

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 04/08/2026
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)		
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based record review and interview, the facility failed to ensure professional standards of quality were maintained related to a nurse administering the incorrect medications to a resident, taking medications from a resident's pill card and attempting to administer to a different resident, and working under the influence of drugs for 1 of 1 resident reviewed for medication administration. (LPN 1 and Resident B)The deficient practice was corrected on 1/26/26, prior to the start of the survey, and was therefore past noncompliance. The facility identified the concern on 1/17/26. At that time, the nurse was suspended pending investigation and then her employment was terminated. On 1/26/26, all staff were provided with in-service education related to medication administration. The in-service included ensuring all nurses had access to Capsa (medication dispenser)/emergency drug kit (edk), education related to the five rights of medication administration, process for contacting pharmacy, cut off times for delivery, Capsa usage, ordering/reordering medications, and not borrowing medications.Finding includes:A Report of Concern form, indicated an incident occurred on 1/17/26 at 6:00 p.m. that was reported to the Director of Nursing Services by Resident B's family member. The description of the concern indicated the nurse smelled like weed, and the wrong medications were in the medicine cup being administered to Resident B. The Department Findings indicated the Executive Director (ED) came to the building when she was made aware of the concern. The nurse was pleasant and did not smell like marijuana. She did appear to be impaired. The nurse was sent home pending the investigation. The Follow Up/Resolution, indicated the nurse was suspended and provided education, and all medications were reviewed and a medication count was completed on the carts.The investigation indicated, At 9:30 p.m. on Saturday, January 17, the Director of Nursing Services (DNS) received a call from the building stating that there was a family looking for her threatening to call the police. DNS contacted the family per the request. Family indicated that the nurse assigned to their loved one appeared to be impaired. DNS spoke with both nurses on the unit and the nurse in question was removed from the unit for the remainder of the shift. The ED was notified and went to the building to observe the nurse. At that time, the nurse did not appear impaired. She did not smell like alcohol or any other substance. She stated that she had no issues or upset families during the shift. The ED spoke with both CNAs on the unit, the other nurse and two residents that were awake and alert and oriented. No one had any concern related to the condition of the nurse during the shift. There was nothing out of the ordinary that took place. Based on the assessment and staff interviews, the ED decided to place the nurse on leave pending the outcome of the investigation. The ED did not feel it would be appropriate to send the nurse for drug testing. Upon taking a statement from the family member that raised the concern, she stated that the nurse smelled like weed and attempted to give her grandmother the wrong medications. She had a picture of the medicine cup with a blue round pill with F5 on it. The resident did not take the medication. In speaking with the nurse, she stated that she did not give the wrong medications. She stated that this resident had orders for famotidine, so she pulled it from another resident. The pictured medication that she pulled was actually identified as finasteride 5 milligrams. Additionally, while the ED was speaking with the nurse, the nurse admitted to smoking marijuana before work. The nurse remains on leave until next steps can be reviewed with the team.The statements from LPN 1 indicated, 1/17/26 at 9:50 (continued on next page)		

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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>p.m.: No issues with new resident. It was a good shift. The family was here with her. They were nice. 1/18/26: I took the cup with her medications into the room. [strikethrough] The resident had requested something for her stomach. [strikethrough] Her meds weren't delivered yet. She had orders for famotidine but did not have any so I took some from the cart. The resident did not take the pills. The family was in the room and questioned what the pills were and took the cup. [strikethrough] I was not impaired. I did smoke weed before coming to work. [strikethrough] 1/19/26: I came in the room with the medication in the cup. The daughter questioned why I was giving her blue pills. I told her it was the famotidine for her GERD (gastroesophageal reflux disease). When asked where she found it, she stated she found it in the cart. Resident B's closed record was reviewed on 4/8/26 at 10:24 a.m. Diagnoses included, but were not limited to, gastroesophageal reflux disease without esophagitis (GERD). The Discharge Minimum Data Set assessment, dated 1/22/26, indicated the resident was cognitively intact. The January 2026 Physician's Order Summary indicated the resident received famotidine oral tablet, 20 milligrams, 1 tablet twice a day for GERD. There were no Physician's Orders for finasteride. The Care Plan, dated 1/22/26, indicated the resident had an alteration in gastrointestinal status related to gastroesophageal reflux disease (GERD). Interventions included, but were not limited to, administer medications as ordered. During an interview on 4/8/26 at 1:12 p.m., the Executive Director indicated Resident B's family had requested to talk to her. They had left a note at the desk saying the nurse smelled like marijuana and the same nurse had brought in a cup of pills to give the resident and the family had questioned what the blue pill was in the cup. The nurse said it was famotidine, but it was not. The family was upset that the nurse had brought in the wrong medication to the resident. The medication cart was searched, and it was determined to be Resident E's medication, finasteride. When the ED had arrived, the nurse did not seem to be impaired. It was the end of the shift for the nurse. The nurse was no longer employed at the facility after the incident occurred. The nurse also retracted her statement about smoking marijuana prior to her shift and then the nurse proceeded to say that she had never said that. The nurse never had any prior history or allegations against her in her file. After the incident, all nurses were in-serviced on medication administration. The FINASTERIDE - finasteride table, film coated drug label, from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=aa3fcd1a-02a1-49db-b40e-75e623d730e1&audien indicated, INDICATIONS AND USAGE. indicated for the treatment of symptomatic benign prostatic hyperplasia (BPH) in men with an enlarged prostate. 3 DOSAGE FORMS AND STRENGTHS, 5 mg blue colored, round, biconvex, film-coated tablets, marked F5 on one side and plain on other side. The FAMOTIDINE 20 MG - famotidine 20 mg tablet, coated drug label, from https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=5a66206b-35b1-4d86-8574-a1e45cb0772f, indicated, USES. relieves heartburn associated with acid indigestion and sour stomach, prevents heartburn associated with acid ingestion and sour stomach brought on by eating or drinking certain food and beverages. Product Information. Product Characteristics, Color White, Shape Round, Size 8 mm, Imprint Code 124. The Medication Pass Guidelines, that was part of the in-servicing for all nursing staff, indicated, .3. Medication Administration. e. Residents identified per facility policy and procedure prior to giving med. F. Resident is properly positioned. G. Medication dose preparation. 1) Nurse verified medication, strength, and labeled directions for use against the MAR. h. Manufacturer specifications are observed. 3. Correct medication administered. This citation relates to Intake 2728361.410 IAC (Indiana Administrative Code) 16.2-3.1-35(g)(1)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observation and interview, the facility failed to ensure medications were kept in a locked medication cart at all times during a medication pass observation. (RN 1, 3A Cart) Findings include: 1. On 4/8/26 at 9:32 a.m., RN 1 was observed preparing medications for a resident. She retrieved the medications from the cart, popped the pills into a medication cup, prepared a dose of Miralax in water, and then walked into the resident's room to administer the medications. The cart was left unlocked and out of sight of the nurse at the time. The nurse returned to the cart and prepared the next resident's medications. 2. On 4/8/26 at 9:41 a.m., RN 1 was observed preparing another resident's medications. She had retrieved the medications from the cart, popped the pills into a medication cup, and went into the resident's room to administer the medications. The cart was left unlocked and out of sight of the nurse at the time. The nurse returned to the cart to prepare more medications. During an interview on 4/8/26 at 9:51 a.m., RN 1 indicated she was supposed to lock the cart any time she stepped away from the cart. The Executive Director was notified of RN 1 leaving the cart unlocked on 4/8/26 at 9:59 a.m., and provided no further information. A facility policy titled, Medication Storage, and noted as current, indicated, .I. General Guidelines: a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under proper temperature controls. c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart. This citation relates to Intake 2728361.410 IAC (Indiana Administrative Code) 16.2-3.1-25(m)</p>		