ENTERS FOR MEDICARE & MEDICAID SERVICES						OM	IB NO. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		JILDING		COMPI	LETED
		155214	B. W.	NG		06/22	/2021
NAMEOEI		D		STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	ĸ	203 FRANCISCAN DR				
SAINT A	NTHONY			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF	3E	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
E 0000							
Bldg							
0	An Emergency Pre	paredness Survey was	E 0	000	The facility requests desk		
		ndiana Department of Health			compliance		
	in accordance with	-					
	Survey Date: 06/2	2/21					
	Facility Number: 0	00120					
	Provider Number:						
	AIM Number: 100						
	At this Emergency	Preparedness survey, Saint					
		d not in compliance with					
	-	edness Requirements for					
		icaid Participating Providers					
	and Suppliers, 42 G						
	The feetlite here 19	0					
	of the survey, the c	9 certified beds. At the time census was 167.					
	Quality Review on						
	Quality Review off	00/23/21					
	The requirement at	: 42 CFR, Subpart 483.73 is					
	NOT MET as evid						
E 0004	403,748(a) 416 5	54(a), 418.113(a),					
SS=C		15(a), 483.475(a),					
Bldg)2(a), 485.625(a),					
Diag.		27(a), 485.920(a),					
	486.360(a), 491.1	., .,					
		, Review and Update					
	Annually	·					
	-	6.54(a), §418.113(a),					
		0.84(a), §482.15(a),					
		.475(a), §484.102(a),					
		.625(a), §485.727(a),					
		6.360(a), §491.12(a),					
	§494.62(a).						1

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

TITLE

(X6) DATE

PRINTED: 07/15/2021 FORM APPROVED

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES I OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	A. B	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS CITY STATE ZIP CO			(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEF	8	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
	Federal, State and preparedness req must develop esta comprehensive er program that mee section. The emer program must incl the following elem (a) Emergency Pla develop and main preparedness plar and updated at lea must do all of the * [For hospitals at §485.625(a):] Emo or CAH] must com Federal, State, an preparedness req CAH] must develor comprehensive er program that mee section, utilizing a * [For LTC Facilitie Emergency Plan. develop and main preparedness plar and updated at lea * [For ESRD Facil Emergency Plan. develop and main	an. The [facility] must tain an emergency in that must be [reviewed], ast every 2 years. The plan following: §482.15 and CAHs at ergency Plan. The [hospital nply with all applicable d local emergency uirements. The [hospital or op and maintain a mergency preparedness ts the requirements of this n all-hazards approach. es at §483.73(a):] The LTC facility must tain an emergency in that must be reviewed, ast annually. ities at §494.62(a):] The ESRD facility must tain an emergency in that must be [evaluated],						

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STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		ONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEF			203 FF	ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DR 'N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE	
	facility failed to dev emergency prepared and updated at least	view and interview, the velop and maintain an dness plan that was reviewed a annually in accordance with This deficient practice could	E 00	004	The facility requests desk compliance E004	07/15/2	
	Based on review of Disaster Preparedne between 9:05 a.m. to Operations Director a complete emerger facility within the n period was not avai emergency plan ava within the past 12 m the time of record r Director said the fa- emergency prepared the facility within the period because of the	The facility's "Emergency & ess" plan on 06/22/21 o 1:00 p.m. with the Plant represent, documentation for ney program reviewed by the nost recent twelve month lable for review. The allable has not been reviewed nonths. Based on interview at eview, the Plant Operations cility has not had its entire dness program reviewed by ne most recent twelve month ne COVID 19 Pandemic. viewed with the Plant r at the time of exit.			 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has bee updated pertaining to Emerger and Disaster Preparedness for the last 12 months. 1.3 The Director of Plant Operations has reviewed and updated its entire emergency 	n ncy	

	R MEDICARE & MEDI	X1) PROVIDER/SUPPLIER/CLIA	(X2)	MULTIPLE C	ONSTRUCTION		MB NO. 0938-0391	
	OF CORRECTION	IDENTIFICATION NUMBER:	· /	BUILDING	<u></u>	(X3) DATE SURVEY COMPLETED		
		155214	B. WING				2/2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIE	ČR.			RANCISCAN DR	2		
SAINT A	NTHONY				/N POINT, IN 46307			
(X4) ID	1	STATEMENT OF DEFICIENCIES	—	ID	1		(X5)	
PREFIX		ENCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL	TON D BE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE	
		,			preparedness program for	the		
					facility to ensure complian			
					In-serviced on Developme			
					Emergency Preparedness			
					review and update annual			
					been completed (Attachm	ent #1).		
					1.4 The Director of Plant			
					Operations will continue to	o update		
					Emergency and Disaster			
					Preparedness on an annu			
					and will be available in the	e		
					Director of Plant's office.			
0013	402 749(b) 446	E4(b) 449 442(b)						
SS=C		54(b), 418.113(b),						
Bldg		15(b), 483.475(b), 02(b), 485.625(b),						
ыuy		02(b), 485.825(b), 27(b), 485.920(b),						
	485.68(b), 485.7 486.360(b), 491.							
		EP Policies and Procedures						
		6.54(b), §418.113(b),						
		60.84(b), §482.15(b),						
		8.475(b), §484.102(b),						
		5.625(b), §485.727(b),						
		36.360(b), §491.12(b),						
	§494.62(b).							
		procedures. [Facilities] must						
		lement emergency						
	preparedness po	licies and procedures,					1	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COI			CON	(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEF	ι		STREET A 203 FRA CROWN	CODE			
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETIO	
TAG	based on the emer paragraph (a) of t assessment at paragraph (c) of th and procedures m updated at least effective and procedures. The develop and imple preparedness poll based on the emer paragraph (a) of t assessment at paragraph (c) of th and procedures m updated at least at *Additional Require ESRD Facilities: *[For PACE at §44 procedures. The develop and imple preparedness poll based on the emer paragraph (a) of t and procedures m updated at least at *Additional Require ESRD Facilities: *[For PACE at §44 procedures. The develop and imple preparedness poll based on the emer paragraph (a) of t assessment at paragraph (c) of th and procedures m of medical and no including, but not power, or water far emergencies; and threaten the healt	ragraph (a)(1) of this ommunication plan at his section. The policies nust be reviewed and every 2 years. as at §483.73(b):] Policies The LTC facility must ement emergency icies and procedures, ergency plan set forth in his section, risk ragraph (a)(1) of this ommunication plan at his section. The policies nust be reviewed and innually. rements for PACE and PACE organization must ement emergency icies and procedures, ergency plan set forth in his section, risk ragraph (a)(1) of this ommunication plan at his section, risk ragraph (a)(1) of this ommunication plan at his section. The policies hust address management nedical emergencies, limited to: Fire; equipment, hilure; care-related I natural disasters likely to h or safety of the or the public. The policies		TAG	DEFICIENCY)		DATE	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION (X	(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIE	2	203 F	T ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DR WN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	Policies and proc facility must deve emergency prepa procedures, base set forth in parage assessment at pa section, and the of paragraph (c) of t and procedures in updated at least of emergencies inclu- fire, equipment or care-related emer- interruption, and in occur in the facility Based on record re- facility failed to rev- emergency prepare at least annually in 483.73(b). This de all residents in the Findings include: Based on review of Disaster Preparedin 12:50 p.m. with the the emergency plan review date during the last date of revi 04/2019. Based on record review the F agreed there was m Emergency & Disa	ties at §494.62(b):] edures. The dialysis lop and implement redness policies and d on the emergency plan raph (a) of this section, risk ragraph (a)(1) of this communication plan at his section. The policies nust be reviewed and every 2 years. These ude, but are not limited to, power failures, gencies, water supply natural disasters likely to y's geographic area. view and interview, the view and updated their dness policies and procedures accordance with 42 CFR ficient practice could affect	E 0013	The facility requests desk compliance E 013 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has been updated pertaining to Emergence and Disaster Preparedness for the last 12 months. 1.3 The Director of Plant Operations has reviewed and updated its entire emergency		

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	A. B	IULTIPLE CO UILDING /ING	DNSTRUCTION	(X3) DAT COM	DMB NO. 0938-039 TE SURVEY PLETED 22/2021
	PROVIDER OR SUPPLIEF	2		203 FR	ADDRESS, CITY, STATE, ZIP C ANCISCAN DR N POINT, IN 46307	ODE	
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) viewed with the Plant t at the time of exit.		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY) preparedness program facility to ensure comp In-serviced on Develop Emergency Preparedn and Policies and Proce been completed (Attac	HOULD BE PPPROPRIATE in for the liance. poment of ess Plan edures has hment #2).	(X5) COMPLETIO DATE
					1.4 The Director of Pla Operations will continu Emergency and Disast Preparedness on an a basis.	e to update er	
: 0029 SS=C Bldg	§403.748(c), §416 §441.184(c), §460 §483.73(c), §483. §485.68(c), §485.	5(c), 483.475(c), 2(c), 485.625(c), 7(c), 485.920(c),					
	an emergency pre plan that complies local laws and mu	ust develop and maintain eparedness communication s with Federal, State and st be reviewed and updated ears [annually for LTC					

	NT OF DEFICIENCIES	x1) provider/supplier/clia identification number: 155214	ì í	ILDING	<u></u> C	(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIE	R		203 FF	ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DR 'N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
	facility failed to ma preparedness comm with Federal, State reviewed and upda accordance with 42	view and interview, the aintain an emergency nunication plan that complies , and local laws that were ted at least annually in 2 CFR 483.73(c). This ould affect all occupants.	E 00)29	The facility requests desk compliance E 029	07/15/20	
	Preparedness" plan Director during rec 06/22/21, document emergency program within the most rec not available for re was 04/2019. Base record review, the stated the Emergen plan, which include not been reviewed twelve months due	the "Emergency & Disaster with the Plant Operations ord review at 12:50 p.m. on ation for a complete reviewed by the facility ent twelve month period was view. The most recent update d on interview at the time of Plant Operations Director ey & Disaster Preparedness s a communication plan, had and updated within the last to the COVID 19 Pandemic.		1.1 T Prepa imme 1.2 A updat and E	 1.1 The Emergency & Disaster Preparedness plan was immediately updated. 1.2 All documentation has been updated pertaining to Emergency and Disaster Preparedness for the last 12 months. 		
				1.3 The Director of Plant Operations has reviewed and updated its entire emergency preparedness program for the facility to ensure compliance. In-serviced on Emergency Communication Procedure has been completed (Attachment #3).			

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	î î	MULTIPLE C	ONSTRUCTION	(X3) DATE SURVI COMPLETED	
		155214	В.	WING		06/2	2/2021
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP C	CODE	
SAINT A	NTHONY				RANCISCAN DR /N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF COR		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DERCEACE)		DATE
					1.4 The Director of Pla Operations will continu Emergency and Disas Preparedness on an a	ie to update ter	
: 0036 SS=C Bldg	441.184(d), 482. 483.73(d), 484.10 485.68(d), 485.72 486.360(d), 491. EP Training and §403.748(d), §41 §441.184(d), §46 §483.73(d), §483 §485.68(d), §485	02(d), 485.625(d), 27(d), 485.920(d), 12(d), 494.62(d)					
	§416.54, Hospice §441.184, PACE §482.15, HHAs a §485.68, CAHs a under 485.727, C at §486.360, and Training and test develop and main preparedness tra that is based on t in paragraph (a) of assessment at pa section, policies a paragraph (b) of communication p	§403.748, ASCs at e at §418.113, PRTFs at at §460.84, Hospitals at t §484.102, CORFs at t §486.625, "Organizations" MHCs at §485.920, OPOs RHC/FHQs at §491.12:] (d) ng. The [facility] must ntain an emergency ining and testing program he emergency plan set forth of this section, risk aragraph (a)(1) of this and procedures at this section, and the lan at paragraph (c) of this ning and testing program					

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	A. 1	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD			(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEF	t.		STREET A 203 FR CROW	DDE			
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	DULD BE	(X5) COMPLETIC DATE	
	2 years. *[For LTC facilities Training and testin develop and main preparedness train that is based on th in paragraph (a) of assessment at paragraph (b) of th communication plasection. The train must be reviewed annually. *[For ICF/IIDs at § testing. The ICF/II maintain an emergency plasection, paragraph (a)(1) of procedures at para and the communication, paragraph (a)(1) of procedures at para and the communication, paragraph (a)(1) of procedures at para and the communication, paragraph (a)(1) of procedures at para and the communication. The program must be least every 2 year the requirements at training at §483.44 *[For ESRD Facilitation] Training, testing, and dialysis facility muture emergency preparation on the emergency (a) of this section,	ragraph (a)(1) of this nd procedures at his section, and the an at paragraph (c) of this ing and testing program and updated at least (483.475(d):] Training and D must develop and gency preparedness g program that is based on an set forth in paragraph risk assessment at of this section, policies and agraph (b) of this section, cation plan at paragraph (c) he training and testing reviewed and updated at s. The ICF/IID must meet for evacuation drills and						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 155214 B. WING 06/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training, testing and orientation program must be evaluated and updated at every 2 years. E 036 Based on record review and interview, the E 0036 07/15/2021 facility failed to maintain an emergency preparedness training and testing program that was reviewed and updated at least annually in accordance with 42 CFR 483.73(d). This deficient practice could affect all occupants. 1.1 The Emergency & Disaster Findings include: Preparedness plan was immediately updated. Based on review of the "Emergency & Disaster Preparedness" plan on 06/22/21 at 12:50 p.m. with the Plant Operations Director, there was 1.2 All documentation has been documentation available to show the facility had an emergency preparedness training and testing updated pertaining to Emergency and Disaster Preparedness for program, however, there was no documentation the last 12 months. to show that the training and testing program has been reviewed and updated within the past twelve months. The last available review date was 04/2019. Based on interview at the time of 1.3 The Director of Plant record review, the Plant Operations Director stated the Emergency & Disaster Preparedness Operations has reviewed and plan had not been updated within the last twelve updated its entire emergency months due to the COVID 19 Pandemic. preparedness program for the facility to ensure compliance. This finding was reviewed with the Plant In-serviced on Emergency Operations Director at the exit conference. Preparedness training and testing has been completed (Attachment #4). 1.4 The Director of Plant Operations will continue to update Emergency and Disaster Preparedness on an annual basis. FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B5JS21 Facility ID: 000120 If continuation sheet Page 11 of 24

PRINTED:

07/15/2021

					OMB NO. 0938-0391 (X3) DATE SURVEY			
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	LETED	
		155214	B. WINC	÷		06/22/2021		
NAME OF I	PROVIDER OR SUPPLIE	R			DDRESS, CITY, STATE, ZIP CODE	1		
	NTHONY				ANCISCAN DR N POINT, IN 46307			
	-				N POINT, IN 40307		I	
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		EFIX FAG	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)		COMPLETION DATE	
K 0000	RECEPTION						DATE	
X 0000								
Bldg. 01								
	A Life Safety Code	e Recertification and State	K 000	0	The facility requests desk			
	-	vas conducted by the Indiana			compliance			
		lth in accordance with 42						
	CFR 483.90(a).							
	Survey Date: 06/22	2/21						
	Facility Number: 0	00120						
	Provider Number: 0							
	AIM Number: 1002							
	-	Code survey, Saint Anthony						
		ompliance with Requirements						
	-	Medicare/Medicaid, 42 CFR						
	•	Life Safety from Fire and the						
		National Fire Protection						
		A) 101, Life Safety Code , Existing Health Care						
	Occupancies and 4	6						
	This three story for	cility with a partial basement,						
	was determined to							
		as fully sprinklered. The						
		larm system with hard wired						
		the corridors, spaces open to						
	the corridors, and b							
		resident rooms. The building						
		ed by a 100 kW diesel						
		y generator. The facility has						
		9 and had a census of 144 at						
	the time of this sur							
	Quality Review on	06/25/21						
K 0351	NFPA 101							
SS=E	Sprinkler System	- Installation						
Bldg. 01	Spinkler System -							

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	ULTIPLE C JILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/22/2021	
		155214	B. W.		<u></u>		
NAME OF	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
SAINT A	NTHONY				RANCISCAN DR /N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO) BE	COMPLETIC
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	by construction ty throughout by an sprinkler system 13, Standard for Systems. In Type I and II c protection measu substituted for sp areas where state prohibit sprinklers In hospitals, sprin clothes closets of where the area of 6 square feet and the closet footprin Standard for Inst Systems. 19.3.5.1, 19.3.5.2 19.3.5.5, 19.4.2, Based on observat failed to maintain 1 Third floor D W accordance with N Installation of Spri 2010 edition, Secti escutcheons, or ott annular space arou metallic, or shall b sprinkler. This de staff and up to 18 f Wing smoke comp Findings include: Based on observat Director on 06/22/ floor D Wing Nurs	akklers are not required in f patient sleeping rooms f the closet does not exceed d sprinkler coverage covers at as required by NFPA 13, allation of Sprinkler 2, 19.3.5.3, 19.3.5.4, 19.3.5.10, 9.7, 9.7.1.1(1) toon and interview, the facility the ceiling construction in 1 of ing Nurse's Station in FPA 13, Standard for the nkler Systems. NFPA 13, on 6.2.7.1 states plates, her devices used to cover the nd a sprinkler shall be e listed for use around a ficient practice could affect residents in the Third floor D	К 0	351	The facility requests desk compliance K 351 1.1 The Third Floor D Win nurse's Station missing escutcheon was repaired immediately.	9	07/15/20

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEF	ι.	203 F	T ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DR NN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETIC DATE
	confirmed the escut an assistant replace survey exit. This finding was re	nt Operations Director acheon was missing and had the escutcheon prior to viewed with the Plant at the exit conference.		1.2 The Director of Plant operations had an assistant replace the escutcheon and ar in-serviced was completed on sprinkler system-installation (Attachment # 5)	n
				1.3 No other escutcheons wer observed that needed replacement. Presence of escutcheons audits will be add to daily preventative maintena schedule for six (6) months to ensure compliance. The Direc of Plant Operations/designee v monitor on a daily basis. Any identified concerns relating to escutcheon will be corrected a observed.	led nce stor will
				1.4 The Director of Plant Operations/designee will repor monthly audit findings to the C Committee meeting monthly for	API

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: A. BUILDING 155214 B. WING				(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEI NTHONY	2	2	203 FRA	DDRESS, CITY, STATE, ZIP CODE ANCISCAN DR I POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
					(6) months beginning July 15, 2021. The QAPI Committee v monitor data presented for an items for trends and determine further auditing is warranted.	vill Y	
(0353 SS=E Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with I Inspection, Testin Water-based Fire Records of system inspection and tes secure location and a) Date sprinkled b) Who provided c) Water system Provide in REMA coverage for any automatic sprinkle 9.7.5, 9.7.7, 9.7.8 Based on observati failed to maintain t areas throughout th edition, Section 3.3 as a continuous cei irregularities, lump ceiling tiles trap ho sprinkler and cause specified temperatu 8.5.4.11 states the o	supply source RKS information on non-required or partial er system. , and NFPA 25 on and interview, the facility he ceiling construction in two e facility. NFPA 13, 2010 .5.4 defines a smooth ceiling ling free from significant s, or indentations. The t air and gases around the the sprinkler to operate at a ure. NFPA 13, 2010 edition, distance between the sprinkler eiling above shall be selected f sprinkler and the type of	K 0353	3	The facility requests desk compliance K 353		07/15/202

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 06/22/2021	
	PROVIDER OR SUPPLIEF	R	203	ET ADDRESS, CITY, STATE, ZIP CODI FRANCISCAN DR WN POINT, IN 46307	E	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL . LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION S) CROSS-REFERENCED TO THE A TAG DEFICIENCY)		TION D BE OPRIATE	(X5) COMPLETIC DATE
	affect up to 43 resid Findings include: Based on observatio Director on 06/22/2 from 1:00 p.m. to 3 noted: a.) a 1/2 inch hole i the third floor A wi station and resident b.) a 1/2 inch hole i	dents and staff. ons with the Plant Operations 1 during a tour of the facility 10 p.m.; the following was n a suspended ceiling tile of ng corridor by the nurse's rooms 309-A and 310-A. n a suspended ceiling tile of		hole in a suspended ceilin and room 309-A, 310-A au 384-A. Due to Wi-Fi mour was repaired. 1.2 The Director of Plant	nd its holes	
	384-A. Based on interview the Plant Operation mounted Wi-Fi uni recently repositione repaired.	ng corridor by resident room at the time of observation, s Director stated the ceiling ts in the corridors were ed and the holes had not been viewed with the Plant r at the time of exit.		operations has completed repairs and a whole Facili inspection with no other a found to have holes.	ty	
	3.1-19(b)			1.3 The Director of Plant Operations in-serviced the Operations staff (Attachm The Plant Director will aud monitor on a daily basis. identified concerns related holes in ceiling tiles will be corrected as observed.	ent # 7). dit and Any d to	
				1.4 The Director of Plant Operations/designee will r monthly audit findings to t Committee meeting month	he QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		· /		(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		te survey pleted 2 2/2021
NAME OF	PROVIDER OR SUPPLIE	R	STR	EET ADDRESS, CITY, STATE, ZIP	CODE	
				FRANCISCAN DR		
SAINT A	NTHONY		CR	OWN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFI			COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
				(6) months beginning 2021. The QAPI Cor monitor data present items for trends and further auditing is wa	nmittee will ed for any determine if	
K 0363 SS=E Bldg. 01	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of					

	NT OF DEFICIENCIES	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	î î	JILDING NG	<u>01</u>	DATE SURVEY COMPLETED 06/22/2021
	PROVIDER OR SUPPLIEF			203 FF	ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DR /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE
	area or fire resista window assemblie 19.3.6.3, 42 CFR 483, and 485 Show in REMARK fire protection ratii devices, etc. Based on observation failed to ensure 1 or doors to the corridon accordance with LS 19.3.6.3.5 states that provided with a me closed. Section 19. shall not be held op those that release w	Parts 403, 418, 460, 482, S details of doors such as higs, automatics closing on and interview, the facility f over 100 resident room r were maintained in C Section 19.3.6.3. Section t corridor doors shall be ans for keeping the door 3.6.3.10 states that doors en by devices other than hen the door is pushed or ent practice could affect staff	К 0	363	The facility requests desk compliance K 363	07/15/20
	Director during a to at 2:15 p.m., the co 232-A on B Wing of latch into the frame Based on interview the door of room 23 closed was acknow Operations Director This finding was re				 1.1 The corridor door to Resident Room 232-A on B wing 2nd floor was repaired to make sure it latches. 1.2 Upon facility inspection no other door was observed to have issues regarding positively latching of the doors. 	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 06/22/2021	
NAME OF F	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
SAINT A	NTHONY			RANCISCAN DR /N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC DATE	
				1.3 The latch has been repaired by the facility. The Director of Plant Operations/designee will monitor on a daily basis. Presence of positive latching to door closing will be added to monthly door audit and preventative maintenance schedule for six (6) months to ensure compliance.		
				1.4 The Director of Plant Operations in-serviced the Plant Operations staff (Attachment # on proper corridor-doors closing as well as removal of any impediment, which would not al proper latching of doors. Presence of impediments to do closing will be added to monthly door audit and preventative maintenance schedule for six (6 months to ensure compliance. (Attachment # 9). The Director Plant Operations/designee will report monthly audit findings to the QAPI Committee meeting monthly for six (6) months beginning July 15, 2021. The QAPI Committee will monitor da presented for any items for tren and determine if further auditing warranted.	8) g low or (5) of of	

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DAT	E SURVEY		
AND PLAN	OF CORRECTION	ECTION IDENTIFICATION NUMBER: A. BUILDING		01		COMPLETED		
		155214	B. WING		06/2	2/2021		
NAME OF	PROVIDER OR SUPPLIE	P	STREET	CODE				
NAME OF	PROVIDER OR SUPPLIE	ĸ	203 FRANCISCAN DR					
SAINT ANTHONY (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			CROW	/N POINT, IN 46307				
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF COR	RECTION	(X5)		
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A		COMPLETIO		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE		
. 0918 SS=F Bldg. 01	Electrical System	is - Essential Electric Syste is - Essential Electric						
	source and asso of supplying serv 10-second criteri monthly test, a p annually confirm safety and critica and testing of the switches are per	ance and Testing r other alternate power ciated equipment is capable ice within 10 seconds. If the on is not met during the rocess shall be provided to this capability for the life I branches. Maintenance e generator and transfer formed in accordance with						
	exercised under year in 20-40 day once every 36 m hours. Scheduled include a comple automatic or mar	re inspected weekly, load 30 minutes 12 times a v intervals, and exercised onths for 4 continuous d test under load conditions te simulated cold start and hual transfer of all EES onducted by competent						
	personnel. Maint energy power so accordance with circuit breakers a a program for pe components is es	enance and testing of stored urces (Type 3 EES) are in NFPA 111. Main and feeder ire inspected annually, and riodically exercising the stablished according to urements. Written records						
	of maintenance a and readily availa and circuits are r and separate from Minimizing the po	and testing are maintained able. EES electrical panels marked, readily identifiable, m normal power circuits. possibility of damage of the er source is a design						

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155214 B. WING 06/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) Based on record review and interview, the K 0918 07/15/2021 The facility requests desk facility failed to ensure a written record of weekly inspections for the generator was compliance maintained for 7 of 52 weeks. NFPA 99, K 918 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of 1.1 The Director of Plant inspection, performance, exercising period, and repairs for the generator to be regularly Operation initiated required inspection and testing of weekly maintained and available for inspection by the authority having jurisdiction. This deficient inspections for the generator. practice could affect all residents, staff and visitors. Findings include: Based on record review with the Plant 1.2 Inspection and testing will be Operations Director on 06/22/21 at 11:15 a.m., corrected immediately. the last documented weekly generator visual inspection was 05/03/2021. Based on an interview at the time of record review, the Plant Operation Director acknowledged weekly visual inspections of the generator had not been 1.3 The Director of Plant documented since 05/03/2021. He further stated that the staff member who performed the **Operations in-serviced Plant** visual inspections recently retired and the weekly Operation staff on the required 52 inspections must have been mistakenly added to week inspections for the the monthly testing. generator and testing in accordance with LLC. The Emergency Power supply should This finding was reviewed with the Plant Operations Director at the exit conference. be inspected weekly and exercised monthly. The Director FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B5JS21 Facility ID: 000120 If continuation sheet Page 21 of 24

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07/15/2021

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155214	A. BUILDING <u>01</u> B. WING		COMPLETED 06/22/2021	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP	CODE	
	NTHONY			/N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COL		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE APPROPRIATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TAG		m vi d	DATE
	3.1-19(b)			of Plant Operations in the Plant Operations s (Attachment # 10).		
				1.4 The Director of Pla Operations/designee of monthly audit Findings QAPI Committee mee for six (6) months beg 15, 2021. The QAPI (will monitor data prese items for trends and d further auditing is ward	will report s to the ting monthly inning July Committee ented for any etermine if	
< 0920 SS=E Bldg. 01	Extens Electrical Equipm Extension Cords Power strips in a only used for com patient-care-relat (PCREE) assemil assembled by qui the conditions of the patient care w non-PCREE (e.g except in long-ten do not use PCRE meet UL 1363A of for non-PCREE in (outside of vicinit non-patient care other UL standar used with general	hent - Power Cords and hent - Power Cords and patient care vicinity are hponents of movable ed electrical equipment oles that have been alified personnel and meet 10.2.3.6. Power strips in ricinity may not be used for ., personal electronics), rm care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms y) meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension ed as a substitute for fixed				

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155214 B. WING 06/22/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility K 0920 07/15/2021 The facility requests desk failed to ensure 1 of 1 Therapy area did not use flexible cords as a substitute for fixed wiring. compliance LSC 9.1.2 requires electrical wiring and K 920 equipment shall be in accordance with NFPA 70, National Electrical Code. NFPA 70, 2011 Edition, Article 400.8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects as many as 3 residents, 2 staff. Findings include: 1.1 The power strip plugged into another power strip was removed. Based on observation with the Plant Operations Director during a tour of the facility on 06/22/21at 2:48 p.m., a laptop was powered by being plugged into a power strip that was plugged into another power strip which was plugged into the wall. Based on interview at the time of observation, the Plant Operations Director 1.2 Upon Facility Inspection no acknowledged the power strip plugged into another power strip as being in use within the other power strips were observed Therapy area. to be used. This finding was reviewed with the Plant Operations Director at the time of exit. 3.1-19(b) 1.3 The Director of Plant Operations in-serviced the Plant FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: B5JS21 Facility ID: 000120 If continuation sheet Page 23 of 24

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07/15/2021

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		(X3) DATE SURVEY COMPLETED 06/22/2021	
NAME OF P	ROVIDER OR SUPPLIE NTHONY	R	STREET 203 FR CROW			
X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDERS PLAN OF CORRECTION PREFIX CROSS-REFERENCED TO THE APPROPRI DEFICIENCY TAG Operations staff (Attachment on proper power cords and extension cords as well as re of any power strips plugged in another. The Director of Plan Operations/designee will mor on a daily basis. Presence of daily inspections and monthly audit and preventative maintenance schedule for six months to ensure compliance		# 11) moval n nt nitor , (6)	(X5) COMPLETION DATE	
				1.4 The Director of Plant Operations/designee will report monthly audit findings to the 0 Committee meeting monthly f (6) months beginning July 15, 2021. The QAPI Committee we monitor data presented for an items for trends and determin further auditing is warranted.	QAPI for six , will iy	

Facility ID: 000120 B5JS21

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