

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/09/2024
NAME OF PROVIDER OR SUPPLIER Saint Anthony		STREET ADDRESS, CITY, STATE, ZIP CODE 203 Franciscan Dr Crown Point, IN 46307	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>43293</p> <p>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)</p> <p>Finding includes:</p> <p>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.</p> <p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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 .</p> <p>This citation relates to Complaint IN00443996.</p> <p>3.1-45(a)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664</p> <p>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)</p> <p>Findings include:</p> <p>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, [NAME] syndrome (body makes too much cortisol hormone), diabetes mellitus, and end stage renal disease.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact. The resident required partial assistance with eating.</p> <p>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.</p> <p>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.</p> <p>The Task Meal Consumption Logs were documented with percentage of meals eaten. The last 30 days lacked documentation for the following meals:</p> <ul style="list-style-type: none"> - Breakfast on 9/11, 9/14, 9/15, 9/19, 9/20, 9/21, 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. <p>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.</p> <p>32788</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Quarterly Minimum Data Set (MDS) assessment, dated 9/23/24, indicated the resident was cognitively impaired and required substantial assistance with eating.</p> <p>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.</p> <p>The resident's weight on 9/18/24 was 170 and on 9/24/24 was 154.</p> <p>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:</p> <p>9/10/24 breakfast and lunch</p> <p>9/13/24 dinner</p> <p>9/14/24 breakfast and lunch</p> <p>9/15/24 breakfast and lunch</p> <p>9/16/24 dinner</p> <p>9/18/24 breakfast and lunch</p> <p>9/20/24 breakfast and dinner</p> <p>9/21/24 breakfast and dinner</p> <p>9/22/24 dinner</p> <p>9/27/24 dinner</p> <p>9/29/24 breakfast and lunch</p> <p>10/2/24 breakfast and lunch</p> <p>10/5/24 dinner</p> <p>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.</p> <p>This citation relates to Complaint IN00441181.</p> <p>3.1-46(a)(1)</p> <p>3.1-46(a)(2)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32664</p> <p>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)</p> <p>Finding includes:</p> <p>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, [NAME] syndrome (body makes too much cortisol hormone), diabetes mellitus, and end stage renal disease.</p> <p>The Admission Minimum Data Set (MDS) assessment, dated 8/20/24, indicated the resident was cognitively intact.</p> <p>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.</p> <p>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.</p> <p>The record lacked any documentation the pulse was monitored prior to the medication being administered on the above dates.</p> <p>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.</p> <p>This citation relates to Complaint IN00441181.</p> <p>3.1-48(a)(3)</p>		