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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46961 Based on observation, interview and record review, the facility failed to ensure a resident was seated at a table with the height adjusted to accommodate the resident's needs for 1 of 1 resident reviewed for accommodation of needs. (Resident 3) Finding includes: During an observation, on 8/13/24 at 12:10 p.m., Resident 3 was sitting at the end of a long table with other residents who required assistance to eat. She was resting her head on the table during the meal. During an observation, on 8/15/24 at 11:56 a.m., Resident 3 was sitting in the dining room at a long table with other residents who were being assisted with meals. The table was at the level of the resident's chin. She was feeding herself. Her head was leaning to the left and forward. She had a clothing protector on, and a CNA was sitting next to the resident. During an observation, on 8/16/24 at 11:44 a.m., the resident was sitting at the long dining room table with other residents who required assistance with meals. Her chin was at the level of the table. She was leaning forward and looking down. She was not interacting with others. The clinical record for Resident 3 was reviewed on 8/15/24 at 10:28 a.m. The diagnoses included, but were not limited to, mild cognitive impairment of uncertain or unknown etiology, bipolar disorder, mild depression, and adjustment disorder with anxiety. A physician's order, dated 7/16/24, indicated occupational therapy (OT) was to evaluate and treat as indicated. OT was to treat the resident for 25 visits in 8 weeks addressing activities of daily living (ADL) retraining, therapeutic activity, therapeutic exercises, and resident/caregiver education. An OT progress note, dated 8/1/24 to 8/13/24, indicated the resident was being seen for active range of motion (AROM) for neck, shoulder, elbow and hand joints to encourage upright sitting, and retraining safety awareness education. On 8/13/24, a note indicated the therapist consulted with the dining room staff and daughter to try a lower dining table. The resident was able to reach food at the time and would continue to monitor. (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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview, on 8/16/24 at 11:53 a.m., RN 6 indicated there was one adjustable table and pointed to the table in the middle, near the half wall, where a patient and another staff member were sitting. During an interview, on 8/16/24 at 12:05 p.m., the Director of Nursing (DON) indicated the resident had been sitting at a lower table before, but the resident was moved due to therapy wanting the resident to improve her posture. A review of the resident's therapy notes did not indicate to seat the resident at a dining table which came to the level of her chin. A current facility policy, titled Resident Rights and Responsibilities, dated as last reviewed 5/2022 and received from DON on 8/19/24 at 10:01 a.m., indicated .You have the right to be treated with respect and dignity, including the right to .reside and receive services in the facility with reasonable accommodations of your needs and preferences 3.1-3(v)(1)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36454 Based on observation, interview and record review, the facility failed to ensure a resident's bruising was documented as being assessed and monitored and to ensure out of range glucometer readings were reported to the physician as ordered for 3 of 3 residents reviewed for quality of care. (Resident 124, 15 and 12) Findings include: 1. During an observation, on 8/13/24 at 1:43 p.m., Resident 124 had purple bruising on the left side of her face on her cheek. The bruising was the size of two 50 cent pieces put together. The clinical record for Resident 124 was reviewed on 8/13/24 at 1:43 p.m. The diagnoses included, but were not limited to, vascular dementia with other behavioral disturbance, severe major depressive disorder with psychotic symptoms, generalized anxiety disorder, and chronic obstructive pulmonary disease. A care plan, dated 7/18/24, indicated the resident had a potential for impaired skin integrity due to her poor physical condition, limited mobility, dementia, and incontinence. The goal included the resident would be free of injury. The interventions included, but were not limited to, provide skin hygiene every shift and report skin concerns to the nurse and physician. A progress note, dated 7/21/24 at 7:10 p.m., indicated the nurse was notified the resident was observed on the floor. The resident was sitting on the floor next to the bed. The resident stated she had rolled over. The resident had a hematoma and bruising to the left forehead and no other injuries were noted. The progress note did not include bruising to the left side of the resident's cheek. A progress note, dated 7/24/24, indicated the resident was noted to be sitting upright in front of the closet door to her room with her knees drawn up and her arms wrapped around them. The resident had bloody drainage from the left side of her head above the ear. There was a small laceration 1.2 centimeters long, 0.1 centimeters in depth, and 0.2 centimeters in width. A physician's order, dated 7/24/24, indicated to monitor a left forehead hematoma each shift for signs of infection. An interdisciplinary team (IDT) progress note, dated 7/25/24, indicated the resident was reviewed in the safety committee. The resident declined an interview to gather more information about the fall. The fall appeared to have happened while the resident was attempting to get in the closet. The IDT note did not include any information about the bruising on the resident's face. A Fall QS (every shift) documentation, dated 7/28/24, indicated the resident's hematoma was starting to resolve and bruising was noted down the side of the resident's face from the hematoma. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The documentation did not include where the hematoma was located or the size of the bruising. A skin assessment, dated 7/31/24, indicated the resident's forehead hematoma had resolved. The resident had bruising on the left side of her cheek. The skin assessment did not include any measurements of the bruising or how much of the cheek was bruised. An occupational therapy daily note, dated 8/1/24, indicated the resident had a bruised left forehead and face. The therapy note did not include the size of the bruising or measurements of the area. A skin assessment, dated 8/16/24, indicated the resident had a left cheek bruise 3.3 centimeters in length and 4 centimeters in width. The area was dark purple in the center and the surrounding area had reddish hues on the edges. The skin assessment did not include how the bruising to the left side of the cheek occurred or the date the bruising was first located. During an interview, on 8/19/24 at 3:10 p.m., the Assistant Director of Nursing (ADON) indicated the resident had a fall on 7/21/24 and had bruising to the left forehead. The resident fell on [DATE] and had an abrasion to her ear. The resident was also on Xarelto (a blood thinner) and prednisone (for inflammation) during the time of the falls. Her healing was delayed due to the medications. The documentation did not show the bruising was being followed. 44598 2. The clinical record for Resident 12 was reviewed on 8/15/24 at 9:56 a.m. The diagnoses included, but were not limited to, diabetes mellitus, respiratory failure, chronic pulmonary edema, cognitive communication deficit, major depressive disorder, anxiety disorder, end stage renal disease, and hypertension. A physician's order, dated 8/3/24, indicated to obtain an Accu check (test used to estimate blood sugar levels) before meals and at bedtime. Call the physician if the blood sugar level was less than 60 or greater than 490. A Medication Administration Record (MAR), dated August 2024, indicated the following: a. On 8/3/24 at 8:00 p.m., the blood glucose level was 56. b. On 8/5/24 at 6:00 a.m., the blood glucose level was 51. c. On 8/5/24 at 4:00 p.m., the blood glucose level was 53. d. On 8/5/24 at 8:00 p.m., the blood glucose level was 51. e. On 8/7/24 at 4:00 p.m., the blood glucose level was 52. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	f. On 8/9/24 at 6:00 a.m., the blood glucose level was 56. g. On 8/11/24 at 6:00 a.m., the blood glucose level was 49. A care plan, dated 6/17/24 and last revised 8/12/24, indicated the resident had diabetes mellitus (DM). The interventions included, but were not limited to, monitor blood sugars and to notify the physician of results as ordered. There was no documentation, from 8/1/24 to 8/17/24, to indicate the physician was notified of the blood glucose levels less than 60. During an interview, on 8/15/24 at 2:37, the DON indicated it was her expectation the staff would follow the physician's order. When the blood glucose fell within the call range, the physician should be notified. The nurses should follow the physician's order. 3. The clinical record for Resident 15 was reviewed on 8/15/24 at 9:52 a.m. The diagnoses included, but were not limited to, diabetes mellitus, dementia, anxiety disorder, and cognitive communication deficit. A care plan, dated as revised 7/3/24, indicated the resident had diabetes mellitus (DM). The interventions included, but were not limited to, monitor blood sugars and to notify the physician of results as ordered and to monitor for hyperglycemia (high blood glucose level). A physician's order, dated 8/13/24, indicated to get an Accu-check before meals and at bedtime. Notify the physician for a blood sugar less than 60 or greater than 400. A Medication Administration Record (MAR), dated August 2024, indicated the following: a. On 8/7/24 at 6:00 p.m., the blood glucose level was 452. b. On 8/14/24 at 6:00 p.m., the blood glucose level was 454. There was no documentation, from 8/1/24 to 8/17/24, to indicate the physician was notified of the blood glucose levels out of range. During an interview, on 8/15/24 at 4:11 p.m., the DON indicated there was no documentation the physician was notified of the high blood glucose levels. 50956 (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 policy, titled Physician Notification, Change in Condition, dated as last reviewed on 8/2021 and received from the DON on 8/15/24 at 4:00 p.m., indicated .To ensure that significant changes in resident status are based on the assessments which are to be documented in the medical record and medical care problems are communicated to the attending physician in a timely, thorough manner .When contacting physicians, the nurse should attempt to have the following information available .change in vital signs outside physician ordered parameters, general guidelines or normal parameters for the resident .Blood sugar >300 or <60 . Laboratory values .Any of the following abnormal reports unless otherwise directed by physician . Any of the following abnormal reports unless otherwise directed by physician .Glucose >300 or <60 in a diabetic on oral hypoglycemic medication, insulin or <60 for any resident (diabetic or non-diabetic) A current policy, titled Skin Condition Assessment, dated as last reviewed on 10/2022 and received from the DON on 8/19/24 at 3:15 p.m., indicated .Each resident will be observed for skin concerns daily during care and on the assigned bath day by nursing staff. Any concerns will be reported to the charge nurse who will assess the area and document accordingly .Skin observations that should be reported include .bruises . A separate skin report will be completed for each identified skin problem area .Previous measurements will be reviewed . 3.1-37(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. 44598 Based on observation, interview and record review, the facility failed to ensure a staff member followed the policy and procedure when verifying the gastrostomy tube (g-tube) placement prior to medication administration for 1 of 1 resident reviewed for a gastrostomy tube. (Resident 9) Finding includes: During a medication administration observation, on 8/16/24 at 1:50 p.m., Registered Nurse (RN) 4 placed 60 milliliters (ml) of water into a piston and attached it to the resident's g-tube. RN 4 then pushed the 60 ml of water into the tube and pulled back on the syringe. She then indicated there was no tube feeding (residual). During an interview, on 8/19/24 at 12:45 p.m., RN 4 indicated she pushed the water into the g-tube first and then pulled back on the syringe. This was how she checked for the residual and did not know what the facility policy indicated. A current policy, titled Enteral Tube Medication Administration, not dated and received from the Director of Nursing on 8/16/24 at 2:21 p.m., indicated .With gloves on, check for proper tube placement by checking stomach contents (residual). Never check placement with water. Check gastric content for residual feeding. Return residual volumes to the stomach. Report any residual above 100ml 3.1-44(a)(1)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36454 Based on observation, interview and record review, the facility failed to ensure all areas of the wireless call system were functioning properly for 5 of 5 halls reviewed for the call system. (Hall A, B, C, D and E) Finding includes: During a resident council meeting, on 8/15/24 at 2:03 p.m., Resident 56 indicated the call light notifications would go to the staff phones. The residents could not tell if the call request had been received since there was no light which turned on. Sometimes during the night, it would take a long time for her roommate's call light to get answered. Resident 56 would then call the nurses desk and the staff would respond to the request for help. 44598 During an observation, on 8/16/24 at 11:18 a.m., Registered Nurse (RN) 2 indicated the call system was new and the old call lights in the hallway no longer worked. If a resident activated a call light, the staff would get notification on their phone. The phone would make a noise or vibrate. The call light was tested in room [ROOM NUMBER]. RN 2 pressed the resident's call light button. RN 2 then turned up the volume on her phone and the phone made a ding sound. During an observation, on 8/16/24 at 11:26 a.m., RN 3 indicated she used her own phone for the call lights. The phone was in her pocket and was turned off. RN 3 turned on her phone and turned up the volume. During an interview, on 8/15/24 at 2:40 p.m., the Director of Nursing (DON) indicated the facility installed a new call light system. The residents could not see or hear the call lights and thought the lights did not work. The facility provided the residents with bells to ring. During an interview, on 8/16/24 at 11:18 a.m., RN 2 indicated the nurses, Certified Nursing Assistants (CNA), and the management team carried phones. The only way they were notified of a call lights were by their own phones or the staff could get a facility phone at the front desk. RN 2 indicated the staff could also check on an iPad (electronic device) on each hall. RN 2 opened the iPad screen and did not know the password to access the call light system. During an interview, on 8/16/24 at 11:28 a.m., RN 4 indicated the CNAs answered the call lights and she did other things. During an interview, on 8/16/24 at 11:36 a.m., the DON indicated anyone could answer a call light. She did not know what staff took the phones from the desk. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A current policy, titled Call Lights, dated as revised 6/2024 and received from the Director of Nursing on 8/19/24 at 9:59 a.m., indicated .All personnel, unless otherwise directed by the Administrator or designee, must always be vigilant and aware of call lights. The notify app will be downloaded to the device being utilized for alerts. This would include personal phones, facility phones, and iPads. The call light button or pad will be accessible to the resident while in their bed or other sleeping accommodations, and/or while sitting in a chair in the resident's room .Answer all call lights promptly, regardless of the resident assignment .At the beginning of the shift, staff will log in to the Notifync app on their device. Scroll to username. Enter 6-digit PIN. Set your zone located under profile or wheel symbol in right lower corner. Go to alerts or lightning symbol in left lower corner. When the resident activates the call light within their living area, the device being used will receive an alert and the room number will appear on the device. It will appear as a red alert. Note what area the alert is coming from i.e. bed A, bed B, bathroom then Hit the green take button on the device . In the event of system or power failure: Each resident will be provided with a bell to ring manually. For those residents unable to utilize a bell, frequent and periodic rounds will be conducted 3.1-19(u)