STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 06/16/2023				
NAME OF P	ROVIDER OR SUPPLIE	R	<u> </u>	203 FR	ADDRESS, CITY, STATE, ZIP COD ANCISCAN DR N POINT, IN 46307	<u> </u>			
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL					ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	ATE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	/ (L	DATE		
F 0000									
F 0000 Bldg. 00	This visit was for a Licensure Survey. Investigation of Co IN00408785, IN00 Complaint IN0040 related to the allegated to the allegated to the allegated to the allegated to the allegations are Complaint IN0040 the allegations are Complaint IN0041 related to the allegated to the	Recertification and State This visit included the complaints IN00408169, 409587 and IN00410203. 8169 - Federal/State deficiencies ations are cited at F695. 8785 - Federal/State deficiencies ations are cited at F690 and 9587 - No deficiencies related to cited. 0203 - Federal/State deficiencies ations are cited at F554, F585, 12, 13, 14, 15 and 16, 2023. 00120 155214 274780	F 00						

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

(X6) DATE

TITLE

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: N8P811 Facility ID: 000120 If continuation sheet Page 1 of 38

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155214		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/16/2023
	PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0554 SS=D Bldg. 00	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/21/23. 483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure a self-medication administration assessment was completed for residents with medications at the bedside for 2 of 2 random observations. (Residents H and F) Findings include: 1. On 6/12/23 at 11:33 a.m., Resident H was observed lying in her bed. There was a Symbicort inhaler on her bedside table. On 6/12/23 at 2:56 p.m., the inhaler was observed still on her bedside table The record for Resident H was reviewed on 6/15/23 at 9:09 a.m. Diagnoses included, but were not limited to cellulitis, dementia and neoplasm of the brain. The Admission Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident had moderate cognitive deficits and required a total of 2 staff assistance for bed mobility and transfers.	F 0554	The corrective actions that were accomplished for those residents to have been affect by from the practice are: Self-administration assessment were completed for residents observed in this deficiency. Family and physicians were notified. Physicians gave new orders for residents to keep medications at bedside/self-administer medications. Residents are in stable condition and experient no negative outcomes as a rest of this observation. How other residents of the facility were identified to potentially be affected by the practice are: Facility to interview cognitive residents to identify any reside who wish to keep medications bed side or self-administer medications. The facility has taken the	ted ints ced sult ents ents eat
	A Physician's Order, dated 5/20/23, indicated to give Symbicort Inhalation 2 puffs, twice daily.		following measures to ensur that the problem has been corrected and will not recur	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811 F

Facility ID: 000120

If continuation sheet

Page 2 of 38

DENTECATION NUMBER 155214 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307 (XA) ID SIAMMARY STATEMENT OF DEFICIENCIE PREFIX (RACH DEFICIENCY MOST BE PRECEDED BY PULL AGE AND POINT, IN 46307 There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in heel. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, at a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheckhair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerlo assal spray observed on the resident's bedside table. Also observed on the resident's bedside table. Also observed on the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoran (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment evaluation, a Physiciania Sorder to successful provided to the resident was cognitively intact. The record lacked any indication a self-medication assessment evaluation, a Physiciania Sorder to the record and the resident was cognitively intact. The record lacked any indication a self-medication assessment evaluation, a Physiciania Sorder to the resident was not completed to the resident was not completed to make sure corrections are achieved and are parament are: DON/Designee will report audit findings to the QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307 (X3) ID SIMMARY STATIMENT OF DEFICIENCIE PREPEX TAG There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:25 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:55 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, Lumigan 0.1% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelshair watching tv. At that time, there was a bottle of Lantanoprost 0.0005% ophthalmic solution with no cap on it and a bottle of Allerfto nasal spary observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Sel (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
SAINT ANTHONY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING DIFORMATION There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigun Q.200.5% ophthalmic solution, Lumigan 0.1% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.0005% ophthalmic solution with no cap on it and a bottle of Allerlo nasal spany observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication DATE REGULATORY OR LSC DENTIFYENG DIPORMATION PREFIX TAG REGULATORY OR LSC DENTIFYENG DIPORMATION PREFIX TAG REGULATORY OR LSC DENTIFYENG DIPORMATION PREFIX TAG PREFIX			155214	B. W	ING		06/16/	2023
SAINT ANTHONY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR LSC IDENTIFYING DIFORMATION There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigun Q.200.5% ophthalmic solution, Lumigan 0.1% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.0005% ophthalmic solution with no cap on it and a bottle of Allerlo nasal spany observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication DATE REGULATORY OR LSC DENTIFYENG DIPORMATION PREFIX TAG REGULATORY OR LSC DENTIFYENG DIPORMATION PREFIX TAG REGULATORY OR LSC DENTIFYENG DIPORMATION PREFIX TAG PREFIX					CTREET	ADDRESS SITY STATE ZID COD		
SAINT ANTHONY (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (X5) (X5) (X6) TAG REGULATORY OR LSC IDENTIFYING INFORMATION There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Cormbigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Allerlo nasal spray observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication	NAME OF P	ROVIDER OR SUPPLIER	t					
CX4 ID SUMMARY STATEMENT OF DEFICIENCE PREFIX CEACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX TAG PREFI	CAINT A	NITHONIN						
REGULATORY OR LSC IDENTIFYING INFORMATION There was no self-medication administration assessment, care plan or Physician order to self administer medications, indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, Lumigan 0.01% ophthalmic solution with no cap on it and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching iv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerlo nasal spray observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication	SAINTAI	NIHONY			CROW	N POINT, IN 46307		
TAG REGILATORY OR ISCIDENTIFYING INFORMATION There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there was a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Allerflo nasal spray observed on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in the resident's bedside table. Also observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication Family and residents were educated to notify clinical leadership if resident wishes to keep medications at bed side or has desire to self-administration with families and residentson. IDT will discuss self-administration with families and residentson. IDT will discuss self-administration with families and residentson on self-administration policy for residents and completing self-administration policy for residents and completent assessments if appropriate. Quality Assurace plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (6) days for (6) months to ensure no medications are kept at bedside prior to self-administration	(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
TAG REGILATORY OR ISCIDENTIFYING INFORMATION There was no self-medication administration assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there was a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Allerflo nasal spray observed on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in the resident's bedside table. Also observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication Family and residents were educated to notify clinical leadership if resident wishes to keep medications at bed side or has desire to self-administration with families and residentson. IDT will discuss self-administration with families and residentson. IDT will discuss self-administration with families and residentson on self-administration policy for residents and completing self-administration policy for residents and completent assessments if appropriate. Quality Assurace plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (6) days for (6) months to ensure no medications are kept at bedside prior to self-administration	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication deducated to notify clinical leadership if resident wishes to keep medications at bed side or has desire to self-administration with families and residents medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT will discuss self-administration with families and residents during care plan medications. IIDT wil	TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
assessment, care plan or Physician order to self administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Allerflo nasal spray observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication		There was no self-n	nedication administration			Family and residents were		
administer medications. Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerfo nasal spray observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication to keep medications at behase deside to self-administration with families and residents during care plan meetings. Nursing staff educated on self-administration with families and residents during care plan meetings. Nursing staff educated on self-administration policy for residents and completing self-administration policy for residents and com		assessment, care pla	an or Physician order to self			educated to notify clinical		
Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with or an abottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the tesident at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. Keep medications at bed side or has desire to self-administration medications. IDT will discuss self-administration with families and residents during care plan meetings. Nursing staff educated on self-administration policy for residents and completing self-administration policy for residents and explained assessments if appropriate. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per very large of the prior to self-administration policy for residents and completing self-administration polic		administer medicati	ions.			-	0	
Interview with QMA 2 on 6/12/23 at 2:56 p.m., indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication						1 · · · · · · · · · · · · · · · · · · ·		
indicated she was not sure if the resident was able to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Aller10 nasal spray observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication medications. IDT will discuss self-administration with families and residents during care plan neetings. Nursing staff educated on self-administration policy for residents and completing self-administration policy for residents parallel self-ad		Interview with QM	A 2 on 6/12/23 at 2:56 p.m.,					
to self administer medications, but she would look into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high tholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication			-					
into it. There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). With families and residents during care plan meetings. Nursing staff educated on self-administration policy for residents and completing self-administration assessments if appropriate. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (6) monitoring practices that have been implemented to make sure corrections are achieved and are perma							ation	
There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the resident's bedside table. Also observed on the resident's that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, trype 2 diabetes, and hyperlipedemia (high type 2 diabetes, and hyperlipedemia (high assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication			,					
There was no additional information provided. 2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication							····•	
2. On 6/12/23 at 9:52 a.m., Resident F was observed in bed. At that time, there were bottles of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside tat that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication		There was no additi	onal information provided.					
observed in bed. At that time, there were bottles of Combigan 0.2/00.5% ophthalmic solution, Lumigan 0.01% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of AllerIo nasal spray observed on the resident's bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication								
of Combigan 0.2/00.5% ophthalmic solution, Lumigan 0.01% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Aller10 nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication		· · · · · · · · · · · · · · · · · · ·				•		
Lumigan 0.01% ophthalmic solution, and a bottle of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication						' '		
of refresh tears sitting on the resident's bedside table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high tholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.		-						
table. On 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.						1	I	
been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee will type 2 diabetes, and hyperlipedemia (high cholesterol). been implemented to make sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.			5					
on 6/13/23 at 9:55 a.m., Resident F was observed sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. Sure corrections are achieved and are permanent are: DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.								
sitting in his wheelchair watching tv. At that time, there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication and are permanent are: DON/Designee will audit (5) residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.		On 6/13/23 at 9:55	a.m., Resident F was observed			-	d	
there was a bottle of Lantanoprost 0.005% ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication							-	
ophthalmic solution with no cap on it and a bottle of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication residents per unit per day for (5) days for (6) months to ensure no medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.		-	_			-		
of Allerflo nasal spray observed on the resident's bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication			-				(5)	
bedside table. Also observed on the bedside table at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication medications are kept at bedside prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.		-	-			1	. ,	
at that time were the bottles of Combigan, Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication prior to self-administration assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.		-	-					
Lumigan and Refresh tears. The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication assessments being completed Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.								
Director of Nursing/Designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. The record lacked any indication a self-medication			_			1 3	1	
The record for the resident was reviewed on 6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.								
6/14/23 at 11:56 a.m. Diagnosis include, but were not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication committee monthly for (6) six months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.		The record for the r	esident was reviewed on					
not limited to, glaucoma (eye condition), stroke, type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.								
type 2 diabetes, and hyperlipedemia (high cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.			_			1	will	
cholesterol). The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication trends & determine if further monitoring/action is necessary for continued compliance.			* • · · · · · · · · · · · · · · · · · ·					
The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication monitoring/action is necessary for continued compliance.							y	
The Annual Minimum Data Set (MDS) Quarterly assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication		,				- ·	/ for	
assessment, dated 5/5/23, indicated the resident was cognitively intact. The record lacked any indication a self-medication		The Annual Minim	um Data Set (MDS) Quarterly					
was cognitively intact. The record lacked any indication a self-medication								
The record lacked any indication a self-medication								
		<i>g y</i>						
		The record lacked a	ny indication a self-medication					
			-					
self-administer mediations, or a care plan to								
self-administer medications had been completed.			-					

08/08/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155214 B. WING 06/16/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE Physician Orders, dated 2/3/23, indicated the following: - Lantanoprost Solution 0.005%, instill 1 drop in the left eye at bedtime. - Timolol Maleate Gel Forming Solution 0.5 %, instill 1 drop in the left eye two times a day. - Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate), instill 1 drop in the left eye every 12 hours. - Carboxymethylcellulose Sod PF Ophthalmic Solution 0.5 % (Carboxymethylcellulose Sodium (Ophth), instill 1 drop in both eyes every 6 hours as needed. Interview with LPN 1 on 6/14/23 at 11:50 a.m., indicated she administered eye drops for resident F that come from her medication cart. She did not administer any medication that the resident had at his bedside. Interview with the Director of Nursing (DON) on 6/15/23 at 1:13 p.m., indicated they did not have a self medication assessment evaluation form on file for this resident. This Federal tag relates to Complaint IN00410203. 3.1-7(a)(2)F 0585 483.10(j)(1)-(4) SS=D Grievances Bldg. 00 §483.10(i) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances

FORM CMS-2567(02-99) Previous Versions Obsolete

without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 4 of 38

08/08/2023 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/16/2023 155214 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include: (i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the

FORM CMS-2567(02-99) Previous Versions Obsolete

advocacy system;

review of the grievance; the right to obtain a

written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 5 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		A. BUILDING B. WING	00 00	COMP	E SURVEY LETED 5/2023	
	PROVIDER OR SUPPLIER NTHONY		203 FF	ADDRESS, CITY, STATE, ZIP COI RANCISCAN DR /N POINT, IN 46307)	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	responsible for own process, receiving through to their conecessary investig maintaining the conformation associex example, the identification of the process submit written grievances submit written grievance and coordinating vagencies as necessary, prevent further poir resident right while being investigated (iv) Consistent with immediately report involving neglect, unknown source, a resident property, services on behalf administrator of the by State law; (v) Ensuring that a decisions included received, a summare resident's grievance investigate the grievance investigate the grievance investigate the grievance, and the was issued; (vi) Taking appropaccordance with State in the grievance of the property of the grievance of the	ated with grievances, for tity of the resident for those ted anonymously, issuing decisions to the resident; with state and federal ssary in light of specific taking immediate action to tential violations of any e the alleged violation is ;				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 6 of 38

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIER		203 FF	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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 APPROPRI. DEFICIENCY)	(X5) COMPLETION DATE
	jurisdiction, such a Agency, Quality Ir or local law enforce violation for any of within its area of reference (vii) Maintaining eresult of all grieva than 3 years from grievance decision Based on record reference failed to report, investigation	vidence demonstrating the nces for a period of no less the issuance of the	F 0585	The corrective actions that were accomplished for thos residents to have been affect	
	reviewed for grieva Findings include: 1. The record for R 6/14/22 at 2:54 p.m not limited to, Park behavioral disturbat disorder. The Quarterly Mini assessment, dated 4 was mildly cognitive extensive assist x 1 bathing.	nces. (Residents D and J) esident D was reviewed on Diagnoses included, but were inson's Disease, dementia with nce, and major depressive mum Data Set (MDS) /21/23, indicated the resident rely impaired and required for personal hygiene and		by the practice are: Grievances for identified residuere completed resolved. Family and physicians were notified. Physicians gave no norders. Residents are in stable condition and experienced not negative outcomes as a result this observation. How other residents of the facility were identified to potentially be affected by the practice are: All residents have the potentials be affected by this practice. The facility has taken the	dents new le o lt of
	resident had not rec The findings indica her shower day mix given a shower on 5 A Grievance form, resident's showers v per the resident's da the resident had not	dated 5/2/23, indicated the eived her shower on 5/1/23. ted the resident's family had ed up and the resident was 5/3/23. dated 5/3/23, indicated the were not given consistently ughter. The findings indicted received her shower on the shower was provided on		following measures to ensu that the problem has been corrected and will not recur Facility staff educated on grievance procedures and po related to reporting requireme Quality Assurance plans an monitoring practices that ha been implemented to make sure corrections are achieve and are permanent are:	by: licies ents. d

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 7 of 38

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155214	B. W	ING		06/16	/2023
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ANCISCAN DR		
SAINT AI	NTHONY				N POINT, IN 46307		
							1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY		DATE
	the following day s	hift.			SSD/designee will conduct au		
		1 . 1 . 1 . 2 . 2 . 2			(1) times a week for (6) month		
		dated 5/26/23, indicated the			identify any grievance trends.	Any	
	-	piced ongoing concerns with			trends will be reported to		
	the resident not receiving showers. The family				Executive Director and		
		assist the resident with			Administrator.		
	_	ey visited. The findings			SSD/designee will report audit		
	indicated the reside 5/25/23.	ent had been given a shower on			findings to the QAPI committe		
	3143143.				monthly for (6) six months. Th QAPI committee will monitor the		
	A Grievance form	dated 6/6/23 indicated the					
	A Grievance form, dated 6/6/23, indicated the resident had again not received a shower in over a				data presented for any trends determine if further	α	
	_	nter. She was also requesting			monitoring/action is necessary	, for	
		ions so she could assist the			continued compliance.	/ 101	
	-	wer when visiting. The			continued compliance.		
		a shower was provided by staff					
	-	vided follow up for future					
	showers.	The second was a second					
	Interview with the l	Executive Director and the					
	Administrator on 6/	/15/23 at 10:15 a.m., indicated					
	they had been staffi	ing challenged on second shift					
	and getting schedul	ed showers done on that shift					
		The grievances had the same					
	repeated concern.	They offered to switch the					
		to day shift but the family					
	*	m on second shift so they					
	could assist at times	s when they were visiting.					
		been missed and they had					
	_	following day shift.2. On					
		m., a locked wheelchair was					
		the entrance into Resident J's					
		indicated the wheelchair was					
	_	nother resident wandering in	1				
	her room at night a	nd stealing her snacks.					
	The record for Resi	ident J was reviewed on 6/14/23					
		oses included, but were not	1				
		limited to, anemia (low iron), depression, type 2					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 8 of 38

` ´		X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155214	B. W	ING		06/16	/2023
NAME OF F	PROVIDER OR SUPPLIER	<u>. </u>			DDRESS, CITY, STATE, ZIP COD		
		-			ANCISCAN DR		
SAINT A	NTHONY			CROWN	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	blood pressure).	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCT		DATE
	blood pressure).						
	The Quarterly Minimum Data Set (MDS)						
	assessment, dated 5	/1/23, indicated the resident					
	was cognitively intact.						
	Interview with CN/	A 3 on 6/13/23 at 3:01 p.m.,					
	indicated another resident had wandered into						
		nd took the resident's snacks.					
		ked for the wheelchair to block					
	her door.						
	1						
	Interview with LPN 1 on 6/14/23 at 9:37 a.m., indicated she had no issues getting into the						
		if there were an emergency,					
		ne chair in seconds. The					
		ced there due to someone					
		and removing her snacks.					
		C					
		Director of Nursing (DON), on					
		., indicated she was unaware a					
	-	ced in front of the resident's					
	_	on of snacks being taken, as					
		ed by floor staff. She would					
	_	t and place a stop sign to see if that worked. The					
		locked wheelchair, indicating					
		t completely bedbound and					
	does get up sometin						
	6 -F						
	A grievance, dated	6/14/23, indicated the					
	resident's concern r	elated to a co-resident					
		nd taking her "snacks". The					
		ed by Social Services on					
	6/14/23.						
	Interview with the	Administrator on 6/15/23 at					
		ed she was unaware a resident					
		staff that someone wandered					
	_	tole her snacks until the day					
		•					İ

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 9 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 06/16/2023		
	PROVIDER OR SUPPLIE	R	203	ET ADDRESS, CITY, STATE, ZIP COD FRANCISCAN DR DWN POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NOY MUST BE PRECEDED BY FULL DUSC DEPUTIENT OF DEFORMATION	ID PREFIX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE COMPLETION
TAG	before. The staff's away so a grievance instead of just putting doorway to preven her room. A facility policy tit Grievances" and re A concern/grievance on a Report of Condirector/Grievance overseeing the griecollaborate with stancessary. The Execution of Condirector with stancessary with stancessary and/or misapproprianyone providing stances as required by the results of the provided stances.	hould have notified her right e could have been completed ing a wheelchair in her t anyone from wandering into led, "Resident Concerns and ceived as current, indicated, " te of any kind is documented cern Form The Executive f Official is responsible for vance process and will atte and federal agencies, as fecutive Director/Grievance allegations of neglect, abuse, ation of resident property, by ervices on behalf of the facility regulations and law of the state rety is located" lates to Complaint IN00410203.	TAG	DEPCHACIT	DATE
F 0677 SS=D Bldg. 00	§483.24(a)(2) A r carry out activities necessary service nutrition, groomin hygiene; Based on record re failed to ensure sho	ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good g, and personal and oral view and interview, the facility owers were provided as sendent resident for 1 of 11	F 0677	The corrective actions the were accomplished for the residents to have been af	iose
	residents reviewed (ADL) care. (Residents) residents reviewed (ADL) care. (Residents)	for activities of daily living		by the practice are: Resident grievance was completed. Shower was proposed interview completes resident showering preferences Family and physicians were	rovided. te for ences.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 10 of 38

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214			UILDING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/16/2023	
NAME OF 1	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	
SAINT A	NTHONY				RANCISCAN DR 'N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		scheduled showers, he hadn't			notified. Physicians gave no n	l l
	been showered in o	over a week.			orders. Residents are in stable	
	The resident's reco	rd was reviewed on 6/14/23 at			condition and experienced no negative outcomes as a result	
		ses included, but were not			this observation.	1 01
		ar Sclerosis and Diabetes			How other residents of the	
	Mellitus.	ar selectors and Blacetes			facility were identified to	
					potentially be affected by the	<u>.</u>
	The Annual Minimum Data Set assessment, dated 5/4/23, indicated the resident was cognitively				practice are:	
					All residents have the potentia	al to
	intact, and required extensive assistance of 2 for bed mobility and transfers.				be affected by this practice.	
					The facility has taken the	
	The shower schedule indicated the resident was to be showered on Wednesday and Saturday				following measures to ensur	·e
					that the problem has been	
					corrected and will not recur	by:
	evenings. Shower s	sheets for the past 30 days			Facility clinical staff were	
		ent had a bed bath on 5/6/23.			educated on providing showe	rs to
		charting (used by CNAs)			resident.	
		ent got a shower on 5/25/23 and			Quality Assurance plans and	l l
	6/7/23. There was	no additional documentation.			monitoring practices that ha	ve
					been implemented to make	
		A 1 on 6/14/23 at 2:25 p.m.,			sure corrections are achieve	ed
		the only CNA on the hall that			and are permanent are:	
		to give 1 of the 4 scheduled			DON/designee will conduct au	l l
		ated it was impossible to give			(5) residents per unit (5) times	l l
	all the showers wh	en working alone.			week for (6) months to ensure	
	Intonvious suith the	Administrator and Executive			showers are provided a sched	
		3 at 10:14 a.m., indicated they			DON/designee will report aud findings to the QAPI committee	
		There was no additional			monthly for (6) six months. Th	
	information provid				QAPI committee will monitor t	•
	information provid	ica.			data presented for any trends	
	This Federal tag re	lates to Complaint IN00410203.			determine if further	α
	l last castal ag le	10 Complaint II 100 110203.			monitoring/action is necessary	v for
	3.1-38(a)(3)				continued compliance.	,
F 0684	483.25					
SS=D	Quality of Care		1			
Bldg. 00	§ 483.25 Quality	of care				
	-	a fundamental principle that				

08/08/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/16/2023 155214 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and F 0684 The corrective actions that 07/07/2023 interview, the facility failed to ensure skin were accomplished for those discolorations were assessed and monitored, a residents to have been affected treatment order for a bandage was in place, and a by the practice are: treatment was in place for dry and flaky legs for 3 Residents were assessed and of 7 residents reviewed for non-pressure skin monitoring put in place for conditions. (Residents H, 5 and D) bruising. MD was notified of treatment placed on resident 5. Findings include: new orders received. Resident D received lotion for her dry flaky 1. On 6/12/23 at 11:33 a.m., Resident H was skin on lower extremity. observed lying in her bed. There was a dark Family and physicians were purplish discoloration on her left forearm and left notified. Residents are in stable thigh. The resident indicated she did not know condition and experienced no what happened to the areas. negative outcomes as a result of this observation. On 6/13/23 at 10:09 a.m., the resident was again How other residents of the observed in bed and the discoloration to her left facility were identified to forearm and left thigh were visible. potentially be affected by the practice are: The record for Resident H was reviewed on All residents have the potential to 6/15/23 at 9:09 a.m. Diagnoses included, but were be affected by this practice. not limited to cellulitis, dementia and neoplasm of The facility has taken the the brain. following measures to ensure that the problem has been The Admission Minimum Data Set (MDS) corrected and will not recur by: assessment, dated 5/26/23, indicated the resident Nursing staff educated on had moderate cognitive deficits and required total obtaining orders for any treatment 2 staff assistance for bed mobility and transfers. placed on residents, monitoring bruises, and ensure orders to be A Medication Care Plan indicated the resident obtained for dry flaky skin. was at increased risk of bruising and bleeding Quality Assurance plans and

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 12 of 38

08/08/2023 PRINTED: FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 06/16/2023 155214 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE related to antiplatelet and aspirin use. monitoring practices that have Interventions included to observe for abnormal been implemented to make signs of bleeding such as increased frequency of sure corrections are achieved bruising and increased size of bruising. Document and are permanent are: findings and notify the Physician. DON/designee will conduct audit (5) residents per unit (5) times a There was no documentation or monitoring of the week for (6) months to identify any discolorations in the resident's record. new non-pressure skin concerns are monitored and addressed. On 6/15/23 at 10:20 a.m., the Executive Director Any trends will be reported to was made aware there was no documentation or **Executive Director and** monitoring of the discolorations. There was no Administrator. additional information provided. 2. On 6/12/23 at DON/designee will report audit 2:14 p.m., Resident 5 was observed lying in bed. findings to the QAPI committee The resident had multiple purple discolorations to monthly for (6) six months. The both arms. The resident also had a bandage to his QAPI committee will monitor the right elbow. The bandage was not dated or data presented for any trends & initialed for when it was applied. The resident determine if further indicated his elbow was cut on the strap from the monitoring/action is necessary for transfer lift and the nurse had applied the continued compliance. bandage. On 6/14/23 at 9:20 a.m., Resident 4 was observed lying in bed. There were multiple purple discolorations observed to both his arms as well as the undated bandage to his right elbow. Record review for Resident 5 was completed on 6/15/23 at 9:24 a.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, and hypertension. The Annual Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was moderately cognitively impaired. The resident required an extensive 2+ person assist for bed mobility, transfers, toilet use, and personal hygiene. The resident had received an

FORM CMS-2567(02-99) Previous Versions Obsolete

anticoagulant (prevent blood clots) medication.

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 13 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIEF	8	203 FR	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR 'N POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
TAG	A Care Plan, dated was at risk for abnormal anticoagulant theral intervention include care for bruising or notify the nurse of a The June 2023 Physimidicated an order from (milligrams) two There was no docur discolorations had be treatment orders in Interview with the Interview	8/30/21, indicated the resident rmal bleeding secondary to by for atrial fibrillation. An ed to inspect the skin during increased bruising and to abnormal findings. Sician's Order Summary (POS) for Eliquis (anticoagulant) 2.5 ice a day for atrial fibrillation. Mentation to indicate the been assessed or monitored, mentation to indicate why the resident's elbow or any place for the bandage. Director of Nursing (DON) on m., indicated the wound nurse resident's bandage on his to provide any documentation sment, monitoring, or the discolorations or the lew with Resident D on 6/12/23 and her legs and feet had dry put any lotion on her legs. With dry flaky skin to both legs had a small dry scabbed area 8 a.m., the resident was her wheelchair in her room. observed to both lower dent D was reviewed on Diagnoses included, but were inson's Disease, dementia with nee, and major depressive	TAG	DEFICIENCY	DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 14 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 06/16/2023			LETED		
	PROVIDER OR SUPPLIE NTHONY	R		STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
	assessment, dated a was mildly cognitive tensive assist of and bathing. The Medication Adand Treatment Adridated 6/2023, indic (a diuretic medicat daily. There was laflaky skin to the retained the resident and there were no of the Interview with the	DON on 6/15/23 at 12:41 p.m., ent's legs were dry and she					
F 0688 SS=D Bldg. 00	§483.25(c) Mobili §483.25(c)(1) The resident who enter range of motion of reduction in range resident's clinical that a reduction in unavoidable; and §483.25(c)(2) A remotion receives a services to increase	Decrease in ROM/Mobility ty. e facility must ensure that a ers the facility without limited oes not experience of motion unless the condition demonstrates a range of motion is esident with limited range of appropriate treatment and se range of motion and/or to ecrease in range of motion.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 15 of 38

, ´		X2) MULTIPLE CONSTRUCTION (X3) DATE SUP			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED			ETED	
		155214	B. W	B. WING 06/16/2023			2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	C			ANCISCAN DR		
SAINT AI	NTHONY		CROWN POINT, IN 46307				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	. , , ,	esident with limited mobility					
		ate services, equipment, and					
	assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is						
	demonstrably una		F.0	(00	The seminative retires ()		07/07/2022
		on, record review and	F 0	880	The corrective actions that		07/07/2023
		ty failed to ensure a resident's			were accomplished for those		
	positioning was maintained related to a hand splint not applied as ordered for 1 of 2 residents reviewed for positioning/ mobility. (Resident 74)				residents to have been affec	ıea	
					by the practice are: Resident 74 was assessed. S	nlint	
	reviewed for positioning/ mobility. (Resident 74)				was placed on residents per M	-	
	Finding includes:				order.	מוא	
	T maning merades.				Family and physicians were		
	On 6/12/23 at 10:12 a.m., Resident 74 was				notified. Physician gave no ne	2///	
		ere was no hand splint on her			orders. Resident is in stable	, v v	
		again observed in her room			condition and experienced no		
	-	a.m., 6/14/23 at 9:25 a.m.,			negative outcomes as a result		
		., and 11:12 a.m., 6/16/23 at 9:41			this observation.		
		, with no hand splint on her			How other residents of the		
	right hand.	•			facility were identified to		
					potentially be affected by the	9	
	The resident's recor	rd was reviewed on 6/16/23 at			practice are:		
	10:08 a.m. Diagnos	es included, but were not			Whole house audit of resident	s	
	limited to, chronic p	pain syndrome and			with splint orders was comple	te.	
	hypertension.				The facility has taken the		
					following measures to ensur	·e	
		um Data Set assessment, dated			that the problem has been		
	· ·	e resident was cognitively			corrected and will not recur	-	
	-	extensive assistance of two			Nursing staff educated on ens	-	
	staff for bed mobili	ty and transfers.			splints are worn by residents	per	
		1 . 11 (12 (22)			MD order.	_	
	-	r, dated 1/13/23, indicated to			Quality Assurance plans and		
	_	right hand at all times, to be			monitoring practices that ha	ve	
	removed for skin cl	necks each shift.			been implemented to make	.1	
	The Inne 2022 Mari	lication Administration Document			sure corrections are achieve	ea	
		lication Administration Record			and are permanent are:		
		nand splint was applied every			DON/designee will conduct at		
	shift, every day in J	une.			residents with splints (5) times		
			1		week each unit for (6) months	ιO	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 16 of 38

08/08/2023 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155214 B. WING 06/16/2023 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR SAINT ANTHONY CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE There was no documentation to indicate the ensure splits are in place per MD resident refused or removed the splint. order. Any trends will be reported to Executive Director and Interview with the resident on 6/16/23 at 10:21 Administrator. a.m., indicated sometimes the staff would put the DON/designee will report audit splint on and sometimes they wouldn't. She findings to the QAPI committee indicated she did not know where the splint was monthly for (6) six months. The currently. QAPI committee will monitor the data presented for any trends & Interview with Executive Director on 6/16/23 at determine if further 11:40 a.m., indicated the resident would sometimes monitoring/action is necessary for remove the splint and she would look into the continued compliance. concern. There was no additional information provided. 3.1-42(a)(2)F 0689 483.25(d)(1)(2) SS=D Free of Accident Bldg. 00 Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that -§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and F 0689 The corrective actions that 07/07/2023 interview, the facility failed to provide supervision were accomplished for those and follow protocols related to random residents to have been affected observations of residents transferred by a Hoyer by the practice are: lift (suspension lift to reposition and transfer into Residents were assessed. a chair or bed) for 2 of 2 Hoyer transfers observed. Family and physicians were (Residents B and 151) notified. Physician gave no new orders. Resident is in stable Findings include: condition and experienced no

FORM CMS-2567(02-99) Previous Versions Obsolete

1. During a random observation on 6/14/23 at 9:30

Event ID:

N8P811

Facility ID: 000120

this observation.

If continuation sheet

negative outcomes as a result of

Page 17 of 38

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CO A. BUILDING B. WING			
	F PROVIDER OR SUPPLIEF		203 FR	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR 'N POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL DESCRIPTION OF THE PROPERTY OF THE PROP	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
TAG	a.m., CNA 2 was of to transfer him from Hoyer lift. CNA 2 the room completing. On 6/14/23 at 9:42 room and the reside wheelchair. Record review for 1 6/13/23 at 2:00 p.m. not limited to, strok disease, and respirate The Admission Min assessment, dated 4 was cognitively impleted to the strength of th	a.m., CNA 2 left the resident's ent was sitting in his Resident B was completed on Diagnoses included, but were te, hemiplegia, end stage renal tory failure. Inimum Data Set (MDS) 17/23, indicated the resident paired. The resident required a set for transfers. The resident on one side of his upper and or a functional limitation in 4/21/23, indicated the resident with activities of daily living. luded the resident required a	TAG	How other residents of the facility were identified to potentially be affected by the practice are: Whole house audit of reside requiring Hoyer lift complete. The facility has taken the following measures to ensith that the problem has been corrected and will not recunsing staff educated on formechanical lift protocols for transfers. Quality Assurance plans as monitoring practices that he been implemented to make sure corrections are achieved and are permanent are: DON/designee will conduct random observation of hoye transfers of (5) residents per (5) times a week for (6) mon DON/designee will report audindings to the QAPI committ monthly for (6) six months. To QAPI committee will monitor data presented for any trend determine if further monitoring/action is necessal continued compliance.	r by: Illowing safe nd lave red r unit ths. dit tee The the the

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMPLETI	(X3) DATE SURVEY COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIE	R	203 FR	ADDRESS, CITY, STATE, ZIP COI RANCISCAN DR 'N POINT, IN 46307	D	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	ULD BE C	(X5) OMPLETION DATE
TAG .	indicated the resid The resident require transfers. The resid side of his upper a functional limitation A Care Plan, dated indicated the resid activities of daily l	ent was cognitively impaired. red an extensive 2+ assist for dent had an impairment on one and lower extremities for on in range of motion. 14/6/23 and revised 5/15/23, ent needed assistance with iving. An intervention included ed an extensive 2 staff	1760			BATE
	indicated she had g Resident 151 out of by herself via the l and 1 nurse working indicated normally worked the hall, so	A 2 on 6/14/23 at 9:59 a.m., gotten both Resident B and of bed and into their wheelchairs Hoyer lift. There were 2 aides ag the hall that day. She there was only 1 aide that a she was use to getting reself. She didn't ask the other or help.				
	6/14/23 at 10:07 a. supposed to use 2 transfer residents v should have asked	DON (Director of Nursing) on m., indicated the staff are staff members when they via a Hoyer lift. The CNA for assistance before sidents by herself with the				
	and received as cu 6/14/23, indicated,	afe Resident Handling/Transfer" rrent from the facility on "10. Two staff members must ansferring residents with a				
	3.1-45(a)(2)					
F 0690 SS=D	483.25(e)(1)-(3) Bowel/Bladder In	continence, Catheter, UTI				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 19 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214		JILDING	nstruction 00	(X3) DATE COMPL 06/16/	ETED
	PROVIDER OR SUPPLIER	R		STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
Bldg. 00	resident who is composed to prevent urinary restore continence. \$483.25(e)(2)For incontinence, bas comprehensive as ensure that- (i) A resident who an indwelling cather unless the resident demonstrates that necessary; (ii) A resident who indwelling cather one is assessed for as soon as possible clinical condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence. \$483.25(e)(3) For incontinence, bas comprehensive as ensure that a residual possible continence as services to restore function as possible.	e facility must ensure that ontinent of bladder and on receives services and nain continence unless his dition is or becomes such not possible to maintain. a resident with urinary ed on the resident's seessment, the facility must enters the facility without eter is not catheterized nt's clinical condition to catheterization was enters the facility with an error subsequently receives for removal of the catheter of the unless the resident's demonstrates that necessary; and to is incontinent of bladder attereatment and services tract infections and to the to the extent possible. The a resident with fecal ed on the resident's dent who is incontinent of oppopriate treatment and eas much normal bowel ole.					
	interview, the facili with a urinary tract necessary treatmen	on, record review, and ty failed to ensure a resident infection (UTI) received the t and services related to red laboratory test timely for 1	F 06	590	The corrective actions that were accomplished for those residents to have been affect by the practice are: Resident UA was complete.		07/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 20 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155214	B. WING 06/16/2023			2023	
			<u> </u>	CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8					
CAINIT AI	NTHONY		203 FRANCISCAN DR CROWN POINT, IN 46307				
SAINT A	NIHONY		'	CROW	1 POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	of 2 residents review	wed for urinary tract infections.			Facility obtained orders for		
	(Resident K)				treatment for UTI.		
					Family and physicians were		
	Finding includes:				notified. Resident is in stable		
					condition and experienced no		
		23 p.m. through 2:36 p.m.,			negative outcomes as a result	of	
		served lying in her bed. The			this observation.		
	_	ively yelling out "I need help.			How other residents of the		
		o go? Somebody help me.			facility were identified to		
	_	The Unit Manager entered the			potentially be affected by the)	
	_	the resident. Upon exiting the			practice are:		
	room, the resident again began repetitively yelling				All residents have potential to	be	
	out.				effective by this deficiency.		
					The facility has taken the		
	The record for Resident K was reviewed on				following measures to ensur	е	
		. Diagnoses included, but were			that the problem has been		
		eimer's Disease, hypertension,			corrected and will not recur	-	
	and atrial fibrillatio	n.			Nursing staff educated on ens	uring	
		31 . 1 . 1 . (1/22			laboratory test are completed		
	1	rogress Note, dated 6/1/23,			timely.		
		nt was experiencing worsening			Quality Assurance plans and		
		ety. A medication change was			monitoring practices that ha	ve	
	I -	rsis (UA, urine test) was			been implemented to make		
	ordered.				sure corrections are achieve	a	
	A Drogress Note J	ated 6/2/23, indicated the urine			and are permanent are:	dit	
	_	d and placed in the refrigerator			DON/designee will conduct audaily (5) times a week for (6)	iuit	
	for pick up.	-			months to identify any pending	,	
	for pick up.				laboratory tests to ensure time		
	Δ Progress Note da	ated 6/3/23, indicated the urine			completion.	71 y	
	sample was availab				DON/designee will report audi	t	
	Sample was availab	10 101 mo presup.			findings to the QAPI committe		
	A Progress Note da	ated 6/5/23 at 1:32 p.m.,			monthly for (6) six months. Th		
	_	sample that was collected on			QAPI committee will monitor the		
		picked up by the lab until			data presented for any trends		
		s unable to use the specimen			determine if further		
	because it was too	•			monitoring/action is necessary	/ for	
					continued compliance		
	A Progress Note. da	ated 6/5/23 at 2:22 p.m.,					
	_	ne sample was obtained and					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 21 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	ì í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE COMPL	
AND FLAIN	OI CORRECTION	155214	B. WI			06/16/2023	
NAME OF P	PROVIDER OR SUPPLIEF	<u>.</u>	<u> </u>	203 FR	ADDRESS, CITY, STATE, ZIP COD ANCISCAN DR N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	placed in the refrige	erator for pick up.					
	indicated the UA re sent to the Physicia A urine culture, dat was positive for > (ated 6/6/23 at 2:17 p.m., esults had been received and n. ed 6/6/23, indicated the urine greater than) 100,000 d >100,000 proteus mirabilis					
	she had seen the res urinalysis. The urin coli (Escherichia co diagnosed with a U	er Note, dated 6/9/23, indicated sident today for an abnormal ne culture was positive for E. bli, a bacteria), the resident was TI and started on Macrobid mg (milligrams) twice a day for 7					
	6/16/23 at 11:33 a.r ordered for a Friday regularly pick up or wasn't picked up un the sample was too collected the same of started until 6/9/23 waiting for the urin indicated she would	Director of Nursing (DON) on m., indicated the UA had been y, 6/2/23. Lab services did not mekends, so the sample still Monday 6/5/23. By then, old and a new sample was day. No antibiotics were because the Physician was e culture to be complete. She dineed to come up with a better to were ordered on the					
	This Federal tag rel 3.1-41(a)(2)	ates to Complaint IN00408785.					
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Trach Suctioning	eostomy Care and ratory care, including					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 22 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DAT		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COMPLETED		
		155214	B. W	ING		06/16/2023
		_	_	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	PROVIDER OR SUPPLIE	R		203 FR	ANCISCAN DR	
SAINT A	NTHONY			CROW	N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		e and tracheal suctioning.				
	The facility must ensure that a resident who					
	needs respiratory					
	1	e and tracheal suctioning,				
	1	care, consistent with				
	1 '	dards of practice, the				
		erson-centered care plan,				
	_	als and preferences, and				
	483.65 of this subpart. Based on observation, record review, and interview, the facility failed to provide proper respiratory care and services related to not		F 00	605	The corrective actions that	07/07/2023
			FU	093	were accomplished for those	
					residents to have been affect	
	changing nebulizer (machine that turns liquid				by the practice are:	iteu
	medications into a mist to be inhaled) masks				Resident was assessed.	
		pleting nebulizer treatment			Assessment and vitals were b	ooth
	•	ered for 1 of 3 residents			within normal limits.)OUT
	reviewed for oxyge				Family and physicians were	
	leviewed for only ge	m (resident 2)			notified. Physician gave no ne	žW.
	Finding includes:				orders. Resident is in stable	···
					condition and experienced no	
	On 6/12/23 at 10:33	3 a.m., a nebulizer mask was			negative outcomes as a result	
	observed in a bag la	aying on Resident B's bed.			this observation.	
	The mask was date	d 5/27.			How other residents of the	
					facility were identified to	
	On 6/13/23 at 10:24	4 a.m., Resident B was observed			potentially be affected by the	e
	lying in bed. A nel	oulizer mask was in a bag on			practice are:	
	the resident's whee	lchair. The mask was dated			Whole house audit of resident	ts
	5/27.				who receive nebulizer treatme	ents.
					The facility has taken the	
		Resident B was completed on			following measures to ensur	re
	_	n. Diagnoses included, but were			that the problem has been	
		ke, hemiplegia, end stage renal			corrected and will not recur	· 1
	disease, and respira	atory failure.			Nursing staff educated on ens	=
					nebulizer treatments are comp	•
		nimum Data Set (MDS)			pr MD orders, masks are char	-
	· ·	1/17/23, indicated the resident			within policy guidelines, and v	ritals
		paired. The resident had			are taken per MD order.	
	received oxygen th	erapy.			Quality Assurance plans and	
		1/01/00 1 11 1 1 1 1 1 1 1 1 1 1 1 1 1 1			monitoring practices that ha	ve
	A Care Plan, dated	4/21/23, indicated the resident	1		been implemented to make	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			ETED
		155214	B. W	ING		06/16/	2023
				CENTER	ADDRESS STEW STATE STR COD		
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
0.411.17.4	NEUGNO				ANCISCAN DR		
SAINTA	NTHONY			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
		iratory distress related to			sure corrections are achieve	d	
	_	An intervention included for			and are permanent are:	-	
		gen saturation as ordered and			DON/designee will conduct au	dit	
	as indicated.	Son saturation as ordered and			(5) residents per unit if applica		
	us marcurea.				(5) times a week for (6) month		
	The June 2023 Phy	sician's Order Summary (POS)			ensure nebulizer equipment is		
	indicated orders for	- · · · · · · · · · · · · · · · · · · ·			changed per policy, nebulizer		
		used to prevent and treat					
	· ·	eness of breath caused by			treatments are complete, and	oo it	
	_	ness of breath caused by) inhalation nebulizer solution;			vitals are taken per MD order		
					related to nebulizer treatments		
	3 ml (milliliters) inhaled via nebulizer two times a day				DON/designee will report audi		
	- document the pulse, respiratory rate, breath				findings to the QAPI committe		
					monthly for (6) six months. Th		
	sounds, oxygen saturation and minutes before and after nebulizer treatments				QAPI committee will monitor the		
					data presented for any trends	&	
	- change nebulizer	tubing weekly			determine if further	_	
					monitoring/action is necessary	for	
		dication Administration Record			continued compliance.		
		er to document the pulse,					
		eath sounds, oxygen saturation					
		the nebulizer treatments. The					
		arks it was completed but there					
	was no documentat	ion of the vital sign results.					
		D					
		Director of Nursing (DON) on					
	•	., indicated the nebulizer masks					
	were supposed to b	e changed weekly.					
	Tukamaian 24 41 3	DOM (/15/22 12 59					
		DON on 6/15/23 at 12:58 p.m.,					
		izer assessment order was not					
		ne MAR should have had					
		signs instead of only check					
	marks when it was	completed.					
	This Federal tag rel	ates to Complaint IN00408169.					
	3.1-47(a)(6)						
F 0725 SS=E	483.35(a)(1)(2) Sufficient Nursing	Staff					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 24 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/16/2023
NAME OF P	PROVIDER OR SUPPLIER		203 FF	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE 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) COMPLETION DATE
Bldg. 00	with the appropria sets to provide nu to assure resident maintain the higher mental, and psychresident, as detern assessments and considering the nudiagnoses of the fin accordance with required at §483.7 §483.35(a)(1) The services by sufficing following types of basis to provide not in accordance with (i) Except when with this section, licensed (ii) Other nursing polimited to nurse aid §483.35(a)(2) Except agraph (e) of the designate a license charge nurse on each adequate nursing staresidents' needs related to the section of	ave sufficient nursing staff the competencies and skills raing and related services safety and attain or est practicable physical, associal well-being of each mined by resident individual plans of care and amber, acuity and acility's resident population in the facility assessment (O(e). If facility must provide ent numbers of each of the personnel on a 24-hour aursing care to all residents in resident care plans: aived under paragraph (e) of sed nurses; and bersonnel, including but not des. ept when waived under his section, the facility must ed nurse to serve as a each tour of duty. on, record review and ty failed to ensure there was aff available to meet the sted to receiving scheduled units reviewed for staffing.	F 0725	The corrective actions that were accomplished for those residents to have been affect by the practice are: Resident received shower. Family and physicians were notified. Physician gave no ne orders. Resident is in stable condition and experienced no negative outcomes as a result this observation.	ted w

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 25 of 38

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 06/16/2023	
	PROVIDER OR SUPPLIER	₹	STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	staff on the unit.	t. There was no additional		facility were identified to potentially be affected by the practice are:	
	The shower book indicated there were four residents scheduled to receive a shower that day			Whole house audit of resider who resides on unit to ensure	
	on day shift.			shower was complete. The facility has taken the	
		A 1 on 6/14/23 at 2:00 p.m.,		following measures to ensu	re
	indicated there was only one CNA that day. There were sometimes two CNAs, or a split that would			corrected and will not recur	by:
	work two units. She indicated they would offer			Clinical leadership educated	
	residents bed baths instead of showers when they were short staffed.			ensuring units have assistand provide showers as schedule	
				Quality Assurance plans an	d
	Interview with CNA 1 on 5/14/23 at 2:25 p.m.,			monitoring practices that ha	ave
		only able to give one of the dents a shower that day.		been implemented to make sure corrections are achieve	ad
		ne it was impossible to give all		and are permanent are:	eu
	four showers during			DON/designee will conduct a	udit
				(5) residents per unit (5) time	s a
		Executive Director and the		week for (6) months to ensur	
		/15/23 at 10:14 a.m., indicated all off or staffing shortage, the		showers are complete. Any to will be reported to Executive	rends
		should assist. They would		Director and Administrator.	
	•	ng on 3A the previous day.		DON/designee will report aud	dit
	There was no addit	ional information provided.		findings to the QAPI committee	
		L4 4 C 1 1 4 DI00400705		monthly for (6) six months. The	
	and IN00410203.	ates to Complaints IN00408785		QAPI committee will monitor data presented for any trends	
	and 11100410203.			determine if further	- α
	3.1-17(b)			monitoring/action is necessar	ry for
				continued compliance.	
				It is stated in the citation,	
				"Interview with C.N.A. 1 on 6	
				at 2:25 p.m indicated she wa	
				only able to give one of the fo	l l
				scheduled residents a showe	
				day. When working alone it wimpossible to give all four sho	

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155214	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 06/16/2023
NAME OF P	PROVIDER OR SUPPLIEI	3	203 FF	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	RESOLUTION OF			during a shift." This interview not indicate if C.N.A. had requested additional assistant from the clinical leadership of date in question or if clinical leadership had addressed caneeds. Furthermore, it was sin the citation, "Interview with Executive Director and the Administrator on 6/15/23 at a.m. indicated when there was call off or staffing shortage, to clinical supervisors should as They would look into the staff on 3A the previous day." This interview indicates that if the need for additional support of floor, clinical leadership respito ensure adequate nursing store additional 68.03 hours of clinical deadership worked for the date additional 68.03 hours of clinical leadership worked for the date additional 68.03 hours of clinical deadership worked for the date additional 68.03 hours of clinicated there was sufficient nursing swithin the facility to provide to care needed. The following is breakdown of the hours for contied 6/14/23 supporting clinicated ship within the facility at time of citation (attachment 2 provides copies of licensure each individual to support appropriate nursing compete and skills). These individuals not assigned to specific units however, were available if a needed assistance providing adequate care. In addition of the staffing adequate care in addition of the support and skills and addition of the support and skills and addition of the support and skills and assigned to specific units however, were available if a needed assistance providing adequate care. In addition of the support and distinct the support and di	r does nce n the are tated n the lo:14 as a he ssist. ifing s re is a n the onds staff. ride at an iical te in the es staff he s a late iical at the cof encies swere s, unit

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 27 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 06/16/2023	
NAME OF P	PROVIDER OR SUPPLIE	R	203 FR	ADDRESS, CITY, STATE, ZIP COD RANCISCAN DR IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				report will indicate all clinical on shift, who were assigned to units for the complete 24 hour 6/14/2023. The following clinical leadership was within the fact within the time frame citied, and able to provide care where note. Courtney Grupka, Cent Supply Director, Certified Nuralide., hours worked 8.67 Falon Wendel, Director Nursing, Registered Nurse, hoursing, Registered Nurse, hoursing, Registered Nurse, hours worked 9.00 Cheryl Young, Infection Control Staff Developer, Lice Professional Nurse, hours worked 9.00 Alice Finney, MDS Coordinator Assistant, Regist Nurse, hours worked 10.38 Katherine Geffert, Staff Scheduler, Qualified Medicati Aide, hours worked 11.83 Michelle Luedtke, Unit Manager, Licensed Profession Nurse, hours worked 10.75 Cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 Cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS Coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis, MDS coordinator Assistant, Licens Professional Nurse, hours worked 10.75 cassie Travis of the New Yours worked 10.75 cassie Travis of the New Yours worked 10.75 cassie Travis of the New Yours worked 1	staff o rs on cal ility ility ind eeded: ral sing of ours nsed orked ared ion nal eed orked .N.A. vide ave th noted ity staff ncies

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 28 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214 NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY IXA BUSINMARY STATEMENT OF DESICUENCIE. REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION FOR THE deficiency does not correlate with insufficient staffing, however, within communication among direct acre staff and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s)-483.45(c)(3) (e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) Apsychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-appressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— \$483.45(c)(1) (Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
NAME OF PROVIDER OR SLIPPLER SAINT ANTHONY NAME OF PROVIDER OR SLIPPLER SAINT ANTHONY SUMMARY STATEMENT OF DEFICIENCIE (EACH) DEFICIENCY MUST BE PRECEDED BY FULL TAG SUMMARY STATEMENT OF DEFICIENCY TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE SUMMARY STATEMENT OF TAG COMPLETION DATE COMPLETION DATE SUMMARY STATEMENT OF TAG SUMMARY SUMMARY TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATEMENT OF TAG SUMMARY STATE	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
ASAINT ANTHONY CROWN POINT, IN 46307 CX3 D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION And related services to assure resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CF(s):483.35(a)(1)(2): scope and severity level E, be removed from survey. FO758 SS=D Fire from Unnec Psychotropic Meds/PRN Use S483.45(e) (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			155214	B. W	ING		06/16/2023	
ASAINT ANTHONY CROWN POINT, IN 46307 CX3 D PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAO REGISTER) (EACH DEFICIENCY OR LSC IDENTIFYING INFORMATION And related services to assure resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CF(s):483.35(a)(1)(2): scope and severity level E, be removed from survey. FO758 SS=D Fire from Unnec Psychotropic Meds/PRN Use S483.45(e) (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			l .	<u> </u>	CTREET	ADDRESS CITY STATE TIP COP		
SAINT ANTHONY CROWN POINT, IN 46307	NAME OF P	ROVIDER OR SUPPLIER	8					
SIJMMARY STATEMENT OF DEFICIENCE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG	SAINIT AN	NTHONY						
PREFIX TAG (6.ACTI DEPICIENCY MIST BE PRECEDED BY BILL REGULATORY OR LSC IDENTIFYING INFORMATION REGULATORY OR LSC IDENTIFYING INFORMATION And related services to assure resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s).483.35(a)(1)(2): scope and severity level E, be removed from survey. FO758 SS=D Bidg. 00 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-depressant; (ii) Anti-depressant; (iii) Anti-danxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(c)(1) Residents who have not used psychotropic drugs are not given these drugs	OAINT AI	*11101*1			CINOWI	11 OINT, IN 70001		
TAG REGILLATORY OR LSC IDENTIFYING INFORMATION TAG and related services to assure resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident" The deficiency does not correlate with insufficient staffing, and exercise the safety and account of the physical of the deficient staffing, and physiological well-being of each resident" The deficiency does not correlate with insufficient staffing, and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s)-483.35(a)(1)(2) scope and severity level E, be removed from survey. F 0758 SS=D Free from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-apsychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— \$483.45(c)(1) Residents who have not used psychotropic drugs are not given these drugs	1 1	SUMMARY	STATEMENT OF DEFICIENCIE					(X5)
and related services to assure resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident" The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s).483.35(a)(1)(2): scope and severity level E, be removed from survey. Bidg. 00 Free from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotro; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— \$483.45(c)(1) Residents who have not used psychotropic drugs are not given these drugs						PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 0758 SS=D Bidg. 00 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(e)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident safety and attain or main the highest practicable physical. Mental, and physiological well-being of each resident" The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s)-483.35(a)(1)(2); scope and severity level E, be removed from survey. 483.45(c)(3) A psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(e) Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the highstyrical. Mental, and physiological well-being of each resident" The deficiency described with insufficient staffind clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s)-483.35(a)(1)(2); scope and severity level E, be removed from survey.	TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	-	TAG			DATE
F 0758 SS=D Bidg. 00 Bidg. 00 Bidg. 00 Vis psychotropic Drugs. \$483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(c) (3) A psychotropic Drugs. \$483.45(c) (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
F 0758 SS=D Bldg. 00 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-epsychotic; (ii) Anti-depressant; (iii) Anti-						-		
well-being of each resident" The deficiency does not correlate with insufficient staffing, however, within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s).483.35(a)(1)(2), scope and severify level E, be removed from survey. F 0758 SS=D Bidg. 00 Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-apychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs							al.	
F 0758 SS=D Bidg. 00 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(e) Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
F 0758 SS=D Bldg. 00						_		
within communication among direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s):483.35(a)(1)(2); scope and severity level E, be removed from survey. F 0758 SS=D Bidg. 00 Bidg						_	vith	
direct care staff and clinical leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s):483.35(a)(1)(2); scope and severity level E, be removed from survey. F 0758 SS=D Bldg. 00 Has 3.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(e)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						_		
leadership. The facility appreciates time and consideration for this IDR and respectfully requests citation F 725 Sufficient Nursing Staff CFR(s):483.35(a)(1)(2); scope and severity level E, be removed from survey. F 0758 SS=D Bldg. 00 Use \$483.45(e) Psychotropic Drugs. \$483.45(e)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						_		
F 0758 SS=D Bldg. 00 Bldg. 00 F ore from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) (e) (1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
F 0758 SS=D Bldg. 00 Systam and prespectfully requests citation F F 725 Sufficient Nursing Staff CFR(s):483.35(a)(1)(2); scope and severity level E, be removed from survey. Here from Unnec Psychotropic Meds/PRN Use \$483.45(c)(3) A psychotropic Drugs. \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs							1	
F 0758 SS=D Bldg. 00 H 38.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(e) Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						na		
F 0758 SS=D Bldg. 00 F 0758 SS=D Bldg. 00 Free from Unnec Psychotropic Meds/PRN Use §483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						_		
F 0758 SS=D Bldg. 00 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(e)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						•		
F 0758 SS=D Bldg. 00 483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-psychotic; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						_		
F 0758 SS=D Bldg. 00 How the following categories: (i) Anti-psychotic; (ii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are formulated.								
F 0758 SS=D SS=D Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(e)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that— §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						-	om	
SS=D Bldg. 00 Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs						survey.		
SS=D Bldg. 00 Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
SS=D Bldg. 00 Free from Unnec Psychotropic Meds/PRN Use \$483.45(e) Psychotropic Drugs. \$483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that \$483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs	F 0758	483.45(c)(3)(e)(1).	-(5)					
Bldg. 00 Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
§483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs			,					
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs.		_	otropic Drugs.					
drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		. , ,	. •					
with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		- ' ' ' ' ' '						
drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		_						
the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		-						
(ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
(iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		(i) Anti-psychotic;						
(iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		(ii) Anti-depressan	nt;					
Based on a comprehensive assessment of a resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		, ,	nd					
resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		(iv) Hypnotic						
resident, the facility must ensure that §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs								
§483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs		-						
psychotropic drugs are not given these drugs		resident, the facilit	ty must ensure that					
psychotropic drugs are not given these drugs		\$400 4E/-\/4\ D	sidente who have not used					
unless the medication is necessary to treat a								
specific condition as diagnosed and								

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 29 of 38

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLET B. WING 06/16/20				
155214			B. W	ING		06/16/	2023
NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY			STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID				(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	16	DATE
	documented in the	e clinical record;					
	§483.45(e)(2) Respsychotropic drug reductions, and be unless clinically or to discontinue the: §483.45(e)(3) Respsychotropic drug unless that medica a diagnosed specidocumented in the §483.45(e)(4) PRI drugs are limited to provided in §483.4 physician or preschat it is appropriate extended beyond document their rate medical record and the PRN order. §483.45(e)(5) PRI drugs are limited to renewed unless the prescribing practite for the appropriate Based on observation interview, the facilia were free from unnumedications related anti-anxiety medical antipsychotic medical reviewed for unnecessity.	sidents who use is receive gradual dose shavioral interventions, contraindicated, in an effort see drugs; sidents do not receive is pursuant to a PRN order ation is necessary to treat iffic condition that is see clinical record; and Norders for psychotropic to 14 days. Except as 45(e)(5), if the attending cribing practitioner believes attended the properties of the PRN order to be 14 days, he or she should the tionale in the resident's indicate the duration for the attending physician or incore evaluates the resident teness of that medication. On, record review, and the tionals of t	F 0°	758	The corrective actions that were accomplished for those residents to have been affect by the practice are: Psych and MD were notified or resident D's lack of documents for Abilify usage. Psych and M were notified of delayed medication. Resident was assessed.	t ed f ation	07/07/2023
	Findings include:				Family and physicians were		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811 Facility ID: 000120

If continuation sheet Page 30 of 38

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONST		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
155214		B. WING 06/16/2023			023		
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
CAINTAI	NITHONIX				ANCISCAN DR		
SAINT AI	NIHONY			CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE .	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	.12	DATE
					notified. Physician gave new o	order	
	1. The record for R	desident D was reviewed on			for GDR of Abilify for resident	D	
	6/14/22 at 2:54 p.m	. Diagnoses included, but were			and no new order for resident		
	-	inson's Disease, dementia with			Residents are in stable conditi		
		nce, and major depressive			and experienced no negative		
		ent was admitted to the facility			outcomes as a result of this		
	on 1/12/23.	ž			observation.		
					How other residents of the		
	The Quarterly MDS	S (Minimum Data Set)			facility were identified to		
		/21/23, indicated the resident			potentially be affected by the	ا ب	
		naviors. She received			practice are:		
	-	ntidepressant medications.			All residents on psychotic		
	1 3	1			medications have potential to	be	
	A Progress Note, da	ated 1/20/23, indicated the			affected by this deficiency.		
	-	as requesting she be started on	The facility has taken the				
		e, an antipsychotic medication)	following measures to ensure		e		
		nallucinations without the	that the problem has been		"		
		nysician was notified of the		corrected and will not recur by:		bv:	
	family's request.				Nursing staff educated on		
	J 1				follow-up with MD and pharma	acv	
	A Psych Services P	rogress Note, dated 1/23/23,			of unavailable medications.		
	-	no reported new or worsening		Nursing staff and MD educated on			
		rs, no reports of delusions,		ensuring residents have supporting			
	* *	aranoia. They spoke with the			documentation for prescribed		
		regarding the resident's		psychotropic medications.			
		ndicated the resident had	Quality Assurance plans and			, !	
		1 for hallucinations where she			monitoring practices that ha		
	had previously resid				been implemented to make		
		bilify abruptly without			sure corrections are achieve	d	
		rvices explained they would		and are permanent are:		_	
	prescribe a differen	-			SSD/designee will conduct au	dit	
	-	e resident's daughter was in			daily (5) times a week for (6)		
					months to identify any new		
	agreement and Nuplazid (an antipsychotic medication) 34 mg (milligrams) daily was ordered.				prescribed psychotropic		
		(medications and ensure there	is	
	An IDT (interdiscin	olinary team) Note, dated			supporting documentation for	.	
		he Physician in house would			medication.		
		The resident was started on a			DON/designee will report audi	,	
		the Physician and family were			findings to the QAPI committe		
					_		
	in agreement with the plan of care.				monthly for (6) six months. Th	ا	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 31 of 38

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		, ,	JILDING	onstruction 00	(X3) DATE COMPL 06/16	ETED			
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 DEFICIEN	STATEMENT OF DEFICIENCIE ICY 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 APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE		
	order for Abilify 10 Medication Adminindicated the reside medication as order				QAPI committee will monitor to data presented for any trends determine if further monitoring/action is necessary continued compliance.	&			
	indicated the Abilif and discontinued at medication had bee	rogress Note, dated 6/8/23, by had previously been reduced a previous facility. The n resumed by the POA (power sible party) and the PCP der).							
	or behaviors for Jar documentation from	any documented hallucinations muary 2023. There was lack of in the Physician of the clinical to the Abilify had been started							
	6/15/23 at 1:48 p.m. had indicated the re years at her previou abruptly discontinu Physician restart it provide any further	Director of Nursing (DON) on a., indicated the resident's family esident was on Abilify for as facility and then it was ed. They requested the and he had. She was unable to documentation of any rogress note from the							
	Resident K was obs resident was repetit Where am I going t Where will I go?" room and spoke to	n 2:23 p.m. through 2:36 p.m., served lying in her bed. The ively yelling out "I need help. o go? Somebody help me. The Unit Manager entered the the resident. Upon exiting the again began repetitively yelling							
	The record for Resi	dent K was reviewed on							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 32 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	a. building <u>00</u>			COMPLETED	
155214		B. WING 06/16/2023				/2023	
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	3			ANCISCAN DR		
SAINT A	NTHONY				N POINT, IN 46307		
	T				,		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	bereiner,		DATE
		. Diagnoses included, but were seimer's Disease, hypertension,					
	and atrial fibrillatio						
	and aurai normano	ш.					
	A Psych Services P	rogress Note, dated 6/1/23,					
	•	nt was experiencing worsening					
		ety. Xanax (an anti-anxiety					1
		illigrams (mg) twice daily was					
	· ·	onazepam (an anti-anxiety					
	medication) 0.25 m	g twice a day for 14 days was					
	started.						
		r, dated 6/1/23, indicated					
	clonazepam 0.25 m	g twice daily for 14 days.					
	The MAR dated 6/	2023, indicated the resident					
		e clonazepam medication as					
		owing dates and times:					
	- 6/2/23 6:00 a.m.	wing dates and times.					
		"Dosage different than entry.					
	Clarification neede						
		"Awaiting med (medication)					
	from pharmacy."						
	- 6/4/23 6:00 a.m.						
	- 6/4/23 6:00 p.m.	"Med (medication) not					
	available."						
	- 6/5/23 6:00 p.m.	"Medicine did not arrive from					
	pharmacy."						
	- 6/6/23 6:00 a.m.						
	A Dayah Camrias - D	rogress Note, dated 6/8/23,					
		with nursing staff regarding					1
	_	dication change. Reported the					
	new medication was started late due to issues with delivery from the pharmacy. Therefore, the						1
		aving the same yelling and					
	screaming episodes						
	- Franking opioodes						
	Interview with the	DON on 6/16/23 at 11:33 a.m.,					
		nt had not received the					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet

Page 33 of 38

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENT		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
155214		B. WI	NG		06/16/	2023	
NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY			STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	clonazepam as orde	red. She was unsure why the arrived from the pharmacy					
F 0761 SS=E Bldg. 00	Drugs and biologic must be labeled in accepted profession the appropriate accinstructions, and the applicable. §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper temps	and Biologicals ang of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include accessory and cautionary the expiration date when are of Drugs and Biologicals accordance with State and afacility must store all drugs allocked compartments accordance controls, and aized personnel to have					
	separately locked, compartments for listed in Schedule Drug Abuse Preve 1976 and other drexcept when the fipackage drug dist the quantity stored dose can be readil Based on observation	on, interview, and record	F 07	761	The corrective actions that		07/07/2023
	were labeled correct sprays, and insuling	failed to ensure medications tly related to eye drops, nasal with no labels and insulin in the for 3 of 5 medication carts			were accomplished for those residents to have been affect by the practice are: Medications were removed fro	ed	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 34 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 06/16/2023			
NAME OF PROVIDER OR SUPPLIER SAINT ANTHONY			STREET ADDRESS, CITY, STATE, ZIP COD 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDENCE NEAR OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
	observed. (3D, 2D,	and 1A Medication Carts)		cart and reordered.			
				Family and physicians were			
	Findings include:			notified. Physician gave no n	ew		
				orders. Residents are in stab			
	1. On 6/14/23 at 10	:26 a.m., the 3D Medication Cart		condition and experienced no			
	was observed with	QMA 3. Resident 149's insulin		negative outcomes as a resu			
	glargine 100 unit/m	illiter (mL) vial was labeled with		this observation.			
	_	of 6/11/23. QMA 3 indicated the		How other residents of the			
	resident was still re	ceiving the medication nightly		facility were identified to			
	and the medication	should have been disposed of		potentially be affected by the	ie		
	on 6/11/23.			practice are:			
				Whole house audit on each u	ınit's		
		05 p.m., the 2D Medication Cart		medication cart was complete	e.		
		LPN 1. The following		The facility has taken the			
	medications were for	ound in the cart:		following measures to ensu	re		
				that the problem has been			
		flo nasal spray, Refresh Tears,		corrected and will not recur	· I		
		ps), and a Novolog insulin vial		Nursing staff educated on ex	pired		
	opened on 5/1/23 in	a drawer with no label.		medication.			
	1 7 11 1501	1		Quality Assurance plans an			
		nd two vials of Lantus insulin		monitoring practices that ha	ave		
		at were opened on 4/1/23 and		been implemented to make			
		[umalog 100 unit/mL vial that		sure corrections are achiev	ed		
	was opened on 5/1/2	23.		and are permanent are:			
	a Desident 211a II.	malog insulin vial was opened		DON/designee will conduct a	l l		
	on 5/1/23.	maiog msumi viai was opened		medication carts (5) times a v			
	OH 3/1/23.			per unit for (6) months to ens			
	d Resident 118's H	umalog insulin vial was opened		no expired medications are ir carts.	1 1110		
	on 5/1/23.	amaiog mounn viai was opened		DON/designee will report aud	lit		
	011 5/11/23.			findings to the QAPI committee			
	LPN 1 indicated eac	ch bottle should have an		monthly for (6) six months. The			
		ith the name of medication,		QAPI committee will monitor			
		nd instructions for use. The		data presented for any trends			
		nly good for 28 days after		determine if further			
		ould have been disposed of		monitoring/action is necessar	ry for		
	prior to 6/14/23.			continued compliance.	, l		
	2.0. (/14/22 / 23	25 4 14 36 7 2 2					
		35 p.m., the 1A Medication Cart					
	was observed with QMA 4. An unlabeled vial of						

N8P811

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION IG 00		SURVEY LETED 5/2023	
	PROVIDER OR SUPPLIEF	R	203	EET ADDRESS, CITY, STATE, ZIP COD 3 FRANCISCAN DR OWN POINT, IN 46307	•	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)		D BE	(X5) COMPLETION
TAG	insulin lispro 100 u opened date of 5/1/medication was exp Interview with the lat 2:01 p.m., indication should have been dispracturer's recommendations.	nit/mL was observed with an 23. QMA 4 indicated the bired 28 days after opening. Director of Nursing on 6/15/23 ted the insulin medications isposed of after 28 days or the emmendations and all have had appropriate labels in s.	TAC	j Direixeri		DATE
F 0812 SS=E Bldg. 00	§483.60(i) Food s The facility must - §483.60(i)(1) - Pro approved or consi federal, state or lo (i) This may includ directly from local applicable State a regulations. (ii) This provision facilities from usin gardens, subject t applicable safe gr practices. (iii) This provision from consuming for facility.	ocure food from sources idered satisfactory by ocal authorities. de food items obtained producers, subject to and local laws or does not prohibit or prevent g produce grown in facility				
	serve food in acco	ordance with professional	F 0812	The corrective actions the	at	07/07/2023

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

N8P811

Facility ID: 000120

If continuation sheet Page 36 of 38

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
	155214		B. WING 06/16/2023			/2023	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ANCISCAN DR		
CAINIT A	NTHONY				N POINT, IN 46307		
SAINTA	INTHOINT			CROW	N POINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to follow pro	per sanitation and food			were accomplished for those)	
		related to the high temperature			residents to have been affec	ted	
		eaching appropriate rinse			by the practice are:		
		e of expired sanitizer test strips			Sanitizer test strips were		
		This had the potential to affect			replaced. Screw was removed	ł	
	170 residents who	received food from the kitchen.			from the booster, dishwasher	was	
	(The Main Kitchen)			re-ran and reached adequate		
					temperature.		
	Findings include:				Residents are in stable condit	ion	
					and experienced no negative		
	1. On 6/14/23 at 9:	40 a.m., the Dietary Food			outcomes as a result of this		
	Manager (DFM) w	as observed wiping down a			observation.		
	preparation counter	with a sanitizer solution. At		How other residents of the			
	the time, a sanitizer	r test strip was used to test the			facility were identified to		
	solution. The test s	trips expired on 6/30/22. The			potentially be affected by the	•	
	strip did not have a	readily discernable color		practice are:			
	change.			All residents have potential to be		be	
					affective by this deficiency.		
	The DFM brought	another package of test strips			The facility has taken the		
	to test the solution,	which had expired on 3/1/22.			following measures to ensur	e	
	The strip did not ha	we a readily discernable color			that the problem has been		
	change.				corrected and will not recur	by:	
					Dietary staff were educated or	n not	
		DFM at the time indicated he			using expired sanitizer test str	ips	
	would send someon	ne out to purchase sanitizer			and booster was repaired.		
	test strips that were	e not expired.			Quality Assurance plans and	i	
					monitoring practices that ha	ve	
		ket Log for the month of June			been implemented to make		
	· ·	n the Executive Director on			sure corrections are achieve	d	
	_	., indicated three buckets in the			and are permanent are:		
		buckets in the evening were			FSD/designee will conduct		
		sanitation levels. There were			monthly audits of test strips to		
	no sanitation levels written, only check marked				ensure they are not expired for	or (6)	
	that it was completed. The instructions indicated				months. FSD/designee will		
	_	ll in the water for 10 seconds			conduct daily audits for (6) mo	onths	
		itation level was between			to final rinse cycle reaches 16	0	
	150-400 parts per r	nillion (ppm).			degrees.		
					FSD/designee will report audi	t	
	2. On 6/14/23 at 9:4	46 a.m., the dishwasher machine			findings to the QAPI committe	е	
	was observed to be	was observed to be in use. The dishwasher was a			monthly for (6) six months. Th	е	

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

PRINTED: 08/08/2023 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155214		(X2) MULTIPLI A. BUILDING B. WING	E CONSTRUCTION G <u>00</u>	(X3) DATE SURVEY COMPLETED 06/16/2023			
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 DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	
	high temperature di reached 160 degree reached 160 degree The U.S. Departme Services, Public He Administration Foo standard for proper High Temperature Wash - 150-16 "Final Rinse - 1 Interview with the rinse cycle should remperature dishwa indicated the same shut down the dishwa company assess and A follow-up intervit the DFM indicated assessed the dishwa working properly, see the problem. They were the total temperature to the problem.	shwasher. The wash cycle s Fahrenheit and the final rinse s Fahrenheit. Int of Health and Human salth Services, Food and Drug od Code indicates the following sanitation temperatures: Dishwasher (heat sanitization): 55 degrees F; 80 degrees F; DFM at the time indicated the reach 180 for final rinse for high asher and the temperature logs parameters. He would have to washer and have the service		QAPI committee will mo data presented for any t determine if further monitoring/action is necontinued compliance.	rends &		

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: N8P811 Facility ID: 000120 If continuation sheet Page 38 of 38