| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155825 | A. Building<br>B. Wing | 09/20/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| St Augustine Home for the Aged | 2345 W 86th St<br>Indianapolis, IN 46260 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50901<br><br>Based on interview and record review, the facility failed to ensure a resident's code status was obtained and accurately documented in the clinical record for 1 of 1 resident reviewed for advanced directives. (Resident 171)<br><br>Finding includes:<br><br>The clinical record for Resident 171 was reviewed on [DATE] at 2:58 p.m. The diagnoses included, but were not limited to, hypertension, severe protein-calorie malnutrition, hemorrhage from respiratory passages, and anemia.<br><br>Resident 171 was admitted to the facility on [DATE].<br><br>A document, titled Long-Term Care Patient Summary, with post-acute care discharge instructions, dated [DATE], indicated Resident 171 did not have advanced directives.<br><br>A document, titled Indiana Physician Orders for Scope of Treatment (POST), was prepared on [DATE]. The designation of the resident's preferences related to, attempt resuscitation/CPR, or do not attempt resuscitation/DNR was left blank.<br><br>A code status was not documented on the face sheet.<br><br>There was no order addressing code status found in the record.<br><br>A baseline care plan meeting, completed on [DATE], lacked documentation to show a discussion was had with the resident or resident representative regarding code status preferences.<br><br>A code status preference was not documented in the care plan for Resident 171.<br><br>During an interview, on [DATE] at 3:00 p.m., RN 3 indicated a newly admitted resident should have a code status preference documented in their clinical record within 24 hours after being admitted . If a code status was not present in the clinical record, staff would treat the resident as a full code and would perform CPR.<br><br>(continued on next page) |



| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on [DATE] at 3:06 p.m., the Director of Nursing (DON) indicated Resident 171 did not have a code status documented in his clinical record. The DON was not aware if the resident's preferences was to attempt resuscitation/CPR, or do not attempt resuscitation/DNR due to it was left blank on the POST form. Residents were seen by the physician within 72 hours after admission and a code status would then be documented in the clinical record. The POST form in the clinical record was from Resident 171's previous place of residence.<br><br>During an interview, on [DATE] at 3:05 p.m., the DON indicated the Social Service Director (SSD) had seen the original POST form for Resident 171 in the clinical record and did not initiate the code status process upon admission.<br><br>A current policy, titled Advance Directive, dated as last revised ,d+[DATE] and received from the DON on [DATE] at 11:18 a.m., indicated .Document on admission, that Advance Directives exist and place a copy of the Advance Directives in the Resident Medical Record .As Advance Directive are completed or modified, a current copy is kept within the Medical/Nursing Chart .Assist with communication of the Advance Directives, as necessary, to physician, Home staff, hospital staff, Resident, Resident Representative and Family according to Resident's desires<br><br>3XXX,d+[DATE](f)(4)(A)(ii)<br><br>3XXX,d+[DATE](f)(5) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate treatment and care according to orders, resident’s preferences and goals.<br><br>38872<br><br>Based on interview and record review, the facility failed to ensure a resident was assessed and treated for constipation, to ensure a resident was assessed for complications of congestive heart failure and to notify the physician of weight gains outside of the physician's ordered parameters for 3 of 3 residents reviewed for quality of care. (Resident 12, 18 and 11)<br><br>Finding includes:<br><br>1. The clinical record for Resident 12 was reviewed on 9/17/24 at 2:31 p.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, asthma, and constipation.<br><br>The bowel movement documentation indicated the resident had not had a bowel movement from 8/27/24 to 8/31/24 (5 days).<br><br>There was no abdominal assessment noted in the record.<br><br>A physician's order, initiated on 8/31/23, indicated .BOWEL CONSTIPATION PROTOCOL: do not go<br><br>more than 2 days without a bowel movement, take Miralax 17 grams in 8 ounces of fluids as needed for constipation<br><br>A physician's order, initiated on 6/21/24, indicated to give half a scoop of Miralax 17 grams in the morning for constipation.<br><br>A physician's order, initiated on 4/19/24, indicated to give Senna-Docusate Sodium 8.6-50 milligram tablet as needed for constipation twice a day.<br><br>A physician's order, initiated on 4/19/24, indicated to give Senna-Docusate Sodium 8.6-50 milligrams daily for constipation.<br><br>A care plan, initiated on 3/30/22, indicated the resident had a potential for constipation related to decreased mobility and medications. Interventions included, but were not limited to, administer stool softener/ laxative as ordered, monitor for symptoms of constipation such as abdominal pain, a distended abdomen and bowel sounds, and administer as needed medications (to promote a bowel movement) after three days.<br><br>During an interview, on 9/20/24 at 8:45 a.m., RN 1 indicated bowel movements were to be charted by the CNA. The nurse would talk with the resident and ask when they last had a bowel movement. If no bowel movement after three days, then the bowel assessment was to be done and charted in the notes. If the resident had an order for medication the nurse was to administer the medication. If there was no order, the nurse would contact the physician.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | During an interview, on 9/20/24 at 3:55 p.m., the Director of Nursing indicated she was not able to find documentation of a bowel movement from 8/27/24 to 8/31/24 or an assessment which was completed. The staff should ask the resident if they have had a bowel movement (if not documented) and then follow the facility bowel movement protocol. The protocol consisted of increasing fluids and assessing the bowel sounds.<br><br>2. The clinical record for Resident 18 was reviewed on 9/17/24 at 3:33 p.m. The diagnoses included, but were not limited to, congestive heart failure, chronic respiratory failure with hypoxia, and chronic kidney disease.<br><br>The documented weights indicated the resident weighed 165.3 pounds on 9/2/24 and 170.4 pounds on 9/3/24 which indicated a gain of 5.1 pounds in a 24-hour period.<br><br>There was no assessment of the lung sounds, edema, or chest pain found in the record. There was no documentation the weight was rechecked for accuracy and there was no note to indicate the physician had been informed of the weight gain.<br><br>A physician's order, dated 5/31/24, indicated to weigh the resident daily in the morning and to report to the physician a weight gain of greater than three pounds in 24 hours or five pounds in a week for a diagnosis of congestive heart failure.<br><br>A physician's order, initiated 7/4/24, indicated to encourage a fluid restriction of 1500 milliliters (ml) daily for chronic heart failure.<br><br>A current care plan, revised on 12/4/23, indicated the resident was at risk for complications due to congestive heart failure, atrial fibrillation and hypertension. She would be free of complications and have clear lung sounds and the heart rate and rhythm would be within normal limits. Interventions included, but were not limited to, monitor for difficulty breathing, weight gain, edema and chest pain, contact the physician as indicated, and weight monitoring as ordered.<br><br>A current care plan, revised on 8/7/24, indicated the resident was at risk for dehydration related to diuretic therapy, edema, hypertension, congestive heart, and a history of hyponatremia (low sodium levels) with a fluid restriction. Interventions included, but were not limited to, monitor weights as ordered and consult the physician as indicated.<br><br>During an interview, on 9/20/24 at 8:45 a.m., RN 6 indicated residents with a diagnosis of congestive heart failure (CHF) should have their oxygen saturation levels assessed per physician's order. Daily weights were to be completed, and the physician notified if there was a weight gain. A respiratory assessment was to be done, a reweigh of the resident, and check the resident for edema and skin turgor. An SBAR (a type of assessment to relay information to the physician) should be completed. If after notifying the physician there were new orders, carry out the orders and continue to monitor the resident.<br><br>48525<br><br>3. The clinical record for Resident 11 was reviewed on 9/17/24 at 2:41 p.m. The diagnoses included, but were not limited to, unspecified dementia, hyperlipidemia, age related osteoporosis, and unspecified atherosclerosis of native arteries of bilateral legs.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician's order, with a start date of 7/1/24, indicated if a gain or loss of 4 pounds since the last weight, then weigh 4 days consecutively and notify provider if the gain or loss was valid.<br><br>A vitals log indicated the following weights:<br><br>On 7/1/2024, the weight was 157.0 pounds.<br><br>On 8/1/2024, the weight was 156.7 pounds.<br><br>On 9/1/2024, the weight was 161.5 pounds.<br><br>On 9/1/24, the resident gained 4.8 pounds compared to the last weight.<br><br>There was no documentation in the record to indicate the resident had been weighed for 4 days after the weight gain or notification to the provider of the gain had occurred.<br><br>During an interview, on 9/19/24 at 3:07 p.m., the Director of Nursing (DON) indicated she did not see documentation to indicate the resident was weighed for those 4 days per the order.<br><br>During an interview, on 9/20/24 at 10:52 a.m., the DON indicated the expectation was staff would follow the physician's orders and if they had any questions, they would call the physician.<br><br>A current facility policy, titled WEIGHT, LOSS OR GAIN, dated as revised in 8/2018 and received from the Director of Nursing on 9/20/24 at 11:10 a.m., indicated .A Resident with weight gain should be assessed and monitored for signs and symptoms of Congestive Heart Failure<br><br>A current facility policy, titled Weights, Techniques, dated as revised 8/2018 and received from the Director of Nursing on 9/20/24 at 11:11 a.m., indicated .Residents with a three to five (3-5) lb. loss or gain are reported to the nurse, Supervisor of Director of Nursing<br><br>A current facility policy, titled Congestive Heart Failure, dated as reviewed 1/2023 and received from the Director of Nursing on 9/19/24 at 2:24 p.m., indicated .In the event of any symptoms of CHF (Congestive Heart Failure) of a Resident, the Physician, Resident Representative, Family will be notified by the Charge Nurse under whose supervision the Resident has been delegated, immediately .Common symptoms are . Weight gain<br><br>A current facility policy, titled BOWEL AND BLADDER PROGRAM SCHEDULE, was received from the Director of Nursing on 9/20/24 at 11:11 a.m. The policy did not address a bowel protocol.<br><br>3.1-37(a) |

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| F 0690<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>38872<br><br>Based on interview and record review, the facility failed to ensure urinary output was monitored as ordered by the physician for 1 of 1 resident reviewed for catheter care. (Resident 18)<br><br>Finding includes:<br><br>The clinical record for Resident 18 was reviewed on 9/17/24 at 3:33 p.m. The diagnoses included, but were not limited to, cerebral ischemia (acute brain injury from impaired blood flow to the brain), heart failure, and chronic respiratory failure with hypoxia (a condition which occurs from lack of oxygen in the blood).<br><br>A care plan, initiated on 4/27/23, indicated the resident had an indwelling catheter related to bladder obstruction and urinary retention. The interventions included, but were not limited to, monitor and document urinary output per the facility policy.<br><br>A physician's order, initiated on 4/6/23, indicated to record urinary output every shift.<br><br>The Medication and Treatment Record, for August 2024, was missing urinary output documentation on the night shift for August 1st, the evening shift on August 18th, the night shift on August 21st, and the day shift on August 27th.<br><br>During an interview, on 9/20/24 at 8:45 a.m., RN 1 indicated urinary output was to be documented on the Medication Administration Record.<br><br>A current facility policy, titled .INTAKE AND OUTPUT, dated as last revised in 01/2024 and received from the Infection Preventionist on 9/20/24 at 4:40 p.m., indicated .To ensure adequate hydration levels of certain Residents and to assist in their assessment and management by using I & O (intake and output) record .I&O records are kept on Residents with the following .Foley catheters .record output from catheters<br><br>3.1-41(a)(2) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide safe and appropriate respiratory care for a resident when needed.<br><br>38872<br><br>Based on observation, interview and record review, the facility failed to ensure oxygen tubing was dated for the day it was changed for 3 of 3 residents reviewed for respiratory care. (Residents 18, 12 and 10)<br><br>Findings include:<br><br>1. During an observation, on 9/17/24 at 9:35 a.m., Resident 18 was observed in a recliner in her room. She was found to be using supplemental oxygen at two (2) liters per minute through a nasal cannula. The oxygen line did not have a date to show when the oxygen tubing had been changed.<br><br>The clinical record for Resident 18 was reviewed on 9/17/24 at 3:33 p.m. The diagnoses included, but were not limited to, cerebral ischemia (acute brain injury from impaired blood flow to the brain), heart failure, and chronic respiratory failure with hypoxia (a condition which occurs from lack of oxygen in the blood).<br><br>A physician's order, initiated on 7/11/24, indicated to provide oxygen at two (2) liters per minute via nasal cannula for chronic respiratory failure with hypoxia.<br><br>2. During an observation, on 9/16/24 at 10:33 a.m., Resident 12 was up in sitting up in her room. She was found to be using supplemental oxygen at two (2) liters per minute through a nasal cannula. The oxygen line did not have a date to show when the oxygen tubing had been changed.<br><br>The clinical record for Resident 12 was reviewed on 9/17/24 at 2:31 p.m. The diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, asthma, and chronic obstructive pulmonary disease (COPD).<br><br>A physician's order, initiated on 3/12/23, indicated to change and date the oxygen tubing and storage bags every evening shift on Tuesday.<br><br>A care plan, revised on 5/29/24, indicated the resident had a potential for respiratory complications due to COPD, asthma, chronic respiratory failure with hypoxia, pulmonary fibrosis, and chronic heart failure. She required supplemental oxygen.<br><br>3. During an observation, on 9/16/24 at 12:19 p.m., Resident 10 was up in a high back wheelchair in the dining area. He was found to be using supplemental oxygen at two (2) liters per minute through a nasal cannula. The oxygen line did not have a date to show when the oxygen tubing had been changed.<br><br>The clinical record for Resident 10 was reviewed on 9/20/24 at 12:02 p.m. The diagnoses included, but were not limited to, hypoxemia, heart failure, and obstructive sleep apnea (a sleep disorder which occurs when the upper airway partially or completely collapses during sleep, interrupting breathing).<br><br>(continued on next page) |

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| F 0695<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A physician's order, initiated on 8/5/20, indicated the resident may use oxygen at two liters per minute.<br><br>A care plan, revised on 9/4/24, indicated the resident required supplemental oxygen to maintain adequate oxygenation.<br><br>During an interview, on 9/17/24 at 2:27 p.m., the Director of Nursing indicated the oxygen tubing should be changed weekly, and the tubing should be labeled with the date it was changed.<br><br>A current facility policy, titled OXYGENATOR, dated as last revised in 8/18 and received from RN 1 on 9/18/24 at 10:46 a.m., indicated .Nasal cannula/face mask and humidifier must be changed weekly<br><br>3.1-47(a)(6) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>48525<br><br>Based on interview and record review, the facility failed to monitor the use of antibiotics including the use of standardized tools for the appropriateness of antibiotics prescribed for 1 of 5 residents reviewed for unnecessary medications. (Resident 11)<br><br>Finding includes:<br><br>The clinical record for Resident 11 was reviewed on 9/17/24 at 2:41 p.m. The diagnoses included, but were not limited to vitamin D deficiency, hypertension, polyosteoarthritis, and age-related osteoporosis.<br><br>A physician's order, with a start date of 7/23/24, indicated the resident took Keflex (an antibiotic) oral capsule 250 milligrams (mg).<br><br>During an interview, on 9/20/24 at 3:27 p.m., the Director of Nursing (DON) indicated their physician did the tracking for antibiotics. She was not aware of anybody who did surveillance using the McGeer criteria (surveillance definitions used to identify infections) in the facility. The nurses would report the signs and symptoms to the physician but did not use a specific protocol.<br><br>There was no documentation of a surveillance tool used for the resident.<br><br>A current policy, titled Antibiotic Stewardship Program, dated 1/2024 and received from the DON on 9/20/24 at 3:45 p.m., indicated .Infection preventionist - coordinates all antibiotic stewardship activities, maintains documentation, and serves as a resource for all clinical staff .Licensed nurses participate in the program through assessment of residents and following protocols as established by the program. 4. The program includes antibiotic use protocols and a system to monitor antibiotic use .The facility uses the (CDC's NHSN Surveillance Definitions, updated McGeer criteria, or other surveillance tool) to define infections . Documentation related to the program is maintained by the Infection Preventionist, including, but not limited to .assessment forms .antibiotic use protocols/algorithms .data collection forms for antibiotic use, process, and outcome measures<br><br>A current policy, titled Infection Prevention and Control Program, dated 1/2024 and received from the DON on 9/20/24 at 3:45 p.m., indicated .The RNs and LPNs participate in surveillance through assessment of residents and reporting changes in condition to the residents' physician's and management staff, per protocol for notification of changes and in-house reporting of communicable diseases and infections .Antibiotic use protocols and a system to monitor antibiotic use will be implemented as part of the antibiotic stewardship program. C. The infection preventionist, with oversight from the Director of Nursing, serves as the leader of the antibiotic stewardship program<br><br>3.1-18(b)(1)(A)<br><br>3.1-18(b)(1)(B)<br><br>3.1-18(b)(1)(C) |