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	04/24/2023

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00401028 and IN00405158. This visit included a State Residential Licensure Survey. Complaint IN00401028 - Federal/ State deficiencies related to the allegations are cited at F921. Complaint IN00405158 - Federal/ State deficiencies related to the allegations are cited at F677, F868 and F9999. Survey dates: April 17, 18, 19, 20, 21 and 24, 2023. Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 79 SNF: 16 Residential: 30 Total: 125 Census Payor Type: Medicare: 16 Medicaid: 57 Other: 22 Total: 95 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/27/23.	F 0000	Please consider this plan of correction as Crown Point Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our Residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Diaz	RN DON	05/16/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review and interview, the facility failed to ensure a resident with medications in his room had a self-medication administration assessment completed for 1 of 1 random observations. (Resident 146) Finding includes: On 4/17/23 at 1:28 p.m. and 4/18/23 at 10:31 a.m., Resident 146 was observed seated in his room. On his counter, visible from the hall, was a bottle Tolnaftate antifungal power and a bottle of Flonase nasal spray. The resident's record was reviewed on 4/19/23 at 8:15 a.m. The resident was admitted on 4/11/23. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Physician's Order, dated 4/11/23, indicated to apply the antifungal power twice daily. There was no order for the Flonase. Interview with the Director of Nursing, on 4/18/23 at 1:10 a.m., indicated the resident did not have a self-medication administration assessment and the medications should not be in his room. 3.1-11	F 0554	**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.** F-554 **Corrective actions which were done for the resident found to have been affected by the deficient practice:** *The medications noted in the room were removed from R 146's room on 4/18/23. Flonase was returned to the resident's representative.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:**	05/26/2023

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			The facility determined all residents who take medications have potential to be affected. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *Nurses were re-educated regarding ensuring residents take their medication when administered and not left at bedside. It was also communicated to the nurses that no medication including OTC's may be in the resident's room without a self-administration assessment and proper storage of the medication.* *The bags of personal belongings sent from the hospital will be checked to ensure the hospital has not sent medications with the resident. Any medications found will be removed from the room and stored appropriately.* *The DON or Designee with conduct audits of resident's rooms of new admissions to check for medications in the room will be conducted as follows:* *Audit all new admissions weekly for 6 months.* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA*	

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			Committee will determine the need for continued or additional corrective actions to maintain compliance. **Correction actions will be completed by: 5/26/2023**	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. Based on record review and interview, the facility	F 0625	**It is the policy of Crown Point**	05/26/2023

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	failed to ensure the transfer/ bed hold policy was sent to a resident's responsible party following a hospitalization for 1 of 3 residents reviewed for hospitalization. (Resident 12) Finding includes: Resident 12's record was reviewed on 4/19/23 at 9:34 a.m. Diagnoses included, but were not limited to, paraplegia, Diabetes Mellitus and unspecified dementia. On 1/30/23, the resident was sent to the hospital due to a change in condition. She was admitted and returned to the facility on 2/13/23. There was no documentation that the transfer/ bed hold policy had been sent to the resident's family/ responsible party. Interview with Director of Nursing, on 4/19/23 at 2:27 p.m., indicated she was unable to locate documentation the transfer/ bed hold policy had been sent to the family. She indicated they sent paperwork with the resident to the hospital. 3.1-12(25)(A)		**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.** F-625 **Corrective actions which will be accomplished for those residents founds to have been affected by the deficient practice:** *R12 was re-admitted to the facility on 2/13/23. R12 was not affected by this deficient practice.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility reviewed the bed hold policy and determined any resident who transfers to the hospital has potential to be affected by the same deficient practice.* **The measures the facility will take or systems the facility will alter to ensure that the**	

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			problem will be corrected and will not reoccur: *Nurses and Business Office Manager will be re-educated on providing bed hold for all residents regardless of payer source with any transfer and admission to higher level of care.* *Business Office Manager will conduct weekly audits on all hospital transfers to ensure the bed hold policy is followed x 6 months.* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The Business Office Manager will present a summary of the audits to the QAPI committee monthly. The QAPI committee will determine if further action is required to attain/maintain compliance.* **Correction actions will be completed by:** 5/26/2023	
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 residents who required staff assistance for activities of daily living (ADLs) received necessary services related to bathing and nail care for 1 of 4 residents reviewed for	F 0677	**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**	05/26/2023

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	ADLs. (Resident B) Finding includes: Interview with Resident B on 4/17/23 at 10:48 a.m. indicated he had not received his shower last week because he was sleeping. He felt staff should have woken him up and offered the shower or came back when he was awake to offer the shower. His fingernails were observed to be long. He indicated he would like them cut but staff had never offered to cut them. On 4/19/23 at 11:33 a.m., Resident B was observed seated in his wheelchair propelling himself toward the dining room for lunch. His fingernails remained long. Resident B's record was reviewed on 4/20/23 at 8:56 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and atrial fibrillation. The Annual Minimum Data Set (MDS) assessment, dated 3/15/23, indicated the resident was cognitively intact, required an extensive assist of one with personal hygiene, and was totally dependent on staff for bathing. The Bathing Tasks documentation indicated the resident was to receive bathing on Tuesdays and Fridays. He received a bed bath on 4/11/23 and 4/18/23. There was lack of documentation any bathing was offered or completed on 4/14/23. There was lack of any documentation nail care was offered or provided. Interview with the Assistant Director of Nursing (ADON) on 4/20/23 at 9:49 a.m., indicated she was unable to find any bathing documentation for		**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.** F-677 **Corrective actions which were done for the resident found to have been affected by the deficient practice:** *Resident B was given a shower on 4/18/23 and 4/21/23.* *Resident B was also given nail care on 4/20/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all residents who need assistance with ADL have potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *C.N.A's were re-educated on providing showers per the*	

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	4/14/23. Staff would clean nails on shower days but not cut the nails. There was no specific place nail care would have been documented. The resident had not requested to have his nails cut. This Federal Tag relates to Complaint IN00405158. 3.1-38(a)(2)(A) 3.1-38(a)(3)(E)		*resident's shower schedule or per resident request and providing nail care on a regular basis to ensure the nails are kept clean, short, and do not have jagged edges.* *Nurses were re-educated on monitoring the shower/bath schedule to ensure resident's receive shower/bath and nail care and to document any reason (including refusal by resident) if the shower/bath or nail care cannot be completed as scheduled.* *The DON or designee will complete audits to ensure shower/bath has been given per plan of care and nail care is done as follows:* *5 audits weekly for one month* *4 audits weekly for one month* *3 audits weekly for one month* *2 audits weekly for 3 months* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance.* **Correction actions will be completed by: 5/26/2023**	
F 0679 SS=D	483.24(c)(1) Activities Meet Interest/Needs Each Resident			

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Bldg. 00	§483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. Based on observation, record review, and interview, the facility failed to ensure a dependent resident received one on one activities as scheduled for 1 of 1 residents reviewed for activities. (Resident 61) Finding includes: On 4/17/23 at 10:53 a.m., Resident 61 was observed lying in bed. There was no television or radio playing. On 4/19/23 at 11:30 a.m. and 1:30 p.m., and 4/20/23 at 8:48 a.m., and 11:00 a.m., the resident was observed lying in bed with the television turned on. The resident's record was reviewed on 4/20/23 at 11:15 a.m. Diagnoses included, but were not limited to, late onset Alzheimer's dementia and dysphagia. The Quarterly Minimum Data Set assessment, dated 4/10/23, indicated the resident had significant cognitive impairment and required extensive 2+ staff assistance for bed mobility and toileting. The current Activity Care Plan indicated the resident was dependent on staff to initiate	F 0679	**F679: Activities Meet Interest/Needs Each Resident** **This Plan of Correction is the Facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.** 1. **Corrective action for residents affected:** Resident 61 has been provided 1:1 activities on May 1st, 3rd, and 4th and will continue to per schedule. 2. **How facility will identify other residents with potential to be affected:** All other residents scheduled for 1:1 activities have	05/26/2023

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	activities due to cognitive impairment. Interventions included to provide one on one visits three times weekly. The Activity Participation Log for February, March and April 2023 indicated the resident had one on one visits on 2/7/23, 3/7/23, 3/13/23, 3/16/23, 3/24/23 and 4/3/23. There were no refusals documented. Interview with the Activity Director (AD) on 4/20/23 at 2:47 p.m., indicated the resident rarely got out of bed, so they would provide one on one visits in his room three times weekly. The AD indicated there was very little documented on the activity log and there had been no participation refusals documented. 3.1-33(a)		the potential to be affected. 3. **What measures or systemic changes will be put in place to ensure deficiency does not recur:** The Activity Director and Activity Assistants will be re-educated on following the schedule for 1:1 activities, documenting participation and/or refusal. 4. **How facility plans to monitor its performance to make sure solutions are sustained:** The Activity Director will audit the scheduled 1:1's to ensure they are taking place weekly for 3 months, then monthly for 3 months and have documentation of participation and/or refusal as necessary. Results of the audits will be reported to the QAPI Committee, which can make further recommendations as needed. 5. **Corrective action will be completed by:** May 26, 2023	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive			

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	treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary treatment and services related to the monitoring and assessment of skin discolorations for 1 of 2 residents reviewed for non-pressure related skin conditions. (Resident 51) Finding includes: On 4/18/23 at 9:06 a.m., Resident 51 was observed with a dark blue discoloration to his left inner arm and smaller dark blue discolorations to the top of his left forearm. He indicated the area to his inner arm was most likely from a recent blood draw and he was unsure if staff was aware or monitoring the area. On 4/20/23 at 11:37 a.m., the resident was observed eating lunch. The dark blue discolorations remained to his left inner arm and left forearm. Record review for Resident 51 was completed on 4/19/23 at 1:15 p.m. Diagnoses included, but were not limited to, congestive heart failure, atrial fibrillation, and end stage renal disease. The Quarterly Minimum Data Set (MDS) assessment, dated 2/21/23, indicated the resident was cognitively intact and received anticoagulant medication. A current care plan indicated the resident was on anticoagulant (blood thinning) therapy. The interventions included daily skin checks.	F 0684	**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.** F-684 **Corrective actions which were done for the resident found to have been affected by the deficient practice:** *The bruises noted on R51 were assessed on April 20, 2023 by the ADON and an investigation initiated.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all residents have potential to be affected.*	05/26/2023

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	The Medication Administration Record, dated 4/2023, indicated the resident was receiving apixaban (Eliquis, an anticoagulant medication) 2.5 milligrams twice a day. The Skin Check Assessments, dated 4/13/23 and 4/20/23, lacked any documentation of the skin discolorations to the left arm. Interview with the ADON on 4/20/23 at 3:41 p.m., indicated she had just looked at the resident's skin discolorations to the top of his left forearm and they looked like purpura. She would have the Nurse Practitioner assess them tomorrow. She had not looked at the discoloration to the left inner forearm yet but indicated it was probably from a blood draw. The skin discolorations should have been noted on the skin check assessment. 3.1-37(a)		**The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *Nurses will be re-educated on completing weekly skin check and accurately documenting the skin status including the presence of bruises.* *C.N.A.'s will be re-educated on reporting any skin condition, including bruising to the nurse.* *The re-education included the requirement for daily monitoring of the resident's skin during care and skin checks during shower/bath.* *The DON/designee will conduct audits to ensure all weekly skin checks are documented accurately as follows.* *3 Audits weekly for one month* *2 Audits weekly for one month* *1 Audit weekly for four months* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance.* **Correction actions will be completed by: 5/26/2023**	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on record review and interview, the facility failed to ensure a resident being monitored for weight loss was accurately assessed and reweighed for 1 of 3 residents reviewed for nutrition. (Resident 43) Finding includes: Resident 43's record was reviewed on 4/19/23 at 3:11 p.m. The resident was admitted on 3/1/23. Diagnoses included, but were not limited to, adult failure to thrive and chronic obstructive pulmonary disease. The Admission Minimum Data Set assessment, dated 3/7/23, indicated the resident was	F 0692	**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**	05/26/2023

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	cognitively intact, and required extensive 2+ staff assistance for bed mobility and transfers. The current Nutrition Care Plan indicated the resident had a nutritional problem related to being underweight. Interventions included weigh resident as ordered and to consume adequate energy to support weight gain. The resident's weights were as follows: 3/3/23 - 102 lbs 3/14/23 - 103 lbs 3/21/23 - 102 lbs 3/28/23 - 89.6 lbs. A Weight Change Note, dated 3/31/23, indicated the resident had a significant weight loss of 12.2% in 30 days. It was recommended the resident be reweighed, and additional supplements were recommended. Interview with the Assistant Director of Nursing, on 4/20/23 at 10:24 a.m., indicated a resident should be reweighed within 72 hours and the resident had not been reweighed until that day. She completed a weight variance form on 4/5/23, due to the resident's hospital weight was 86 pounds. She did not believe the 102 pounds was accurate and not sure where it came from. The resident's weight on 4/20/23 was 89 pounds. 3.1-46(a)(1)		**correction will serve as credible allegation of compliance.** F-692 **Corrective actions which were done for the resident found to have been affected by the deficient practice:** *R 43 was weighed on 3/28/23 with weight of: 89.6 pounds.* *R 43 was weighed again on 4/2/23 with a weight of 89 pounds.* *R43's physician was notified regarding weight variance on 4/5/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all resident with nutritional deficits or weight loss have potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *The DON/designee will re-educate nurses on weight monitoring including the requirement for timely re-weights.* *The DON/designee will conduct weekly audits to ensure the policy is followed for weight monitoring, including obtaining reweights when a significant weight change has been noted.* *The DON/designee will conduct*	

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			weekly audits of all significant weight changes for 6 months. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance. **Correction actions will be completed by: 5/26/2023**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident received proper respiratory treatment and care related to an outdated humidifier bottle on an oxygen concentrator for 1 of 1 residents reviewed for respiratory care. (Resident 146) Finding includes:	F 0695	**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.**	05/26/2023

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	On 4/17/23 at 1:15 p.m., Resident 146 was observed seated in his room. He had oxygen via nasal cannula in use. The cannula was attached to a humidifier bottle on the oxygen concentrator. The humidifier bottle was dated 3/20/23. The resident's record was reviewed on 4/19/23 at 8:15 a.m. The resident was admitted on 4/11/23. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease. A Physician's Order, dated 4/15/23, indicated the oxygen tubing and humidifier bottle were to be changed every 7 days. Interview with the Director of Nursing, on 4/18/23 at 1:10 p.m., indicated the humidifier bottle was outdated and she would exchange it for a new one. 3.1-47(a)(6)		**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.** F-695 **Corrective actions which will be accomplished for those residents founds to have been affected by the deficient practice:** *The humidifier bottle for R146 was replaced on 4/18/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all resident who use oxygen have potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *The DON/designee will re-educate all nurses of the policy to change humidifier bottles and oxygen tubing weekly.* *The DON or Infection Preventionist will audit residents using oxygen to ensure that humidifier bottles and tubing are changed weekly as follows:*	

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			DON/designee will audit all resident using oxygen weekly for three months, then monthly for 3 months. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance.* **Correction actions will be completed by: 5/26/2023**	
F 0760 SS=D Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, interview, and record review, the facility failed to ensure a resident was free from significant medication errors related to the incorrect administration of insulin for 1 of 6 residents observed during medication pass. (Resident B) Finding includes: During a medication administration observation on 4/20/23 at 11:05 a.m., LPN 1 prepared Resident B's insulin. She took the Novolog Flexpen (insulin) out of the cart, cleaned the hub with an alcohol prep pad, and attached the needle. She then dialed the pen to 4 units and entered the	F 0760	**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**	05/26/2023

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	resident's room. She cleaned the resident's right side of his abdomen with an alcohol prep pad and injected the insulin. She had not primed the insulin pen or performed an air shot prior to administering the insulin. Interview with the LPN indicated she had not primed the insulin pen prior to administering the resident's insulin. She only primed the insulin pen when it was new and first opened. Interview with the Director of Nursing (DON) on 4/20/23 at 11:13 a.m., indicated the nurse should have primed the insulin pen prior to each administration. A facility policy titled, "Insulin Pen Use - Procedure", and received as current from the Assistant Director of Nursing (ADON), indicated, "...1.8 Prime the insulin pen: 1.8.1 Dial 2 units by turning the dose selector clockwise. 1.8.2 With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle...." 3.1-48(c)(2)		**implementation of this plan of correction will serve as credible allegation of compliance.** F-760 **Corrective actions which will be accomplished for those residents founds to have been affected by the deficient practice:** *On 4/20/23, Resident B was assessed for any side effects of insulin injections, no side effects were observed.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all resident receiving insulin via insulin pen injections have the potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *On 4/20/23, the DON and ADON provided one on one education to LPN1, which included review of policy and procedure for insulin administration. LPN1 accurately demonstrated insulin administration per the insulin administrations skills competency.* *Nurses were reeducated on proper insulin administration via insulin pen, including priming insulin*	

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			pens. *The DON or Designee will complete random skills competencies on insulin injections weekly for four weeks, then monthly for 5 months.* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance.* **Correction actions will be completed by: 5/26/2023**	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.			

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	§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation and interview, the facility failed to ensure medications were properly stored for safety, labeled, and dated for 2 of 3 medication carts and 1 of 2 medication storage rooms observed. (Grace Point Medication Cart, Grace Point Medication Room and C Hall Medication Cart) Findings include: 1. On 4/24/23 at 9:23 a.m., with QMA 1 and LPN 2, the Grace Point Medication Cart and the Grace Point Medication Room was observed. a. In the cart there was a Levemir Flexpen (insulin pen) with no open date and an insulin glargine pen with no instructions on how to administer the insulin. b. In the medication room there was a 3 compartment plastic bin with drawers. In each drawer there were multiple vials of different antibiotics for intravenous administration. There were no resident names on any of the bottles. Interview at the time of the observations with LPN 2 indicated the insulin pens are supposed to be dated with the open date. The bag on how to administer the insulin was probably in the	F 0761	**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.** F-761 **Corrective actions which were done for the resident found to have been affected by the deficient practice:** *No residents were identified as being affected by this practice. All medications that were not properly labeled or dated were*	05/26/2023

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	refrigerator with the extra insulin pens. She was unsure why the multiple vials of antibiotic medication were in the plastic bins or for which residents they were prescribed. 2. On 4/24/23 at 9:44 a.m., with LPN 2, the C Hall Medication Cart was observed. There were 5 insulin pens with no instructions on how to administer the insulin. One of the insulin pens did not have a resident's name visible on the pen. Interview with LPN 2 indicated the directions on how to administer the insulins were usually on the bags, but she was unsure where the insulin bags were located. Interview with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) on 4/24/23 at 10:04 a.m., indicated the pens should have been labeled with the directions and open dates. The antibiotic vials should not have been in the plastic bins with no resident identifiers on them. 3.1-25(j) 3.1-25(o)		*removed from the medication cart and/or medication prep room on 4/24/23.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all residents have potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *The DON/designee will re-educate nurses on proper storage of medication in medication carts and proper labeling of all medications. Nurses will be re-educated on removing any medications that are not properly labeled from the med carts or medication prep rooms by returning them to pharmacy. Nurses will also be re-educated on the requirement to date an insulin pen or any vial when opened.* *The pharmacy has changed their labeling of insulin pens to ensure each individual pen is properly labeled with resident's name and instructions.* *The DON/designee will audit med carts and medication prep rooms to ensure all medications are properly stored and labeled as follows:* *All medication carts and medication prep rooms weekly x 4*	

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			weeks then monthly x 5 months. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The DON will report the findings to the QA Committee monthly for review and recommendations as needed for 6 months. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance.* **Correction actions will be completed by: 5/26/2023**	
F 0865 SS=F Bldg. 00	483.75(a)(1)-(4)(b)(1)-(4)(f)(1)-(6)(h)(i) QAPI Prgm/Plan, Disclosure/Good Faith Attmpt §483.75(a) Quality assurance and performance improvement (QAPI) program. Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI program that focuses on indicators of the outcomes of care and quality of life. The facility must: §483.75(a)(1) Maintain documentation and demonstrate evidence of its ongoing QAPI program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities;			

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	§483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(a)(3) Present its QAPI plan to a State Survey Agency or Federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request; and §483.75(a)(4) Present documentation and evidence of its ongoing QAPI program's implementation and the facility's compliance with requirements to a State Survey Agency, Federal surveyor or CMS upon request. §483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.			

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	§483.75(f) Governance and leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that: §483.75(f)(1) An ongoing QAPI program is defined, implemented, and maintained and addresses identified priorities. §483.75(f)(2) The QAPI program is sustained during transitions in leadership and staffing; §483.75(f)(3) The QAPI program is adequately resourced, including ensuring staff time, equipment, and technical training as needed; §483.75(f)(4) The QAPI program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information. §483.75(f)(5) Corrective actions address gaps in systems, and are evaluated for effectiveness; and §483.75(f)(6) Clear expectations are set around safety, quality, rights, choice, and respect. §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.			

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	§483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. Based on record review and interview, the facility failed to ensure a complete Quality Assurance and Performance Improvement (QAPI) program that addresses the full range of services the facility provides was in place related to lack of a QAPI plan and lack of an ongoing Performance Improvement Project (PIP). This had the potential to affect all residents in the facility. Finding includes: The Quality Assessment and Assurance (QAA) and QAPI program was reviewed on 4/21/23 at 10:30 a.m. The QAA and QAPI policies were available for review. Interview with the Assistant Director of Nursing (ADON) on 4/21/23 at 10:40 a.m. indicated she ran the monthly QAA and QAPI meetings. She indicated each department would present reports and review any concerns. Some issues, such as falls, were discussed at each meeting. When asked for the current QAPI plan, she indicated she was unsure what that was. They would discuss issues, but did not have a formal plan for documentation, monitoring and analysis. She further indicated there was not a PIP in progress. The current policy, "Crown Point Christian Village QAPI Program Plan", indicated, "...3. The Facility shall present this QAPI plan to a State Agency of Federal surveyor at each annual recertification survey...4. The Facility shall present	F 0865	**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.** F-865 **Corrective actions which will be accomplished for those residents founds to have been affected by the deficient practice:** *No residents were identified as being affected. The community does have an ongoing QAPI plan. A Performance Improvement Project will be initiated.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:**	05/26/2023

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

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	documentation and evidence of its ongoing QAPI program's implementation and the Facility's compliance with requirements to a State Agency, Federal surveyor or CMS upon request...."		*The facility determined that all residents have potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *The DON, ADON, and Executive Director will be re-educated on the QAPI plan and Performance Improvement components of QAPI. The QAPI committee will meet on May 15th to review the QAPI Plan and Performance Improvement Plan. The QAPI Committee will maintain ongoing Performance Improvement Projects, which addresses the full range of services the facility provides, indefinitely.* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The Executive Director will review the QAPI minutes each month for the next six (6) months to ensure the QAPI plan is being executed and Performance Improvement Plan is being implemented. The QA Committee will determine the need for continued or additional corrective actions to maintain compliance.* **Correction actions will be completed by: 5/26/2023**	

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F 0868 SS=F Bldg. 00	483.75(g)(1)(i)-(iii)(2)(i); 483.80(c) QAA Committee §483.75(g) Quality assessment and assurance. §483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (iv) The infection preventionist. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (i) Meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI program, such as identifying issues with respect to which quality assessment and assurance activities, including performance improvement projects required under the QAPI program, are necessary. §483.80(c) Infection preventionist participation on quality assessment and assurance committee. The individual designated as the IP, or at least one of the individuals if there is more than one IP, must be a member of the facility's quality assessment and assurance			

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	committee and report to the committee on the IPCP on a regular basis. Based on record review and interview, the facility failed to ensure the required staff were present at the monthly Quality Assessment and Assurance (QAA) and Quality Assurance and Performance Improvement (QAPI) meetings related to the Administrator not being present. This had the potential to affect all residents in the facility. Finding includes: The QAA and QAPI Minutes sign in sheets were reviewed on 4/21/23. January, February and March, 2023 lacked indication the Administrator was present at the meetings. Interview with the Assistant Director of Nursing, on 4/21/23 at 10:51 a.m., indicated she ran the monthly meetings. The Administrator was not present at the meetings, and did not participate by phone or videochat. The current policy, "Quality Assessment and Assurance", indicated, "...(QAA Committee, which shall consist, at a minimum of the following individuals: i. The director of nursing services; ii. The medical director or his or her designee; iii. At least three other members of the Facility's staff, at least one of whom must be the administrator, owner, or board member...." This Federal tag relates to Complaint IN00405158. 3.1-52	F 0868	**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.** F-868 **Corrective actions which will be accomplished for those residents founds to have been affected by the deficient practice:** *No residents were identified as affected.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined that all residents could be affected by this practice.* **The measures the facility will take or systems the facility will alter to ensure that the**	05/26/2023

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			problem will be corrected and will not reoccur: *The facility has a new Executive Director and will have an Interim Administrator until a permanent Administrator is identified. The Administrator and/or Executive Director will be present for future QAPI meetings. The QAPI committee will meet on May 15th.* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The Executive Director and Regional Director will audit the participation of QAPI members monthly for 6 months. The audits will be reported to the QA Committee, who will determine the need for continued or additional corrective actions.* **Correction actions will be completed by: May 26, 2023**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment was clean and in good repair related to gouged walls, peeled ceiling paint, a rusty grab bar and a dirty over the toilet riser on 1 of 3 units. (Pathway Unit) Findings include: During the Environmental tour with the Directors	F 0921	**F921:** **Safe/Functional/Sanitary/Comfortable Environment** **This Plan of Correction is the Facility's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the**	05/26/2023

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	of Maintenance and Housekeeping on 4/24/23 at 11:07 a.m., the following was observed: Pathway Unit a. In Room 137, the over the toilet riser in the bathroom had a dark brown substance on the front. Two residents resided in the room. b. In Room 142, the ceiling had paint peeling, holes in the bathroom ceiling, and the light switch by the entryway door was cracked. One resident resided in the room and two residents shared the bathroom. c. In Room 146, the ceiling had paint peeling, gouges in the wall behind the chair, holes in the wall next to the window, and the grab bar in the bathroom was rusted on one end. One resident resided in the room. Two residents shared the bathroom. Interview with the Directors of Maintenance and Housekeeping at the time, indicated all of the above were in need of repair or cleaning. This Federal tag relates to Complaint IN00401028. 3.1-19(f)		**Provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. The Plan of Correction is prepared and/or executed solely because it is required by the provisions of Federal and State Law.** 1. **Corrective action for residents affected:** The identified gouged walls and peeled ceiling have been patched and painted. The toilet risers have been cleaned. 2. **How facility will identify other residents with potential to be affected:** All other residents have the potential to be affected. 3. **What measures or systemic changes will be put in place to ensure deficiency does not recur:** The Maintenance & Housekeeping Directors have been re-educated on maintaining a safe, functional, sanitary, and comfortable environment. 4. **How facility plans to monitor its performance to make sure solutions are sustained:** The Maintenance Director will audit the walls and ceilings weekly for 3 months, then monthly for 3 months. The Housekeeping Director will audit	

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			the cleanliness of 5 different toilet risers weekly for 3 months, then monthly for 3 months. Results of the audits will be reported to the QAPI Committee, which can make further recommendations as needed. 5. **Corrective action will be completed by:** May 26, 2023	
F 9999 Bldg. 00	3.1-13 Administration and management (e) An administrator shall be employed to work in each licensed health facility. For purposes of this subsection, an individual can only be employed as an administrator in one (1): (1) health facility; or (2) hospital-based long-term care unit; at a time. (f) In the administrator's absence, an individual shall be authorized, in writing, to act on the administrator's behalf. This state rule was not met as evidenced by: Based on record review and interview, the facility failed to ensure the Administrator was licensed solely at this facility related to the current Administrator being claimed as the licensed Administrator at two separate Indiana health facilities. This had the potential to affect all residents in the facility. Finding includes: The document, "Administrator or Director of	F 9999	**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.** F9999 (State rule) **Corrective actions which will be accomplished for those residents founds to have been affected by the deficient**	05/26/2023

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	Nursing Change" indicated the current identified Administrator was appointed the as the new Administrator for Crown Point Christian Village effective 11/11/22. She was also named as the current Administrator of a sister facility as of 3/13/23. There was no documentation of a waiver being issued to permit the Administrator to oversee both facilities. Interview with the Administrator on 4/18/23, indicated she was currently the Administrator at both facilities. She indicated she believed there was a waiver in place that allowed her to oversee both facilities. She physically came to visit Crown Point Christian Village once every two weeks. This state finding relates to Complaint IN00405158.		**practice:** *No residents were identified as being affected by this deficient practice.* **How the facility will identify other residents having the potential to be affected by the same deficient practice:** *The facility determined all residents have potential to be affected.* **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not reoccur:** *The facility will employ an Interim Administrator who is solely licensed/employed at CPCV. The Administrator Change form will be submitted to the IDOH on Monday, May 8th, 2023.* **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** *The VP of Community Operations will monitor.* **Correction actions will be completed by: 5/8/2023**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00401028 and IN00405158.	R 0000	Please consider this plan of correction as Crown Point Christian Village's credible plan of correction. This plan of correction constitutes a written allegation of	

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	Complaint IN00401028 - Federal deficicencies related to the allegations are cited at F0921. Complaint IN00405158 - Federal deficicencies related to the allegations are cited at F0677, F0868 and F9999. Survey dates: April 17, 18, 19, 20, 21 and 24, 2023. Facility number: 001198 Residential Census: 30 Crown Point Christian Village was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.		substantial compliance under Federal and Medicare requirements. Submission of this plan of correction is not an admission that a deficiency exists or that the community agrees they were cited correctly. This plan of correction reflects a desire to continuously enhance the quality of care and services provided to our Residents solely as a requirement of the provision of the Federal and State Law. Please accept this evidence in lieu of an onsite post survey re-visit for recertification and state licensure.	