| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155214 | A. BUILDING _____ B. WING _____ | C 07/17/2024 |

| 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 000 | INITIAL COMMENTS<br><br>This visit was for the Investigation of Complaints IN00437126, IN00437267, IN00438344, and IN00438487.<br><br>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the Investigation of Complaint IN00431905 completed on May 20, 2024.<br><br>Complaint IN00437126 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00437267 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00438344 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00438487 - No deficiencies related to the allegations are cited.<br><br>Complaint IN00431905 - Corrected.<br><br>Survey dates: July 17 and 18, 2024<br><br>Facility number: 000120<br>Provider number: 155214<br>AIM number: 100274780<br><br>Census Bed Type:<br>SNF/NF: 149<br>SNF: 31<br>NCC: 3<br>Total: 183<br><br>Census Payor Type: | F 000 | | |

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 |
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| **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 000 | Continued From page 1<br>Medicare: 24<br>Medicaid: 106<br>Other: 53<br>Total: 183<br><br>Saint Anthony was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the Investigation of Complaints IN00437126, IN00437267, IN00438344, and IN00438487.<br><br>Quality review completed on 7/19/24. | F 000 | | |