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	02/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWN POINT HEALTH CAMPUS	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. This visit included the Investigation of Complaints IN00450257, IN00453351 and IN00453429. This visit included a State Residential Licensure Survey. Complaint IN00450257 - No deficiencies related to the allegations are cited. Complaint IN00453351 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00453429 - Federal/State deficiencies related to the allegations are cited at F880 Survey dates: February 17, 18, 19, 20, 21, and 24, 2025 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF: 14 SNF/NF: 87 Residential: 42 Total: 143 Census Payor Type: Medicare: 12 Medicaid: 71 Other: 18 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	03/17/2025

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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	Quality review completed on 2/28/25.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review and interview, the facility failed to ensure residents were assessed to self-administer medication and had a physician's order to self-administer medication for 2 of 2 residents observed self-administering medications. (Residents 41 and 201) Findings include: 1. During a random observation on 2/17/25 at 9:09 a.m., Resident 41 was observed seated in her wheelchair in her room. There was a medicine cup with several pills on her overbed table in front of her. Several minutes later, the pills were again observed on the resident's table. The resident asked if she had to take all of them. RN 1 entered the room and then assisted the resident with taking the medications. During an interview on 2/17/25 at 9:13 a.m., the nurse indicated she had left them with the resident because she was taking her time, and she should not have left the medications with the resident. The resident's record was reviewed on 2/17/25 at 9:20 a.m. There was no self-medication administration assessment and no Physician's order to self-administer medications. 2. On 2/17/25 at 9:35 a.m., RN 1 was observed passing medications to Resident 201. The resident was in her bed. On her nightstand, there was a tube of antibiotic ointment and loperamide tablets	F 0554	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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 554 Resident Self-Administration Medications-Clinically Approp** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 41 had medications bedside. The medications removed from the bedside. There were no adverse effects noted. Resident's family and MD have been notified. Resident 201 had medications bedside. The medications removed from the bedside. There were no adverse effects noted. Resident 201's significant other was educated that all medications needed to have a physician's order. Resident 201 no longer resides at the facility. **How the facility will identify**	03/17/2025

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	(anti diarrhea medication). The resident indicated she had diarrhea from the antibiotics she was taking. The RN did not remove the medications. The resident's record was reviewed on 2/17/25 at 10:00 a.m. There was no self-medication assessment, physician's order to self-administer medications, or orders for the antibiotic ointment or loperamide. During an interview on 2/18/25 at 8:45 a.m., the Director of Nursing indicated the resident's companion had brought the medications and had been educated that all medications needed to have a physician's order. 3.1-11		**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;** RN1 was in-serviced to stay with each resident until the entire medication administration is completed. Nurses were re-educated on completing self-administration medication assessments and orders for self-administration in PCC for residents who desire to have medications in room/ bedside. If a resident is unable to pass the assessment, there should be no medications left bedside. **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;** DON/designee will randomly audit 5 residents 2x's/week for 6	

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			months, to ensure there are no medications left bedside, and if resident is able to pass medication, they have completed a self-administration medication assessment and orders for the self-administration of the medications is in PCC. 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: 3.17.25**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on record review and interview, the facility failed to ensure a comprehensive care plan was developed and in place for residents with significant weight loss for 2 of 24 care plans reviewed. (Residents 75 and 85) Findings include: 1. Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated 1/2/25, indicated the resident was	F 0656	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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 656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those**	03/17/2025

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	cognitively intact and was dependent on staff assist for toileting and bed mobility. He had a weight loss of 5% or more in a month or 10% or more in 6 months and was not on a physician-prescribed weight loss regimen. The resident's admission weight on 8/8/24 was 324.4 pounds. The resident's weight on 11/5/24 was 293.6 pounds and on 2/5/25, was 246.5 pounds. This was a weight loss of 30.8 pounds, a 24% change, in six months. A Dietary Note, dated 2/13/25, indicated the resident had a significant weight loss. The resident had reported difficulty chewing foods and holding cups. His diet had been downgraded to pureed and Speech and Occupational Therapy had been ordered. There was not a care plan in place to related to the significant weight loss. During an interview on 2/21/25 at 2:50 p.m., the Director of Nursing indicated there was no care plan related to the significant weight loss. 2. The record for Resident 85 was reviewed on 2/19/24 at 9:54 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, general anxiety disorder, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the resident was cognitively impaired and had a significant weight loss. A care plan, updated 7/30/24, indicated the resident was on a regular diet. The interventions included to provide supplements per orders. There was no care plan related to significant weight loss.		**residents found to have been affected by the deficient practice;** Resident 75 no longer resides in this facility. Resident 85 had care plan updated related to significant weight loss. No adverse effects from not having care plan were noted. Resident 85'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;** Licensed nursing staff and the dietician were re-educated to ensure a comprehensive care plan was developed and in place for residents with significant weight loss. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	The resident's weight on 7/19/24 was 154 pounds and on 2/3/25 was 135 pounds. The Culinary Nutritional Comprehensive Assessment, dated 11/1/24, indicated the resident had a significant weight loss x 90 days. The Culinary Nutritional Quarterly Assessment, dated 1/29/25, indicated the resident had a significant weight loss x 180 days. During an interview on 2/21/25 at 1:44 p.m., the Director of Nursing indicated there should have been a care plan in place for weight loss. 3.1-35(a)		**assurance programs will be put into place;** DON/designee will audit 5 residents with significant weight loss weekly x 2 months, then 5 residents bi-weekly x 2 months, then 5 residents monthly to ensure a comprehensive care plan was developed and in place for residents with significant weight loss 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: 3.17.25**	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision Based on observation, record review, and interview, the facility failed to ensure care plans were updated for 1 of 24 resident care plans reviewed. (Resident 7) Finding includes: On 2/17/25 at 2:46 p.m., Resident 7 was observed in a wheelchair. Her left hand appeared to be contracted (a condition where the fingers or palm of the hand are involuntarily bent or curled in). The resident was unable to communicate if she	F 0657	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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 657 Care Plan Timing and**	03/17/2025

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	was able to open her hand or if she wore any splinting devices. The record for Resident 7 was reviewed on 2/20/25 at 10:25 a.m. Diagnoses included, but were not limited to, cerebral palsy, mild intellectual disabilities, and hemiplegia and hemiparesis (paralysis and weakness) following a stroke affecting the left side. The Quarterly Minimum Data Set (MDS) assessment, dated 11/19/24, indicated the resident was moderately cognitively impaired, had a functional limitation in range of motion on one side of the upper extremities, and required assistance from staff with toileting, showering, and transfers. The February 2025 Physician Order Summary indicated the resident may participate in restorative programs if indicated. A Care Plan, dated 8/22/24, indicated the resident had an ambulation activity of daily living (ADL) self-care performance deficit. Interventions included, but were not limited to, ambulation program with restorative to assist resident by ambulating up to 50 feet with platform walker and gait belt. A Care Plan, dated 8/30/24, indicated the resident was to maintain range of motion. Interventions included, but were not limited to, restorative to instruct and supervise active range of motion (AROM) to the bilateral lower extremities (BLE), 10 repetitions twice daily for 6 to 7 days per week. The CNA Task List indicated restorative was to ambulate the resident up to 50 feet as tolerated with left hand platform walker and restorative was		**Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 7 has been assessed for therapy for recommendations regarding splinting device. Resident 7's family and MD aware, no adverse effects. **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;** Staff were re-educated to ensure that care plans were updated and reviewed, including for restorative therapy. **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;**	

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	to instruct and supervise AROM to the BLE 10 repetitions twice daily for 6 to 7 days per week. There was no restorative therapy documented for the last 30 days reviewed. During an interview on 2/21/25 at 1:43 p.m., the Director of Nursing indicated the facility has not had restorative therapy since September 2024 and the Care Plan should have been removed. The resident had cerebral palsy and was seen by therapy in the past with no recommendations for splinting devices. 3.1-35(c)(1)		DON/Designee will audit 5 residents 2xs/week for 6 months, to ensure that care plans were updated and reviewed, including for restorative therapy. 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: 3.17.25**	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on record review and interview, the facility failed to document incontinence care for a resident who was dependent on staff for activities of daily living (ADLs) for 1 of 7 residents who were reviewed for ADLs. (Resident C) Finding includes: During an interview on 2/18/25 at 9:14 a.m., Resident C's Power of Attorney (POA) indicated she had come to the facility on multiple occasions and found the resident in a soaking wet brief. The resident was fully dependent on the staff for all activities of daily living (ADLs) including, but not limited to, toileting, eating, and drinking.	F 0677	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been**	03/17/2025

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	The record was reviewed on 2/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/24, indicated the resident was severely cognitively impaired and was dependent on staff for all ADLs including eating, toileting, personal hygiene, and transfers. She was always incontinent of bowel and bladder and received hospice care. The current Care Plans indicated the resident needed assistance with ADLs due to cognitive deficit and was totally dependent on staff for all ADL care. The resident was incontinent of bladder due to decreased mobility and cognition. She had a diagnosis of Alzheimer's disease and did not alert staff of her need to use the bathroom. Interventions included, but were not limited to, encourage fluids, and incontinence care with each incontinence episode. The CNA Task: Incontinence Care was reviewed for the last 30 days (1/23-2/20/25). The documentation frequency was every shift. The following dates and shifts were not documented: - 1st shift on 1/28, 2/11, 2/17, and 2/18/25 - 2nd shift on 2/1, 2/4, 25, 2/6, 2/8, 2/9, 2/11, 2/14, 2/16, 2/17, and 2/18/25 - 3rd shift on 1/23, 1/26, 1/28, 2/2, 2/10, and 2/19/25 During an interview on 2/21/25 at 8:17 a.m., the Director of Nursing had no further information to provide. This citation relates to Complaint IN00453351.		**affected by the deficient practice;** Resident C was assisted with all needed ADL's, which included providing incontinence care. ADL care has been documented. **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;** Staff were re-educated to ensure that the facility will document incontinence care for residents who are dependent on staff for activities of daily living (ADLs). **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;** DON/Designee will audit 10 residents 2xs/week for 6 months, to ensure that the facility documents on incontinence care	

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			for residents who are dependent on staff for activities of daily living (ADLs). 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: 3.17.25**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure physician's orders were followed for non-pressure skin condition treatments and non-pressure skin areas were assessed and monitored for 2 of 5 residents reviewed for skin conditions, non-pressure related. (Residents 1 and 16). Findings include: 1. During an interview and observation on 2/17/25 at 9:42 a.m., Resident 1 indicated she had a sore area on her right upper chest. She had it for the last couple of weeks and told the staff about it the night before. The area was observed to be a large scab with the surrounding skin red in color. On 2/20/25 at 11:09 a.m., Resident 1 had a 4 by 4 padded gauze covering the area on her right upper	F 0684	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 1 was assessed, and MD orders were followed for skin	03/17/2025

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	chest. The resident indicated the staff put a cream on it the night before and was keeping it covered so her top would not rub the area. Resident 1's record was reviewed on 2/19/25 at 11:10 a.m. Diagnoses included, but were not limited to, hereditary motor and sensory neuropathy (affecting the peripheral nerves) and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 2/2/25, indicated the resident was cognitively intact for daily decision making. She had an impairment to range of motion on one side of the upper extremities. She was totally dependent for toileting and transfers and required maximal assistance with showering/bathing. The Skin Check Assessment, dated 2/14/25, indicated there were no skin concerns. During an interview on 2/19/25 at 2:59 p.m., the Wound Nurse indicated she was unaware of the scabbed area until Tuesday (2/18/25) when the resident told her about the area, she was then assessed by the Nurse Practitioner (NP) and received orders for a treatment to the area. During an interview on 2/21/25 at 1:40 p.m., the Director of Nursing indicated she would follow up with the Wound Nurse regarding the scabbed area. There was no further information provided. 2. Resident 16's record was reviewed on 2/18/25 at 3:11 p.m. Diagnosis included, but were not limited to, lymphedema, venous insufficiency, and non-pressure chronic ulcer of the right and left calf.		condition treatments. R1's plan of care has been updated. Resident 1's family and MD were notified, no adverse effects identified. Resident 16 was assessed; wound assessments have been completed. Resident 16's TAR was reviewed, and care plan has been updated. Resident 16's family and MD have been notified; no adverse effects have been noted. **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;** Licensed Nurses and the Wound Nurse were re-educated to ensure the physician's orders were followed for non-pressure skin condition treatments and non-pressure skin areas were assessed and monitored. **How the corrective action(s) will be monitored to ensure the**	

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CROWN POINT HEALTH CAMPUS	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

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	The Quarterly Minimum Data Set (MDS) assessment, dated 1/6/25, indicated the resident was moderately cognitively impaired and required assistance from staff for activities of daily living (ADL) care. The current Care Plan indicated the resident had a non-pressure wound to her right lower shin, venous ulcers to the right and left posterior calf, and a history of a neoplasm tumor to the left lower shin. Interventions included, but were not limited to, observe the areas at least daily, document weekly until resolved, and complete the treatments as ordered. A Physician's Order, dated 10/24/24, indicated to cleanse the left lower shin area with normal saline, pat dry, apply hydrofera blue to the wound bed and cover with a dry dressing every Monday, Wednesday, and Friday and as needed. The December 2024 and January 2025 Treatment Administration Records (TARs) indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, 1/17/25, 1/22/25, and 1/24/25. A Physician's Order, dated 12/6/24, indicated to cleanse the left posterior calf area with normal saline, apply calcium alginate to the wound bed, cover with an abdominal (ABD) pad, wrap with kerlix and secure with tape every Monday, Wednesday, and Friday. The December 2024 and January 2025 TARs indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, and 1/8/25. A Physician's Order, dated 12/6/24, indicated to cleanse the right posterior calf area with normal		**deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit all residents with non-pressure skin condition treatments and non-pressure skin areas, weekly for 6 months, to ensure the physician's orders were followed for non-pressure skin condition treatments and non-pressure skin areas were assessed and monitored. DON/Designee will audit 5 TARs records weekly for 6 months, for any changes noted to residents' treatment orders. 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: 3.17.25**	

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	saline, pat dry, apply calcium alginate to the wound bed, cover with an ABD pad, wrap with kerlix, and secure with tape every Monday, Wednesday, and Friday. The December 2024 and January 2025 TARs indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, and 1/8/25. A Physician's Order, dated 12/9/24, indicated to cleanse the right shin with normal saline, pat dry, apply hydrofera blue to the wound bed and cover with a dry dressing every Monday, Wednesday, and Friday. The December 2024 and January 2025 TARs indicated the treatment was not completed as ordered on 12/18/24, 12/25/24, 1/1/25, 1/8/25, 1/17/25, and 1/22/25. A Physician's Order, dated 1/10/25, indicated to cleanse the right posterior calf with normal saline, pat dry, apply xeroform to the wound bed, cover with an ABD pad, wrap with kerlix, then secure with tape every Monday, Wednesday, and Friday. The January 2025 TAR indicated the treatment was not completed as ordered on 1/17, 1/22, and 1/24/25. A Physician's Order, dated 1/10/25, indicated to cleanse the left posterior calf with normal saline, pat dry, apply xeroform to the wound bed, cover with an ABD pad, wrap with kerlix and secure with tape every Monday, Wednesday, and Friday. The January 2025 TAR indicated the treatment was not completed as ordered on 1/17, 1/22, and 1/24/25.			

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	During an interview on 2/19/25 at 1:40 p.m., the Wound Nurse indicated there should have been a progress note corresponding to any day the resident refused a treatment. The resident had frequently refused treatments in the past. During an interview on 2/21/25 at 1:50 p.m., the Director of Nursing had no further information to provide. A facility policy titled, "Wound Assessment," indicated "....3. New wounds and/or other skin impairments/abnormalities will be assessed and documented in the medical record upon being observed." 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer Based on observation, record review and interview, the facility failed to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to weekly wound assessments not completed and a physician's treatment order not updated for 2 of 2 residents reviewed for pressure ulcers. (Residents D and 4) Findings include: 1. On 2/19/25 at 10:42 a.m., the Wound Nurse was observed providing care for a pressure ulcer on Resident D's left heel. There was a round, dime-sized scabbed area on the left heel. The nurse indicated it was a healing stage 4 pressure ulcer. The resident's record was reviewed on 2/18/25 at	F 0686	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F686- Treatments/Svcs to Prevent/Heal Pressure Ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D no longer resides in	03/17/2025

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	3:05 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression and chronic respiratory failure. The Quarterly Minimum Data Set assessment, dated 12/24/24, indicated the resident had severe cognitive impairment, was dependent for toileting, eating, bed mobility and transfers and had a stage 4 pressure ulcer. The Pressure Injury Care Plan, dated 5/29/24, indicated the resident had a history of pressure ulcers and the potential to develop additional pressure ulcers. Interventions included, but were not limited to, provide daily skin monitoring and weekly skin checks. A Skin and Wound Evaluation, dated 12/19/24, indicated there was a stage 4 pressure ulcer on the left heel that measured 0.9 centimeters (cm) x 1.4 cm, scab, no drainage. There were no additional skin and wound evaluations. During an interview on 2/19/25 at 2:56 p.m., the Wound Nurse indicated she did not do weekly wound assessments because it was just a scab. During an interview on 2/21/25 at 2:50 p.m., the Director of Nursing indicated there should be weekly wound assessments. The current policy, "Wound Assessment", indicated, "...5. A complete wound assessment will be completed weekly for all wounds and skin impairments/abnormalities using the Skin and Wound Program in the electronic medical record...." 2. On 2/19/25 at 2:16 p.m., the Wound Nurse was		the facility. Resident 4 was assessed. Wound assessments have been completed. Resident 4's family and MD have been notified, no adverse effects have been noted. **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;** Nursing staff and Wound nurse were re-educated to ensure residents with pressure ulcers received the necessary treatment and services to promote healing related to weekly wound assessments completed, and ensure that physician's treatment orders are completed and updated for pressure ulcers as ordered. Wound Nurse completed a skin sweep audit for the facility to identify any new or worsened areas. **How the corrective action(s)**	

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	observed providing treatment to a pressure ulcer on Resident 4's right lower leg. The nurse removed the old dressing. She cleansed the wound with normal saline and gauze, then applied calcium alginate (an absorbent wound material) to the wound bed and covered the wound with a border dressing. The resident's record was reviewed on 2/19/25 at 9:53 a.m. Diagnoses included, but were not limited to, diabetes mellitus and schizophrenia. The Significant Change Minimum Data Set assessment, dated 1/30/25, indicated the resident had moderate cognitive impairment, was dependent on bed mobility and toileting, and had a stage 4 pressure ulcer. A Physician's Order, dated 12/27/24, indicated the right lower leg treatment was to clean with normal saline and pat dry, apply Hydrofera Blue (an antimicrobial wound foam) to the wound bed and cover with a dry dressing every Monday, Wednesday and Friday. During an interview on 2/19/25 at 2:56 p.m., the Wound Nurse indicated the physician had changed the order a couple weeks ago and she had overlooked changing it in the medical record, but had just . updated it. 3.1-40		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit to all residents with pressure ulcers weekly, to ensure residents with pressure ulcers received the necessary treatment and services to promote healing, wound assessments completed, and ensure that physician's treatment orders are completed and updated for pressure ulcers as ordered 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: 3.17.25**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility Based on observation, record review, and interview, the facility failed to ensure an order for a palmar guard and a resting hand splint device was followed and in place for a resident with a	F 0688	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** Please accept the following as the	03/17/2025

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	right hand contracture for 1 of 1 resident reviewed for range of motion. (Resident 42) Finding includes: During random observations on 2/17/24 at 2:17 p.m., on 2/19/25 at 9:26 a.m., and on 2/20/25 at 10:35 a.m., Resident 42 was observed lying in bed. At those times, the resident was observed with her right hand clenched against her chest. On 2/19/25 at 2:01 p.m., CNA 1 indicated the resident could not open her right hand without forcing her hand open or using a hot water towel to open the resident's hand. She had never used a palm protector and did not know if the resident was supposed to have a palm protector applied to her right hand. The record for Resident 42 was reviewed on 2/17/25 at 2:17 p.m. Diagnoses included, but were not limited to, Alzheimer's disease with late onset, generalized muscle weakness, and stiffness. The Quarterly Minimum Data Set (MDS) assessment, dated 1/29/25, indicated the resident was cognitively impaired. An Occupational Therapy (OT) Plan and Treatment Note, dated 1/7/25-2/17/25, indicated Resident 42 was recommended to wear a palmar guard and a resting hand splint on the right hand and on the right wrist at all times except bathing and exercise in order to develop and establish a wearing schedule, reduce pain caused by joint deformity, and reduce pain caused by muscle tightening. During an interview on 2/21/25 at 2:37 p.m., Physical Therapist (PT) 1 indicated that 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. **F688- Increase/Prevent Decrease in ROM/Mobility** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 42 was assessed, palmar guard and resting hand splint device was provided. Resident 42's family and MD have been notified, no adverse effects have been noted. **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;** Nursing staff, Restorative nurse	

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	nursing staff were educated and a schedule for splinting was supposed to be implemented for Resident 42. The schedule for the splint/soft palm protector was to wear daily and take off for showers and baths. There was also a restorative program that was written for the resident. During an interview on 2/21/25 at 3:02 p.m., the Assistant Director of Nursing indicated she thought therapy had tried to apply the splint and found her hand to be too tight, so they were attempting to possibly discontinue the splint order. She indicated that the nursing staff did not put a splint order in for the resident. 3.1-42(a)(2)		and CNA-1 were re-educated to ensure that all palmar guards and resting hand splint devices are in place for residents with contractures. Restorative Nurse completed audit for the facility to ensure all splints/ palmar protectors are in place as ordered. **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;** DON/Designee will audit to all residents with contractures weekly, to ensure that all palmar guards and resting hand splint devices are in place for residents with contractures as ordered 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: 3.17.25**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices			

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	Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for a resident with a history of falls for 1 of 5 residents reviewed for accidents. (Resident 34) Finding includes: On 2/19/25 at 1: 49 p.m., Resident 34 was observed seated in his wheelchair in the unit dining room. There were no anti-rollback bars or anti-tippers noted to the wheelchair. On 2/19/25 at 2:50 p.m., Resident 34 was observed seated in his wheelchair propelling himself around the unit dining room. There were no anti-rollback bars or anti-tippers noted to the wheelchair. On 2/20/25 at 10:11 a.m., Resident 34 was observed seated in his wheelchair and was brought to the unit dining room by a CNA. There were no anti-rollback bars or anti-tippers noted to the wheelchair. The record for Resident 34 was reviewed on 2/19/25 at 2:56 p.m. Diagnoses included, but were not limited to, Alzheimer's Disease, hypertension, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 12/26/24, indicated the resident was cognitively impaired. He had two or more falls with minor injury since the prior assessment and was dependent on staff for transfers. A Care Plan, dated 10/1/24, indicated the resident was at risk for falls. An intervention, dated 11/9/24, indicated to apply front and rear anti-tippers to the wheelchair.	F 0689	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F689-Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 34 is in the correct wheelchair with appropriate fall interventions. Resident 34's family and MD have been notified, no adverse effects have been noted. **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**	03/17/2025

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	A Care Plan Note, dated 11/11/24 at 2:51 p.m., indicated the resident had a fall on 11/9/24 while attempting to self-transfer. Anti-tippers were put in place to the resident's wheelchair as an intervention. During an interview on 2/21/25 at 1:51 p.m., the Director of Nursing (DON) indicated anti-tippers were added to the resident's wheelchair on 11/11/24 per the completed work order. She had determined staff had been putting the resident in his roommate's wheelchair by mistake, which did not have anti-tippers. He was now in the correct wheelchair. A facility policy, titled "Fall Prevention," indicated, "...Residents are identified as at risk for falls, clinically appropriate interventions will be put into place to reduce the risk for falls and/or to prevent recurrence of falls..." 3.1-45(a)		**ensure that the deficient practice does not recur;** Nursing staff and Restorative nurse were re-educated to ensure all resident with history of falls have appropriate fall interventions in place. Restorative Nurse completed audit for the facility to ensure all fall interventions are in place as ordered. **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;** DON/Designee will audit 10 residents weekly, to ensure that residents with history of falls have all fall interventions in place as ordered 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: 3.17.25**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI			

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	Based on record review and interview, the facility failed to ensure urinary output was recorded and the physician was notified for low urinary output as ordered for 1 of 1 resident reviewed for urinary catheters. (Resident 37) Finding includes: The record for Resident 37 was reviewed on 2/20/25 at 10:38 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, history of urinary tract infections (UTIs), urethral stricture (narrowing of the urethra), and obstructive and reflux uropathy (disorders of the bladder causing problems with urine flow). The Quarterly Minimum Data Set (MDS) assessment, dated 12/22/24, indicated the resident was severely cognitively impaired and had an indwelling urinary catheter. The current February 2025 Care Plans indicated the resident had an indwelling urinary catheter. An intervention indicated to monitor and document intake and output. The current February 2025 Physician Order Summary indicated monitor Foley catheter output every shift. If output was less than 300 milliliters (ml), notify the physician. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 2/2025, indicated the Foley output was not documented for the following dates and shifts: - 1st shift: 2/4/25 - 2nd shift: 2/1, 2/2, and 2/9/25 - 3rd shift: 2/1 and 2/11/25 The Medication Administration Record (MAR)	F 0690	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 37 was assessed, and all urinary outputs have been recorded since 2.24.25 and notified MD for low urinary output. Resident 37's family and MD have been notified; no adverse effects have been noted. **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**	03/17/2025

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	and Treatment Administration Record (TAR), dated 2/2025, indicated the Foley output was less than 300 ml on the following shifts: - 1st shift: 2/2, 2/9, 2/10, and 2/16/25 - 2nd shift: 2/3, 2/6, 2/8, 2/10, 2/11, and 2/17/25 - 3rd shift: 2/5, 2/6, and 2/9/25 There was no documentation of the physician being contacted when the Foley output was less than 300 milliliters. During an interview on 2/21/25 at 1:45 p.m., the Director of Nursing indicated she had no further information to provide. 3.1-41(a)(2)		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-educated to ensure residents with indwelling catheters have the urinary output recorded and notify the physician for low urinary output as ordered. **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;** DON/Designee will audit 5 residents with indwelling catheters/week to ensure urinary output was recorded and notify the physician for low urinary output as ordered 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: 3.17.25**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility	F 0692	**Crown Point Christian Village**	03/17/2025

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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
	failed to monitor weekly weights and document nutritional intake for fluids, meals, and supplements as ordered for residents with significant weight loss for 3 of 3 residents reviewed for nutrition. (Residents 75, 85 and C) Findings include: 1. Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated 1/2/25, indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. He had a weight loss of 5% or more in a month or 10% or more in 6 months and was not on a physician-prescribed weight loss regimen. The resident's admission weight on 8/8/24 was 324.4 pounds. The resident's weight on 11/5/24 was 293.6 pounds and on 2/5/25, was 246.5 pounds. This was a weight loss of 30.8 pounds, a 24% change, in six months. A Physician's Order, dated 11/19/24, indicated to check a weekly weight. The 2025 Medication Administration Record (MAR) indicated the following weekly weights: 1/13/25: n/a 1/20/25: n/a 1/27/25: 256 pounds 2/3/25: n/a 2/10/25: 246.5 pounds 2/17/25: blank During an interview on 2/21/25 at 1:55 p.m., the		**Annual/ Complaint Survey 2.24.25** 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. **F692 Nutrition/Hydration Status Maintenance** 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. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 75 no longer resides at the facility. Resident 85 was assessed; all supplement consumptions have been documented since 2.24.25. Resident 85's family and MD have been notified; no adverse effects noted and care plan has been updated accordingly. Resident C was assessed, all supplement consumptions, meals and fluid intakes have been documented since 2.24.25. Resident C's family and MD have been notified; no adverse effects	

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	155637	A. BUILDING 00 B. WING	02/24/2025

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	Director of Nursing indicated there were no additional weekly weights available. 2. On 2/20/25 at 11:36 a.m. Resident 85 was observed seated at a table in the unit dining room eating lunch. He had a mighty shake open in front of him but was not drinking it. The record for Resident 85 was reviewed on 2/19/24 at 9:54 a.m. Diagnoses included, but were not limited to, Alzheimer's Disease, general anxiety disorder, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 1/24/25, indicated the resident was cognitively impaired and had a significant weight loss. A Care Plan, updated 7/30/24, indicated the resident was on a regular diet. The interventions included to provide supplements per orders. There was no care plan related to significant weight loss. The resident's weight on 7/19/24 was 154 pounds and on 2/3/25 was 135 pounds. The Culinary Nutritional Comprehensive Assessment, dated 11/1/24, indicated the resident had a significant weight loss x 90 days. A Nurse Practitioner (NP) Note, dated 12/31/24 at 3:01 p.m., indicated the resident's weight was continuing to decline. The mighty shake was increased from two to three times a day and a 2 cal supplement was added twice a day. A Physician's Order, dated 9/16/24, indicated mirtazapine (Remeron, an antidepressant medication also used as an appetite stimulant) 45 milligrams at bedtime for insomnia and appetite		noted. **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;** Nursing staff and the Registered Dietician have been re-educated to ensure weekly weights will be monitored and document nutritional intake for fluids, meals and supplements as ordered for residents with significant weight loss. The IDT has reviewed residents POC charting to ensure all documentation is completed for residents with significant weight loss during the weekly NARS meetings. **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;**	

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	stimulant. Physician's Orders, dated 12/31/24, indicated to give 2 cal supplement twice a day and a mighty shake with meals for weight loss. The Culinary Nutritional Quarterly Assessment, dated 1/29/25, indicated the resident had a significant weight loss x 180 days. The Medication Administration Record (MAR), dated 2/2025, indicated the mighty shake and 2 cal supplements had been administered, however, there was no amount or percentage consumed documented. There was only a check mark documented with each administration. During an interview on 2/21/25 at 1:44 p.m., the Director of Nursing indicated the supplement orders had not been put in the computer correctly to leave an area for the percentage consumed to be documented. She had now updated the orders.3. Resident C's record was reviewed on 2/20/25 at 11:20 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/24, indicated the resident was severely cognitively impaired and was dependent on staff for all ADLs including eating, toileting, personal hygiene, and transfers. She received hospice care. The resident weighed 155.4 pounds on 8/1/24 and 139 pounds on 2/1/25. The current Care Plans indicated the resident needed assistance with ADLs due to cognitive deficit and was totally dependent on staff for all ADL care. The resident had a nutritional problem		DON/Designee will audit 10 residents/weekly to ensure weekly weights will be monitored and document nutritional intake for fluids, meals and supplements as ordered for residents with significant weight loss 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: 3.17.25**	

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	and was admitted to hospice. Interventions included, but were not limited to, monitor intake and record. The February 2025 Physician's Order Summary indicated the resident received super cereal in the morning and a Mighty Shake with meals for supplement. The February 2025 Medication and Treatment Administration Records indicated the Mighty Shake was administered with meals, but did not include how much of the supplement was consumed. The CNA Task: Nutritional Intake was reviewed for the last 30 days (1/23-2/20/25). The following meals were not documented: - Breakfast: 1/28, 2/17, and 2/18/25 - Lunch: 1/28, 2/17, and 2/18/25 - Dinner: 1/24, 1/27, 2/1, 2/4, 2/6, 2/16, and 2/18/25 The CNA Task: Fluid Intake was reviewed for the last 30 days (1/23-2/20/25). The frequency of documentation was at each meal and as needed. There were no documented amounts of fluids consumed at the following meals: - Breakfast: 2/11, 2/17, and 2/18/25 - Lunch: 2/11, 2/17, and 2/18/25 - Dinner: 2/11, 2/16, and 2/18/25 During an interview on 2/21/25 at 9:27 a.m., the Director of Nursing indicated she had no further information to provide. 3.1-46(a)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills			

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	Based on record review and interview, the facility failed to provide proper feeding tube (gastrostomy tube) (g-tube) care as per professional standards, related to a lack of documentation of tube feeding administration for a resident with a history of weight loss for 1 of 2 residents reviewed for tube feeding. (Resident 47) Finding includes: Resident 47's record was reviewed on 2/20/25 at 8:32 a.m. Diagnoses included, but were not limited to, vascular dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 1/7/25, indicated the resident was severely cognitively impaired. She had a feeding tube and was receiving hospice care. The current Care Plans indicated the resident was as risk for dehydration related to the g-tube use. Interventions included, but were not limited to, administer all tube feedings and fluids via g-tube per order. The resident had a g-tube related to dysphagia after a stroke. Interventions included, but were not limited to, registered dietician (RD) to evaluate quarterly and as needed and tube feedings per order. The resident had a potential nutritional problem. Interventions included, but were not limited to, RD to evaluate and make diet changes as needed, supplements as ordered, and monitor signs and symptoms of malnutrition such as significant weight loss: 3 lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months. A Dietary Note, dated 1/15/2025 at 6:20 p.m., indicated the resident was not receiving any food by mouth and only received tube feeding. She weighted 151.8 pounds (lbs) on 10/11/24, 146.8 lbs on 12/1/24 and 140.2 lbs on 12/18/24. With	F 0693	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F693 Tube Feeding Mgmt/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 47 was assessed, all the tube feedings have been marked as administered since 2.24.25. Resident 47's family and MD have been notified, no adverse effects have been noted. **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**	03/17/2025

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	significant weight loss evident, it was recommended to increase the duration of the tube feeding to 18 hours at 45 ml per hour with Jevity 1.5 formula. The current February 2025 Physician's Order Summary indicated enteral feed of Jevity 1.5 per g-tube via pump at 45 milliliters per hour. Start the infusion at 2:00 p.m. and turn off at 8:00 a.m. or until total volume was infused for 18 hours. Record all fluid administered through the g-tube every shift. The February 2025 Medication and Treatment Administration Records indicated the tube feeding was not administered on the following days: - 7:00 a.m. to 3:00 p.m.: 2/9, 2/10, and 2/13/25 - 11:00 p.m. to 7:00 a.m.: 2/11 and 2/17/25 During an interview on 2/21/25 at 1:34 p.m., the Director of Nursing indicated the nurse had just forgotten to sign off on the tube feeding administration. 3.1-44(a)		**changes will be made to ensure that the deficient practice does not recur;** Nursing staff were re-educated to ensure that all documentation of tube feeding administration for a resident with a history of weight loss has been completed as ordered and provide the proper feeding tube care as per professional standards. **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;** DON/Designee will audit all residents on feeding tubes weekly, to ensure that all documentation of tube feeding administration for a resident with a history of weight loss has been completed as ordered and provide the proper feeding tube care as per professional standards 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:**	

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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 residents received the necessary care and treatment related to incorrect oxygen flow rates and not monitoring an oxygen level for 2 of 3 residents reviewed for respiratory care. (Residents 75 and 74) Findings include: 1. On 2/17/25 at 11:12 a.m. and 2/18/25 at 2:58 p.m., Resident 75 was observed lying in his bed with his nasal cannula in place and oxygen flowing at a rate of 3 liters per minute (lpm). Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated 1/2/25, indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. A Physician's Order, dated 11/5/24, indicated to administer oxygen at 2 lpm continuously. On 2/19/25 at 10:05 a.m., the resident was observed with LPN 2. The nurse indicated the oxygen was incorrectly set between 2.5 and 3 lpm and she adjusted it to 2 lpm at that time. 2. On 2/18/25 at 10:33 a.m., Resident 74 was observed in his wheelchair wearing oxygen per nasal cannula. Resident 74's oxygen concentrator was set at 2.5 liters of oxygen.	F 0695	**3.17.25** **Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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 affected by the deficient practice;** Resident 75 no longer resides at the facility. Resident 74 was assessed, oxygen has been provided at the correct rate 2L, oxygen saturation orders have been clarified. Resident 74's family and MD have been notified, no adverse effects have been noted. **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	03/17/2025

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	On 2/19/25 at 2:51 p.m., Resident 74 was observed in his wheelchair, his oxygen was set to 2.5 liters. On 2/20/25 at 10:52 a.m., the resident was observed with the ADON. She indicated the oxygen was set to 4 liters. She adjusted the oxygen to 2 liters at that time. The record for Resident 74 was reviewed on 2/18/25 at 10:33 a.m. Diagnoses included, but were not limited to, chronic combined systolic congestive and diastolic heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 1/9/25, indicated the resident was cognitively intact. A Physician's Order, dated 10/10/24, indicated oxygen use at 2 liters via nasal cannula to be administered every 24 hours as needed for hypoxia. Administer oxygen if oxygen saturation falls below 92%. An Assessment of Resident 74's vital record tasks indicated Resident 74's oxygen saturation levels were last checked on 1/20/25, and the resident was saturating at 98% room air. During an interview on 2/20/25 at 10:57 a.m., the Assistant Director of Nursing verified that Resident 74 should be on 2 liters of oxygen. She indicated she would turn the concentrator to the correct rate immediately. The ADON indicated that Resident 74's oxygen saturation levels were last documented on 1/20/25. She indicated she would get a current oxygen saturation level on the resident immediately. 3.1-47(a)(6)		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;** Nursing staff, LPN 2 and ADON were re-educated to ensure that residents receive the necessary care and treatment related to correct oxygen flow rates and monitoring an oxygen level as ordered. **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;** DON/Designee will audit 10 residents/weekly to ensure that residents receive the necessary care and treatment related to correct oxygen flow rates and monitoring an oxygen level as ordered 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.	

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			Monitoring will be on going. **Date by which systemic corrections will be completed: 3.17.25**	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on observation, record review and interview, the facility failed to ensure routine and emergency drugs were received in a timely manner and procedures for accurate dispensing were provided for 2 of 2 residents reviewed for pharmacy services. (Residents 32 and 77) Findings include: 1. On 2/17/25 at 2:00 p.m., Resident 32 was observed seated in her recliner in her room. She indicated she had an itching rash on both arms and her left leg for about a week. She had requested to see the Nurse Practitioner. The resident's record was reviewed on 2/20/25 at 1:30 p.m. Diagnoses included, but were not limited to, diabetes mellitus, asthma and colostomy. The Quarterly Minimum Data Set assessment, dated 1/25/25, indicated the resident was cognitively intact and was independent for toileting, transfers, bed mobility and eating. A Physician's Progress Note, dated 2/18/25, indicated the resident was seen that day for a complaint of itching. She had about five red patches to her upper arms and left leg. An order was given for triamcinolone cream twice daily for 14 days to the affected areas.	F 0755	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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. **F755 Pharmacy Srvcs/Procedures/Pharmacist/Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 32 was assessed; all medications have been given as ordered. Resident 32's family and MD were notified, no adverse effects noted. Resident 77 was assessed; all medications have been given as ordered. Resident 77's family and MD have been notified; no adverse effects have been noted. **How the facility will identify other residents having the**	03/17/2025

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	A Progress Note, dated 2/21/25 at 6:15 a.m., indicated the resident was upset the triamcinolone cream had not arrived yet. The pharmacy was called and indicated they would check on it. During an interview on 2/21/25 at 9:25 a.m., the Director of Nursing (DON) indicated medications ordered from the pharmacy should be received within 24 hours. At 3:43 p.m., the DON indicated the pharmacy received the order on 2/18/25 and sent it out via a delivery service on 2/19/25. There was a back up pharmacy for emergency medications. The resident received the medication on 2/21/25. 2. On 2/21/25 at 9:35 a.m., a family interview was held with Resident 77's son. He indicated that he was the power of attorney for his mother and he believed that his mother may have been receiving a discontinued medication named Sertraline (Sertraline is used to treat depression, panic attacks, obsessive compulsive disorder, post-traumatic stress disorder, and social anxiety disorder). He indicated that he believed the medication was in the medication cart and was possibly being administered to his mother during daily medication pass times. The record for Resident 77 was reviewed on 2/21/25 at 9:35 a.m. Diagnoses included, but were not limited to, anxiety disorder, unspecified, other forms of tremors, unspecified dementia, unspecified severity without behavioral disturbance, psychotic disturbance, and mood disturbance. The Admission Minimum Data Set assessment, dated 11/20/24, indicated the resident was cognitively impaired. A Physician's Order, dated 1/23/25, indicated		**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;** Nursing staff and LPN 2 were re-educated to ensure that routine and emergency drugs are received in a timely manner and procedures for accurate dispensing were provided as ordered. Medication cart audit was completed, all medications are current in med carts since 2.24.25. New pharmacy in place as of 2.28.25. **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;** DON/Designee will audit 10 residents/weekly to ensure that routine and emergency drugs are received in a timely manner and procedures for accurate	

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	Sertraline HCl Oral Tablet 25 milligrams (mg). The Sertraline was also discontinued on 1/23/25. On 2/21/25 at 9:40 a.m., it was observed that the medication cart was found to have Resident 77's discontinued Sertraline HCI 25 milligrams in the weekly cycled medication roll. There was a hand written note that indicated not to administer Resident 77's Sertraline when passing daily medications to the resident. During an interview on 2/21/25 at 9:41 a.m., LPN 2 indicated she had called the pharmacy several times to inform them to stop sending the Sertraline order. She indicated the medication continued to be delivered, so she wrote a note to inform the other nursing staff not to administer the discontinued Sertraline medication to Resident 77. During an interview on 2/21/25 at 3:48 p.m., the DON indicated the pharmacy was interfaced with the facility and received all new and discontinued medication orders. She spoke with the pharmacy and the pharmacist informed her that the medication was originally discontinued, however another pharmacy staff member reordered the Sertraline, which caused the Sertraline to be delivered to the facility weekly. 3.1-25(o)		dispensing were provided as ordered 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: 3.17.25**	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to giving narcotic pain medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 75)	F 0757	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** Please accept the following as the facility's credible allegation of compliance. This plan of	03/17/2025

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	Finding includes: Resident 75's record was reviewed on 2/18/25 at 10:55 a.m. Diagnoses included, but were not limited to, heart failure, spinal stenosis, iron deficiency anemia and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated 1/2/25, indicated the resident was cognitively intact and was dependent on staff assist for toileting and bed mobility. The resident had pain that occurred almost constantly, did not receive prn (as needed) pain medication or non-medication interventions for pain. A Pain Care Plan, dated 8/8/24, indicated the resident had chronic pain due to spinal stenosis. Interventions included, but were not limited to, encourage resident to try different pain-relieving methods such as positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, ultra sound, muscle stimulation. A Physician's Order indicated to give Norco (an opioid pain medication) 5 milligrams (mg)/325 mg, every six hours as needed for pain. A Physician's Order, dated 11/19/24, indicated to monitor pain: non-pharmacological interventions documentation as follows: ice; heat; reposition; elevate; massage; spiritual /meditation; visual imagery; music; other. The 2025 Medication Administration Record (MAR) indicated the resident received seven Norco in January and eight in February. The January and February 2025 MARs lacked documentation to indicate any		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F757 Drug Regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 75 no longer resides in the facility. **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;** Nursing staff were re-educated to ensure non-pharmacological interventions have been attempted prior to giving narcotic pain medications. **How the corrective action(s) will be monitored to ensure the**	

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	non-pharmacological interventions had been attempted prior to the administration of the Norco. During an interview on 2/21/25 at 1:55 p.m., the Director of Nursing indicated there was no documentation non-pharmacological interventions has been attempted. 3.1-48(a)(4)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 10 residents/ weekly to ensure non-pharmacological interventions have been attempted prior to giving narcotic pain medications 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: 3.17.25**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review and interview, the facility failed to ensure infection control guidelines were in place and implemented related to improper personal protective equipment (PPE) worn in an isolation room and lack of signage in place for a room on contact isolation. (Residents D and B) Findings include: 1. On 2/19/25 at 3:34 p.m., LPN 1 was observed giving medications by g-tube to Resident D. She	F 0880	**Crown Point Christian Village** **Annual/ Complaint Survey 2.24.25** 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	03/17/2025

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	donned a pair of gloves, assessed the g-tube for placement and checked residual. She then administered the medication dissolved in water into the g-tube. There was a sign on the resident's door that indicated Enhanced Barrier Precautions should be used. Everyone that entered the room should wash hands before entering and when leaving. Staff must also: Wear gloves and a gown for the following high-contact resident care activities. Activities included, but were not limited to, device care or use: central line, urinary catheter, feeding tube, tracheostomy. During an interview on 2/19/25, immediately after the observation, the LPN indicated the resident wasn't on isolation any longer. The sign on the door was observed and she again indicated the resident was no longer on isolation. During an interview on 2/19/25 at 3:54 p.m., the Director of Nursing indicated the nurse should have been wearing a gown during the g-tube medication administration and she would speak to her. 2. During observations on 2/18/25 at 3:06 p.m., 2/19/25 at 9:22 a.m., and 2/20/25 at 3:25 p.m., Resident B was in the day room and her room was observed with an isolation bin next to the entrance with no signage posted on or near the door. Resident B's record was reviewed on 2/24/25 at 8:49 a.m. Diagnoses included, but were not limited to, dementia, colon and breast cancer, and traumatic brain injury. The February 2025 Physician's Order Summary indicated the resident was in contact isolation related to candida auris.		requirement. **POC F-880 Infection Prevention & Control** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** LPN 1 was immediately re-educated related to ensure infection control guidelines are in place and implemented related to wearing protective equipment properly in an isolation room for Resident D during g-tube medication administration. Resident B's contact isolation has been rehung on her door. Resident B's family and MD were notified, no adverse effects were reported. **How the facility will 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 medical records to identify other residents having the potential to be affected by the alleged deficient practice.	

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	During an interview on 2/20/25 at 4:05 p.m., the Infection Preventionist indicated the resident was contact isolation precautions as she had candida auris. She believed the family had removed the contact isolation sign. This citation relates to Complaint IN00453429. 3.1-18(b)		**The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur:** Christian Horizons Clinical Nurse Consultant with Infection Preventionist Certification re-educated the facility Administrator, Director of Nursing and Assistant Director of Nursing to ensure infection control guidelines are in place and implemented related to wearing protective equipment properly in an isolation room and ensuring that all signage is in place for a resident room on contact isolation. Clinical staff re-educated to ensure they are wearing proper PPE in Enhanced Barrier Precaution rooms. Clinical staff re-educated to ensure all signage is in place for a resident room who is on contact isolation. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** The DON/designee will conduct surveillance observation audits for 5 g-tube med pass 3 times weekly	

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			for 3 months, then 5 g-tube med pass weekly for 3 months, to ensure compliance of infection control practices. The DON/designee will observe that all residents in contact isolation have the correct signage on their doors 5x/weekly 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: 3.17.25**	
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii) COVID-19 Immunization Based on record review and interview, the facility failed to ensure the residents' medical records included documentation the resident or resident representative was provided education on the benefits and potential risk associated with the COVID-19 vaccination and documentation why the vaccine was not administered for 4 of 5 residents reviewed for COVID-19 vaccinations. (Residents 53, B, 201, and 300) Findings include:	F 0887	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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.	03/17/2025

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	1. Resident 53's record was reviewed on 2/21/25 at 9:55 a.m. The COVID-19 vaccination had not been documented as offered or administered since 9/22/22. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. 2. Resident B's record was reviewed on 2/21/25 at 10:10 a.m. The resident received the first COVID-19 vaccination on 2/26/22. The COVID-19 vaccination had not been documented as offered or administered since 2/26/22. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. 3. Resident 201's record was reviewed on 2/21/25 at 10:00 a.m. The COVID-19 vaccination had not been documented as offered or administered. There was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. 4. Resident 300's record was reviewed on 2/21/25 at 10:05 a.m. The COVID-19 vaccination had not been documented as offered or administered. There		**F 887 COVID-19 Immunization** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was assessed, COVID-19 vaccine was provided. Resident B's family and MD were notified. Resident 53 was assessed, COVID-19 vaccine was offered, declined at this time. Resident 53's family and MD were notified. Resident 201 no longer resides in the facility. Resident 300 was assessed, COVID-19 vaccine was provided. Resident 300'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;** Licensed nursing staff and the	

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	was no documentation education on the benefits and potential risk of the the COVID-19 vaccine had been provided to the resident or the resident's representative. During an interview on 2/20/25 at 2:42 p.m., the Infection Preventionist (IP) indicated she had offered vaccinations at the time of admission. She did not offer vaccinations at other times. The COVID-19 vaccination was not available from their pharmacy, so she had been trying to set up a clinic with the county health department, but she was having difficulty getting it completed. She was not aware she needed to periodically ask the long term residents if they were interested in receiving the COVID-19 vaccinations when eligible, she had only been offering the influenza vaccine when those were available. During an interview on 2/24/25 at 1:22 p.m., the Director of Nursing indicated the IP had been trying to get things set up and in place so that they could have a COVID-19 vaccination clinic. They had not hosted a clinic lately. She did not provide any further information. A policy titled "COVID-19 Vaccination Policy," indicated "...Procedure...4.2 COVID-19 vaccinations will be offered as per CDC (ACIP) and/or FDA guidelines unless such immunization is medically contraindicated. This will include additional doses or booster doses when appropriate and available...4.5 Prior to administration of the vaccine, the person receiving the immunization, or representative, will be provided with a copy of the CDC's current vaccine information statement...4.9 The resident's medical record will include documentation that the resident was provided education regarding the benefits and potential side effects of the		Infection Preventionist Nurse were re-educated to ensure that the COVID-19 vaccination has been offered and/or administered; will document education on the benefits and potential risk of the COVID-19 vaccine given to the resident or the resident's representative. Infection Preventionist Nurse has scheduled a COVID-19 clinic on March 27, 2025. **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;** DON/designee will audit 10 residents/weekly to ensure that the COVID-19 vaccination has been offered and/or administered and that there is documentation of education on the benefits and potential risk of the COVID-19 vaccine given to the resident or the resident's representative 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:**	

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	immunization..."		**3.17.25**	
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 IN00450257, IN00453351, and IN00453429. Complaint IN00450257 - No deficiencies related to the allegations are cited. Complaint IN00453351 - Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00453429 - Federal/State deficiencies related to the allegations are cited at F880 Survey dates: February 17, 18, 19, 20, 21, and 24, 2025 Facility number: 001198 Residential Census: 42 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 2/28/25.	R 0000	The facility kindly requests a desk review.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure service plans were signed and/ or updated with changes related to a urinary catheter and oxygen for 2 of 7 service plans reviewed. (Residents 4 and 3)	R 0217	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** Please accept the following as the	03/17/2025

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	Findings include: 1. On 2/24/25 at 12:01 p.m., Resident 4 was observed in the hallway outside his room. A urinary catheter bag was observed hanging from the side of his wheelchair in a dignity bag. He indicated he had a urinary catheter and was able to empty the drainage bag himself. Resident 4's record was reviewed on 2/24/25 at 10:54 a.m. Diagnoses included, but were not limited to, urine retention and neuromuscular dysfunction of the bladder. The resident was admitted to the facility on 2/18/23. The Physician's Order Summary, dated 2/2025, indicated to monitor the urinary catheter insertion site twice a day and drain the catheter bag every shift. A Service Plan, dated 9/17/24, lacked any documentation the resident had a urinary catheter, if he needed assistance taking care of the catheter, and who was to change the urinary catheter. During an interview on 2/24/25 at 2:37 p.m., the Assisted Living Director indicated the resident took care of the urinary catheter himself. He would go out to the physician's office to have the catheter changed and had an appointment coming up. She would update the service plan. 2. Resident 3's record was reviewed on 2/24/25 at 10:28 a.m. Diagnoses included, but were not limited to, hypothyroidism and vitamin D deficiency. The Resident Service Plan, dated 2/6/25, indicated the resident was severely cognitively impaired. She had a 24 hour per day, 7 day a week caregiver.		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. **R217** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Service plans have been updated for residents 4 and 3 to ensure that they are reflective of the resident. **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;** Staff have been educated on the requirements to ensure service plans are reflective of the resident and include oxygen therapy and	

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	She was receiving hospice care. The February 2025 Physician Order Summary indicated 2 liters per minute oxygen via nasal cannula as needed. The Resident Service Plan was marked "not applicable" for oxygen therapy. During an interview on 2/24/25 at 2:05 p.m. the Assisted Living Director indicated the resident had a current order for as needed oxygen therapy and the service plan should have been updated.		catheter use. **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;** DON/designee will complete a monthly audit by the AL director to ensure that service plans are reflective of each resident. This audit will include 5 random residents/month 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: 3.17.25**	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 3 of 5 residents reviewed. (Residents 2, 4, and 6) Findings include: The resident Emergency Binder was reviewed on 2/24/25 at 2:00 p.m.	R 0356	**Crown Point Christian Village Annual/ Complaint Survey 2.24.25** 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	03/17/2025

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	a. Resident 2 was missing a phone number and address. b. Resident 4 was missing allergy information. Resident 4's record was reviewed on 2/24/25 at 10:54 a.m. His allergies were listed as: barium sulfate. c. Resident 6 was missing allergy information. Resident 6's record was reviewed on 2/24/25 at 1:54 p.m. Her allergies were listed as: amoxicillin, metformin, spironolactone, sulfamethoxazole/trimethoprim, green beans, cats, latex, mold, and adhesive tape. During an interview on 2/24/25 at 2:30 p.m., the Assisted Living Director indicated she would update the binder.		response to the regulatory requirement. **R356** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The emergency forms for Resident 2, 4, and 6 have been updated to include the cited missing information. **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;** AL Director and nursing staff have been educated on the required information for the emergency binder. **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**	

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	02/24/2025

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

(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
			into place; DON/designee will create a checklist to reflect required components for the emergency binder. The checklist will be completed when creating an emergency form for each new resident. Additionally, the AL director will audit the emergency binder monthly to ensure all required components are present. 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: 3.17.25**	