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	01/16/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00446754, IN00449509, IN00449543, IN00449574, IN00450162, and IN00450279. Complaint IN00446754 - No deficiencies related to the allegations are cited. Complaint IN00449509 - Federal/State deficiencies related to the allegations are cited at F732. Complaint IN00449543 - Federal/State deficiencies related to the allegations are cited at F557 and F689. Complaint IN00449574 - Federal/State deficiencies related to the allegations are cited at F557 and F689. Complaint IN00450162 - Federal/State deficiencies related to the allegations are cited at F732. Complaint IN00450279 - No deficiencies related to the allegations are cited. Survey dates: January 13, 14, 15, and 16, 2025 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 142 SNF: 25 NF: 3 Total: 170 Census Payor Type:	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jami	Moore	01/31/2025

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

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	Medicare: 13 Medicaid: 110 Other: 47 Total: 170 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/21/25.			
F 0557 SS=E Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property Based on record review and interview, the facility failed to ensure residents on the Memory Care Unit were treated with respect and dignity, related to a staff member yelling and using foul language in the hallway where residents could hear the staff member. This had the potential to affect all the residents on the Memory Care Unit. (Terminated Employee 1 and Resident G). The deficient practice was corrected on 12/16/24, prior to the start of the survey, and was therefore past noncompliance. Finding includes: A facility initiated staff to resident incident reported to the Indiana Department of Health (IDOH), dated 12/6/24, was reviewed on 1/15/25 at 1:03 p.m. The incident indicated an altercation between Terminated Employee 1 and Resident G. Review of the facility's finished investigation of the incident, dated 12/11/24, indicated staff to resident abuse had not occurred. Terminated Employee 1 was immediately placed on administrative leave and was instructed to leave the building. She admitted to using some profanity in front of the residents.	F 0557	Past noncompliance: no plan of correction required.	01/31/2025

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	A typed statement from the ED, dated 12/6/24 at 9 p.m., indicated CNA 2 indicated Resident G had grabbed Terminated Employee 1's hair. CNA 2 and RN 1 assisted and and separated the resident from Terminated Employee 1. Terminated Employee 1 was upset and called RN 1 a, "f****** b****" when RN 1 instructed her to leave the facility. A typed statement from the ED, dated 12/6/24 at 9 p.m., indicated RN 1 and CNA 2 assisted Terminated Employee 1 with freeing the grasp Resident G had on her hair. Terminated Employee 1 called RN 1 a "f****** b****" when she was instructed to leave the facility. The ED and Administrator were contacted immediately. A typed statement from the Administrator and Executive Director (ED), dated 12/9/24, indicated Terminated Employee 1 indicated during the incident with Resident G the employee began to yell out profanity due to the pain of the resident pulling her hair. She stated, "get this b**** off of me". The co-workers assisted with the resident and the employee's hair was released. Terminated Employee 1 then indicated she was yelling at RN 1, "f*** you b****" because she was upset about the incident. During an interview on 1/15/25 at 2:18 p.m., RN 1 indicated Terminated Employee 1 was not violent with the resident and the altercation was a reaction from the CNA and not purposeful harm. Terminated Employee 1 had refused to leave the unit/facility when instructed to do so and was yelling foul language and calling her a "b****", and saying "f*** you as she was walking down the hallway. There were residents in the hallway and the common area when this occurred and could hear Terminated Employee 1 using the foul			

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	language. She indicated the incident occurred on the Memory Care Unit and the residents on the unit have diagnoses of Alzheimer's disease and/or dementia. The deficient practice was corrected by 12/16/24 after the facility implemented a systemic plan that included the following actions: staff were interviewed, head to toe assessments were completed on all the residents with severely impaired cognitive status on Memory Care Unit with no negative findings, all residents who had a moderate to intact cognitive status on the units Terminated CNA 1 had worked in the past 30 days were interviewed to determine if there were concerns. There were no negative findings. All staff members were educated on abuse prevention/policy and reporting abuse. The background checks for all CNA's were audited and validated they were completed with no outstanding background check. Weekly audits have been and continue to be completed for abuse concerns of five random residents are to be completed until it is deemed compliant in the QAPI (quality assurance and performance improvement) meeting. Weekly audits have been and continue to be completed of five random staff members in regards to how they respond to aggressive dementia residents and the abuse policy until deemed compliant in the QAPI meeting reviews. All grievances were reviewed fro the last 30 days to identify trends and no trends were found. Resident G has psychosocial follow up assessments with no concerns or change of behavior. This citation relates to Complaints IN00449543 and IN00449574. 3.1-3(t)			

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F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, interview, and record review, the facility failed to ensure care-planned interventions to prevent injuries due to a fall were in place, related to a non-slip pad not on the wheelchair pad when the resident was sitting in the wheelchair and a mat not placed on the floor next to the bed when the resident was lying in bed, for 1 of 3 residents reviewed for falls and fall interventions. (Resident D) Finding includes: Resident D was observed on 1/14/25 at 9 a.m., 10:05 a.m. and 11:31 a.m., sitting by herself in the wheelchair in her room. During an observation on 1/14/25 at 11:35 a.m., QMA 3 and CNA 4 assisted the resident from the wheelchair to the bed. The resident was assisted to stand from the wheelchair. A non-slip pad was not under the resident in the wheelchair. During an interview at the time of the observation, QMA 3 and CNA 4 indicated they were unsure if a non-slip pad was to be on the wheelchair pad and both indicated it was not on the wheelchair. The resident was assisted in a lying position on the bed and incontinence care was completed. She was positioned for comfort in bed and CNA 4 indicated the resident would be assisted up in the wheelchair before lunch. QMA 3 and CNA 4 left the room. The floor mat was not placed on the floor next to the resident's bed and was left leaning against the wall in the room. During an interview on 1/14/25 at 12:26 p.m., CNA 4 indicated the staff have care cards available with the interventions to be used to prevent falls and	F 0689	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** Interventions for Resident D were put into place. Family and physicians were notified. Physicians gave no new orders. Resident is in stable condition and experienced no negative outcomes as a result of this observation. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of resident fall interventions to ensure interventions are in place. Whole house audit of C.N.A. care cards to ensure current fall interventions are listed for each resident. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Nursing staff educated on importance of ensuring fall interventions are in place appropriately before, during, and after care as it applies. Nurse manager educated on updating care cards timely to ensure floor staff has current interventions. Facility leadership team educated	01/31/2025

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	other care information. Review of the care card with CNA 4 indicated a non-slip pad was to placed on the wheelchair. The floor mat next to the bed was not on the care card. CNA 4 indicated the care cards were not always kept up to date. Resident D's record was reviewed on 1/14/25 at 10:15 a.m. The diagnoses included, but were not limited to, dementia and repeated falls. A Quarterly Minimum Data Set assessment, dated 12/24/24, indicated a moderately impaired cognitive status and a past fall. A Care Plan, dated 2/10/20, indicated a risk for falls and a history of falls. The interventions included on 11/5/24, a non-slip pad would be applied to the seat of the wheelchair and on 3/15/20, a mat was to placed on the floor next to the bed. This citation relates to Complaints IN00449543 and IN00449574. 3.1-45(a)(2)		on walking round policy and procedures that included ensuring fall interventions are in place. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will conduct random observation of fall interventions of (5) residents (5) times a week for (6) months. 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.	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing information was up-to-date and current. THis had the potential to affect all residents in the facility. Finding includes: The Nurse Staffing Information was posted on the desk by the front door of the facility and was observed on 1/13/25 at 9:13 a.m. The information	F 0732	**The corrective actions that were accomplished for those residents to have been affected by the practice are:** No resident was directly affected by this deficiency. **How other residents of the facility were identified to potentially be affected by the practice are:** No resident was directly affected	01/31/2025

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	posted was dated 1/8/25. During an interview on 1/13/25 at 9:15 a.m., the Administrator indicated either the Scheduler or the Nursing Supervisor was responsible for posting the current Nurse Staffing Information daily. This citation relates to Complaints IN00449509 and IN00450162.		by this deficiency. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Scheduler, nurse managers, and reception staff were educated on this deficiency and the requirements for compliance related to deficiency. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** ED/designee will conduct daily audits (7) days a week for 6 months to ensure compliance with this deficiency. ED/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.	