STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING _____ B. WING _____	C 10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	**203 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaints IN00385285, IN00385596, IN00387571, IN00387777, and IN00390960. Complaint IN00385285 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00385596 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387571 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00387777 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00390960 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: October 3, 4, and 5, 2022 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 149 SNF: 19 NCC: 2 Total: 170 Census Payor Type: Medicare: 23 Medicaid: 108 Other: 39 Total: 170	F 000		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING _____ B. WING _____	C 10/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	**203 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 PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	Continued From page 1 Saint Anthony was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00385285, IN00385596, IN00387571, IN00387777, and IN00390960. Quality review completed on 10/6/22.	F 000		