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	06/17/2024

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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.73. Survey Date: 06/17/2024 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Emergency Preparedness survey, Saint Anthony was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 189 and had a census of 180 at the time of this survey. Quality Review completed on 06/21/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 06/17/2024 Facility Number: 000120 Provider Number: 155214 AIM Number: 100274780 At this Life Safety Code survey, Saint Anthony was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR	K 0000		

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

Jami Moore 07/03/2024

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 01 B. WING	06/17/2024

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
	Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This three story facility was determined to be of Type I (332) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and hard wired smoke detectors in the resident rooms with battery smoke detection in certain areas of the building. The facility has a capacity of 189 and had a census of 180 at the time of this survey. All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered. Quality Review completed on 06/21/24			
K 0211 SS=E Bldg. 01	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 18 means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. This deficient practice could affect approximately 10 staff and an unknown number of residents.	K 0211	**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Exit was clear of obstruction. **How other residents of the facility were identified to**	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
	Findings include: Based on an observation during a tour of the facility with the Facilities Director, Administrator and Executive Director on 06/17/24 between 11:51 a.m. and 3:12 p.m., the old Hospice Hall was observed to have excessive storage of window coverings which took up approximately half of the corridor. The boxes were located near the emergency exit door which further impeded egress outside. Based on interview at the time of observation, the Facilities Director acknowledged the storage in the hall and stated that they will be moved to another location so they would be outside of the corridor. The findings were reviewed with the Administrator, Facilities Director and Executive Director during the exit conference. 3.1-19(b)		**potentially be affected by the practice are:** Whole house audit of all exits to ensure exits are clear of obstruction. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Staff educated on ensuring that all exits, even those spaces that are not commonly used, are free from obstruction. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Director/Designee will audit (5) exits per day for (5) days a week for (6) months to ensure exits are free from obstruction. Plant Director/ 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.	
K 0300 SS=F Bldg. 01	NFPA 101 Protection - Other Protection - Other List in the REMARKS section any LSC Section 18.3 and 19.3 Protection requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
	should be included on Form CMS-2567. Based on record review, interview, and observation, the facility failed to ensure documentation for the preventative maintenance of 15 of 15 battery operated smoke alarms were complete. NFPA 101 in 4.6.12.3 states existing life safety features obvious to the public, if not required by the Code, shall be maintained. NFPA 72, 29.10 Maintenance and Tests. Fire-warning equipment shall be maintained and tested in accordance with the manufacturer's published instructions and per the requirements of Chapter 14. NFPA 72, 14.2.1.1.1 Inspection, testing, and maintenance programs shall satisfy the requirements of this Code and conform to the equipment manufacturer's published instructions. This deficient practice could affect all residents, staff, and visitors. Findings include: Based on record review with the Facilities Director on 06/17/24 between 08:48 a.m. and 11:49 a.m., battery smoke detector testing was available for review which had been conducted on a monthly basis. During a tour of the facility between 11:51 a.m. and 3:12 p.m., the battery smoke detector located in the Environmental Director's office indicated that weekly testing is required. Based on interview at the time of observation and record review, the Facilities Director indicated that the online maintenance program 'TELS' indicates that they need to be tested on a monthly basis, however he was unaware that the testing needed to be conducted weekly and acknowledged that the weekly testing has not been conducted. Findings were discussed with the Facilities Director, Executive Director and Administrator at exit conference.	K 0300	**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Battery operated smoke detectors were inspected. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of all battery-operated smoke detectors was complete. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Staff educated on ensuring battery operated smoke detectors preventive maintenance is conducted per manufacturers published instructions. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Director/Designee will provide weekly preventive maintenance to all battery operated smoke detectors per manufacturer published instructions for all installed devices until that device is removed. This process will be monitored and presented to the QAPI committee monthly for (6) months. The QAPI committee will	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
	3.1-19(b)		monitor the data presented for any trends & determine if further monitoring/action is necessary for continued compliance.	
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
	Based on observation and interview, the facility failed to ensure 1 of 1 200-hall soiled utility room was protected as a hazardous area with a self-closing door that would automatically latch into the frame. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation the Facilities Director, Administrator and Executive Director on 06/17/24 between 11:51 a.m. and 3:12 p.m., the 200-hall soiled utility (which contained barrels of trash and soiled linen) next to resident room 268 was equipped with self-closing door, but the door did not fully close and latch into the frame due to a malfunctioning latch. When closed, the door would stop approximately 2 inches from the crash plate on the door frame. Based on interview at the time of observation, the Facilities Director agreed that the door would not properly fully self-close and latch due to the latching hardware sticking and would have to be adjusted. This finding was reviewed with the Administrator, Executive Director and Facilities Director during the exit conference. 3.1-19(b)	K 0321	**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Door latch was repaired to ensure door properly closed during self-closing. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit of all self-closing doors properly latch upon closure. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Staff educated on ensuring the importance of ensuring self-closing doors latch upon closure. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Director/Designee will audit (5) self-closing doors per day for (5) days a week for (6) months to ensure exits are free from obstruction. Plant Director/ 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.	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical wiring's in the 100-Hall was protected. NFPA 70, 2011 Edition. Article 406.5 (F) Exposed Terminals, Receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect approximately 20 residents and staff. Findings include: Based on observation during a tour of the facility with the Facilities Director, Administrator and Executive Director on 06/17/24 between 11:51 a.m. and 3:12 p.m., above the drop ceiling of the smoke barrier near resident rooms 111/112, a junction box was located in the ceiling which had exposed wires due to no coverplate. Furthermore, the wire ends were taped up using what was observed to be masking tape. Based on interview at the time of observation, the Facilities Director confirmed the exposed wires and was unsure why there was not a cover for the junction box and would get the fixes started. This finding was reviewed with the Facilities Director, Administrator, and Executive Director at the exit conference. 3.1-19(b)	K 0511	**The corrective actions that were accomplished for those residents to have been affected by from the practice are:** Electrical wiring was properly secured. **How other residents of the facility were identified to potentially be affected by the practice are:** All residents have the potential to be effective by this deficiency. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Staff educated on ensuring that all electrical wiring be properly secured to ensure that wiring terminals are not exposed to contact. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Director/Designee will audit (5) areas that have junction box access per day for (5) days a week for (6) months to ensure	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
			wiring is properly secured. Plant Director/ 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.	
K 0920 SS=E Bldg. 01	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 Based on observation and interview, the facility failed to ensure 1 of 1 power strips were not used	K 0920	**The corrective actions that were accomplished for those**	07/03/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155214	A. BUILDING 01 B. WING	06/17/2024

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
	as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA-70/2011, 400.8 state unless specifically permitted in 400.7 flexible cords and cables shall not be used for (1) as a substitute for fixed wiring. This deficient practice could affect approximately 10 residents and staff. Findings include: Based on observation during a tour of the facility with the Facilities Director, Administrator and Executive Director on 06/17/24 between 11:51 a.m. and 3:12 p.m., a refrigerator (high power draw equipment) was plugged into and supplied power by a power strip in the Therapy Office. Based on interview at the time of observation, the Administrator confirmed that the fridge was plugged into the power strip and agreed that the high draw appliance should be plugged directly into the wall. Findings were discussed with the Facilities Director, Administrator and Executive Director at exit conference. 3.1-19(b)		**residents to have been affected by from the practice are:** Refrigerator was plugged into wall outlet, power strip was removed. **How other residents of the facility were identified to potentially be affected by the practice are:** Whole house audit to ensure that all high power draw equipment was plugged directly into a wall outlet. **The facility has taken the following measures to ensure that the problem has been corrected and will not recur by:** Staff educated on ensuring that no high power draw equipment is plugged into a power strip. **Quality Assurance plans and monitoring practices that have been implemented to make sure corrections are achieved and are permanent are:** Plant Director/Designee will audit (5) areas/offices per day for (5) days a week for (6) months to ensure exits are free from obstruction. Plant Director/ 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.	