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	10/09/2024

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 IN00441181, IN00441233, and IN00443996. Complaint IN00441181 - Federal/State deficiencies related to the allegations are cited at F692 and F757. Complaint IN00441233 - No deficiencies related to the allegations are cited. Complaint IN00443996 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: October 8 and 9, 2024 Facility number: 000120 Provider number: 155214 AIM number: 100274780 Census Bed Type: SNF/NF: 157 SNF: 13 NCC: 3 Total: 173 Census Payor Type: Medicare: 17 Medicaid: 112 Other: 44 Total: 173 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/15/24.	F 0000		

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

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.

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	10/09/2024

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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for a resident with a history of falls for 1 of 3 residents reviewed for accidents. (Resident D) Finding includes: On 10/8/24 at 2:05 p.m., Resident D's room was observed. There were no non-skid strips on her bathroom floor. The record for Resident D was reviewed on 10/8/24 at 11:15 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, hypertensive chronic kidney disease, type 2 diabetes mellitus, osteoarthritis, dementia, and repeated falls The Quarterly Minimum Data Set (MDS) assessment, dated 8/29/24, indicated the resident was severely cognitively impaired and required substantial assistance with activities of daily living. A Care Plan, updated 10/23/23, indicated the resident was at risk for falls. An intervention, dated 9/23/24, indicated non-skid strips were to be placed on the bathroom floor, near the toilet. An Indiana Department of Health reportable incident, dated 9/9/24, indicated new bruising was found under the resident's eye and on both arms. Staff reported the resident had behaviors of hitting/ punching/kicking walls, bumping into objects as she self-propelled in her wheelchair, and self-transferring without assistance.	F 0689	F 689 Free of Accidents Hazards/Supervision/Devices The corrective actions that were accomplished for those residents to have been affected by the practice are: Resident D non-skid strips were placed in bathroom. Nurse manager notified the family and physician. Physician 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: Nurse managers/designee completed whole house audit of resident fall interventions to ensure accuracy and placement. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: IPSD/designee educated nursing staff on ensuring fall interventions are in place. Nurse managers/designee audited care cards and care plans to ensure fall interventions were accurate. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:	10/23/2024

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	10/09/2024

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
	A Nurse's Note, dated 9/22/24 at 4:01 p.m., indicated the resident was propelling herself in her wheelchair on the unit, in and out of rooms, banging on exit door and yelling. A Fall IDT (interdisciplinary team) Note, dated 9/23/24 at 1:30 p.m., indicated the resident was found sitting on her bathroom floor, yelling for help, with her wheelchair nearby. The suggested new intervention was to place non-skid strips on the bathroom floor, near the toilet. A Nurse's Note, dated 10/6/2024 at 11:21 a.m., indicated the resident was observed propelling herself in her wheelchair to both exit locations, banging her hands on and kicking the doors. During an interview on 10/8/24 at 2:10 p.m., CNA 1 indicated she thought the resident had non-skid strips on her bathroom floor. After observing the bathroom, CNA 1 confirmed there were no non-skid strips on the floor. During an interview on 10/9/24 at 11:00 a.m., the Administrator indicated the non-skid strips were just placed on the resident's bathroom floor. A facility policy, titled "Fall Management," received as current from the facility on 10/9/24, stated, "...Fall risk will be assessed upon admission, quarterly and with significant change ... All falls will be discussed by the interdisciplinary team at the 1st IDT meeting after the fall to determine root cause and other interventions to prevent future falls ..." This citation relates to Complaint IN00443996. 3.1-45(a)		Nurse manager/designee will conduct random observation of fall interventions for (3) residents per unit (5) times a week for (6) months. 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.	

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	10/09/2024

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 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to ensure food consumption logs were completed for residents with a history of weight loss for 2 of 3 residents reviewed for nutrition. (Residents F and C) Findings include: 1. Record review for Resident F was completed on 10/8/24 at 2:34 p.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, hypertension, Cushing syndrome (body makes too much cortisol hormone), diabetes mellitus, and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact. The resident required partial assistance with eating. A Care Plan, dated 8/14/24, indicated the resident was at risk for complications and symptoms of hypoglycemia or hyperglycemia due to diabetes. An intervention included to document the resident's meal and snack intake. An IDT Risk Review, dated 10/3/24, indicated the resident's most recent weight on 10/3/24 was 203 pounds. The previous weight on 9/24/24 was 227 pounds. The resident's meal intakes had recently declined related to depression. The Task Meal Consumption Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals: - Breakfast on 9/11, 9/14, 9/15, 9/19, 9/20, 9/21,	F 0692	**F692 Nutrition- Food consumption** **The corrective actions that were accomplished for those residents to have been affected by the practice are:** Nurse managers notified families and physicians of deficiency. Nurse managers assessed residents C and F. Both residents observed to be 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:** DON completed whole house audit of residents who consume a PO diet with significant weight loss and their meal consumption documentation in the past 30 days. Facility unable to correct any missing documentation. All residents are in stable condition and experienced no negative outcomes as a result of this observation. Families and MD notified. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** DON/designee re-educated nursing staff educated on ensuring	10/23/2024

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	10/09/2024

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
	9/22, 9/23, 9/25, 9/26, 9/27, 9/29, 10/1, 10/3, 10/4, and 10/5/24. - Lunch on 9/15, 9/20, 9/21, 9/22, 9/25, 9/27, 9/29, 10/1, 10/3, 10/4, 10/5, and 10/7/24. - Dinner on 9/11, 9/13, 9/14, 9/16, 9/17, 9/18, 9/19, 9/20, 9/22, 9/24, 9/25, 9/26, 9/27, 9/28, 9/30, 10/1, 10/3, 10/4, 10/5, 10/6, and 10/7/24. During an interview on 10/9/24 at 2:46 p.m.., the Director of Nursing (DON) indicated she was unable to provide any documentation the resident's meal consumption logs were completed on the above dates. 2. On 10/9/24 at 12:28 p.m., Resident C was observed sitting up in her bed. A CNA was seated at the resident's bedside assisting her with eating lunch. The record for Resident C was reviewed on 10/8/24 at 3:45 p.m. Diagnoses included, but were not limited to Alzheimer's disease, chronic kidney disease, and coronary artery disease. The Quarterly Minimum Data Set (MDS) assessment, dated 9/23/24, indicated the resident was cognitively impaired and required substantial assistance with eating. A current Care Plan, updated 6/26/24, indicated the resident had potential nutritional risk related to her mechanically altered diet. An intervention indicated to document food and fluid intakes. The resident's weight on 9/18/24 was 170 and on 9/24/24 was 154. The food consumption task documentation, dated 9/10/24 through 10/8/24, indicated there was no meal consumption documented for the following days and meals: 9/10/24 breakfast and lunch		meal consumption documentation with each meal. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** DON/designee will audit daily (5) times per week of residents who have significant weight loss to ensure timely completion. 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.	

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	10/09/2024

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
	9/13/24 dinner 9/14/24 breakfast and lunch 9/15/24 breakfast and lunch 9/16/24 dinner 9/18/24 breakfast and lunch 9/20/24 breakfast and dinner 9/21/24 breakfast and dinner 9/22/24 dinner 9/27/24 dinner 9/29/24 breakfast and lunch 10/2/24 breakfast and lunch 10/5/24 dinner During an interview on 10/9/24 at 11:07 a.m., the Director of Nursing (DON) was made aware of the missing food consumption documentation and indicated she would look into it. No further information was provided. This citation relates to Complaint IN00441181. 3.1-46(a)(1) 3.1-46(a)(2)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to not monitoring the resident's pulse as ordered prior to administering a blood pressure medication for 1 of 3 residents reviewed for unnecessary medications. (Resident F) Finding includes: Record review for Resident F was completed on	F 0757	The corrective actions that were accomplished for those residents to have been affected by from the practice are: Nurse manager completed order clarification for resident F observed in this deficiency. Nurse manager notified the family and physicians of deficiency for resident F. This resident in stable condition and no adverse reactions noted. How other residents of the facility	10/23/2024

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	10/09/2024

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
	10/8/24 at 2:34 p.m. Diagnoses included, but were not limited to, atrial fibrillation, heart failure, hypertension, Cushing syndrome (body makes too much cortisol hormone), diabetes mellitus, and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact. The October 2024 Physician's Order Summary indicated an order for metoprolol succinate (treats high blood pressure) 100 mg (milligrams) one time a day. Hold the medication for heart rate less than 60. The September and October 2024 Medication Administration Records indicated the metoprolol succinate was administered at 7:00 a.m. on 9/3, 9/4, 9/7, 9/8, 9/15, 9/20, 9/28, 10/1, 10/4, 10/5, and 10/6/24. The record lacked any documentation the pulse was monitored prior to the medication being administered on the above dates. During an interview on 10/9/24 at 11:07 a.m., the Director of Nursing indicated she was unable to provide any documentation the pulse was monitored before the medication was administered on the above dates. This citation relates to Complaint IN00441181. 3.1-48(a)(3)		were identified to potentially be affected by the practice are: DON and Medical Director completed a whole house audit of all antihypertensive medication orders and updated parameters as clinically appropriate. Residents are in stable condition and experienced no negative outcomes as a result of this observation. The facility has taken the following measures to ensure that the problem has been corrected and will not recur by: IPSD/Designee educated nursing staff on documenting parameters as indicated per MD order for antihypertensive medications. Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are: Nurse manager will audit (3) residents per day per unit for (5) days for (6) months to ensure parameters are followed per MD order and documented. 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 continued compliance.	