated 3/19/24, indicated the resident was cognitively intact for daily decision making. He had no impairment to both lower extremities for range of motion. There was no care plan related to a contracture or splinting device. The May 2024 Physician's Order Summary indicated the resident was to wear a left hand splint for up to 8 hours during the day as tolerated to promote skin integrity and prevent further contracture. During an interview on 5/16/24 at 11:09 a.m., the Administrator indicated the resident had a contracture to the left hand. The staff put the splinting device on and he would take it off. He did not have any care plans related to the contracture or splinting device or documentation of refusals. 3.1-42(a)(2)

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32788 Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for 2 of 3 residents reviewed for accidents. (Residents B and 91) Findings include: 1. On 5/14/24 at 10:03 a.m., Resident B was observed lying in bed with his eyes closed. There were no floor mats in place at the bedside. Both mats were leaning up against the wall by the window. On 5/15/24 at 10:42 a.m., Resident B was observed lying in bed with his eyes closed. There were no floor mats in place at the bedside. Both mats were leaning up against the wall by the window. Record review for Resident B was completed on 5/15/24 at 3:50 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, dementia with behavioral disturbance, and chronic kidney disease. The Significant Change Minimum Data Set (MDS) assessment, dated 3/5/24, indicated the resident was cognitively impaired and required substantial/maximal assist with bed mobility and transfers. A current Care Plan, updated 3/11/24, indicated the resident was at risk for falls An intervention included, mat beside bed. During an interview with the Director of Nursing (DON) on 5/15/24 at 3:10 p.m., she was made aware the floor mats had not been in place. No further information was provided. 2. On 5/14/24 at 9:47 a.m., Resident 91 was observed seated in her Broda chair near the Nurse's Station. She was not wearing any socks and had bare feet. On 5/15/24 at 10:03 a.m., Resident 91 was observed seated in her Broda chair near the Nurse's Station. She was not wearing any socks and had bare feet. The record for Resident 91 was reviewed on 5/16/24 at 9:35 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, osteoarthritis, and hypothyroidism. The Significant Change Minimum Data Set (MDS) assessment, dated 3/20/24, indicated the resident was cognitively impaired and one fall since the prior assessment. A current Care Plan, updated 3/27/24, indicated the resident was at risk for falls. An intervention included, encourage and assist to wear appropriate non-skid footwear. During an interview with the Director of Nursing (DON) on 5/15/24 at 3:10 p.m., she indicated she was unsure why the resident had not been wearing socks. She would find out and if she liked to keep them off or kick them off, she would update the care plan to reflect that. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-45(a)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 32664 Based on observation, record review, and interview, the facility failed to ensure urinary output was recorded as per the plan of care for 1 of 1 residents reviewed for urinary catheters. (Resident 89) Finding includes: On 5/13/24 at 1:57 p.m., Resident 89 was observed lying in bed. The resident had a urinary catheter attached to the side of his bed. The bag was observed with a small amount of urine in the bag. The resident indicated staff did not empty his catheter bag and he would have to tell them multiple times a day to make sure they emptied it. Record review for Resident 89 was completed on 5/16/24 at 1:37 p.m. Diagnoses included, but were not limited to, obstructive uropathy, diabetes mellitus, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 4/1/24, indicated the resident was cognitively intact. The resident was dependent for toileting and required substantial assistance with bed mobility. The resident had an indwelling urinary catheter. A Care Plan, dated 5/8/23 and revised 6/28/23, indicated the resident was at risk for infection or complications related to an indwelling catheter. An intervention included to document the catheter output every shift. The Bowel and Bladder Care in the Tasks section, dated 4/16/24-5/15/24, indicated the catheter output was not documented on the following dates and shifts: - Evening shifts on 4/18, 4/19, 4/24, and 4/27/24 - Midnight shifts on: 4/16, 4/17, 4/19, 4/21, 4/22, 4/23, 4/27/24, 4/28, 4/29, 4/30, 5/1, 5/2, 5/3, 5/5, 5/10, 5/12, 5/13, 5/14, and 5/15/24 During an interview on 5/17/24 at 1:38 p.m., the Director of Nursing indicated the staff should have documented the urinary output on the Tasks documentation every shift. 3.1-41(a)(2)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32582 Based on record review and interview, the facility failed to ensure interventions were implemented for a resident with a significant weight loss, failed to ensure food consumption logs were completed and weekly weights were completed as ordered for 3 of 7 residents reviewed for nutrition. (Residents 59, 91 and 158) Findings include: 1. Resident 59's record was reviewed on 5/14/24 at 2:42 p.m. Diagnoses included, but were not limited to, Lewy body dementia, psychotic disorder, depressive disorder, and diabetes mellitus. The resident resided on the locked dementia unit and was admitted on [DATE]. The Quarterly Minimum Data Set (MDS) assessment, dated 3/29/24, indicated the resident had severe cognitive impairment and required limited staff assistance for bed mobility and transfers, and could eat independently after set up. The current May 2024 Physician Order Summary indicated the resident was on a regular diet. There were no nutritional supplements or fortified food ordered. The resident's weights were as follows: 2/5/24: 232 pounds (lbs) 2/11/24: 230 lbs 2/18/24: 218 lbs 2/25/24: 217 lbs 3/6/24: 217 lbs This indicated a weight loss of 15 lbs in one month. A Quarterly Nutrition Review, dated 3/29/24, indicated the resident had a significant weight loss of 5% in 30 days. The resident did not receive snacks, supplements or fortified food. The resident's weight had been stable since 2/18. The resident's intake of food and fluid was estimated to meet needs at this time. There were no new nutritional recommendations at this time. The resident's continued weights were as follows: 4/2/24: 220 lbs (+3 lbs) 5/3/24: 203 lbs 5/7/24: 203 lbs (reweigh) (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This was an additional weight loss of 14 pounds, for a total weight loss of 29 pounds, 12.5%, since her admission on 2/5/24. There was no documentation in the record the weight loss between 4/2 and 5/7/24 had been identified. There were no progress notes, Nutrition at Risk (NAR) notes, or Nutrition Reviews completed. The food consumption task documentation, dated 4/18/24 through 5/15/24, indicated there were no meal consumptions documented on the following days and meals: 4/18/24 - breakfast, lunch 4/19/24 - dinner 4/20/24 - breakfast, lunch & dinner 4/21/24 - breakfast, lunch 4/22/24 - breakfast, lunch & dinner 4/23/24 - breakfast, lunch 4/24/24 - breakfast, lunch 4/27/24 - dinner 4/29/24 - breakfast, lunch 5/1/24 - lunch 5/2/24 - breakfast, lunch & dinner 5/3/24 - breakfast, lunch & dinner 5/4/24 - dinner 5/6/24 - breakfast, lunch & dinner 5/9/24 - breakfast, lunch 5/10/24 - breakfast, lunch & dinner 5/11/24 - breakfast, lunch & dinner 5/14/24 - dinner 5/15/24 - breakfast, lunch & dinner (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nutrition Care Plan, initiated on 2/7/24, indicated the resident had potential nutritional risk related to above BMI (body mass index) for height. A care plan revision, on 3/20/24, indicated the resident had a significant weight loss since admission with more mobility which was currently stabilizing. The goal was for the resident not to exhibit a significant weight change. Interventions included, but were not limited to, Registered Dietician to evaluate and make diet change recommendations as needed and document food and fluid intakes. During an interview on 5/16/24, the Director of Nursing Services (DNS) indicated she was just made aware of the significant weight loss and she would look into it. During a follow up interview on 5/16/24 at 1:40 p.m., she indicated the resident would be reviewed in the NAR meeting today and they would complete a Significant Change MDS. During an interview on 5/17/24 at 10:15 a.m., the Dietary Technician (DT) indicated she completed the Nutrition Reviews. If a resident had a significant weight loss, the Registered Dieticians (RD) were consulted and they would make recommendations. The DT indicated the first significant weight loss may have been attributed to an incorrect admission weight, but no interventions were put into place and that was an oversight on her part. The current significant weight loss had also been overlooked by her. She was not made aware of it until yesterday, 5/16/24, when surveyors identified it. The policy, Resident Weight Monitoring, indicated, .A weight report will be generated monthly and reviewed by the DM (Dietary Manager), RD, DNS, and MDS for significant changes. A significant weight change is defined as 5% in 30 days, 7.5% in 90 days and 10% in 180 days . and, .Residents with verified significant weight change will be followed by IDT (interdisciplinary team) in the Risk Nutrition meeting . 32788 2. The record for Resident 91 was reviewed on 5/16/24 at 9:35 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, osteoarthritis, and hypothyroidism. The Significant Change Minimum Data Set (MDS) assessment, dated 3/20/24, indicated the resident was cognitively impaired, required substantial/maximal assist with eating, and had a significant weight loss. A Care Plan, updated 3/27/24, indicated the resident had shown significant weight loss. An intervention included to serve the diet and supplements as ordered and record the amount of consumption. The resident weighed 137 pounds on 1/3/24 and 119 pounds on 3/26/24. A Registered Dietitian (RD) Review, dated 3/27/24, indicated the resident had lost 6% of her body weight in one month. The food consumption task documentation, dated 4/17/24 through 5/15/24, indicated there were no meal consumption intakes documented for the following days and meals: 4/17/24 breakfast 4/18/24 dinner (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4/19/24 breakfast and dinner 4/20/24 breakfast and lunch 4/21/24 breakfast and dinner 4/22/24 dinner 4/24/24 breakfast 4/25/24 breakfast and dinner 4/27/24 breakfast and dinner 4/28/24 dinner 4/29/24 dinner 5/1/24 dinner 5/3/24 breakfast, lunch, and dinner 5/4/24 breakfast, lunch, and dinner 5/5/24 breakfast and lunch 5/7/24 breakfast and dinner 5/8/24 dinner 5/9/24 breakfast and dinner 5/10/24 breakfast and dinner 5/11/24 dinner 5/12/24 dinner 5/13/24 breakfast and dinner 5/14/24 breakfast and dinner 5/15/24 breakfast, lunch, and dinner During an interview with the Administrator on 5/16/24 at 11:13 a.m., she was made aware of the lack of documentation of meal consumption. No further information was provided. 45666 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident 158's record was reviewed on 5/15/24 at 10:26 a.m. Diagnoses included, but were not limited to, congestive heart failure and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment, dated 4/23/24, indicated the resident was severely cognitively impaired for daily decision making. He required supervision for eating and received a therapeutic diet. The Weights and Vitals log indicated the resident weighed 175 pounds on 4/21/24 and 162 pounds on 5/10/24. A Physician's Order, dated 5/19/24, indicated weekly weights for four weeks. The Medication/Treatment Administration Record for May 2024 indicated there was not a weekly weight obtained on 5/5/24. The Nutrition - Amount Eaten CNA Task was blank for the following meals: - Breakfast on 4/17/24, 4/24/24, 4/29/24, 5/10/24, and 5/13/24 - Lunch on 4/17/24, 4/19/24, 4/24/24, 4/26/24, 4/29/24, and 5/13/24 - Dinner on 4/18/24, 4/19/24, 4/20/24, 4/21/24, 4/22/24, 4/23/24, 4/26/24, 4/28/24, 4/29/24, 4/30/24, 5/1/24, 5/3/24, 5/4/24, 5/5/24, 5/8/24, 5/9/24, 5/10/24, and 5/13/24 During an interview on 5/17/24 at 2:07 p.m., the Director of Nursing had no further information to provide. 3.1-46(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 32664 Based on observation, record review, and interview, the facility failed to ensure a resident with a gastronomy tube (g-tube) received appropriate treatment related to not completing water flushes before medication administration as ordered by the physician, for 1 of 7 residents reviewed during medication administration. (Resident 115 and RN 1) Finding includes: On 5/16/24 at 11:11 a.m., RN 1 was observed preparing Resident 115's medication to administer via a g-tube. The nurse crushed Tylenol 325 mg (milligrams) x 2 tablets and poured them into a medicine cup. She then proceeded to add 30 ml (milliliters) of water to the cup with the Tylenol. RN 1 checked placement of the g-tube, attached a syringe to the g-tube and poured the medicine cup into the syringe. After the diluted medication went through the tubing, she then proceeded to administer 30 ml of water into the tubing. Record review for Resident 115 was completed on 5/16/24 at 11:08 a.m. The May 2024 Physician's Order Summary indicated an order to administer 30 ml of water before and 30 ml of water after medication administration via the g-tube. During an interview after the observation, RN 1 indicated she forgot to flush the g-tube with water before she administered the medication. 3.1-44(a)(2)

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NAME OF PROVIDER OR SUPPLIER Saint Anthony		STREET ADDRESS, CITY, STATE, ZIP CODE 203 Franciscan Dr Crown Point, IN 46307	

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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 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. 45666 Based on observation, record review, and interview, the facility failed to ensure to deliver care and services and to address the needs of a resident with a diagnosis of post-traumatic stress disorder (PTSD) related to not following care plan interventions or updating care plans for a PTSD diagnosis for 1 of 1 residents reviewed for behaviors. (Resident 134) Finding includes: On 5/13/24 at 9:54 a.m., Resident 134 was noted to be yelling out. On 5/16/24 at 10:10 a.m., Resident 134 was observed in a broda chair in a common area with other residents. He was observed making noises under his breath. On 5/17/24 at 10:23 a.m., Resident 134 was observed in his room in a broda chair loudly yelling out. Resident 134's record was reviewed on 5/15/24 at 1:57 p.m. Diagnosis included, but were not limited to, dementia, PTSD, psychosis, major depressive disorder, and generalized anxiety disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/24, indicated the resident was severely cognitively impaired for daily decision making. He displayed inattention, disorganized thinking, and altered level of consciousness. His behaviors were present and fluctuated. He had physical behavioral symptoms directed towards others, verbal behavioral symptoms directed towards others and other behavioral symptoms not directed towards others. A Care Plan, dated 11/24/23, indicated the resident required room visits or one to one activities due to a frequent preference to be in lower stimulating environments along with verbal expressions of comprehension and emotional experiences which may cause the resident to have difficulty participating in group settings successfully. Interventions included, but were not limited to, provide monthly activity calendar, provide room visits of choice, provide sensory stimulation in room, and discuss past interests with resident and family. A Care Plan, revised on 11/24/23, indicated the resident had behavioral symptoms including restlessness, resistive to care, combativeness, and going into other resident's rooms. Interventions included, but were not limited to, assess the resident's needs, document behaviors, identify behavior triggers and reduce exposure to triggers, and provide a diversional activity. A Care Plan, dated 9/26/23, indicated the resident had a history of trauma and diagnosis of PTSD and exhibited yelling out, anxiety, restlessness, and irritability. Interventions included, but were not limited to, the resident would learn and utilize relaxation techniques, have positive social interactions, participation in relaxation exercises, and he would share feelings. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An Activities-Quarterly Review note, dated 12/8/23 at 10:45 a.m., indicated the resident was passive in most group programs, he made loud noises that could be heard by peers. One to one activities with staff were provided for more appropriate interactions. He preferred a setting of one to ones and independent. A Psychiatric Note, dated 4/10/2024, indicated during his clinical intake on 9/18/23, the resident was referred to psychiatric services for having ongoing issues with yelling out, anxiety, restlessness, depression, and delusions. There were a lot of times where he would scream out in his room. When asked what is wrong he would often not be able to tell them and would continue screaming. He possibly had some PTSD related to his service as most of his delusions are focused around violence and weapons. He was calm, but very dysphoric and told the writer that everything was wrong and he felt sad. He would also often grind his teeth and squirm in his chair. He sometimes put himself on the floor. His yelling out also often disturbed other residents. An Activities-Quarterly Review note, dated 2/26/24 at 1:09 p.m., indicated the resident attended group activities with peers. He responded and interacted when prompted on a one to one basis. During an interview on 5/17/24 at 11:19 a.m., the Activity Director indicated the resident went to group activities and had never done any one to one activities with staff that she was aware of. During an interview on 5/20/24 at 3:14 p.m., the Social Services Director indicated the resident was having flashbacks and they were unable to determine what the triggers were for those. She had never reached out to the family to see what interventions were appropriate for the resident or what had triggered his yelling out. The family was invited to care plan meetings, but had never attended.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 32664 Based on observation and interview, the facility failed to ensure medications were properly stored for 4 of 5 medication carts observed. (1A Medication Cart, 2C Medication Cart, 2B Medication Cart, and 3D Medication Cart) Findings include: 1. On 5/20/24 at 9:13 a.m., the 1A Medication Cart was observed with RN 2. There were approximately 20 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. 2. On 5/20/24 at 9:26 a.m., the 2C Medication Cart was observed with LPN 2. There were approximately 40 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. 3. On 5/20/24 at 9:33 a.m., the 2B Medication Cart was observed with RN 3. There were approximately 12 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. 4. On 5/20/24 at 9:47 a.m., the 3D Medication Cart was observed with LPN 3. There were approximately 4 pills of different sizes and colors that were loose and out of the packages throughout the bottoms of the drawers in the cart. The nurse indicated nursing was responsible for making sure the medication carts were cleaned. During an interview on 5/20/24 at 10:48 a.m., the Director of Nursing indicated all of the nursing staff was responsible to making sure the medication carts were cleaned. 3.1-25(j) 3.1-25(o)

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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. 32788 Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to medication administration, for 1 of 2 residents reviewed for antibiotic use. (Resident 74) Finding includes: During an interview with Resident 74 on 5/14/24 at 9:32 a.m., she indicated she had a urinary infection and was being treated with antibiotics. The record for Resident 74 was reviewed on 5/16/24 at 11:22 a.m. Diagnoses included, but were not limited to, anemia, congestive heart failure, and hypertension. The Quarterly Minimum Data Set (MDS) assessment, dated 5/10/24, indicated the resident was cognitively intact and had septicemia and a urinary tract infection in the last 30 days. A Physician's Order, dated 5/6/24, indicated to give piperacillin-tazobactam (Zosyn, an antibiotic) 3.375 grams intravenously every 8 hours for 7 days for sepsis due to pseudomonas (bacteria). The Medication Administration Record (MAR), dated 5/2024, indicated the antibiotic medication had not been signed off as given on the following dates and times: 6 a.m. on 5/9/24 and 5/10/24 2 p.m. on 5/7/24, 5/8/24, and 5/12/24 10 p.m. on 5/7/24 During an interview with the Director of Nursing (DON) on 5/16/24 at 12:01 p.m., she had checked the medication storage room and there were no antibiotics left. She believed the medication had been administered as ordered, but had not been signed out on the MAR. 3.1-50(a)(1)

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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. 32664 Based on observation, interview, and record review, the facility failed to ensure infection control guidelines were in place and implemented related to a lancet disposed of improperly for a random observation during a blood sugar check. (Resident 37 and RN 1) Finding includes: On 5/16/24 at 11:25 a.m., RN 1 was observed testing Resident 37's blood sugar level. The nurse washed her hands, donned gloves, cleaned the resident's finger, and then poked the resident's finger with a lancet to obtain the blood sample. The resident's blood sugar level was then assessed. The nurse then took off her gloves and disposed of them into the resident's garbage can along with the lancet. The nurse then proceeded to walk out of the resident's room into the hallway. During an interview after the observation, RN 1 indicated she disposed of the lancet into the resident's garbage can. She should have disposed of the lancet into the sharps container. A facility policy titled, Sharps Disposal and received as current from the Administrator indicated, .2. Contaminated sharps will be discarded into containers that are: a. Closable .d. Labeled or color-coded in accordance with our established labeling system . 3.1-18(b)