STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155604	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anthony Rehab and Nursing Center	1205 N 14th St Lafayette, IN 47904

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. Based on observation, interview, and record review, the facility failed to ensure narcotic medications were free from theft of an employee for 1 of 3 residents reviewed for misappropriation of property. (Resident F) The deficient practice was corrected on 10/7/25, prior to the start of the survey, and was therefore past noncompliance.Findings include:During an interview, on 1/28/26 at 12:02 p.m., the Director of Nursing (DON) indicated LPN 6 reported, on 9/28/25, Resident F had a narcotic medication card and a narcotic count sheet missing. LPN 6 indicated when she last left the facility, there were 3 sheets and 3 medication cards for Resident F. On 9/28/25, there were only 2 sheets and 2 cards. The pharmacy was contacted and it was confirmed the resident should have had 3 sheets and 3 narcotic medication cards. The facility video from the weekend was reviewed and LPN 7 was seen removing one sheet and one narcotic medication card from the medication cart. The police were notified. LPN 7 was terminated and arrested by the local police department. The missing medication card was in LPN 7's home, according to the police investigation which continued to be ongoing.The clinical record for Resident F was reviewed on 1/28/26 at 4:03 p.m. The diagnoses included, but were not limited to, paranoid schizophrenia, hyperlipidemia, dementia, chronic pain, and anxiety.A physician's order, dated 5/25/25, indicated to administer hydrocodone acetaminophen (a narcotic pain medication) 7.5-325 milligram (mg) every 8 hours as needed for pain. During an observation, on 1/28/26 at 3:33 p.m., the Administrator showed a video on his computer of LPN 7 removing narcotics from the narcotic drawer of the medication cart. LPN 7 then removed the narcotic count sheet and placed them both between two other pieces of paper. She then went down the hallway to the employee exit and to her car. She exited the facility with the papers and medication then entered her car and returned to the facility with only 2 papers and no medications. LPN 7 was notified by the DON she was suspended due to the suspicious video of her at the medication cart. LPN 7 denied any wrongdoing and was informed the facility would be notifying the authorities.A facility documented telephone interview, on 10/1/25 at 2:23 p.m., indicated LPN 7 was notified and explained the reason for the phone call. She was asked to make a statement on the phone or to come to the facility for an interview. LPN 7 indicated she would come to facility to discuss the incident. LPN 7 did not come to the facility. A facility document indicated LPN 7 was terminated, on 10/2/25, and her license and the incident were reported to the state board of licensing.During an interview, on 1/29/26 at 11:59 a.m., LPN 6 indicated she had remembered Resident F had 3 narcotic medication cards and count sheets when she had left work on 9/26/25. She returned to work, on 9/29/25, and discovered one narcotic medication card and record was missing. LPN 6 reported the missing medication to her supervisor. Her supervisor reported the missing medication to the Director of Nursing. The DON called the pharmacy and confirmed Resident F had a medication card missing. A current facility policy, titled Abuse and Unusual Occurrence, dated 9/6/24 and provided by the DON on 1/29/26 at 4:00 p.m., indicated .Misappropriation of resident property-Deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the resident's consent The deficient practice was corrected by 10/7/25, after the facility audited all the narcotic sheets, interviewed residents, LPN 7 was terminated, all nurses were re-educated on a new narcotic count system, and the pharmacy completed a house wide audit of narcotic medications.This citation relates to Intake 2634382.3.1-28(a)