PRINTED:	08/12/2022
FORM APP	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/19/2022
NAME OF F	PROVIDER OR SUPPLI NTHONY	ER	203 FR	ADDRESS, CITY, STATE, ZIP COD ANCISCAN DR N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E COMPLETION
E 0000					
Bldg			E 0000		
	Facility Number: Provider Number AIM Number: 10	: 155214			
	Anthony was four Emergency Prepa	y Preparedness survey, Saint nd in compliance with redness Requirements for dicaid Participating Providers CFR 483.73			
	The facility has 1 the survey, the ce	89 certified beds. At the time of nsus was 160.			
	Quality Review c	ompleted on 07/20/22			
< 0000					
Bldg. 01	Licensure Survey	de Recertification and State was conducted by the Indiana ealth in accordance with 42 CFR	K 0000		
	Survey Date: 07/1	19/22			
	Facility Number: Provider Number AIM Number: 10	: 155214			
		y Code survey, Saint Anthony compliance with Requirements			

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214	(X2) MULTIPLE CONSTRUCTION (X A. BUILDING <u>01</u> B. WING		COMF	(X3) DATE SURVEY COMPLETED 07/19/2022	
NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY			STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIE) REGULATORY O for Participation in	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Medicare/Medicaid, 42 CFR		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Ε	(X5) COMPLETION DATE
	2012 edition of the Association (NFP/ Chapter 19, Existin 410 IAC 16.2. This three story fac was determined to and was fully sprin alarm system with the corridors, space battery operated sr rooms. The facilit	Life Safety from Fire and the National Fire Protection A) 101, Life Safety Code (LSC), ng Health Care Occupancies and cility with a partial basement, be of Type I (332) construction aklered. The facility has a fire hard wired smoke detection in es open to the corridors, and noke-detectors in resident y has the capacity for 189 and 0 at the time of this survey.					
(0271 SS=B Bidg. 01	NFPA 101 Discharge from E Discharge from E Exit discharge is 7.7, provides a le the provisions of changes in eleva free of obstructio discharge shall b travel surface. 18.2.7, 19.2.7 Based on observat failed to maintain accordance with N by Section 19.2.7. exit discharge shall size to provide all a public way. This	Exits arranged in accordance with vel walking surface meeting 7.1.7 with respect to tion and shall be maintained ns. Additionally, the exit e a hard packed all-weather ion and interview, the facility 1 of 18 Exit Discharges in FPA 101 Section 7.7 as required Section 7.7.1.1 state that the 1 be of the required width and occupants with a safe access to deficient practice could affect	K 02	271	The corrective actions that were accomplished for tho residents to have been affe by from the practice are: Passenger car was immedia removed from exit door area	ected ately a.	07/20/2022
	staff in the first flo Findings include:	or Hospice Wing.			How other residents of the facility were identified to potentially be affected by t practice are:		

ENTERS FOI					OMB NO. 0938-039		
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01		PLETED
	155214		B. WI	NG		07/1	9/2022
NAME OF	PROVIDER OR SUPPLIEF	t.	STREET ADDRESS, CITY, STATE, ZIP COD				
			203 FRANCISCAN DR				
SAINTA	NTHONY			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECT	ON	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO) BE	COMPLETIO
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		on with the Plant Operations			All residents have the pote		
		2 during a tour of the facility			be affected by this practice		
	-	:10 p.m., the Exit Discharge from			The facility has taken the		
		vas blocked by a passenger			following measures to en		
	car. The car was parked in in the painted hashed out area in front of the exit door. Based on				that the problem has bee		
		the exit door. Based on e of observation, the Director			corrected and will not red	ur by:	
		agreed that the door was			Maintenance department contacted a whole house a	audit to	
	-	d the exit discharge was			ensure all exits were free		
		Operations Director had the			obstructions.	10m	
		and the car was moved from					
		d parked in a parking space			Quality Assurance plans	and	
	prior to survey exit.				monitoring practices that		
	1 5				been implemented to ma		
	This finding was re	viewed with the Administrator			sure corrections are achi		
		as Director at the exit			and are permanent are:		
	conference.				Plants Operations		
					Director/Designee will con	duct	
	3.1-19(b)				rounds daily (5) times per	week for	
					6 months to ensure exits a	re free	
					from obstructions.		
					Plant Operations		
					Director/Designee will repo		
					findings to the QAPI comn		
					monthly for (6) six months		
					QAPI committee will monit		
					data presented for any treat determine if further		
					monitoring/action is neces	sarv for	
					continued compliance.		
0920	NFPA 101						
SS=E		ent - Power Cords and					
Bldg. 01	Extens						
		ent - Power Cords and					
	Extension Cords						
		patient care vicinity are only					
	used for compone						
		ed electrical equipment					
		les that have been					1

SAINT ANTHO (X4) ID PREFIX TAG I asso the the non exco do r mee for r (out non othe use corro wirii tem corr insta 10.2 (NF Bass faile not wirii equi Nati	SUMMARY (EACH DEFICIEN REGULATORY OF sembled by qua- e conditions of e patient care v n-PCREE (e.g. cept in long-ter not use PCRE et UL 1363A of non-PCREE ir utside of vicinity n-patient care in ner UL standard ed with genera rds are not use ring of a structu mporarily are re mpletion of the	R STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION alified personnel and meet 10.2.3.6. Power strips in icinity may not be used for , personal electronics), m care resident rooms that E. Power strips for PCREE or UL 60601-1. Power strips in the patient care rooms ()) meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension of as a substitute for fixed are. Extension cords used emoved immediately upon purpose for which it was ets the conditions of 10.2.4.		203 FR	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR 'N POINT, IN 46307 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	(X5) COMPLETION DATE
(X4) ID PREFIX TAG I asso the the non exco do r mee for r (out non othe use coro wirit tem corr insta 10.2 (NF Bass faile not wirit	SUMMARY (EACH DEFICIEN REGULATORY OF sembled by qua- e conditions of e patient care v n-PCREE (e.g. cept in long-ter not use PCRE et UL 1363A of non-PCREE ir utside of vicinity n-patient care in ner UL standard ed with genera rds are not use ring of a structu mporarily are re mpletion of the	ACY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION alified personnel and meet 10.2.3.6. Power strips in icinity may not be used for , personal electronics), m 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 ure. Extension cords used emoved immediately upon purpose for which it was		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re	COMPLETION
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for r (out non othe use corc wirin tem com inst 10.2 (NF Bass faile not wiri equi Nati	non-PCREE ir utside of vicinity n-patient care in ner UL standard ed with genera rds are not use ring of a structu nporarily are re mpletion of the	n the patient care rooms y) meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension d as a substitute for fixed ire. Extension cords used emoved immediately upon purpose for which it was					
(out non othe use corc wirin tem com inst 10.2 (NF Base faile not wiri equi	utside of vicinity n-patient care in ner UL standard ed with genera rds are not use ring of a structu mporarily are re mpletion of the	y) meet UL 1363. In rooms, power strips meet ds. All power strips are I precautions. Extension d as a substitute for fixed ire. Extension cords used emoved immediately upon purpose for which it was					
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cord wirit tem com inst 10.2 (NF Base faile not wiri equi Nati	rds are not use ring of a structu nporarily are re mpletion of the	d as a substitute for fixed ire. Extension cords used moved immediately upon purpose for which it was					
wirit tem corr insta 10.2 (NF Bass faile not wiri equi Nati	ring of a structu nporarily are re mpletion of the	rre. Extension cords used moved immediately upon purpose for which it was					
tem com insta 10.2 (NF Base faile not wiri equi Nati	mporarily are re mpletion of the	moved immediately upon purpose for which it was					
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insta 10.2 (NF Base faile not wiri equi Nati	•						
10.2 (NF Base faile not wiri equi Nati							
(NF Base faile not wiri equi Nati	.2.3.6 (NFPA 9	9), 10.2.4 (NFPA 99), 400-8					
Base faile not wiri equi Nati		(D) (NFPA 70), TIA 12-5					
not wiri equi Nati		on and interview, the facility	K 0	920	The corrective actions that		07/25/2022
wiri equi Nati	led to ensure 1 o	of 1 first floor therapy office did			were accomplished for those		
equi Nati	t use flexible cor	ds as a substitute for fixed			residents to have been affect	ed	
Nati	ring. LSC 9.1.2 i	requires electrical wiring and			by the practice are:		
	uipment shall be	in accordance with NFPA 70,			Power strip was immediately		
Δrti	tional Electrical	Code. NFPA 70, 2011 Edition,			removed from office spaces.		
	•	res that, unless specifically			How other residents of the		
-		cords and cables shall not be			facility were identified to		
		for fixed wiring of a structure.			potentially be affected by the		
	-	tice could affect up to 8			practice are:		
		ff near the first floor Physical			All residents have the potential	l to	
The	erapy office.				be affected by this practice.		
					The facility has taken the		
Fine	ndings include:				following measures to ensure	e	
	and on alterna (on mode with the Direct			that the problem has been		
		on made with the Plant r on 07/19/22 during a tour of			corrected and will not recur b	y:	
-		n 1:30 p.m. and 3:10 p.m., a			Plant Operations Director conducted a whole house audi	it to	
		use in the Assistant Director of			ensure that no non-PCREE we		
-					plugged into power strips in		
Bas	irsing's office wi	th a refrigerator plugged into it.	1		I plugged into power surps in	t	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214	A. BUILDING <u>01</u> COMPLI		(X3) DATE SURVEY COMPLETED 07/19/2022	
	NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY		STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307			
K 0923 SS=E Bldg. 01	SUMMARY (EACH DEFICIE REGULATORY C Plant Operations I strip usage as a sul stated they had spo usage and would r This finding was r and Plant Operation conference. 3.1-19(b) NFPA 101 Gas Equipment - Storag	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION Director confirmed the power ostitute for fixed wiring and oke to staff about power strip eeducate staff. eviewed with the Administrator ns Director at the exit			ety c care d ave ed ct s in ctly audit ee he the s &	
	Storage locations and ventilated in and 5.1.3.3.3. >300 but <3,000 Storage locations enclosure or with	equal to 3,000 cubic feet s are designed, constructed, accordance with 5.1.3.3.2 cubic feet s are outdoors in an in an enclosed interior limited- combustible				

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214	A. BUILDING <u>01</u> COM B. WING 07/1		ate survey Mpleted /19/2022	
NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY		203 F	STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307			
(X4) ID PREFIX	SUMMARY	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO	OULD BE	(X5) COMPLETIO
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE AF DEFICIENCY)	PROPRIATE	DATE
	construction, with	n door (or gates outdoors)				
	stored with flamm from combustible sprinklered) or en noncombustible minimum 1/2 hr. Less than or equ In a single smoke cylinders availab patient care area of less than or equ required to be sto Cylinders must b as specified in 1 ² A precautionary s on each door or g room, where the a minimum "CAL STORED WITHII Storage is planne order of which th supplier. Empty from full cylinders cylinders with inte threshold pressu established. Em avoid confusion. are protected from 11.3.1, 11.3.2, 1 ² 99) Based on observat	sign readable from 5 feet is gate of a cylinder storage sign includes the wording as ITION: OXIDIZING GAS(ES) N NO SMOKING." ed so cylinders are used in ey are received from the cylinders are segregated s. When facility employs egral pressure gauge, a re considered empty is pty cylinders are marked to Cylinders stored in the open m weather. 1.3.3, 11.3.4, 11.6.5 (NFPA ion and interview, the facility	K 0923	The corrective actions	that	07/25/202
	gases were proper 99, Health Care Fa Section 11.3.3 stat gases with a total greater than 8.5 cu comply with 11.3.	of 1 cylinders of nonflammable by secured from falling. NFPA acilities Code, 2012 Edition, es storage for nonflammable volume equal to or less than bic meters (300 cubic feet) shall 3.1 and 11.3.3.2. NFPA 99, ates precautions in handling		 were accomplished for residents to have been by the practice are: O2 cylinder was immed properly secured. How other residents of facility were identified potentially be affected 	n affected iately f the to	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>01</u> B. WING		COMI	(X3) DATE SURVEY COMPLETED 07/19/2022	
	PROVIDER OR SUPPLIE NTHONY	R	STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY O cylinders specified accordance with 1 freestanding cylind or supported in a p This deficient prace residents and staff floor C Wing nurse Findings include: Based on observat Director during a t to 3:10 p.m. on 07/ cylinder was stand less than a 45 degr nurse's station on C was not properly c cylinder stand or c time of the observat Director agreed the in the aforemention properly chained of stand or cart.	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION In 11.3.3.1 shall be in 1.6.2. Section 11.6.2.3(11) states ders shall be properly chained roper cylinder stand or cart. tice could affect over 10 in the vicinity of the second e's station. ion with the Plant Operations our of the facility from 1:30 p.m. /19/22, one 'E' type oxygen ing on the floor and leaning at ee angle against a cart in the C Wing of the second floor and hained or supported in a proper art. Based on interview at the ation, the Plant Operations e 'E' type oxygen cylinder stored ned nurse's station was not r supported in a proper cylinder eviewed with the Administrator ns Director during the exit	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTLY (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) practice are: All residents with urinary Ca bags have the potential to affected by this practice. The facility has taken the following measures to en that the problem has been corrected and will not real Plant Operations Director conducted a whole houses ensure all 02 cylinders wer properly stored and secure All staff educated on proper securing and storing O2 cy Quality Assurance plans monitoring practices that been implemented to mal sure corrections are achinand and are permanent are: Plant Operations Director/designee will cond audit (5) times a week for (months to 02 cylinders are properly secure and stored Plants Operations Director/designee will repo findings to the QAPI common monthly for (6) six months. QAPI committee will monit data presented for any trend determine if further monitoring/action is necess continued compliance.	atheter be sure n cur by: audit to re erly /linders. and chave ke eved duct (6) duct (6) duct (6)	(X5) COMPLETION DATE	

GWQ221 Facility ID: 000120

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If continuation sheet Page 7 of 7