## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		155214	B. WING _	B. WING		12/29/2021	
NAME OF PROVIDER OR SUPPLIER  SAINT ANTHONY				2	TREET ADDRESS, CITY, STATE, ZIP CODE 03 FRANCISCAN DR CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	F 000			
	This visit was for a C Control Survey.	OVID-19 Focused Infection					
	Survey dates: December 29, 2021						
	Facility number: 000 Provider number: 15 AIM number: 100274	5214					
	Census Bed Type: SNF/NF: 135 SNF: 27						
	NCC: 1 Total: 163						
	Census Payor Type: Medicare: 28 Medicaid: 103 Other: 32 Total: 163						
	42 CFR Part 483, Sul	the COVID-19 Focused					
	Quality review comple	eted on 1/3/22.					
LABORATORY	DIRECTOR'S OR PROVIDER!	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(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.