STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	05/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWN POINT CHRISTIAN VILLAGE	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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
F 0000 Bldg. 00	This visit was for Investigation of Complaint IN00354193. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00354193 - Substantiated. Federal/State deficiencies related to the allegations are cited at F558, F583, F584, F677, and F688. Survey dates: May 26 & 27, 2021 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 77 SNF: 26 Residential: 25 Total: 128 Census Payor Type: Medicare: 10 Medicaid: 72 Other: 21 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/1/21.	F 0000		
F 0558 SS=D Bldg. 00	483.10(e)(3) Reasonable Accommodations Needs/Preferences §483.10(e)(3) The right to reside and receive services in the facility with reasonable			

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

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	accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. Based on observation, record review, and interview, the facility failed to meet a resident's need, related to a call light not placed within reach for 1 of 6 residents observed for call light placement. (Resident G) Finding includes: During an observation on 5/26/21 at 11:07 a.m., Resident G was sitting in a wheelchair, located in the middle of the room. The call light was laying across the bed, not in reach of the resident. During an observation on 5/26/21 at 11:49 a.m., Resident G remained in the wheelchair, in the middle of the room. The call light remained on the bed out of the reach of the resident. During an interview on 5/26/21 at 11:51 a.m., Resident G was asking for more water. The Social Service Director entered the room. She indicated the call light was not in the resident's reach. Resident G's record was reviewed on 5/27/21 at 10 a.m. The diagnoses included, but were not limited to, Parkinson's disease. A Quarterly Minimum Data Set assessment, dated 4/8/21, indicated an impaired cognition status, extensive assistance of two staff for bed mobility, transfers, and toileting. A Care Plan, dated 1/17/20 indicated a risk for falls. The interventions included, the call light was to be within reach.	F 0558	**It is the policy of Crown Point Christian Village to follow all federal, state and local guidelines, laws and statutes. This plan of correction is not to be construed as an admission of deficient practice by the facility manager, employee, agents or other individuals. The response to the alleged insufficient practice cited in this statement does not constitute agreement with the insufficiency. The preparation, submission and implementation of this plan of correction will serve as credible allegation of compliance.** **F558 Reasonable Accommodations Needs/Preferences 483.10(e)(3)** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 5/26/2021 at 12:00 PM, Resident G was repositioned and given water then the call light was placed within easy reach. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what**	06/22/2021

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	This Federal tag relates to Complaint IN00354193. 3.1-35(b)(1)		**corrective action(s) taken:** On 5/27/2021, the Director of Nurses and nursing managers completed environmental rounds to identify other residents having the potential to be affected by the alleged deficient practice with call lights repositioned within reach as indicated or placed per the resident's preferences. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Nurses or designee will provide in-service education for direct care staff addressing placement and accessibility of call lights in resident rooms. This educational training focuses on reviewing regulatory guidelines for accommodation of resident needs and facility expectations of staff to assure proper placement and resident accessibility to call lights. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The unit managers will conduct random environmental audits of call light accessibility for five (5) residents four (4) times per week for four (4) weeks then two (2)	

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			times per week for twenty (20) weeks to ensure compliance with accommodation of resident needs with call light accessibility. Concerns identified from the audit will be reported to the Director of Nursing or designee for follow up corrective actions. Findings from the environmental audits will be presented to the Quality Assurance Committee for review and recommendations in maintaining substantial compliance with accommodation of needs for call light accessibility. **By what date the systemic changes for the alleged deficiency will be completed:** June 22, 2021	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including			

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	the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. Based on observation, record review and interview, the facility failed to ensure each resident was provided privacy during scheduled visitations with family members for 3 of 3 residents observed during scheduled visitation times. (Residents H, J, and K) Finding includes: During an interview on 5/26/21 at 12:55 p.m., Employee 1 indicated he assisted the residents to the, "Blue Room" (room for residents' visitation) for their scheduled visitation times. He stayed in the Blue Room in case the resident or visitor would need anything. He did not leave the room during the visits. During an interview on 5/26/21 at 1:54 p.m.. Employee 2 indicated she assisted the residents	F 0583	**F583 Personal Privacy/Confidentiality of Records 483.10(h)(1)-(3)(i)(ii)** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 5/27/2021, the Administrator re-educated the helping hands staffing aiding with family visitations including providing oversight with reasonable privacy granted during visitation activities. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what**	06/22/2021

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	to the Blue Room. She stayed in the room during all the residents' visits. During an observation on 5/26/21 at 2:03 p.m., Employee 2 assisted Resident H's visitors to the Blue Room, then exited the room to assist the resident to the visitation. On 5/26/21 at 2:13 p.m., Employee 1 assisted Resident J's visitors into the Blue Room. Resident J was already in the room. On 5/26/21 at 2:15 p.m., Employee 2 assisted Resident H into the Blue Room to meet with her visitors. She indicated the visitations were to be supervised and they would stay in the room during the visits. She indicated there was, "no way" the residents had privacy during the scheduled visitation. During an observation on 5/26/21 at 2:17 p.m., Residents H and J were in the Blue Room with visitors at their distanced tables. Employees 1 and 2 were sitting at a table in the room. Conversations for the visitors could be heard. During an interview on 5/26/21 at 2:23 p.m., The Administrator indicated the staff were not to stay in the visitation room. Employee 1 and 2 had been educated on the protocol about providing privacy during the scheduled visitations. During an observation on 5/26/21 at 4:12 p.m., Resident K was sitting at a table in the Blue Room with visitors and Employee 1 and 2 remained at a table inside the visitation room. Employee 2 indicated the Administrator had informed them there was a privacy issue with the visitations and they it would be discussed on		**corrective action(s) taken:** The community has determined that any residents with out of resident room visitations have the potential to be affected by the alleged deficient practice with re-education provided to the helping hands staff aiding with family visitations for reasonable privacy granted during visitations. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** On 6/09/21, the community updated the visiting practices to correspond with revised Indiana guidelines. The administrator or designee will conduct in-service education for community personnel addressing the regulatory guidelines for privacy, updated visiting practices, and accommodation of resident privacy during visitations activities. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The department heads or designee(s) will conduct random observational audits of resident visitations four (4) times per week for four (4) weeks then two (2)	

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	5/27/21. A, "Visitation Protocol", dated 3/17/21 and received as current from the Administrator, indicated the designated visitation area would have oversight with "reasonable privacy" granted. This Federal tag relates to Complaint IN00354193. 3.1-3(p)(5)		times per week for twenty (20) weeks to ensure staff compliance with providing resident privacy during visitation activities. Concerns identified from the audit will be reported to the Administrator or designee for follow up corrective actions. Findings from the observational will be presented to the Quality Assurance Committee for review and recommendations in meeting and sustaining compliance with providing resident privacy with visitation activities. **By what date the systemic changes for the alleged deficiency will be completed:** June 22, 2021	
F 0584 SS=B Bldg. 00	483.10(i)(1)-(7) Safe/Clean/Comfortable/Homelike Environment §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.			

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	(ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. Based on observation and interview, the facility failed to ensure the residents had a homelike environment, related to the clocks in the residents' rooms were not set to the correct time of the day for 6 of 15 resident rooms on 2 of 5 Units observed for a homelike environment. (Gracepoint 1 and 2) During the initial tour on 5/26/21, the following was observed: At 10:37 a.m., room 263's clock was set at 9:40. At 10:38 a.m., room 265's clock was set at 11:01.	F 0584	**F584** **Safe/Clean/Comfortable/Homelike Environment 483.10(i)(1)-(7)** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 5/27/2021, the maintenance staff reset the clocks for rooms 262, 265, 267, 269, 272, and 273. **How other residents having the potential to be affected by the same alleged deficient practice**	06/22/2021

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	At 10:38 a.m., room 267's clock was set at 2:35. At 10:40 a.m., room 269's clock was set at 9:40. At 10:42 a.m., room 272's clock was set at 6:30. At 10:45 a.m., room 273's clock was set at 9:50. During an interview on 5/27/21 at 1:35 p.m., the Administrator indicated Maintenance had gone through and set the clocks in the resident rooms to the correct time. This Federal tag relates to Complaint IN00354193. 3.1-(f)(5)		**will be identified and what corrective action(s) taken:** On 5/27/2021, the community determined that all resident rooms have the potential to be affected by the alleged deficient practice with maintenance staff conducting environmental rounds to re-set clocks as indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The administrator or designee will provide the departments heads and housekeeping staff educational training on maintaining a safe, clean, comfortable, and homelike environment including clocks in the resident rooms being set at the correct time of day. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The unit managers will conduct random environmental audits of five (5) resident rooms checking that clocks are set at the correct time four (4) times per week for four (4) weeks then two (2) times per week for twenty (20) weeks to ensure compliance with maintaining a homelike	

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			environment. Concerns identified from this auditing process will be reported to the Housekeeping supervisor or designee for corrective actions. Findings from the environmental audits will be presented to the Quality Assurance Committee for review and recommendations in sustaining substantial compliance with maintaining a homelike environment related to clocks set to the correct time of day. **By what date the systemic changes for the alleged deficiency will be completed:** June 22, 2021	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure necessary care and services were provided to residents who required extensive and dependent care for activities of daily living (ADL's) related to showers, for 2 of 3 residents reviewed for ADL's. (Residents B and D) Findings include: 1. Resident B's record was reviewed on 5/26/21 at 12:32 p.m. The diagnoses included, but were not limited to, dementia.	F 0677	**F677 ADL Care Provide for Dependent Residents 483.24(a)(2)** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** Residents B and D were given additional showers on 5/27/2021. **How other residents having the potential to be affected by the same alleged deficient practice**	06/22/2021

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	A Quarterly Minimum Data Set (MDS) assessment, dated 3/3/21, indicated an impaired cognitive status, no behaviors, required extensive assistance of one staff for bed mobility and hygiene. She required extensive assistance of two staff for transfers, had not been bathed in the past seven days, was frequently incontinent of urine and occasionally incontinent of bowel. A Care Plan, dated 6/18/19, indicated a self-care deficiency of activities of daily living (ADL's). The interventions included, she preferred to take showers on day shift. The bathing documentation indicated she was scheduled for showers on Monday and Thursday on day shift and received the following bathing for 5/2021: 5/3/21 - None 5/6/21 - bed bath 5/10/21 - partial bath 5/13/21 - shower 5/17/21 - refused 5/20/21 - shower 5/24/21 - shower The bathing documentation for April 2021 indicated a bed bath was given on 4/29/21. She had not received a shower from 4/29/21 through 5/13/21. 2. Resident D's record was reviewed on 5/27/21 at 9:46 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly MDS assessment, dated 5/17/21, indicated a severely impaired cognitive status and required extensive assistance of one staff for bathing.		**will be identified and what corrective action(s) taken:** On 5/28/2021, the Director of Nurses and unit managers conducted reviews of resident ADL records to determine other residents having the potential to be affected by the alleged deficient practice with additional showers or baths provided as indicated. **What measures will be put into place and what systemic changes will be made to ensure that the deficient practice does not recur:** The Director of Nursing or designee will conduct in-service education to direct care personnel addressing resident preferences in bathing, showers/bathing schedules, documentation of bathing ADLs, and facility expectations that resident shower or baths be given as scheduled. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The unit managers or designee(s) will monitor Point of Care reports to determine if showers and baths were documented as required. The unit managers will conduct random bathing audits reviewing resident showers and baths four	

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	A Care Plan, dated 5/14/18, indicated a self care deficiency for ADL's. The interventions included, her preference was to take showers. The shower documentation for 4/29/21 through 5/27/21 indicated the following bathing had been completed on Monday and Thursdays (scheduled days): 4/29/21 - shower 5/3/21 - none 5/6/21 - none 5/10/21 - partial bath 5/13/21 - shower 5/20/21 - shower 5/24/21 - none 5/26/21 - partial During an interview on 5/27/21 at 9:08, LPN 1 indicated she was unable to locate hand written shower sheets for Resident B and D. This Federal tag relates to Complaint IN00354193. 3.1-38(b)(2)		(4) times per week for four (4) weeks then two (2) times per week for twenty (20) weeks to ensure compliance with providing showers or baths for dependent residents including accurate documentation and validating showers or baths as given. Concerns identified from the audit will be reported to the Director of Nursing or designee for follow up corrective actions. Findings from the environmental audits will be presented to the Quality Assurance Committee for review and recommendations in sustaining substantial compliance with providing ADLs showers and baths for dependent residents. **By what date the systemic changes for the alleged deficiency will be completed:** June 22, 2021	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or			

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	to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure residents who required Restorative Nursing for range of motion and ambulation received treatment and services to increase or maintain range of motion and ambulation status, related to Restorative Nursing not completed as scheduled for 2 of 3 residents reviewed for Restorative Nursing. (Residents B and E) Findings include: 1) Resident B was observed on 5/26/21 from 10:45 a.m. through 1:30 p.m. The resident had not been assisted to ambulate nor was she assisted with active range of motion (AROM). At 1:16 p.m., she activated her call light and indicated she needed to use the bathroom. At 1:22 p.m., Employee 3 and 4 entered the room, used a sit to stand lift, and assisted her to the bathroom. Employee 3 indicated the resident was unable to walk. She was assisted back to the recliner with the sit to stand lift when she was finished using the bathroom. Resident B's record was reviewed on 5/26/21 at 12:32 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set (MDS) assessment, dated 3/3/21, indicated an impaired	F 0688	**F688 Increase/Prevent Decrease in ROM/Mobility 483.25(c)(1)-(3)** **Corrective actions accomplished for those residents found to have been affected by the alleged deficient practice:** On 5/27/2021, the Restorative manager and Director of Nursing reviewed the restorative programs for residents B and E with referrals made for therapy follow up screenings. **How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) taken:** On 6/01/2021, the Director of Nursing, Restorative manager and restorative aides reviewed clinical records to identify other residents having the potential to be affected by the alleged deficient practice with updates to restorative program plans as indicated. **What measures will be put into place and what systemic**	06/22/2021

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	155637	A. BUILDING 00 B. WING	05/27/2021

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	cognitive status, no behaviors, required extensive assistance of one staff for bed mobility and locomotion. She required extensive assistance of two staff for transfers. Ambulation of assistance of one staff occurred once or twice within the past 7 days. She was not steady while walking without staff assistance, had no impairment of range of motion of the upper and lower extremities, and received one day of restorative walking. A Care Plan, dated 6/18/19, indicated an Activity of Daily Living (ADLs) self care deficiency. The interventions included, the Restorative Nursing Assistant (RNA) to assist with ambulation up to 20 feet with a rolling walker and two assistants six to seven days per week and AROM to all extremities for 20 repetitions twice daily, six to seven days per week. Extensive toileting and transfer assistance and to use a gait belt and rolling walker. A CNA care information form, dated 5/26/21, indicated to educate CNAs to use gait belt for all transfers, Extensive assistance of one person and a gait belt to be used when transferred. The rolling walker was always to be used. Restorative was to assist with ambulation up to 20 feet with a rolling walker and two staff, six to seven times a week and AROM to all extremities for 20 repetitions, two times a day, six to seven days per week. A Physical Therapy Discharge Summary, dated 4/30/21, indicated Nursing education and training was provided for the restorative programs of lower extremity exercises and ambulation with a rolling walker. The resident would remain in long term care with a restorative program.		**changes will be made to ensure that the deficient practice does not recur:** The Director of Nursing or designee will provide in-service education to the restorative manager and restorative aides on restorative nursing requirements, scheduling of restorative services, and facility expectations that restorative nursing services are completed as scheduled. **How the corrective action(s) will be monitored to ensure the alleged deficiency practice will not recur (i.e., what quality assurance program will be put into place):** The Restorative manager will conduct restorative nursing audits for eight (8) residents weekly for four (4) weeks then four (4) residents weekly for twenty (20) weeks to ensure compliance with completing restorative nursing programs as scheduled. Concerns identified from the audit will be reported to the Director of Nursing or designee for follow up corrective actions. Findings from the restorative nursing audits will be presented to the Quality Assurance Committee for review and recommendations in sustaining compliance with providing restorative nursing services to residents as scheduled.	

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	The restorative documentation, from 5/1/21 through 5/26/21, indicated the restorative ambulation was completed on 5/19/21, walked 40 feet, 5/20/21, walked 20 feet, 5/22/21, walked 10 feet, 5/23/21, walked 10 feet, and 5/24/21, walked 20 feet. The restorative documentation from 5/1/21 through 5/26/21, indicated the AROM was completed one time on 5/23/21 and she tolerated the AROM well. During an interview on 5/26/21 at 3:40 p.m., the Restorative Nurse indicated the Restorative CNAs both had the day off and were off on the same day every other Wednesday. The sit to stand lift was not to be used with the transfers and the Care Plan indicated to use a gait belt and rolling walker with two staff members. 2) Resident E's record was reviewed on 5/27/21 at 11:32 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. The Significant Change MDS assessment, dated 4/28/21, indicated a moderately impaired cognition, required minimal assistance of one staff for transfers, ambulated in the corridor one-two times in the last seven days with one staff, Restorative Nursing provided one date of AROM and two days of transfer restorative therapy. A Care Plan, dated 4/18/16, indicated she was at risk for ADL self care deficiency. The interventions added on 2/3/21 were Restorative Nursing rehabilitation was to be completed for ambulation of 125 feet with a rolling walker, gait belt and assistance of one staff daily for six to		**By what date the systemic changes for the alleged deficiency will be completed:** June 22, 2021	

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	seven days per week. Restorative Nursing rehabilitation for AROM was to be competed with instruction and supervision for 10 repetitions twice daily, six to seven days per week. Restorative Nursing was to assist her with transfers from surface to surface with assistance of one staff and gait belt usage daily, six to seven days per week. The Nursing Restorative Notes, dated 5/2021, indicated ambulation restorative was completed on 5/2/21 - 30 feet, 5/17/21 - 30 feet, 5/17/21 - 100 feet, 5/19/21 - 40 feet, 5/20/21 - 50 feet, 5/22/21 - 75 feet, 5/23/21 - 25 feet, and 5/24/21 - 125 feet. The AROM restorative was completed once on 5/15/21, 5/16/21, 5/18/21, 5/24/21, 5/25/21, and 5/26/21. The transfer restorative was completed on 5/4/21, 5/15/21, 5/6/21, 5/17/21, 5/18/21, 5/19/21, 5/20/21, 5/22/21, 5/23/21, 5/24/21, 5/25/21, and 5/26/21. During an interview on 5/26/21 at 4:37 p.m., the Restorative Nurse indicated Resident B was to start Restorative Nursing on 5/4/21. The Restorative CNAs had been pulled off of restorative to work as floor CNAs. There were several residents on restorative and most had restorative ordered to be completed six to seven days a week and it was not "feasible" to get everyone's restorative rehabilitation completed. This Federal tag relates to Complaint IN00354193. 3.1-42(a)(2)			