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	09/25/2024

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 32362 Based on observation, interview and record review, the facility failed to ensure a staff member did not photograph or video tape a resident and post the video online on social media for 1 of 1 resident reviewed for respect and dignity. (Resident F) The deficient practice was corrected on 9/6/24, prior to the start of the survey, and therefore was past noncompliance. Finding includes: A document, titled Indiana State Department of Health Survey Report System, indicated Resident F was videotaped and photographed in the facility while she was sleeping by Staff Member 10. The video was posted online. On 9/24/24 at 2:29 p.m., an online video was reviewed with the Executive Director (ED). The video showed Resident F in her wheelchair at the facility asleep. A comment wake up Grandma was heard, and then a can of Red Bull drink appeared on the screen. The video was posted online on social media. The clinical record for Resident F was reviewed on 9/25/24 at 12:30 p.m. The diagnoses included, but were not limited to, unspecified dementia, difficulty walking, anemia, and depression. The resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated she had a severe cognitive deficit. A care plan indicated the resident had confusion and a memory deficit. She was forgetful and needed reminders. She needed assistance with activities of daily living, and she had an impaired thought process. She preferred to be called grandma. A nursing note, dated 8/17/24, indicated the resident was assessed and no injury was noted. Resident F's guardian was notified of the incident and had no concerns at this time. The resident was reassessed by the DON and the resident was found to be happy and content with no signs of distress. A nursing note, dated 8/22/24, indicated Staff Member 10 threatened Staff Member 11 and accused her of posting the video online. Staff Member 11 told the DON she did not see the video and she did not post the video. She indicated she was aware of the policy and procedure which indicated no photos of residents were to be taken in the facility. (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 - Few	A nursing note, dated 9/5/24, indicated on 8/16/24 at 1:05 p.m., the Director of Nursing (DON) received a text message which she opened and saw a picture of Resident F on snapchat/social media. The correspondence did not reveal the texter's identity. A video was then sent to the DON with the resident on the video and a story line attached. The video had Staff Member 10 as the account holder. Staff member 10 denied posting the video. Staff Member 10 did admit the photo and video were on her camera roll. The guardian for the resident was advised of the investigation and the staff member's termination. During an interview, on 9/24/24 at 3:10 p.m., the DON indicated she was made aware of the video by an anonymous caller. Staff Member 10 was identified. The staff member denied posting the video. Staff Member 10 admitted the phone was her phone with the video on it. Staff Member 10 was fired from employment at the facility and the nursing board was notified. Staff Member 10 failed to follow facility policies and procedures. During an interview, on 9/24/24 at 12:57 p.m., Resident F indicated she did not know if anyone had taken her photo or had posted a video of her online. The resident was confused. During an interview, on 9/24/24 at 12:52 p.m., Staff Member 7 indicated she was aware Resident F's photo was posted online. She had been in-serviced on abuse and knew residents were not to be photographed by staff. During an interview, on 9/24/24 at 12:56 p.m., Staff Member 8 indicated she was aware Resident F's photo was posted online. She had been in-serviced on abuse and knew residents were not to be photographed by staff even if the resident said it was okay. During an interview, on 9/24/24 at 12:59 p.m., Staff Member 9 indicated he was aware Resident F's photo was posted online. He had been in-serviced on abuse and knew residents were not to be photographed by staff. Staff would be terminated if they posted photos of residents online. A current policy, titled Imaging of Residents, Videotaping, Photographing and Other, dated as revised 4/2021 and provided by ED on 9/25/24 at 3:10 p. m., indicated .Resident photographs are considered health care records and will be retained and released in accordance with current applicable regulations and statutes governing the release of protected health information The deficient practice was corrected by 9/6/2024, after the facility implemented a systemic plan which included the following: Staff Member 10 was terminated and all staff members were in-serviced/educated on Abuse and Imaging of Residents, Videotaping, Photographing and other policies and procedures. This citation relates to Complaint IN00441445. 3.1-3(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32362 Based on observation, interview and record review, the facility failed to ensure a resident received adequate supervision when the resident exited the facility, without staff knowledge, and was found down the street 3 blocks away for 1 of 3 residents reviewed for accidents. (Resident B) The deficient practice was corrected on 9/20/24, prior to the start of the survey, and therefore was past noncompliance. Finding includes: An Indiana Department of Health Intake Information Form, dated 9/2/24, indicated a resident had eloped out of the facility, on 9/2/24 at 8:07 a.m., and was returned to the facility by the staff at 8:40 a.m. The clinical record for Resident B was reviewed on 9/24/24 at 1:04 p.m. The diagnoses included, but were not limited to, congestive heart failure, vascular dementia, anxiety disorder, and peripheral vascular disease. The resident had a Brief Interview for Mental Status (BIMS) score of 3 out of 15 which indicated she had a severe cognitive deficit. A facility investigative report indicated the resident left the facility at 8:07 a.m., and she was last seen by the staff at 8:00 a.m. She traveled south with her walker as her mobile assist on 14th street (facility was located on 14th street) crossed 3 blocks and was seen by Staff Member 2 on her way to work at 8:23 a.m. Staff Member 2 notified the facility staff of the resident elopement. The resident was returned to the facility at 8:40 a.m. The resident had traveled 0.2 miles. The resident had been missing from the facility for 20 minutes. A nursing note indicated the resident was assessed with no injuries. The family and physician were notified. The resident indicated she wanted to go for a walk. She did not notify staff, nor did she sign the resident Leave of Absence (LOA) log book. A wandering tool assessment for elopement, dated 7/6/24, indicated the resident was not a risk for wandering behaviors or exit seeking. During an interview, on 9/24/24 at 1:03 p.m., Resident B indicated she was not aware she had eloped from the facility, she indicated she had gone for a walk and the staff helped her come back to the facility. She was not aware she had to tell anyone she was leaving the facility. She was not aware she had to sign in and out to leave the facility. The resident was observed to be independent with mobility. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 9/24/24 at 2:00 p.m., the Executive Director (ED) indicated there was an alarm on the doors of the facility which was alarmed at night at 6:00 p.m., and was turned off at 8:00 a.m. There was a secondary alarm at the nursing station which remained on until the receptionist on duty turned it off when she arrived. On 9/2/24, the receptionist arrived at 9:00 a.m. The secondary alarm sounded at 8:07 a.m., when the resident left the facility. Staff Member 3 turned off the secondary alarm and did not look to see if a resident was missing. Staff Member 3 was terminated for not following policy and procedure. Staff member 3 should have looked for who left the facility and searched for all residents to see if the residents were all in the facility. During an interview, on 9/24/24 at 3:59 p.m., Staff Member 2 indicated she saw Resident B walking down 14th street to the corner of Salem Street at 8:23 a.m. She traveled to the facility and notified staff of the resident's location. She then returned to find the resident at 8:27 a.m. She found the resident between Salem and Union Streets walking towards Union Street. She stayed with the resident until the nursing staff arrived to transport the resident to the facility During an interview, on 9/24/24 at 4:13 p.m., Staff Member 4 indicated she received a call at 8:25 a.m. regarding the resident's elopement. She saw the resident back in the facility at 8:40 a.m. During an interview, on 9/24/24 at 4:20 p.m., the Director of Nursing (DON) indicated the resident was observed leaving the building per video surveillance at 8:07 a.m., then the resident was seen by Staff Member 2 while she was on her way to work at 8:23 a.m. Staff Member 2 notified staff at the facility and returned to find the resident at 8:27 a.m. Staff Member 2 stayed with the resident until nursing staff arrived to transport the resident to the facility. The resident arrived back at the facility at 8:40 a.m. The resident was gone from the facility from 8:07 a.m. until 8:27 a.m. 20 minutes. During an interview, on 9/24/24 at 1:12 p.m., the DON indicated Resident B was not an elopement risk. The nursing staff should have investigated the alarm sounding when the resident left the faciity on [DATE]. During an interview, on 9/24/24 at 12:52 p.m., Staff Member 7 indicated she was aware of Resident B's elopement. She had been in-serviced on the alarm system and to look for residents if the alarm sounded. During an interview, on 9/24/24 at 12:56 p.m., Staff Member 8 indicated she was aware of Resident B's elopement. She had been in-serviced on the alarm system and to look for residents if the alarm sounded. During an interview, on 9/24/24 at 12:59 p.m., Staff Member 9 indicated he was aware of Resident B's elopement. He had been in-serviced on the alarm system and to look for residents if the alarm sounded. He was the staff member conducting the weekly checks on the door alarms A current policy, titled Family Resident Orientation Guide, dated as revised 10/2023 and provided by ED on 9/25/24 at 3:15 p. m., indicated .If a resident leaves the building, it is a requirement to sign out and sign in at the nurse's station and notify the resident's nurse before leaving and upon return. This will allow the staff to know the whereabouts of the resident (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The deficient practice was corrected by 9/20/24, after the facility implemented a systemic plan which included the following: Staff Member 3 was terminated, all staff members were in serviced and educated on the alarm system, the alarm system had an ongoing audit for the exit door and the receptionist's schedule had been changed to coordinate with the automatic alarm door system. This citation relates to Complaint IN00442388. 3.1-45(a)