STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
		155214	B. WI	NG	_	11/16/	2016
				CTD FET	ADDRESS CITY STATE ZIR CODE	Ь	
NAME OF F	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
OT ANTL	IONY HOME - CRO	NAMI DOINT			ANCISCAN DR N POINT, IN 46307		
STAINT	IONT HOWE - CRO	JWN FOINT		CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIES		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	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
			F 00	000	St. Anthony Home - Crown Po		
	This visit was fo	or a Recertification and			("the provider") submits this Pl	an	
	State Licensure	Survey			of Correction ("POC) in		
	State Elections	201 Vey.			accordance with specific	all	
	C 1.4 3	January 1 0 10 14 16			regulatory requirements. It sh not be construed as an admiss		
	_	November 7, 9, 10, 14, 16,			of any alleged deficiency cited		
	and 17, 2016.				The Provider submits this PO		
					with the intention that it be		
	Facility number	: 000120			inadmissible by any third party	/ in	
	Provider numbe	r: 155214			any civil or criminal action aga		
	AIM number: 1	00274780			the Provider or any employee,	,	
		.002/4/00			agent, officer, director, or		
					shareholder of the Provider. T		
	Census bed type	· ·			Provider hereby reserves the I		
	SNF/NF: 147				to challenge the findings of thi		
	SNF: 20				survey if at any time the Provid	der	
	NCC: 3				determines that the disputed finding: (1) are relied upon to		
	Total: 170				adversely influence or serve a	6.2	
	10001. 170				basis, in any way, the selectio		
	Comaria marram tra	70.0			and/or imposition of future		
	Census payor ty	pe.			remedies, whether such remedies	dies	
	Medicare: 27				are imposed by the Centers fo		
	Medicaid: 105				Medicare and Medicaid Service	es	
	Other: 38				("CMS"), the state of Indiana of		
	Total: 170				any other entity; or (2) to serve		
					any way, to facilitate or promo		
	These deficience	ies reflect State findings			action by any third party again	st	
					the Provider. Any changes to		
		nce with 410 IAC			Provider policy or procedures should be considered to be		
	16.2-3.1.				subsequent remedial measure	76	
					as that concept is employed in		
	Quality review of	completed by 32883 on			Rule 407 of the Federal Rules		
	11/21/16.	-			Evidence and should be		
					inadmissible in any proceeding	g on	
					that basis.		

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

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	DING	00	COMPL	ETED
		155214	B. WING			11/16/	2016
				TDEET AL	DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	ROVIDER OR SUPPLIE	R			NCISCAN DR		
OT ANTL	IONY HOME - CRO	NAN BOINT			I POINT, IN 46307		
	IONT HOWL - CIN	3WW 1 OIN 1			11 0111, 111 40307		
(X4) ID		STATEMENT OF DEFICIENCIES		D	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	NCY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	T	AG	DEFICIENCY)		DATE
F 0279 SS=D Bldg. 00	PLANS A facility must use assessment to de the resident's con The facility must of care plan for each measurable object meet a resident's mental and psychidentified in the constitution of the care plan must that are to be furnithe resident's high mental, and psychiat would otherw §483.25 but are resident's exercise including the right §483.10(b)(4). Based on record the facility failed had a comprehenal resident receivemedication for 1	e the results of the evelop, review and revise aprehensive plan of care. develop a comprehensive resident that includes exives and timetables to medical, nursing, and associal needs that are comprehensive assessment. st describe the services alshed to attain or maintain mest practicable physical, mosocial well-being as 183.25; and any services rise be required under not provided due to the e of rights under §483.10, at to refuse treatment under the review, and interview, do to ensure each resident ansive care plan related to ring a diuretic (water pill) and 16 residents whose the reviewed. (Resident	F 0279		1:1 Resident #47, the Nurse Manager assessed this reside for adverse reactions related to her diuretic use without any abnormal findings. A diuretic care plan was completed and placed in the chart. 1:2 Resident Assessment Director/Nurse Manager designee reviewed the current	o	12/09/2016

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STATEMENT OF DEFICIENCIES X3) DATE SURVEY X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 00 COMPLETED 155214 B. WING 11/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR ST ANTHONY HOME - CROWN POINT **CROWN POINT. IN 46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG residents care plans for inclusion Finding includes: of all areas pertinent to their plan of care with any deficiencies Resident #47's record was reviewed on corrected at that time. 11/14/16 at 11:24 a.m. Diagnoses 1:3 The Resident Assessment included, but were not limited to, heart Director in-serviced the care plan team regarding diuretic care failure and hypertension (high blood plans. The Resident pressure). Director/Designee will audit five (5) records of care plans for inclusion of all areas pertinent to The Quarterly Minimum Data Set (MDS) their plan of care on each unit assessment completed on 8/3/16 weekly for twelve (12) weeks, indicated the resident had received a then monthly for six (6) diuretic medication. months utilizing audit tool entitled Resident Assessment Director Audit Tool (enclosed The November 2016 Physician Order attachment #1), for a diuretic care Sheet indicated an order for plan that is complete and hydrochlorothiazide (diuretic, treats high accurate. blood pressure and fluid retention) 25 mg 1:4 The Resident Assessment Director/Designee will report audit (milligrams) every day. findings to QAPI Committee monthly for nine (9) months The record lacked any indication a care beginning December 2016. The plan for the diuretic medication with QAPI Committee will monitor data presented for any trends and interventions to monitor side effects of determine if further auditing is the medication was in place. warranted. 1:5 Systemic changes will be Interview with Unit Manager #1 on completed by 12-9-16 11/15/16 at 11:15 a.m., indicated she was unable to find a diuretic care plan for Resident #47. The medication was usually addressed under the dietary care plan, but had not been addressed there either. 3.1-35(a)

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CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLETED	
		155214	B. W	ING		11/16/2016	
NAME OF	PROVIDER OR SUPPLIEI	?		STREET.	ADDRESS, CITY, STATE, ZIP CODE		
					RANCISCAN DR		
ST ANT	HONY HOME - CRO	DWN POINT		CROW	'N POINT, IN 46307		
(X4) ID		TATEMENT OF DEFICIENCIES		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	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	—
F 0282 SS=D Bldg. 00	CARE PLAN The services prover facility must be propersons in accord written plan of car Based on observer interview, the fast services in accord written plan of control dialysis access and supplements not 2 of 16 residents were reviewed. Findings included 1. On 11/10/16 #18 was observer resident had a barright shoulder. Supplements and a barright shoulder. Supplements had a barright shoulder had a barright shoulder. Supplements had a barright shoulder. Supplements had a barright shoulder had a barright shoulder. Supplements had a barright shoulder had a barright shoulder had a barright should be barri	vation, record review and acility failed to provide rdance with a resident's care related to lack of aite monitoring, post aents, and dietary a provided as ordered for s whose plans of care (Residents #18 and #65) e: at 3:00 p.m., Resident and added to the front of her she identified the s a dialysis access site. Sicated the nurses in the sometimes" check her perfore and after her	F 02	282	1:1 Resident #18, the Nurse Manager assessed the dialysis access site without abnormal findings. New orders were obtained from the Physician in accordance with the Facility pron proper care and monitoring post dialysis. Resident #65's meal ticket was updated to include the supplements and other dietary interventions to prevent weight loss and was given the supplement when noticed missing. 1:2 Nurse Managers reviewed and found no other residents currently receiving dialysis services at this time. All residmeal tickets were reviewed for accuracy and completeness a no other deficiencies were fou 1:3 Director of Nursing/design in-serviced the licensed staff regarding the Arterial/Venous Fistula Dialysis Catheter policy which includes requirements for dialysis site monitoring and post dialysis assessments.	dent or and und. nee	

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8:47 a.m. Diagnoses included, but were

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Director of Dining

Services/designee in-serviced the

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING AND PLAN OF CORRECTION 00 COMPLETED 155214 B. WING 11/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR ST ANTHONY HOME - CROWN POINT **CROWN POINT. IN 46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG dietary staff on review of tray not limited to, hypertension (high blood cards during meal service to pressure) and end stage renal disease. ensure supplements and super foods are served as ordered by A Care Plan indicated the resident had the physician. potential for complications related to Director of Nursing/designee will audit all dialysis records weekly dialysis. An intervention included to for twelve (12) weeks and then monitor the dialysis access port for signs monthly of six (6) months utilizing and symptoms of infection. audit tool entitled Nursing/Unit Manger Audit Tool (enclosed attachment #2) to ensure the The November 2016 Physician Order policy and procedure for dialysis Sheet (POS) indicated an order for access site monitoring and post dialysis treatments three times a week. dialysis assessments are completed. Director of Nursing/designee will The record lacked any indication the complete random rounds/audits dialysis access site was being monitored on five (5) staff members on all or post dialysis assessments were being shifts weekly for twelve completed whenever the resident returned (12) weeks and then monthly of six (6) months utilizing audit tool from dialysis. entitled Nursing/Unit Manger Audit Tool (enclosed attachment Interview with Unit Manager #1 on #2) to ensure the staff member is 11/16/16 at 11:00 a.m., indicated the following the residents plan of care. nurses were supposed to check the access Director of Dining site for any bleeding or signs of infection Services/designee will audit 5 diet every shift and also to complete vitals orders each week for twelve (12) when the resident returned from dialysis weeks and then monthly for six (6) months against meal tickets and and then document the assessments. She trays served utilizing audit tool was unable to find any documentation the entitled Director of Dining assessments were being completed. She Services Audit Tool (enclosed

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indicated the order to do the assessments

had been discontinued a while ago but it

2. On 11/15/16 at 12:29 p.m., Resident

#65 was observed sitting in a wheelchair

should not have been.

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attachment #3), to ensure accuracy and completeness.

and Director of Dining Services/designee will report

audit finding to the QAPI Committee monthly for nine (9)

1:4 Director of Nursing/designee

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPLE	ETED
		155214	B. W	ING		11/16/2	2016
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ANCISCAN DR		
ST ANTH	HONY HOME - CRO	OWN POINT			N POINT, IN 46307		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		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 APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	in his room. A l	unch tray was delivered			months beginning December		
	to the resident by	y Unit Manager #2. The			2016. The QAPI Committee w		
	tray included no	odles, chicken, zucchini,			monitoring data presented for trends and determine if	any	
	a glass of milk a	and a cup of coffee. The			further auditing is warranted. 1:5 Systemic changes will be		
	_	ude mashed potatoes,					
	pudding, or a sh				completed by 12-9-16		
	pudding, or a sin	uno.					
	On 11/15/16 -4 1	12:40 n m a CN14					
		12:49 p.m., a CNA was					
	1	ng the resident's tray from					
		om. The tray did not					
	1	hed potatoes, pudding or					
	a shake and the	meal ticket did not have					
	listed any supple	ements the resident was					
	supposed to rece	eive.					
	The resident's re	ecord was reviewed on					
	11/15/16 at 11:2	4 a.m.					
	record review or	n 11/15/16 at 11:24 a.m.					
		ded, but were not limited					
	1	hyperlipidemia, atrial					
	fibrillation and a						
		ilixiety.					
	A Care Plan ind	icated the resident had a					
		appetite, meal intakes					
		I had a weight loss.					
		cluded to provide dietary					
		-					
	supplements at r	iicais.					
	The November 2016 POS indicated						
	orders for dietary supplements which included:						
	- Suner-Mached	Potatoes with lunch and					
	dinner	1 omioes with function and					

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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 COMPI 11/16.	LETED			
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE		
	- Fresh Benefits dinner - Mighty Shake	pudding with lunch and with all meals						
	RN #1 indicated had his dietary s tray and dietary putting the suppl Nursing was res	the resident should have upplements on the lunch was responsible for lements on the tray. ponsible to make sure the d the dietary supplements						
	Cook #1 indicate resident was sup dietary supplement	115/16 at 12:54 p.m., with ed she was unaware the pose to receive any ents and if residents were applements it would be et.						
	Dietary Tech #1 unaware the resi listed the supple supposed to rece and ticket system the day before an	indicated she was dent's ticket did not have ments which he was eive. A new diet order in had been put into place and his supplements must d being added to the						
	the Dietary Serv they had switche	215/16 at 3:05 p.m. with ice Manager indicated and menu systems the day esident's ticket was not						

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MI	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	00	COMPL	ETED
		155214	B. WI	NG		11/16/	2016
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F 0000	reviewed all residuals an isolated in resident found has missing from the 3.1-35(g)(2)	supplements. He had dents' tickets and this neident with no other aving supplements meal tickets.					
F 0309 SS=D Bldg. 00	must provide the riservices to attain of practicable physical psychosocial well-the comprehensive care.	BEING st receive and the facility necessary care and or maintain the highest al, mental, and being, in accordance with e assessment and plan of					
	interview, the face each resident recutreatment and set of dialysis access post dialysis asset for 1 of 1 resider of the 2 residents dialysis. (Reside Finding includes On 11/10/16 at 3 was observed lyihad a bandage to		F 03	309	1:1 Resident #18, the Nurse Manager assessed the dialysis access site without abnormal findings. New orders were obtained from the Physician in accordance with the Facility poon proper care and monitoring post dialysis. 1:2 Nurse Managers reviewed and found no other residents currently receiving dialysis services at this time. 1:3 Director of Nursing/designe in-serviced the licensed staff regarding the Arterial/Venous Fistula Dialysis Catheter policy which includes requirements for dialysis site monitoring and podialysis assessments. Director of Nursing/designee were received assessments.	ee or st	12/09/2016

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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 11/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 203 FRANCISCAN DR ST ANTHONY HOME - CROWN POINT **CROWN POINT. IN 46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG audit all dialysis records weekly area as a dialysis access site. The for twelve (12) and then monthly resident indicated the nurses in the for six (6) months utilizing audit facility would "sometimes" check her tool entitled Nursing/Unit blood pressure before and after her Manager Audit Tool (enclosed attachment #2), to ensure the dialysis appointments. policy and procedure for dialysis access site monitoring and post The record was reviewed on 11/16/16 at dialysis assessments are 8:47 a.m. Diagnoses included, but were completed. 1:4 Director of Nursing/designee not limited to, hypertension (high blood will report audit findings to the pressure) and end stage renal disease. QAPI Committee monthly for nine (9) months beginning December The Quarterly Minimum Data Set (MDS) 2016. The QAPI Committee will assessment completed on 8/31/16 monitor data presented for any trends and determine if any indicated the resident had a Brief further auditing is warranted. Interview of Mental Status (BIMS) score 1:5 Systemic changes will be of 15, and was cognitively intact. The completed by 12-9-16 resident had received dialysis treatments. A Care Plan indicated the resident had potential for complications related to dialysis. An intervention included to monitor the dialysis access port for signs and symptoms of infection. The November 2016 Physician Order Sheet (POS) indicated an order for dialysis treatments three times a week. The record lacked any indication the dialysis access site was being monitored or post dialysis assessments were being completed when the resident returned from dialysis.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214			JILDING	NSTRUCTION 00	(X3) DATE COMPL 11/16/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE	
	nurses were supposite for any bleed every shift and a when the resider and then docume was unable to fir assessments were indicated the ord had been discont should not have A facility policy Fistula Dialysis as current from the 11/16/16 indicated Nursing Actions dialysis assessments assessments were indicated the ord had been discont should not have A facility policy Fistula Dialysis as current from the 11/16/16 indicated Nursing Actions dialysis assessments were upon return to far documented in the Signs" "b. Cableeding. c. Dress fistula is dry and venous access should not have stethoscope" "stethoscope" "stethoscope.	Unit Manager #1 on 0 a.m., indicated the cosed to check the access ding or signs of infection also to complete vitals at returned from dialysis ent the assessments. She and any documentation the debeing completed. She are to do the assessments are inued awhile ago but it been. It titled, "Arterial/Venous Catheter", and received the Administrator on ed, "Procedure: 1. The following ents are to be performed acility after dialysis and the Nurses' Notes: a. Vital atheter site is free of sing over perma cath or a intact. d. Arterial / the assessed with a meaning the form of the contact of the every shift assess the						

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CENTERS FOR	R MEDICARE & MEDIC	_			OMB NO. 0938-0391
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155214	B. WING		11/16/2016
	PROVIDER OR SUPPLIER		203 FR	ADDRESS, CITY, STATE, ZIP CODE RANCISCAN DR IN POINT, IN 46307	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	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)	DATE
F 0325	483.25(i)	, , , , , , , , , , , , , , , , , , ,			
SS=D	\	ITION STATUS UNLESS			
Bldg. 00	UNAVOIDABLE				
Blug. 00		ent's comprehensive			
		acility must ensure that a			
	resident -	•			
	(1) Maintains acce	eptable parameters of			
	nutritional status,	such as body weight and			
	protein levels, unle	ess the resident's clinical			
		trates that this is not			
	possible; and				
	(2) Receives a the a nutritional proble	erapeutic diet when there is em.			
	Based on observ	ation, record review and	F 0325	1:1 Resident #65's meal ticket	t 12/09/2016
	interview, the fa	cility failed to provide		was updated to include the	
		ents at meal service as		supplements and other dietary	
				interventions to prevent weigh	it
		hysician for 1 of 4		loss and was given the	
		ed for nutrition of the 10		supplement when noticed to b missing.	,e
	who met the crit	eria for nutrition.		1:2 All resident meal tickets w	ere
	(Resident #65)			reviewed for accuracy and completeness and no other	
	Finding includes	X.		deficiencies were found nor supplements missing.	
	On 11/15/16 at 1	2:29 p.m., Resident #65		1:3 Director of Dining	
		ting in a wheelchair in		Services/designee in-serviced	the
		· ·		dietary staff on review of tray	
		ch tray was delivered to		cards during meal service to	
	the resident by U	Jnit Manager #2. The		ensure all supplements are served as ordered by the	
	tray included no	odles, chicken, zucchini,		physician.	
	a glass of milk a	nd a cup of coffee. The		Director of Dining	
	_	ide mashed potatoes,		Service/designee will audit five	e (5)
	pudding, or a sha	•		diet orders each week for twel	• •
	pudding, or a sile	urc.		(12) weeks and then monthly	
		- 40		six (6) months against meal	
		2:49 p.m., a CNA was		tickets and trays served utilizing	ng
	observed carryin	g the resident's tray from		audit tool entitled Director of	
	the resident's roo	om. The tray did not		Dining Services Audit Tool	
		hed potatoes, pudding or		(enclosed attachment #3), to	
	include any mas.	nea pointoes, padding of	1	ensure accuracy and	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214 A. BUILDING B. WING OO 11/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL OO PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETED 11/16/2016 STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307 (X5) PREFIX OO COMPLETED 11/16/2016	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY		
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME - CROWN POINT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICE BY AND	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	00	COMPL	ETED
ST ANTHONY HOME - CROWN POINT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION			155214	B. W	ING		11/16/	/2016
ST ANTHONY HOME - CROWN POINT (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (COMPLETION COMPLETION)	NAME OF I	PROVIDER OR SUPPLIE	ER	•				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION								
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION	ST ANTE	HONY HOME - CR	OWN POINT		CROW	N POINT, IN 46307		
CROSS-REFERENCED TO THE APPROPRIATE	1							
TAC DECULATORY OF LOCADENTERANC DECOMPATION TAC DESCRETO						(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	
TAG REGULATORY OR ESCIEDENTIAL TANGENT ORNINGTON TAGES OF THE DATE	TAG	+	<u> </u>	+	TAG			DATE
ordered								
supposed to receive. 1:4 Director of Dining		supposed to rec	ceive.					
Services/designee will report								
The resident's record was reviewed on audit finding to QAPI Committee monthly for nine (9) months						_	iee	
beginning December 2016. The							he	
record review on 11/15/16 at 11:24 a.m. QAPI Committee will monitor data						QAPI Committee will monitor		
Diagnoses included, but were not limited presented for any trends and		_						
to hypertension, hyperlipidemia, atrial determine if any further auditing is warranted.						-	ng is	
fibrillation and anxiety. warranted. 1:5 Systemic changes will be		fibrillation and	anxiety.					
completed by 12-9-16						, ,		
A Care Plan indicated the resident had a								
history of poor appetite, meal intakes								
were varied, and had a weight loss.		•	•					
Interventions included to provide dietary		Interventions in	ncluded to provide dietary					
supplements at meals.		supplements at	meals.					
A Nutrition Assessment completed on		A Nutrition As	sessment completed on					
10/7/16 indicated a recommendation to			*					
add enhanced foods to provide adequate								
calories and protein. The assessment			• •					
indicated to add Fresh Benefits pudding		_						
at lunch and dinner, Fresh Benefits cereal			1 0					
at breakfast, and Fresh Benefits mashed			-					
potatoes at lunch and dinner. Adequate		· · · · · · · · · · · · · · · · · · ·						
with meals to promote stable weight and		-	_					
enhance texture tolerance.		_	_					
The November 2016 POS indicated		The November	2016 POS indicated					
orders for dietary supplements which								
included:								
- Super-Mashed Potatoes with lunch and		Super Macha	d Dotatoes with lunch and					
dinner		_	a i otatoes with fullell and					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214		(X2) MULT A. BUILD B. WING		NSTRUCTION 00	(X3) DATE (COMPL 11/16/	ETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	
	- Fresh Benefits dinner - Mighty Shake	pudding with lunch and with all meals						
	RN #1 indicated had his dietary so tray and dietary putting the suppl Nursing was resp	15/16 at 12:50 p.m. with the resident should have upplements on the lunch was responsible for ements on the tray. Donsible to make sure the I the dietary supplements						
	Cook #1 indicate resident was sup dietary supplement	15/16 at 12:54 p.m., with ed she was unaware the pose to receive any ents and if residents were applements it would be et.						
	Dietary Tech #1 unaware the residence is the supplementary supposed to recease and ticket system the day before an	15/16 at 1:10 p.m. with indicated she was dent's ticket did not have ments which he was ive. A new diet order in had been put into place and his supplements must dibeing added to the						
	the Dietary Servithey had switche	15/16 at 3:05 p.m. with ice Manager indicated d menu systems the day sident's ticket was not						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		ILDING	00	COMPL	
		155214	B. WI	NG		11/16/	2016
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F 0332 SS=D Bldg. 00	reviewed all resi- was an isolated i resident found ha missing from the 3.1-46(a)(1) 3.1-46(a)(2) 483.25(m)(1) FREE OF MEDICA OF 5% OR MORE The facility must e medication error ra- greater.	ATION ERROR RATES	F 03	332	1:1 Resident #121 and Reside	nt	12/09/2016
	interview, the face medication error 2 of 7 residents of medication pass errors in medicate during 26 opport medication admit in a medication of (Residents #121). Findings include 1. During a mediobservation on 1	cility failed to ensure a rate of less than 5% for observed during 5 observations. Three cions were observed unities for errors in nistration. This resulted error rate of 11.5 %. and #207)			#207 were both assessed by the Nurse without any abnormal findings. The Physicians for buresidents were made aware of medication errors and gave orders to change the times of the medication administration. 1:2 Nurse Manager in-serviced the License Nurse on the medication administration time policy. No other residents were affected at that time. 1:3 Director of Nursing/designed in-serviced the Licensed Staff Qualified Medication Assistant regarding the Medication Administration Time policy and procedure. Director of Nursing/designee were affected at the policy and procedure.	oth the the ee and s	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155214		` ′	UILDING	onstruction 00	(X3) DATE : COMPL 11/16/	ETED	
	PROVIDER OR SUPPLIER		<u>, </u>	203 FR	ADDRESS, CITY, STATE, ZIP CODE ANCISCAN DR N POINT, IN 46307	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	included in the a cevimeline hcl (t (milligrams). The administered artistic resident's eyes as have to wait a little administered the medication. At a returned to Reside administer her of drops administer 1 drop to each eye. Resident #121's 11/14/16 at 4:44 included, but we syndrome (autoin combines dry eye hypertension. The November 2 Sheet (POS) included to give 1 times daily at 6:0 p.m.), and ceviments.	medication that was dministration was reats dry mouth) 30 mg he LPN #1 had also ficial tears drops into the hid indicated she would the bit before she resident's other eye drop 4:29 p.m., LPN #1 hent #121's room to ther eye drops. The eye hed were Restasis 0.05% record was reviewed on p.m. Diagnoses re not limited to, sicca mmune disease that hes and dry mouth) and 1016 Physician Order huded orders for Restasis hdrop to both eyes two ho a.m. and 18:00 (6:00 heline hcl 30 mg to give 1 hes daily at 9:00 a.m., and			complete a random medication pass with two (2) Licensed State or Qualified Medication Assist weekly for twelve (12) weeks amonthly for six (6) months utilizing audit too entitled Nursing/Unit Manager Audit T (enclosed attachment #2), to ensure accurate medication administration times. 1:4 Director of Nursing/design will report medication pass findings to the QAPI Committe monthly for nine (9) months beginning December 2016. T QAPI Committee will monitor presented for any trends and determine if further monitoring/action is warranted 1:5 Systemic changes will be completed by 12-9-16.	aff ants and ool ee he data	
	2. During a med observation on 1 LPN #1 prepared	lication administration 1/14/16 at 4:13 p.m., I Resident #207's administered the					

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		COMPLETED			
1		155214	B. WING			11/16/2016		
NAME OF I	PROVIDER OR SUPPLIER	3	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE	•		
					ANCISCAN DR			
ST ANTHONY HOME - CROWN POINT				CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	RRECTIVE ACTION SHOULD BE		
PREFIX TAG		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	COMPLETION DATE	
TAG	medications to the resident. A			TAU			DATE	
	medication that was included in the administration was levetiracetam (for							
	seizures) 1000 mg give in the evening.							
	Resident #207's	record was reviewed on						
		p.m. Diagnoses						
		ere not limited to,						
	· ·	-						
	epilepsy and hypertension.							
	The November 2016 POS included an							
	order for levetiracetam 1000 mg to give							
	two times daily at 6:00 a.m. and 18:00.							
	Interview with LPN #1 on 11/14/16 at							
	4:51 p.m., indicated the resident's eye							
	drops were not s	supposed to be given until						
	at least 5:00 p.m	and she had given them						
	too early. The cevimeline hcl medication							
	was not scheduled to be given until 9:00							
	p.m. and she mu	st have looked at the						
	order time wrong and should not have							
	given the medication at that time.							
	Interview with U	Jnit Manager #3 on						
	11/14/16 at 5:00	p.m., indicated the nurse						
	was allowed to g	give the medications one						
	hour before or one hour after the							
	medications were supposed to be							
	administered. LPN #1 had administered							
	the medications too early and should have waited until at least 5:00 p.m. to administer them. The medication that was not supposed to be administered							

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED		
155214		B. WING 11/16/2016			2016			
NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME - CROWN POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307					
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OF T	(X5) COMPLETION		
F 0364 SS=E Bldg. 00	until 9:00 p.m. was also given too early and the nurse just looked at the medication strip which said to administer in the evening, but should have checked the administration time in the computer. 3.1-25(b)(9) 3.1-48(c)(1) 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, interview, and record review, the facility failed to serve food at the proper temperature. This had the potential to affect 6 of the 10 residents who received food from 1A Dining Room. (1A Dining Room) Findings include: During an observation on 11/7/16 at 12:04 p.m., Dining Assist #6 obtained temperatures for the following foods on the steam table in the 1A Dining Room: - mashed potatoes: 136 degrees Fahrenheit			TAG	DEFICIENCY)		DATE	
			F 0.	364	1:1 Residents in the 1A Dining Room were not noted to have adverse consequences resulting from the incorrect food temperatures. 1:2 No other residents were known to be affected by improfood temperatures. 1:3 Director of Dining Services in-serviced the Dining Assistar and other Dining staff regarding the policy and procedure for ensuring proper food temperatures before serving. Director of Dining Services/Designee will complet three (3) random dining room audits each week for twelve (1) weeks and monthly for six (6)	per s nt ng	12/09/2016	

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING <u>00</u>		00	COMPLETED		
155214		155214				11/16/2	2016	
NAME OF B	AND CAMPED ON CAMPAGE			STREET A	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
NAME OF PROVIDER OR SUPPLIER				203 FR	ANCISCAN DR			
ST ANTHONY HOME - CROWN POINT			CROWN POINT, IN 46307					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG		(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE	
TAG				TAG	months utilizing Director of Dir	ning	DATE	
	- ground sausage	e. 130 degrees			Services Audit Tool (enclosed	-		
	Fahrenheit - green beans: 101.5 degrees Fahrenheit Interview with Dietary Assistant #6 and Dietary Assist #7 at 12:10 p.m. on				attachment #3), to ensure prop			
					food temperatures.			
					1:4 Director of Dining Services/designee will report			
					audit findings to the QAPI			
		•			Committee monthly for nine (9))		
		ed the food temperatures			months beginning December			
	were at the proper temperature to be				2016. The QAPI Committee we monitor the data presented for			
	served.				any trends and to determine if			
	A + 12.17 m m +1	hanna mlataa yyyana gamyad ta			further monitoring is warranted			
	At 12:17 p.m., three plates were served to residents with ground sausage, mashed potatoes and green beans.				1:5 Systemic changes will be			
					completed by 12-9-16			
	At 12:33 p.m., three room trays which							
	contained mashed potatoes and green beans were sent to residents.							
	Scaris were sent	to residents.						
	Interview with Dining Service Assistant (DSA) #1 on 11/7/16 at 12:42 p.m.							
	indicated all foo	d served should be at						
	least 165 degree	s Fahrenheit and Dietary						
	Assistant #6 sho	ould not have served the						
	food, but instead should have sent it back to the kitchen.							
	_	cy tilted, "The 12						
	Fundamental Rules of Food Safety,"							
	provided by the Dietary Manager on							
	11/7/16 at 12:45 p.m. This policy stated, "Following the 12 fundamental rules of food safety will ensure our operations maintain an environment that protects food through the entire flow of food							
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME - CROWN POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 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)		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	process. Rule 1: Never Time/Temperature rules hot food above 141 degrees. temperature logs throug of food process to ensur abuse does not occur' 3.1-21(a)(2)	e. Always keep rees and cold Maintain h the entire flow te temperature							

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