STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00365463, IN00368065, IN00370383, IN00371058, and IN00371683. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00365463 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689, F759, and F9999. Complaint IN00368065 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00370383 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F684, and F712. Complaint IN00371058 - Substantiated. Federal/State deficiencies related to the allegations are cited at F600, F684, and F689. Complaint IN00371683 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: January 24, 25, and 26, 2022 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 130 SNF: 26 Total: 156 Census Payor Type: Medicare: 39	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Medicaid: 85 Other: 32 Total: 156 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/31/22.			
F 0600 SS=D Bldg. 00	483.12(a)(1) Free from Abuse and Neglect §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; Based on observation, record review, and interview, the facility failed to ensure residents were free from neglect, related to not answering call lights in a timely manner and meeting a resident's needs upon answering the call light for 2 of 16 residents reviewed for abuse and neglect. (Residents G and F) Findings include: 1. The following was observed on 1/24/22: At 5:32 a.m., Resident G's call light was on. LPN	F 0600	F600 1:1 Regarding residents G & F both residents were assessed for injuries. No injuries were noted. 1:2: Unit Managers/designee completed a whole house observation/interview with the residents to ensure their needs were met timely & no concerns were voiced related to abuse/neglect. Any deficiencies	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	4 was in the hallway by the Medication Cart. He indicated there was there was a CNA scheduled for the hallway and the CNA was also assigned to another hallway (census of nine residents on the other hallway). At 5:42 a.m., Resident G's call light remained activated. At 5:56 a.m. the call light remained activated. At 6 a.m., the call light remained activated. LPN 4 was sitting at the desk at the Nurses' Station. At 6:03 a.m., Resident G was interviewed and indicated she had her call light on since 3:30 a.m. A staff member had been in her room and shut the call light off without helping her and she reactivated the call light. She was unable to state what time this occurred. She indicated she was uncomfortable and needed help with repositioning in the bed. She was observed to be lying with her head over to the the right side of the bed and her feet to the left. The head of the bed was elevated and she was not lying in straight alignment. She stated, "I am very uncomfortable" and was "hopeful" someone from the day shift would help her. At 6:07 a.m., LPN 4 remained at the Nurses' Desk. Resident G's call light remained on. At 6:08 a.m., LPN 4 indicated the resident required two staff for bed mobility. He then entered room 222 and the call light was shut off, he exited the room and repeated that the resident required two staff for bed mobility. At 6:10 a.m., the Resident G reactivated her call light.		were reported if applicable at that time. 1:3: Director of Nursing /designee re-in-serviced the nursing staff on the Abuse Prevention Program as well as the expectations of the staff when answering resident call lights & meeting the resident's needs. Unit Manager/designee will observe/interview (5) five residents per unit per week to ensure their call lights are answered timely/needs are met as well the residents being free of abuse & neglect for (6) six months. 1:4 The DON/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. 1:5 Systemic changes will be completed by 2-14-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

At 6:17 a.m., the call light remained activated.

At 6:22 a.m., the call light remained activated. LPN 4 again indicated the resident required two staff for care and he needed to find the CNA to help, though was unsure if the CNA was still in the facility. He indicated he would try to find the CNA. He then entered the other hallway.

At 6:25 a.m., the call light remained activated and neither LPN 4 nor the CNA had returned to the hallway.

At 6:36 a.m., Day Shift QMA 4 entered the resident's room, assisted the resident, and the call light was turned off.

At 6:42 a.m., Resident G indicated LPN 4 entered her room earlier, turned off the call light and informed her the Indiana Department of Health was in the building. She indicated QMA 4 had just repositioned her.

Resident G's record was reviewed on 1/25/22 at 2:30 p.m. The diagnoses included, but were not limited to, stroke.

The Quarterly Minimum Data Set assessment, dated 12/27/21, indicated no cognitive impairment and required extensive assistance of two for bed mobility.

A Care Plan, dated 2/21/20, indicated assistance was needed for Activity of Daily Living and extensive assistance of two for bed mobility was required.

2. Resident F's call light was observed on and not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	answered on 1/24/22 from 5:32 a.m. to 6:33 a.m. At 5:32 a.m., LPN 4 was standing in the hallway outside the residents room, by the Medication Cart. At 6 a.m. through 6:07 a.m., LPN 4 was sitting at the Nurses' Station. During an interview on 1/24/22 at 6:07 a.m., Resident F indicated he wanted to talk to the CNA. The call light was answered by Day Shift CNA 6 on 1/24/22 at 6:33 a.m. Resident F's record was reviewed on 1/25/22 3:40 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set assessment, dated 12/8/21, indicated a severely impaired cognitive status. A facility policy, titled, "Abuse Prevention Program", dated March 2021 and received from the Director of Nursing as current, indicated the residents have a right to be free from abuse and neglect. Neglect was the failure to provide goods and services to a resident. This Federal tag relates to Complaints IN00370383 and IN00371058. 3.1-27(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	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 interview, the facility failed to ensure treatments and care were provided in accordance with professional standards of practice, related to non-pressure and arterial wound care not completed as ordered by the physician for 2 of 16 residents reviewed for quality of care. (Residents D and E) Findings included: 1. During an observation on 1/24/22 at 7:49 a.m., Resident D had a dressing on her right forearm. The dressing was dated 1/18/22. During an observation on 1/25/22 at 11:36 a.m., the Wound Nurse indicated the dressing was used for a skin tear. She indicated the date on the dressing was 1/18/22. Resident D's record was reviewed on 1/25/22 at 9:49 a.m. The diagnoses included, but were not limited to, multiple myeloma. A Physician's Order, dated 1/14/22, indicated the right upper extremity skin tear was to be cleansed with normal saline, patted dry and covered with a collagen dressing (aid in healing) and a border gauze dressing was to be applied every two days. The Medication Administration Record (MAR),	F 0684	F684 1:1 Regarding residents D & E both residents were assessed. No adverse reactions were noted from not following the physician's orders. 1:2: The Unit Managers/designee completed a whole house audit/observation to ensure dressing changes were completed per the physician's orders. Any deficiencies were corrected at that time. 1:3: Director of Nursing /designee re-in-serviced the licensed staff on following physician's orders, proper documentation, timely dressing changes, & possible adverse reactions related to not following physician's orders. The Unit Manager/designee will observe (3) three resident's dressings per unit per week to ensure the physician's orders have been followed for (6) six months. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) six	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	dated 1/2022, was marked with initials that indicated the dressing had been changed 1/20/22, 1/22/22, and 1/24/22. 2) Resident E was observed on 1/24/22 at 6:10 a.m. He was lying in bed. The right lower extremity was uncovered and there was a dressing on the right shin with a date of 1/21/22. The resident indicated the dressing was not changed daily and the areas on his leg were stasis ulcers (caused by poor circulation) During an observation on 1/25/22 at 11 a.m., the dressing to the right shin had been removed. LPN 5 indicated he had a shower and the dressing was taken off. The Wound Nurse indicated the dressing was to be changed daily. Resident E's record was reviewed on 1/26/22 at 9:16 a.m. The diagnoses included, but were not limited to, Parkinson's disease and peripheral vascular disease. A Quarterly Minimum Data Set assessment, dated 1/5/22, indicated a severely impaired cognitive status. A Care Plan, dated 10/12/21, indicated there was impaired skin integrity. The interventions included the treatment would be competed as ordered by the Physician. A Physician's Order, dated 1/15/22, indicated the right shin area was to be cleaned with wound cleaner, patted dry, and covered with xeroform gauze (keep wound moist) and a border dressing daily. The MAR, dated 2022, was marked with initials that indicated the dressing had been changed on		months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 2-14-22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1/22/22, 1/23/22, 1/24/22, and 1/25/22. This Federal tag relates to Complaints IN00370383 and IN00371058. 3.1-37			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident 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, interview, and record review, the facility failed to ensure adequate supervision was provided to a resident during a transfer, related to a resident who required 2 assistance and a mechanical lift for transfers being transferred by 1 staff member, for 1 of 4 residents reviewed for supervision/ accidents. (Resident L) Finding includes: On 1/24/22 at 5:40 a.m., CNA 3 was observed transferring Resident L in a mechanical lift by herself. The resident was transferred from the bed to his Broda chair (high back/reclining chair). Interview with CNA 3 at the time of the transfer, indicated the resident was contracted and light to lift, so she "felt comfortable" transferring him with the mechanical lift by herself.	F 0689	F689 1:1 Resident L was assessed for injuries. No injuries were noted. 1:2: The Executive Director re-in-serviced C.N.A. #3 on the proper technique while transferring residents via the full body mechanical lift & the -to-stand mechanical lift. Director of Nursing /designee re-in-serviced the nursing staff on the proper technique to transfer a resident while utilizing the full body mechanical lift as well as the -to-stand mechanical lift. 1:3: Director of Nursing /designee re-in-serviced the nursing staff on the proper technique to transfer a	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Resident L's record was reviewed on 1/24/22 at 11:00 a.m. Diagnoses included, but were not limited to, seizures and intellectual disability. The Quarterly Minimum Data Set assessment, dated 10/21/22, indicated the resident was an extensive two person assist with transfers. A Care Plan, updated on 12/14/21, indicated assistance was needed for activities of daily living. The interventions included two staff members and a mechanical lift was required for transfers. Interview with the Executive Director on 1/24/22 at 11:30 a.m., indicated it was her expectation for the staff to use two staff members when a mechanical lift was used. The Indiana Department of Health, "Core Curriculum for Nurse Aide Training", dated July 1998, indicated to have at least one co-worker assist when using a mechanical lift. This Federal tag related to Complaints IN00365463 and IN00371058. 3.1-45(a)(2)		resident while utilizing the full body mechanical lift as well as the -to-stand mechanical lift. Unit Manager/designee will observe (3) three resident transfers per unit per week to ensure nursing staff are properly transferring the residents via the full body mechanical lift as well as the -to-stand mechanical lift for (6) six months. 1:4 The DON/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. 1:5 Systemic changes will be completed by 2-14-22	
F 0712 SS=D Bldg. 00	483.30(c)(1)-(4) Physician Visits-Frequency/Timeliness/Alt NPP §483.30(c) Frequency of physician visits §483.30(c)(1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. §483.30(c)(2) A physician visit is considered			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	timely if it occurs not later than 10 days after the date the visit was required. §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. Based on record review and interview, the facility failed to ensure a resident was seen by a Physician or Nurse Practitioner at least every 60 days, for 1 of 3 residents reviewed for Physician's visits. (Resident C) Finding includes: During an interview on 1/24/22 at 9:11 a.m., Resident C indicated he had not seen a Physician or a Nurse Practitioner since May of 2021. Resident C's record was reviewed on 1/24/22 at 9:41 a.m. The diagnoses included, but were not limited to, peripheral vascular disease. A Quarterly Minimum Data Set assessment, dated 12/17/21, indicated there were no short or long term memory problems. A Physician's Progress Note, dated 7/10/21, indicated the the Physician had a face to face visit with the resident. There were no other Physician/ Nurse	F 0712	F712 1:1 Regarding resident C the Physician assessed this resident on 1/25/22. New orders obtained. 1:2: Manager of Medical Records/designee reviewed the medical record for residents to ensure Physician visits were timely & up to date. notification was made at that time to ensure compliance and all visits are up to date at this time. 1:3: Executive Director/designee re-in-serviced the Physicians, Manager of Medical Records, & DNS regarding timely physician visits. The Manager of Medical Records will audit (5) five resident medical records per unit per week for (6) months to ensure compliance.	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Practitioner Progress Notes located in the record. During an interview on 1/25/22 at 8:33 a.m., the Executive Director indicated the last Physician's Progress Note found in the record was 7/10/21. This Federal tag relates to Complaint IN00370383. 3.1-22(d)(1)		1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) months. The QAPI committee will monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 2-14-22	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure the medication error rate was less than 5% for 2 of 7 residents observed during medication pass. Two errors were observed during 25 opportunities for errors during medication administration. This resulted in a medication error rate of 8.0%. (Residents N and M) Findings include: 1. On 1/25/22 at 9:56 a.m., QMA 3 was observed preparing medications for Resident N. The QMA indicated Cardizem (a medication for high blood pressure) was missing from her cart,	F 0759	F759 FREE OF MEDICATION ERROR 1:1 Regarding resident N the physician was notified. No new orders obtained. Regarding resident M the physician was notified. No new orders obtained. 1:2: The Director of Nursing/designee audited current resident medication administration records. No deficiencies were noted at that time.	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and she would have to call other nursing staff to search in the Emergency Drug Kit (EDK). LPN 3 delivered 1 Cardizem 120 milligram (mg) extended-release capsule and QMA 3 prepared and administered the medication to Resident N. The record for Resident N was reviewed on 1/25/22 at 11:15 a.m. The current Physician's Order Summary (POS) indicated the resident was to receive Cardizem tablet extended release 24-hour, 240 mg one time a day. Interview with QMA 3 on 1/25/22 at 11:45 a.m., indicated the Medication Administration Record (MAR) indicated to give one tablet and there was not a dosage for the Cardizem on the MAR. Interview with LPN 3 on 1/25/22 at 12:13 p.m., indicated she clarified orders with the doctor and the resident should have received 240 mg of Cardizem once a day. LPN 3 rewrote the order to reflect the correct dosage of 240 mg per day. 2. On 1/25/22 at 12:03 p.m., QMA 2 was observed preparing the medications for Resident M. She prepared two tablets of Acetaminophen 325 mg, crushed the tablets and place them in applesauce for the resident to take by mouth. The record for Resident M was reviewed on 1/25/22 at 1:00 p.m. The Physician's Order indicated the resident was to receive Acetaminophen 325 mg, 2 tablets by mouth every 8 hours for pain. The medication was scheduled to be given at 6:00 a.m., 2:00 p.m., and 10:00 p.m. Interview with QMA 2 on 1/25/22 at 2:14 p.m., indicated she was unaware she had given the medication an hour too early.		1:3: The Director of Nursing/designee re-in-serviced the licensed nurses and QMAs on administering medications as ordered, physician notification, documentation, and following physician orders. The Director of Nursing Services/designee re-in-serviced the Nurse Managers regarding the Drug Regimen Review process which will be completed on new admissions & re-admissions at the clinical meeting on the next business day. The Director of Nursing/designee will audit the new admission/re-admissions Drug Regimen Review weekly for (6) six months to ensure compliance. The Director of Nursing/designee will complete a medication administration pass with a licensed nurse/QMA (3) three times a week for (6) months to ensure medications are being administered per order. 1:4 The 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A facility policy, dated 4/2019, titled, "Administering Medications", received from the Director of Nursing as current, indicated medications were to be administered within one hour of their prescribed time. This Federal tag relates to Complaint IN00365463. 3.1-48(c)(1)		continued compliance. 1:5 Systemic changes will be completed by 2-14-22	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented to properly prevent and or contain COVID-19 related to eye protection not worn or worn correctly, masks not worn correctly, and hand hygiene for 7 of 9 resident hallways in the facility (Halls 1A, 2A, 2B, 2C, 3A, 3B, and 3D). The facility also failed to ensure infection prevention was in place for a resident with a urinary catheter, related to the catheter bag was on the floor, for 1 of 1 residents observed for infection control with a urinary catheter. (Resident G) Findings include: 1) The following was observed on 1/24/22: At 5:26 a.m. on the 1A Hall, CNA 8 was wearing a surgical mask and was not wearing eye protection. She indicated she was not scheduled on the Yellow Zone (quarantine due to possible COVID-19 exposure) or the Red Zone (positive for COVID-19) and the eye protection was not needed. At 5:32 a.m. on Hall 2A, LPN 4 was wearing a surgical mask. He was not wearing eye protection. He indicated he was not working the COVID-19 Unit, and was not required to wear the eye protection. At 5:34 a.m. on Hall 2B, CNA 5 had a surgical mask on with an N95 mask over it. The N95 was not sealed to the face. Eye protection was not	F 0880	Quality Improvement Initiative (Intervention and Improvement Plan) Tool p paraid="924862384" paraeid="{abbe49d2-8109-4153-8fa4-e5aae431ab95}{170}" >QII ID: Directed Plan of Correction: Infection Prevention and Control p paraid="1604476934" paraeid="{abbe49d2-8109-4153-8fa4-e5aae431ab95}{205}" >Email information to: kdawson@qsource.org (Kara Dawson) p paraid="904677936" paraeid="{abbe49d2-8109-4153-8fa4-e5aae431ab95}{231}" >Provider Contact: Kara Dawson	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	worn. She indicated she only had to wear eye protection in the Yellow and Red Zones. At 5:46 a.m. on Hall 2C, RN 3 was assisting a resident in the hallway. The surgical mask she was wearing was below her nose and she was not wearing eye protection. At 6:32 a.m., Dietary Aide 2 delivered the breakfast trays to Hall 2A. There were residents in the hallway between the elevator and the dining room. She was not wearing eye protection. At 6:33 a.m., CNA 6 entered Hall 2A, the surgical mask was below her nose and she was not wearing eye protection. She entered a resident's room to answer a call light. At 6:38 a.m., Dietary Aide 3 was in the hallway outside of the 2A dining room. She wore a KN95 mask with no eye protection on. She indicated she was aware she was to be wearing eye protection, but had forgotten her face shield. At 6:40 a.m., CNA 6 continued to not have eye protection on while working on Hall 2A. At 7:30 a.m., QMA 4 was working on Hall 2A. She was wearing an N95 mask over a surgical mask. The N95 was not sealed on the face. At 8:31 a.m., CNA 6 was picking up breakfast trays from resident rooms on Hall 2A, the surgical mask continued to fall below her nose and eye protection continued to not be worn. During an observation on 1/25/22 at 9:50 a.m., CNA 9 was making a resident's bed on Hall 3D. The resident was sitting in the wheelchair in the room. The CNA's eye protection was on top of		p paraid="1786194681" paraeid="{abbe49d2-8109-4153-8fa4-e5aae431ab95}{248}" >Phone: 317-628-1145 p paraid="1906986419" paraeid="{0bd0a1cf-5053-4a3f-b31c-90ec3cef97bd}{9}" >Title: Quality Improvement Advisor / Infection Preventionist Consultant p paraid="1250136676" paraeid="{0bd0a1cf-5053-4a3f-b31c-90ec3cef97bd}{24}" >Email: kdawson@qsource.org p paraid="2101136509" paraeid="{0bd0a1cf-5053-4a3f-b31c-90ec3cef97bd}{40}" >Department:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	her head and not covering her eyes. CNA 9 indicated the eye protection fogged up. During an observation on the Red Unit (Hall 3B) on 1/26/22 at 11:15 a.m., CNA 7 was wearing a surgical mask under her N95 mask. The N95 was not sealed on the face. 2) The following was observed on the third floor on 1/24/22: At 5:20 a.m., LPN 2 was observed on Hallway 3A with a surgical mask on and without eye protection. At 5:24 a.m., LPN 2 enter Room 310 with his medication. She was not wearing eye protection and she was within inches of the resident's face to explain to him about his antibiotic medication that he was about to receive. Interview with the LPN at that time, indicated she was unaware that she needed to wear eye protection and thought only if you worked in the COVID unit, you needed to wear a face shield. At 5:30 a.m., RN 2 and CNA 2 were observed without any eye protection on the 3D Hallway. There was a resident who had sat in his wheelchair within 6 feet and visited with them. At 5:35 a.m., CNA 2 was observed to enter Room 395, without eye protection. She had donned gloves and applied lotion to the resident's hands. Interview with RN 2 and CNA 2 on 1/24/22 at 5:37 a.m., indicated eye protection was only needed if working the COVID Unit. At 5:40 a.m. on 3D Hall, CNA 3 transferred Resident L with a mechanical lift from his bed to		p paraid="372996606" paraeid="{0bd0a1cf-5053-4a3f-b31c-90ec3cef97bd}{57}" >Fax: Instructions for Section I: Writing an Aim Statement It is necessary for your facility to have a clear Aim Statement when you identify an opportunity for improvement, either based on your discovery or information provided to you. It is important that you establish a measurable objective, which we refer to as Aims or Goals. The Aims/Goals are what you want to accomplish during a quality improvement initiative. This should be clearly stated, quantifiable, and represent a challenge for your facility. An example of an Aim Statement is: “Increase the number of staff appropriately washing hands per infection prevention protocol by ___% by _____ (date).” p paraid="16972176" paraeid="{0bd0a1cf-5053-4a3f-b31c-90ec3cef97bd}{119}" >Quality	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	his Broda chair (high back/reclining chair). She lacked eye protection. Interview at that time indicated she was unaware she needed eye protection. The Green Stop Sign on the doorway to the 3D hall, indicated a surgical mask, eye protection, and gloves were to be worn in all zones. At 5:45 am, CNA 10 was observed without eye protection while in the hallway of the 3C Hall. Interview with her at that time, indicated that she was unaware she needed to wear eye protection. A facility policy, dated 12/2021, titled, "COVID-19 PPE (personal protective equipment) Guidance", received from the Executive Director as current, indicated eye protection was required when within six feet of a resident/providing care when in the Green and Yellow Zone. Eye protection must be worn at all times when in the Red Zone. Frequent hand hygiene was to be completed. A Professional Resource Web Site at "www.CDC.gov", titled, "How to Use Your N95 Respirator", indicated the mask must form a seal to the face to work properly. 3) The following was observed on 1/24/22: At 6:03 a.m., Resident G was lying in bed. The urinary catheter bag was on the floor on the left side of the bed. The urine in the tubing was a dark yellow. At 6:08 a.m., LPN 4 had entered and exited the room. The urinary catheter bag remained on the floor.		Improvement Initiative ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="1" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Aim Statement: Staff will adhere to the facilities infection control policies and procedures as it relates to eye protection in resident care areas, proper/appropriate PPE utilization at a compliance rate of 80% 31, 2022. ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Provider Name: St. Anthony Home Provider #: 155214	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	At 6:36 a.m., QMA 4 entered the room to answer the call light and exited. The urinary catheter bag remained on the floor At 6:42 a.m., the urinary catheter bag remained on the floor. At 8:34 a.m., the urinary catheter bag remained on the floor. A facility policy, dated 2014, titled, "Catheter Care, Urinary", received from the Executive Director as current, indicated for infection control, the catheter tubing and drainage bag were to be kept off the floor.4) On 1/25/22 at 9:23 a.m., QMA 3 was observed preparing medications to administer to a resident. She pulled two gloves from her pocket and donned them without sanitizing her hands first. She walked down the hall to find a gown, opened an isolation cart, removed a plastic bag from the drawer and placed it back inside the drawer with the same gloved hands. She then walked to another isolation cart further down the hallway, opened the drawer with the same gloved hands and reached in to grab a gown. She donned the gown with the same gloved hands and entered a resident room. Interview with QMA 3 on 1/25/22 at 9:30 a.m., indicated she was aware hand hygiene should have been performed prior to donning gloves and PPE should not be worn while walking through hallways. 3.1-18(b)		ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="3" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Identify improvement team members: (include name and title) Cathy Wood – Administrator Falon Wendel – Director of Nursing Cheryl Young – Infection Preventionist Nick White – Regional Nurse Consultant Do you have a physician champion(s)? ¿ Yes ¿ No Name(s): Dr. William Bisset Who is the lead team member? Cathy Wood	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="4" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Provide a description of the root cause of the concern(s) identified: Problem Statement: Facility failed to ensure staff were wearing appropriate PPE related to eye protection while in resident care areas Staff failed to ensure that they had proper eye at all times when in resident care areas Lack of knowledge and/or adherence to the facilities policies and procedures related to the use of eye protection Need for re-education and increased monitoring related to eye protection and the facilities policies and procedures. Problem Statement: Staff wearing masks below their nose and wearing surgical masks under N95 mask.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Staff wearing face masks under their nose and wearing surgical masks under their N95 resulting in an improper seal for the N95 mask Lack of knowledge and/or adherence to the facilities policies and procedures related to appropriate utilization of face masks both surgical and N95 Need for re-education and increased monitoring related to the proper usage of face masks both surgical and N95 and review of facilities policy and procedure Problem Statement: Staff wearing PPE in hallways Staff wearing gloves in the hallway Lack of knowledge and/or adherence to the facilities policies and procedures around PPE utilization Need for re-education and increased monitoring related to PPE utilization ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="5" style="margin:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Describe in detail interventions you plan to implement to address the identified concern(s). You may attach any supporting documents, including revised procedures, monitoring process, approval process, evaluation process, etc. Based on a review of recent infection control deficiencies on complaint surveys and corrective action that are being implemented with the plan of correction the following interventions were identified as opportunities to ensure that all systems continued to remain in place and are being followed according to the facilities policies and Project Plan Perform a Root Cause Analysis and develop/implement needed solutions/system changes to address findings within the RCA 11, 2022	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			In-services PPE Appropriate utilization of PPE (masks, eye protection, gloves) Review of proper PPE donning and doffing PPE Usage – what is required in different areas and how to properly wear PPE Monitoring Tools to be ensure infection control practices are being followed Appropriate PPE Utilization to include proper face masks, eye protection and gloves five times a week for 6 weeks then monthly until end of project Facility will implement this monitoring on a routine quarterly basis Quarterly monitoring will be random and will cover all shifts Completed audits will be presented and reviewed in routine QAPI meetings Review of Deficient Survey elements to ensure compliance in all areas - conducted by QIO/Infection Preventionist	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			Consultant – to be scheduled Resources from QIO on an ongoing basis throughout the project time period. ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="6" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Specify start date of interventions, projected date of completion and key interim implementation dates, if there are multiple steps to full implementation. Start Date – February 11, 2022 End Date - August 31, 2022 ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="7" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" List date(s) that improvement implementation will be evaluated. Midway Check Point 2022 Final Check and Wrap Up – August 2022 ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="8" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" Describe in detail how you will check progress: (include your plan for interim monitoring of cases) Touch base meetings – onsite Initial to be scheduled – February/March 2022 As needed and/or requested throughout the project February 28, 2021 March 28, 2021 Evaluation of processes during midway check point	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="9" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type: upper-roman;" If needed, indicate when alternative measures would be instituted: (trigger or projected timeline) Alternative measures will be instituted immediately if indicated by non-compliance Need for alternative measures would be evaluated through completed audits on a monthly basis ol class="NumberListStyle5 SCXW205249511 BCX8" role="list" start="10" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text; list-style-type:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			upper-roman;" Describe actions you will implement if original corrective measures are ineffective: Will meet with project team to discuss and perform an additional RCA Start performance improvement plan according to results of RCA p paraid="1217213586" paraeid="{b4aa15e4-ace5-40fe-b512-cc9b951db4fd}{70}" >Your final report should include answers to the following questions: (This will be reviewed during final meeting) Did you achieve your stated goal? (Please include a brief description of where you were and where you are now after QII conclusion) ol class="NumberListStyle1 SCXW205249511 BCX8"	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			role="list" start="2" style="margin: 0px; padding: 0px; user-select: text; -webkit-user-drag: none; -webkit-tap-highlight-color: transparent; overflow: visible; cursor: text;" Would you consider the improvement project you just completed a success? If “yes”, please explain why. If “no”, please explain and/or provide any barriers that may have prevented you from achieving the level of success you envisioned at the start. Did your experience lead to changes in the current protocols? p paraid="1740462302" paraeid="{b4aa15e4-ace5-40fe-b512-cc9b951db4fd}{137}" > Do you have any new protocols related to this improvement project that you are willing to share with others?	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 9999 Bldg. 00	3.1-14 PERSONNEL (j) Medication shall be administered by licensed nursing personnel or qualified medication aides. This State rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure QMA's (Qualified Medication Aides) received prior authorization from a Licensed Nurse before administering a PRN (as needed) medication, for 2 of 3 residents reviewed for prn medication administration by a QMA. (Residents Q & R) Finding includes: 1) Resident Q's record was reviewed on 1/26/22 at 1:30 p.m. Diagnoses included, but were not limited to, chronic kidney disease. A Physician's Order, dated 12/7/21, indicated Tylenol Extra Strength tablet 500 mg (milligrams), give one tablet every six hours as needed for pain. The Medication Administration Record (MAR), dated 1/2022, indicated QMA 5 administered the prn medication at 1:41 a.m. on 1/15/22 for a pain level of 10 out of 10. There was no documentation prior authorization had been received by a Licensed Nurse prior to the medication being administered.	F 9999	F9999: PERSONNEL 1:1: Regarding resident Q the physician was notified. No new orders obtained. Regarding resident R the physician was notified. No new orders obtained. 1:2: The Director of Nursing/Designee audited current PRN resident medication administration records in the past 30 days to ensure compliance. Physicians were notified of any deficiencies at that time. The Director of Nursing/designee re-in-serviced QMA 5 regarding administering PRN medications as ordered & obtaining a licensed nurse’s approval along with documentation prior to administration. 1:3: The Director of Nursing/designee re-in-serviced the Licensed staff & QMAs on administering PRN medications as ordered and obtaining a licensed nurse’s approval along with documentation prior to administration. The Nurse Manager/designee will	02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 00 B. WING	01/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAINT ANTHONY	203 FRANCISCAN DR CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	2) Resident R's record was reviewed on 1/26/22 at 1:49 p.m. The diagnoses included, but were not limited to Parkinson's disease. A Physician's Order, dated 10/29/19, indicated gavilax (laxative) 17 grams could be given every 24 hours as needed for constipation. The MAR, dated 1/2022, indicated the gavilax was administered by QMA 6 on 1/8/22 at 9:05 a.m. There was no documentation prior authorization had been received by a Licensed Nurse prior to the medication being administered. During an interview on 1/26/22 at 3:32 p.m., the Director of Nursing indicated there was no documentation that indicated prior authorization for the prn's was obtained by the QMA's. The "Indiana State QMA Scope of Practice", indicated PRN medications were only to be administered if authorization was obtained from the facility's licensed nurse on duty or on call. If the authorization was obtained, the QMA was to ensure the resident's record was cosigned by the licensed nurse who gave permission by the end of the nurse's shift. This state finding relates to Complaint IN00365463.		audit (3) resident's medication administration records per unit per week to ensure the QMA received approval from a licensed nurse prior to administering a PRN medication. 1:4 The DON/designee will report audit findings to the QAPI committee monthly for (6) six months. The QAPI committee will monitor the data presented for any & determine if further monitoring/action is necessary for continued compliance. 1:5 Systemic changes will be completed by 2-14-22	