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	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anthony	203 Franciscan Dr Crown Point, IN 46307

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents had physician's orders for self-administration of medications and an assessment to self-administer their own medications for 1 of 2 residents reviewed for self-administration of medication. (Resident 144) Finding includes: During an observation of Resident 144 on 6/10/25 at 11:13 a.m., there were three small medication cups on the bedside table and night stand containing multiple Tums (an antacid medication). There were also two large Tums medication bottles and an inhaler at the bedside. The resident indicated at the time that she would take the Tums medication whenever she ate and as she needed them for heartburn. On 6/11/25 at 10:24 a.m., Resident 144 was observed in bed. The Tums medication and inhaler were observed at the bedside. On 6/12/25 at 9:57 a.m., Resident 144 was observed in bed. The Tums medication and inhaler were observed at the bedside. Resident 144's record was reviewed on 6/11/25 at 10:33 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, asthma, and gastroesophageal reflux disease (GERD). The Annual Minimum Data Set (MDS), dated [DATE], indicated the resident was cognitively intact. The current June 2025 Physician's Order Summary indicated the resident received albuterol sulfate 108 microgram per actuation (mcg/act) 2 puff inhale orally every 4 hours as needed, patient may keep at the bedside and calcium carbonate tablet 500 milligrams every 6 hours as needed. There were no orders for self-administration of the Tums medication. There were no self-administration of medication assessments completed for the resident to keep Tums or the inhaler at the bedside. There were no care plans related to self-administration of medications. During an interview on 6/16/25 at 4:30 p.m., the Director of Nursing had no further information to provide. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A policy titled, Self-Administration of Medications, indicated, .1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities to determine whether self-administering medications is clinically appropriate for the resident. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment . 3.1-11(a)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to antianxiety and antiplatelet medications for 2 of 32 MDS assessments reviewed. (Residents 107 and 375) Findings include: 1. Resident 107's record was reviewed on 6/12/25 at 10:22 a.m. Diagnoses included, but were not limited to, schizoaffective disorder, general anxiety disorder, and dementia with behavioral disturbance. The Quarterly MDS assessments, dated 5/23/25, 5/7/25, and 2/13/25, indicated the resident had not received any antianxiety medications. A Care Plan, updated 5/28/24, indicated the resident had schizoaffective disorder and was currently receiving antipsychotic, antidepressant, anticonvulsant, and antianxiety medications. A Physician's Order, dated 12/2/22, indicated Klonopin (clonazepam, an antianxiety medication) 0.5 mg (milligrams) two times a day. The Medication Administration Record (MAR), dated 5/2025, indicated the resident had received the antianxiety medication twice daily. During an interview on 6/12/25 at 1:42 p.m., the MDS Coordinator indicated the resident was receiving antianxiety medication. It had been coded as an anticonvulsant because that was how it was classified in the computer charting system. She would make corrections. 2. The record for Resident 375 was reviewed on 6/16/25 at 9:44 a.m. Diagnoses included, but were not limited to, history of stroke, congestive heart failure, and chronic kidney disease. The admission MDS assessment, dated 6/4/25, indicated the resident had not received any antiplatelet medications in the past seven days. The current Physician's Order Summary indicated to give ticagrelor (Brilinta, an antiplatelet medication) 90 mg every 12 hours. The MAR, dated 5/2024 and 6/2025, indicated the resident had received the antiplatelet medication twice daily beginning on 5/30/25. During an interview on 6/16/25 at 2:17 p.m., the MDS Coordinator indicated the MDS was incorrect and needed to be modified. 3.1-31(i)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to twice weekly showering and nail care for 2 of 3 residents reviewed for ADLs. (Residents 52 and 105) Findings include: 1. During an interview on 6/10/25 at 10:00 a.m., Resident 52 indicated she did not always receive showers twice a week. Resident 52's record was reviewed on 6/11/25 at 10:37 a.m. Diagnoses included, but were not limited to, heart failure, chronic kidney disease, and stage 3 pressure ulcer of the sacral region. The Quarterly Minimum Data Set assessment, dated 4/30/25, indicated the resident was cognitively intact for daily decision making. The resident had an impairment affecting range of motion to one side of the lower extremities. She was dependent on staff for toileting, showering, bed mobility, and transfers. A Care Plan, revised on 5/1/25, indicated the resident needed assistance with activities of daily living. Interventions included, but were not limited to, the resident required total assistance for bathing/showering, provide additional assistance as needed. The Shower CNA Task was reviewed from 3/27-6/10/25. The resident was scheduled for showers every Tuesday and Friday evening. The Shower CNA Task lacked documentation of the resident receiving a shower on 4/11/25, 4/25/25, 5/2/25, 5/16/25, and 6/6/25. During an interview on 6/12/25 at 1:30 p.m., the Director of Nursing indicated she did not receive her showers twice weekly and was unable to provide any further documentation. A policy titled, Showers, indicated .1. residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety . 2. During an observation and interview on 6/10/25 at 9:23 a.m., Resident 105 was sitting in her bed. She indicated she had asked for someone to cut her toenails and it had not happened yet. At the time, both of the resident's feet were observed with long toenails. Resident 105's record was reviewed on 6/11/25 at 8:53 a.m. Diagnoses included, but were not limited to, edema and type 2 diabetes mellitus. The admission Minimum Data Set assessment, dated 3/18/25, indicated the resident was cognitively intact for daily decision making. The resident was dependent on staff for toileting, showering, and transfers. She required a substantial to maximal assist for personal hygiene. A Care Plan, revised on 6/6/25, indicated the resident required assistance with activities of daily living. Interventions included, but were not limited to, nail care on bath day and as necessary and report any changes to the nurse. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The shower sheets were reviewed from April to June 2025. There was no documented nail care performed during that timeframe. During an interview on 6/16/25 at 4:30 p.m., the Director of Nursing had no further information to provide. 3.1-38(b)(2) 3.1-38(a)(3)(E)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident 100) Finding includes: On 6/9/25 at 11:36 a.m., Resident 100 was sitting in a wheelchair in the hallway. A dark purple discoloration was observed to the top of his right hand. On 6/11/25 at 9:32 a.m., Resident 100 was observed lying in bed with his eyes closed. The dark purple discoloration was still observed to the top of his right hand. Record review for Resident 100 was completed on 6/12/25 at 1:18 p.m. Diagnoses included, but were not limited to, anemia, atrial fibrillation, heart failure, hypertension, and dementia. The Annual Minimum Data Set (MDS) assessment, dated 6/4/25, indicated the resident was cognitively impaired. The resident required a substantial maximal assistance with bed mobility, transfers, and upper body dressing. The resident had received an anticoagulant (blood thinning) medication. A Care Plan, dated 5/31/22 and revised 6/10/25, indicated the resident was at risk for abnormal bleeding secondary to anticoagulant therapy for atrial fibrillation. An intervention included to inspect skin during care for bruising or increased bruising and to notify the nurse of abnormal findings. The June 2025 Physician's Order Summary (POS) indicated the resident had received Eliquis (blood thinner) 2.5 mg (milligrams) twice a day. A Weekly Skin Assessment, dated 6/11/25, indicated the resident had no new skin area concerns. The record lacked any documentation to indicate the resident's discoloration had been assessed or was being monitored. During an interview on 6/12/25 at 2:53 p.m., the Wound Nurse indicated she was unaware of the resident's discoloration to the top of his hand and staff should have assessed the area. A facility policy for discolorations was not provided. 3.1-37(a)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure residents with a history of falls with injuries had preventions in place to prevent more falls/injuries related to a resident's call light not in reach and a Dycem (non slip mat) and non-skid strips were not in place as ordered for 2 of 2 residents reviewed for falls. (Residents 95 and 117) Findings include: 1. On 6/11/25 at 9:35 a.m., Resident 95 was observed sitting in a wheelchair next to her bed in her room watching television. The resident had darkened discolorations to the top and right side of her head and right hand. The resident also had a visible lump to the top of her head. The resident indicated she had fallen recently out of her wheelchair when she was trying to reach for something out of her nightstand. The resident's call light was not visibly in reach to the resident. The resident indicated she was unsure where her call light was located. On 6/11/25 at 11:28 a.m., Resident 95 was observed sitting in her room in the same position. The resident's call light was still not in reach to the resident. The call light cord was halfway underneath the resident's mattress and the call button at the end of the cord was not visible. The resident indicated she was unsure where her call light was located. Record review for Resident 95 was completed on 6/11/25 at 9:49 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, anemia, atrial fibrillation, hypertension, dementia, depression, and anxiety. The Significant Change Minimum Data Set (MDS) assessment, dated 5/19/25, indicated the resident was cognitively intact. The resident required a substantial maximal assistance to propel herself in her wheelchair and was dependent for bed mobility and transfers. The resident had no falls since the previous assessment. A Care Plan, dated 8/16/23 and revised 5/28/25, indicated the resident was at risk for falls or fall related injuries. An intervention included to keep the call light and frequently used personal items within reach. A Progress Note, dated 6/8/25 at 8:15 a.m., indicated the resident was calling for help. When the nurse entered the room she found the resident laying on her right side next to the bed and nightstand with her wheelchair behind her. The resident was sent out to the hospital. During an interview on 6/11/25 at 11:29 a.m., LPN 1 indicated the resident was able to use her call light and the call light should be in reach at all times. The resident had fallen recently while attempting to reach for something. She would locate the resident's call light and make sure it was within the resident's reach. 2. On 6/9/25 at 11:35 a.m., Resident 117 was observed lying in bed. He had sutures to his left eye area and a sling in place to his left arm. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/11/25 at 12:05 p.m., the resident was seated in the recliner in his room. There were no non-skid strips observed to the floor anywhere near his recliner. There were non-skid strips on the floor on the other side of the room, near the dresser. There was no Dycem observed to the resident's wheelchair. The resident indicated he had fallen recently and gone to the hospital. On 6/11/25 at 2:13 p.m., the resident was seated in the recliner in his room. There were no non-skid strips observed to the floor anywhere near his recliner. There was no Dycem observed to the resident's wheelchair. Record review for Resident 117 was completed on 6/11/25 at 9:18 a.m. Diagnoses included, but were not limited to, fracture of left humerus, type 2 diabetes mellitus, and congestive heart failure. The admission MDS assessment, dated 4/4/25, indicated the resident was cognitively intact and required a substantial/maximal assist with bed mobility and transfers. A Care Plan, updated 6/9/25, indicated the resident was at risk for falls or fall related injury. The interventions included: Dycem to wheelchair seat and non-skid strips in front of recliner. An Indiana Department of Health (IDOH) Reportable Incident, dated 6/1/25, indicated the resident was found on the floor in his room. He indicated he was trying to pull his pants up from sitting on his recliner and fell. He was sent to the emergency room for evaluation and was found to have a left humerus fracture. The Interdisciplinary Team (IDT) recommendation was non-skid strips in front of the recliner. The resident returned to the facility on 6/5/25. A Progress Note, dated 6/6/25 at 1:47 p.m., indicated the resident was yelling out and was found sliding out of his wheelchair. Staff was able to assist him back to the wheelchair. A Dycem was placed in the wheelchair to prevent sliding out. During an interview on 6/11/25 at 3:47 p.m., the Director of Nursing was made aware of the Dycem and non-skid strips not in place. She indicated the resident's daughter may have moved the recliner. During an interview on 6/11/25 at 3:54 p.m., the Executive Director indicated she had placed the non-skid strips in front of the recliner herself, and the recliner had been near the dresser. Someone must have moved the recliner since then. The resident did not like the Dycem and was noncompliant with interventions frequently. She had provided him with education on Friday. A current facility policy, titled Incidents, Accidents & Supervision, indicated, .Supervision. The resident will remain as free of accident hazards as possible. Each resident will receive adequate supervision and assistive devices to prevent accidents. This includes: .3. Implementing interventions to reduce hazards and risks. 4. Monitoring for effectiveness and modifying interventions when necessary . 3.1-45(a)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to ensure a resident received the necessary care and treatment related to oxygen not administered as ordered for 1 of 1 resident reviewed for respiratory care. (Resident 51) Finding includes: On 6/10/25 at 9:21 a.m., Resident 51 was observed lying in her bed. She had a nasal cannula in place and oxygen was flowing at 5 liters per minute (lpm). On 6/11/25 at 9:59 a.m., the resident was again observed in bed with oxygen flowing at 5 lpm. The resident's record was reviewed on 6/11/25 at 8:45 a.m. Diagnoses included, but were not limited to, dementia, asthma and chronic obstructive respiratory disease. The admission Minimum Data Set assessment, dated 5/16/25, indicated the resident had severe cognitive impairment, and was dependent for bed mobility, transfers and toileting assistance. The current Physician's Orders indicated the resident was to receive oxygen at 3 lpm continuously. During an interview on 6/11/25 at 10:00 a.m., LPN 4 indicated the resident's oxygen should be set at 3 lpm. She entered the room and adjusted the oxygen to the correct flow rate. 3.1-47(a)(6)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation, record review and interview, the facility failed to ensure a medication cart drawer was closed and locked while unattended for 1 of 5 medication carts observed. (1A Medication Cart) Finding includes: On 6/12/25 at 9:00 a.m., QMA 1 was observed preparing Resident 18's medications. She finished preparing the medications, locked the medication cart, and entered Resident 18's room at 9:12 a.m. The bottom drawer on the right side of the medication cart was not pushed in all the way and medications were visible. QMA 1 administered the medications to Resident 18 and returned to the medication cart at 9:18 a.m. During an interview on 6/12/25 at 9:18 a.m., QMA 1 indicated she was not aware the drawer had not been closed all the way. During an interview on 6/12/25 at 1:16 p.m., the Director of Nursing was made aware the medication cart drawer had been left open. The medication storage policy was requested. A current facility policy, titled Medication and Biological Storage Requirements, indicated, .2. The facility is required to secure all medications in a locked storage area and to limit access to only authorized or licensed personnel consistent with state or federal requirements and professional standards of practice. a. Storage areas may include, but are not limited to, drawers, cabinets, medication rooms, refrigerators, and carts . 3.1-25(m)