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	09/05/2024

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 the Investigation of Complaint IN00442079. Complaint IN00442079 - Federal/state deficiencies related to the allegations are cited at F583 and F609. Unrelated deficiency is cited. Survey dates: September 5, 2024 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 80 SNF: 16 Residential: 46 Total: 142 Census Payor Type: Medicare: 9 Medicaid: 65 Other: 22 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/11/24.	F 0000	The facility kindly requests a desk review.	
F 0583 SS=D Bldg. 00	483.10(h)(1)-(3)(i)(ii) Personal Privacy/Confidentiality of Records Based on interview and record review, the facility failed to ensure a resident's privacy was	F 0583	**Crown Point Christian Village Complaint Survey**	09/20/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	09/20/2024

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	respected, related to RN 2 using her private cell phone to take pictures of bruising on the left arm and left breast of a cognitively impaired resident (Resident B) without the approval of the resident's Responsible Party, for 1 of 1 resident reviewed for privacy. See F609 for additional information regarding Resident B. Finding includes: Resident B's record was reviewed on 9/5/24 at 9:47 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 6/22/24, indicated a moderately impaired cognitive status. A Nurse's Progress Note, dated 8/24/24 at 5:46 a.m. and signed by RN 2, indicated a large bruised area was observed on the left breast and left upper arm and the left ankle was slightly swollen. The resident complained of pain with movement of the ankle and was unable to remember how she received the bruises. Cross reference F609. During an interview on 9/5/24 at 1:16 p.m., RN 1 indicated the bruising of the left arm and breast area was purple when she first observed them on the morning of 8/24/24. The DON had asked her to take pictures and the pictures were sent to the Director of Nursing (DON). The pictures were taken on her personal cell phone and sent to the DON. During an interview on 9/5/24 at 1:30 p.m., the		**9.5.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F 583 Personal Privacy/ Confidentiality of Records** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** RN 1 was counseled for the HIPPA violation for asking RN 2 to take a picture of Resident B's bruises and text them on her personal cell phone. RN 2 was counseled for the HIPPA violation for taking picture of Resident B's bruising and texting them to RN1. Resident B has no adverse effects from HIPPA violation; Resident B's family and MD were notified of HIPPA violation. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and	

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	DON indicated the pictures were sent to her personal cell phone. The only facility cell phone available was the on-call cell phone. During an interview on 9/5/24 at 2:04 p.m., the Administrator indicated taking pictures of the residents on a cell phone was against the facility policy. The Resident's "Authorization to Disclose Resident Photographs and Voices" consent, signed by the Responsible Party on 2/14/19, indicated photographs could be used for marketing or promoting the community. The facility's Employee Handbook, dated 9/2019, indicated cell phone cameras or any cameras were not to be used in any resident areas nor to capture photos of the residents. This citation relates to Complaint IN00442079.		medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Staff in services were conducted to ensure HIPPA compliance is followed according to the facility's policies and procedures. Staff have been in-serviced on: ·Resident rights to privacy ·Resident rights to privacy on regarding not taking pictures or sending on non-secured platforms per facility's policy. HR has audited that all current employees have a completed HIPPA Policy Compliance Agreement in their files. **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Administrator/designee will conduct 5 staff interviews regarding HIPPA compliance/week to ensure that HIPPA compliance is followed according to facility policy for 6 months. Director of Nursing/designee will present a summary of the audits	

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			to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9.20.24**	
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on observation, record review, and interview, the facility failed to ensure an injury of unknown source was immediately reported to the Administrator/Abuse Coordinator and the Indiana Department of Health (IDOH) and failed to ensure the injury was investigated/assessed thoroughly for 1 of 3 residents reviewed for injuries and abuse. (Resident B) Finding includes: During an observation on 9/5/24 at 1:50 p.m., CNA 1 lifted up Resident B's shirt and removed her left arm from the sleeve of the shirt. There was a fading purplish/red bruised area from the underarm to the elbow, approximately 20 centimeters (cm) by 13 cm. The entire side and underneath the left breast had a purple bruise. CNA 1 indicated she was unsure how the injury occurred. The resident was unable to recall how the bruise occurred. Resident B's record was reviewed on 9/5/24 at 9:47 a.m. The diagnoses included, but were not limited	F 0609	**Crown Point Christian Village Complaint Survey 9.5.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. F609 Reporting of Alleged Violations What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Upon notification by the surveyor, the facility immediately reported the allegation to ISDH and initiated an investigation. The facility completed the investigation, and a final report was sent to ISDH.	09/20/2024

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	to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 6/22/24, indicated a moderately impaired cognitive status, no behaviors, no impaired movements of the upper and lower extremities, was dependent on staff for toileting, showers, dressing, hygiene, bed mobility, transfers and wheelchair mobility, and was not receiving blood thinners or anticoagulant medications. A Care Plan, dated 12/31/23, indicated assistance was required for activities of daily living. The interventions included two staff members and a mechanical lift was required for all transfers. A Nurse's Progress Note, dated 8/24/24 at 5:46 a.m. and signed by RN 2, indicated a large bruised area was observed on the left breast and left upper arm and the left ankle was slightly swollen. The resident complained of pain with movement of the ankle and was unable to remember how she received the bruises. There were no measurements of the bruising of the left arm or breast documented. A Nurse's Progress Note, dated 8/24/24 at 7:31 a.m., indicated the Nurse Practitioner ordered STAT X-rays for the left ankle and chest. The X-ray results, received by the facility on 8/24/24 at 11:46 a.m., indicated there were no fractures observed on the left ankle and there were no rib fractures. During an interview on 9/5/24 at 11:16 a.m., the Director of Nursing (DON), indicated the staff from 8/22/24, 8/23/24, and 8/24/24 had been interviewed. The interviews and the investigation		How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The facility has re-in serviced staff, including RN 1, RN 2, CNA 1, CNA 2, CNA 3, CNA 4, CNA 5, CNA 6, CNA 7, LPN 8 regarding the Facility Abuse Policy. Training included: *Types of abuse *Immediate reporting requirements including immediately reporting if any bruising of unknown origin observed. *Reporting any injury of unknow origin would be an injury that was not observed and was suspicious because of the extent or the injury or the location of the injury. Wound Nurse has completed a skin sweep of all residents to	

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	had not been typed up. None of the staff had reported the resident had fallen. During an interview on 9/5/14 at 1 p.m., the DON indicated the bruising had not been measured when it was found. The policy indicated the the nurse who initially observed the bruising was to measure the bruise. The bruising had been observed by the DON on 8/24/24 and the bruise on the left arm went from the shoulder area to the mid arm and was approximately 7 cm by 4 cm. The left chest bruising went from under the arm to the left side of the breast and was about 4 cm by 4 cm. The DON indicated the following staff had been interviewed after the bruising was reported on 8/24/24: CNA 3 and CNA 4, who had worked night shift on 8/22/24 through the morning of 8/24/24, and they were unaware of the bruising and of a fall. They indicated CNA 5 had taken care of the resident. CNA 5 indicated she had been floated to another area and had not taken care of the resident. CNA 2 had reported there was gossip the resident had been "dropped" and was transferred off the floor without the incident being reported to the nurse. None of the other staff interviewed had indicated they heard the resident had been "dropped". CNA 6 had indicated the bruises were observed on 8/23/24 on the evening shift while night time care was provided. The bruising was not reported at this time because she thought it had already been reported. During an interview on 9/5/24 at 1:16 p.m., RN 1 indicated the bruising of the left arm and breast		ensure that all injuries/ skin issues have been identified. For any resident that had skin issue identified during the skin sweep, the Residents' families and MDs have been notified. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; The Administrator/designee will complete 10 interviews weekly, a combination of both employees and visitors, regarding abuse and the reporting of abuse. After 3 months the facility will interview 5 employee/visitors weekly regarding abuse and the reporting of abuse for an additional 3 months. The facility will follow the abuse policy related to reporting. The Administrator/Human Resource Director will present a summary of the interview findings to the Quality Assurance committee monthly for three months. Thereafter, the facility if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:**	

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	area was purple when they were first observed on the morning of 8/24/24. The DON had asked her to take pictures of the areas and send them to her. The bruising was observed on the whole side of the left breast and the left arm had bruising from the elbow up to the shoulder. She had not measured the bruising and would estimate the bruising on the left arm at 20 cm by 7 cm. The ankle was a little puffy and Resident B complained of pain with movement. CNA 6 had worked a double shift and notified her. CNA 6 informed RN 1 she had seen the bruising earlier and had forgotten to report the bruising. CNA 7 came into work on 8/24/24 and indicated she had seen the bruises on the morning of 8/23/24. During an interview on 9/5/24 at 1:30 p.m., the DON indicated she forgot about the pictures. The pictures from 8/24/24 were observed on the cell phone. The left arm bruising was from under the arm at the shoulder to the elbow and the whole side of the left breast had purple bruising. The DON estimated the bruising of the breast to be 20 cm by 7 cm, and then indicated she was not good at estimating the size. The bruising had not been reported to the IDOH. During an interview on 9/5/24 at 1:35 p.m., CNA 7 indicated the bruises on the left arm and breast were observed when the resident was assisted with dressing on the morning of 8/23/24. She was unable to locate the nurse and went back to work and had not reported the bruising until she left for day around 11 a.m. The bruising was reported to LPN 8. During an interview on 9/5/24 at 1:44 p.m., LPN 8 indicated CNA 7 reported the bruising of the left arm and breast. CNA 7 had informed her the bruising had been reported to another nurse. LPN		**9.20.24**	

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	8 had not followed up/assessed the bruising. During an interview on 9/5/24 at 2:04 p.m., the Administrator indicated the bruising had just been reported to IDOH. During an interview on 9/5/24 at 2:05 p.m., CNA 2 indicated the bruises were observed on 8/24/24. There had been rumors the resident had rolled out of bed on the night of 8/22/24 and was placed back into bed without the nurse being notified. During an interview on 9/5/24 at 2:11 p.m., the DON indicated CNA 3 had reported the resident was turned and repositioned. The resident had not been transferred from the bed the morning of 8/23/24. CNA 4 had indicated CNA 5 had taken care of the resident. CNA 5 was interviewed and had been floated to another unit and had not been in the resident's room. During an interview on 9/5/24 at 2:32 p.m., CNA 3 indicated CNA 5 had been assigned to the resident until she was moved to another unit around 1:00 a.m. The resident had not screamed out or fallen during the night and was unable to move around in the bed independently. During an interview on 9/5/24 at 3:25 p.m., CNA 6 indicated a report was given by CNA 7 on 8/23/24 about the bruising. There was a nurse sitting at the desk and CNA 6 was unsure if the nurse heard CNA 7 report the bruising. CNA 6 indicated she had not reported the bruising because she thought CNA 7 had already reported it. The facility abuse policy, dated 5/30/17 and received as current from the DON, indicated when an incident of neglect or abuse of a resident was suspected, the Abuse Coordinator was to be be			

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	notified immediately. An initial report was to be sent to IDOH. All alleged violations involving abuse, neglect and injuries of unknown source were to be reported immediately but no later than two hours. Injuries of unknown origin will be investigated. An injury of unknown origin would be an injury that was not observed and was suspicious because of the extent or the injury or the location of the injury. A facility wound assessment policy, dated 1/2024 and received as current from the Administrator, indicated bruising would be assessed if considered "significant" in size, location or characteristics. This citation relates to Complaint IN00442079. 3.1-28(c) 3.1-28(d)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure a resident who required respiratory care received care consistent with profession standards and was administered oxygen as ordered by the physician, for 1 of 1 resident reviewed for respiratory care. (Resident E) Finding includes: During an observation on 9/5/24 at 9:38 a.m., LPN 8 responded to an activated call light activated by Resident F. Resident F indicated Resident E's oxygen concentrator was alarming and it was driving him crazy. LPN 8 indicated she needed to administer medications then she would take care	F 0695	**Crown Point Christian Village Complaint Survey 9.5.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F695 Respiratory/Tracheostomy care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been**	09/20/2024

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	of the concentrator, said she would be back, then left the room. During an observation on 9/5/24 at 9:42 a.m., Resident E was lying in bed with the head of the bed elevated. A nasal cannula for the oxygen was in place. The oxygen concentrator was alarming and a lit picture of a wrench was flashing on the concentrator. The concentrator was set at less than 0.5 liters per minute. During an interview on 9/5/24 at 9:59 a.m., Minimum Data Set (MDS) Nurse 9 indicated she was unsure what the wrench meant. She acknowledged the alarm continued and the concentrator was setting for oxygen administration at "a little bit over zero." Another concentrator would be needed and she would also report this to the resident's nurse. During an observation on 9/5/24 at 10:06 a.m., LPN 8 entered the room and indicated all the other concentrators were broken. MDS Nurse 9 had brought an oxygen cylinder into the room. LPN 8 obtained the resident's oxygen saturation at 83% and indicated the resident was still wheezing and he had just received a nebulizer treatment. The oxygen had been working during the night shift and the setting would not go higher than the 0.5 liters per minute. MDS Nurse 9 applied the oxygen at 2 liters per minute through the oxygen cylinder and the resident's oxygen saturation result was 93%. LPN 8 indicated she had been in the room about "30-40 minutes" ago and had turned the concentrator on and off and it still beeped. No one else had been notified and the oxygen cylinder had not been used because they have never used them. During an interview on 9/5/24 at 10:12 a.m., the		**affected by the deficient practice;** Resident E was assessed, oxygen saturation level and pulse were taken, no adverse effects. Resident E's oxygen concentrator was replaced. Resident E's family and MD were notified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Clinical staff were re-educated to ensure a resident who required oxygen has a working concentrator machine/ portable and to ensure that Residents on oxygen would provided to the resident as ordered by the attending physician. All residents who are on oxygen have been assessed and have working oxygen equipment available. **How the corrective action(s)**	

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	Administrator indicated the concentrator not working was just reported to her and there were other concentrators in the building. A different nurse had retrieved another concentrator was taking it to the resident's room There were also cylinders in the building the staff could have used. Resident B's record was reviewed on 9/5/24 at 4:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Care Plan, dated 8/23/24, indicated a diagnosis of pneumonia. The interventions included medications would be administered as ordered. A current Physician's Order indicated oxygen to be delivered at two liters per nasal cannula. A Nurse Practitioner's Progress Note, dated 8/22/24, indicated wheezing and congestion. The oxygen saturation had been low the past week and oxygen was started at two liters by nasal cannula. There was difficulty obtaining a good oxygen saturation reading due to clenching of hands. A facility oxygen administration policy, dated 9/2009 and received as current, indicated oxygen would be provided to the resident as ordered by the attending physician. 3.1-47(a)(6)		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place;** DON/designee will audit 5 residents with oxygen weekly x 2 months, then 5 residents bi-weekly x 2 months, then 5 residents monthly to ensure that oxygen concentrators/ oxygen equipment is functioning properly for 6 months. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9.20.24**	