STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to accurately code a resident's discharge location on the Discharge Return not Anticipated MDS (Minimum Data Set) assessment for 1 of 6 residents reviewed for hospitalization (Resident 72). Finding includes: The record for Resident 72 was reviewed on 03/09/20 at 10:55 a.m. [DIAGNOSES REDACTED]. A progress note, dated 01/29/2020 at 10:00 a.m., indicated the resident was being discharged to an assisted living facility. The discharge instructions, dated 01/24/2020, indicated the resident was going to receive at home therapy services. The MDS Discharge Return not Anticipated assessment, dated 01/29/2020, indicated the resident was being discharged to an acute hospital. During an interview, on 03/09/20 at 11:10 a.m., the MDS Coordinator indicated the MDS assessment indicated the resident discharged to the hospital and it was not coded correctly. It should have indicated she went home and not to the hospital. During an interview, on 03/09/20 at 11:16 a.m., the MDS Coordinator indicated the facility followed the RAI (Resident Assessment Instrument) manual for all assessments. 3.1-31(d)
F 0644 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to complete a Preadmission Screening and Resident Review (PASARR) Level II as directed by the PASARR Level I for 1 of 1 resident reviewed for PASARR (Resident 8). Finding includes: The record for Resident 8 was reviewed on 3/5/2020 at 3:49 p.m. [DIAGNOSES REDACTED]. A PASARR Level I, dated 4/8/19, indicated the resident had the mental health [DIAGNOSES REDACTED]. The Level I outcome was to refer for a PASARR Level II onsite. The PASARR Level II was to be completed as an onsite face to face evaluation. During an interview, on 3/5/2020 at 3:00 p.m., the Medical Records Coordinator indicated she did not tell the Social Services Director the resident needed to be referred for a PASARR Level II and it did not get completed. A current policy, titled Preadmission Screening and Resident Review (PASRR}, dated as revised 2/18/2020 and received from the Medical Records Coordinator on 3/5/2020 at 3:08 p.m., indicated, .The facility must coordinate assessments with the preadmission screening and resident review (PASRR) program under Medicaid to the maximum extent possible to avoid duplicative testing and effort. A PASRR Level I Mental Screening is required for all admissions .The Level I and II screening forms are placed in the resident's current medical record .The facility will follow the instructions outlined in the Indiana PASRR Level I &Level of Care Screening Procedures for Long Term Care Services Provider Manual for the completion of the PASARR review process 3.1-16(d)(1)(A) 3.1-16(d)(1)(B)
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** Based on observation, interview and record review, the facility failed to ensure medications were appropriately labeled and stored in 1 of 4 medication carts observed for medication storage (D Hall Cart). Finding includes: During an observation, with LPN 2 on 03/06/20 at 9:16 a.m., the D Hall cart had an unlabeled, open medication cup with 10 pills. The cup was found in the top drawer of the medication cart. LPN 2 indicated she had pulled the medications for Resident 71 earlier, but the resident had gone to the dining hall. She realized she should have labeled the cup with a name and saved the pill wrappers. During an interview, on 03/06/20 at 9:18 a.m., LPN 2 indicated she should have labeled the medication cup with the resident's name, date and time and initialed. She should not have left the medications unlabeled in the medication cart. During an interview, on 03/06/20 at 9:29 a.m., the Assistant Director of Nursing (ADON) indicated the nurse should have covered the medication cup and labeled the cup with the resident's name. It should not be a common practice to leave unlabeled medications in the medication cart. A facility policy, titled Medication Storage in the Facility, dated 7/31/17, provided by the ADON, on 03/06/20 at 9:30 a.m., indicated .Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier .A. The provider pharmacy dispenses medications in containers that meet regulatory requirements, including standards set forth by the United States Pharmocopeia (USP). Medications are kept in these containers 3.1-25(k)(1)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.