STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. Building B. Wing	08/19/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anthony Rehab and Nursing Center	1205 N 14th 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)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 50901 Based on observation, interview and record review, the facility failed to ensure a resident's functional limitation in range of motion was included in the comprehensive care plan for 1 of 2 residents reviewed for mobility. (Resident 53) Finding includes: During an observation, on 8/13/24 at 2:01 p.m., Resident 53 had contractures of the fingers on both hands. The clinical record for Resident 53 was reviewed on 8/15/24 at 12:15 p.m. The diagnoses included, but were not limited to, myoclonus (sudden, involuntary muscle jerks, shakes or spasm), polyosteoarthritis (arthritis affecting five or more joints at once), and right shoulder pain. An occupational therapy (OT) service note, dated 4/17/24, indicated both resident's hands had minimum to moderate arthritis deformities but were functional with maximum difficulty. A Minimum Data Set (MDS) assessment, dated 4/23/24, indicated the resident had a functional limitation in range of motion of her upper extremities which could include, the shoulders, elbows, wrists and hands. A care plan, initiated 4/16/24, indicated the resident had polyosteoarthritis. The care plan did not include the parts of the body affected by arthritis. During an interview, on 8/19/24 at 3:08 p.m., the Assistant Director of Nursing (ADON) indicated the occupational therapist note showed the resident had arthritic changes in her hands. A current policy, titled Care plan, Comprehensive, dated as last reviewed on 7/2021 and received from the Administrator on 8/20/24 at 11:47 a.m., indicated .The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS .Each resident's comprehensive care plan is designed to describe .Identified problem areas .Assessments of residents are ongoing and care plans are revised as information about the resident and the resident's condition change .The Care Planning/Interdisciplinary Team is responsible for the review and updating of care plans .After each assessment, including both the comprehensive and quarterly review assessments . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-35(a)