STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155214	A. BUILDING -- B. WING	07/12/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SAINT ANTHONY	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 07/12/2023 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Emergency Preparedness survey, Saint Anthony was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 189 and had a census of 168 at the time of this survey. Quality Review completed on 07/18/23	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 07/12/2023 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Life Safety Code survey, Saint Anthony was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jami Moore	Executive Director	08/02/2023

Any defiencystatement 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.

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	Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms with battery smoke detection in certain areas of the building. The facility has a capacity of 189 and had a census of 168 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 07/18/23			
K 0324 SS=E Bldg. 01	NFPA 101 Cooking Facilities Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with			

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	conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 Based on observation and interview, the facility failed to maintain 1 of 1 kitchens in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, 2011. NFPA 96, Section 12.1.2.4 states all deep-fat fryers shall be installed with at least a 16 inches space between the fryer and surface flames from adjacent cooking equipment. Section 12.1.2.5 states where a steel or tempered glass baffle plate is installed at a minimum 8 inches in height between the fryer and surface flames of the adjacent appliance, the requirement for a 16 inches space shall not apply. This deficient practice could affect all residents in the dining room/kitchen area. Findings include: Based on an observation with the Director of Plant Operations on 07/12/23 between 12:27 p.m. and 3:45 p.m., the deep fat fryer was located next to a gas powered grill. The deep fat fryer had approximately two inches of space between the two appliances. The grill did have a separation plate on the grill but had only measured three inches in height which both did not meet the requirements of separation. Based on interview at the time of observation, the Director of Plant Operations acknowledged the measurements and lack of separation. The measurements were provided by a kitchen staff employees tape measure.	K 0324	**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** 8 inch steel baffle was installed between gas grill and deep fat fryer. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** No other gas grill or deep fast fryer in facility. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Maintenance Director/Designee will ensure steel baffle remains in place weekly for (6) months. Maintenance Director/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	07/31/2023

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	Findings were discussed with the Director of Plant Operations and Executive Director at exit conference. 3.1-19(b)		monitoring/action is necessary for continued compliance.	
K 0345 SS=C Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants. Findings include: Based on record review with the Director of Plant Operations on 07/12/23 between 09:11 a.m. and 12:23 p.m., the last fire system inspection dated 06/08/23 by the facility's fire alarm vendor indicated "panel had 8 troubles. Smoke detectors, heat detectors, duct detectors, and data card troubles. Maintenance has order in with Safecare to fix detectors. Fire panel and all other devices	K 0345	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Repair for trouble lights in fire alarm panel was scheduled. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Plant Operations Director conducted audit of fire panel to ensure no other trouble lights were noted. **Quality Assurance plans and**	07/31/2023

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	tested are working properly. Troublex8 on departure." Based on observation during a tour of the facility between 12:12 p.m. and 3:45 p.m., the main fire panel and subpanels both had a trouble lights illuminated for the system. Based on interview at the time of record review and observation, the Director of Plant Operations stated that they were aware of the issue and are working with Safecare to gather parts for replacement. This finding was reviewed with the Director of Plant Operations during the exit conference. 3.1-19(b)		**monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Operations Director/designee will conduct audit (5) times a week for (6) months to ensure no trouble lights are illuminated on fire panel. Plants Operations Director/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.	
K 0351 SS=E Bldg. 01	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler			

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	Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) Based on observation and interview, the facility failed to ensure the spray pattern for sprinkler heads were not obstructed in 1 of 5 kitchen freezers in accordance with 19.3.5.1. NFPA 13, 2010 edition, Section 8.5.5.1 states sprinklers shall be located so as to minimize obstructions to discharge as defined in 8.5.5.2 and 8.5.5.3 or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Sections 8.5.5.2 and 8.5.5.3 do not permit continuous or noncontinuous obstructions less than or equal to 18 inches below the sprinkler deflector or in a horizontal plane more than 18 inches below the sprinkler deflector that prevent the spray pattern from fully developing. This deficient practice could affect approximately 6 staff and 20 residents who use the adjacent dining area. Findings include: Based on observation with the Director of Plant Operations on 07/12/23 from 12:27 p.m. to 3:45 p.m., kitchen freezer #2 in the kitchen had storage touching or within a 4 inches of the sprinkler head. Based on interview at the time of observation, the Director of Plant Operations acknowledged the aforementioned sprinkler head was obstructed and did move some of the items off of shelves. Findings were discussed with the Director of Plant Operations and Executive Director at exit conference. 3.1-19(b)	K 0351	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Boxes were moved so they did not obstruct sprinklers. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Plant Operations Director conducted a whole house audit to ensure all boxes and supplies were 18 inches below sprinklers deflector. All staff educated on properly storing supplies. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Operations Director/designee will conduct audit (5) times a week for (6) months to ensure no items are stored less than 18 inches from sprinkler deflector. Plants Operations Director/designee will report audit findings to the QAPI committee	07/31/2023

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			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.	
K 0353 SS=E Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 2 of 4 sprinkler heads in the Senior Fit area and 1 of 10 sprinkler heads in first floor dining were not loaded or covered with foreign material in accordance with LSC 9.7.5. NFPA 25, 2011 edition, at 5.2.1.1.1 sprinklers shall not show signs of leakage; shall be free of corrosion, foreign materials, paint, and physical damage; and shall be installed in the correct orientation (e.g., up-right, pendent, or sidewall). Furthermore, at 5.2.1.1.2 any sprinkler that shows signs of any of the following shall be replaced: (1) Leakage (2)	K 0353	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Sprinkles heads were covered and cleaned. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice.	07/31/2023

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	Corrosion (3) Physical Damage (4) Loss of fluid in the glass bulb heat responsive element (5) Loading (6) Painting unless painted by the sprinkler manufacturer. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations on 07/12/23 between 12:27 p.m. and 3:47 p.m. the following sprinkler heads were coved in dust or showed signs of loading, a) Two sprinkler heads in the Senior Fit room, across from the first floor dining room, were loaded with dirt, were completely gray, and had excessive amounts of lint on them. Fixed upon observation b) One sprinkler head in the first floor dining room next to the entrance door had excessive amount of lint and dirt making the fuse gray. Based on interview at the time of observation, the Maintenance Director confirmed the aforementioned sprinkler heads showed dirt accumulation and loading and would start to fix both issues. Findings were discussed with the Director of Plant Operations and Executive Director at exit conference. 3.1-19(b)		**The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Plant Operations Director conducted a whole house audit to ensure sprinkler heads were free from debris. All maintenance staff educated on ensuring sprinkler heads are covered and free from debris. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Operations Director/designee will conduct audit (5) times a week for (6) months to ensure sprinkler heads are free from debris and covered properly. Plants Operations Director/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.	
K 0741 SS=D Bldg. 01	NFPA 101 Smoking Regulations Smoking Regulations Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room,			

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	ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4			
	Based on observation and interview; the facility failed to ensure 1 of 1 areas outside the kitchen were maintained by disposing cigarette butts in a metal or noncombustible container with self-closing cover devices. This deficient practice could affect approximately 6 staff and an unknown amount of residents.. Findings include: Based on observation during a tour of the facility with the Director of Plant Operations on 07/12/23 between 12:27 p.m. and 3:45 p.m., in the area outside the kitchen emergency exit, there were approximately 10 cigarette butts disposed on the	K 0741	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Cigarette butts were cleaned from the area affected. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been**	07/31/2023

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	ground in and around the area. The area was not a designated smoking area. Based on interview at the time of observations, the Maintenance Director agree there were cigarette butts on the ground in the aforementioned location. This finding was reviewed with the Director of Plant Operations and Executive Director during the exit conference. 3.1-19(b)		**corrected and will not recur by:** Plant Operations Director conducted a whole house audit to no cigarette butts on the ground of campus. All staff educated proper method of disposing cigarette trash. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Operations Director/designee will conduct audit (5) times a week for (6) months to ensure cigarette butts are properly discarded. Plants Operations Director/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.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics),			

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	except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 2 of 2 power strips were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 5 staff and an unknown amount of residents. Findings include: Based on observations during a tour of the facility with the Director of Plant Operations on 07/12/23 between 12:27 p.m. and 3:45 p.m., a minifridge (high power draw equipment) was plugged into and supplied power by a power strip in the Pastoral Care office. Furthermore, a Microwave (high power draw equipment) and Minifridge (high draw power draw equipment) was plugged into and supplied power by a power strip in the Activities office near the Central Supply room. Based on interview at the time of observation, the Director of Plant Operations acknowledged power strips were supplying power to high power draw	K 0920	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Power strip was immediately removed from office spaces. Items plugged incorrectly, were plugged into proper power sources. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be affected by this practice. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Plant Operations Director conducted a whole house audit to ensure that no non-PCREE were plugged into power strips in patient care vicinity that did not meet regulation. All management staff educated on	07/31/2023

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	equipment and removed both strips during observation. Findings were discussed with the Director of Plant Operations and Executive Director at exit conference. 3.1-19(b)		K 920 Electrical Equipment and standards on power strip and other electronics properly plugged into for safety and proper use within patient care vicinities and offices. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Operations Director/designee will conduct audit (5) times a week for (6) months to ensure power strips in patient care vicinity and electrics in office space are correctly being utilized if applicable. Plants Operations Director/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.	