	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 02/24/2025	
	PROVIDER OR SUPPLIED		6685 E	ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE /N POINT, IN 46307		
(X4) ID PREFIX TAG F 0000	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
F 0000 Bldg. 00	Licensure Survey. Investigation of Coll IN00453351 and IN State Residential L. Complaint IN0045 the allegations are decomplaint IN0045 related to the allegation of Complaint IN0045 related to the allegation	0257 - No deficiencies related to cited. 3351 - Federal/State deficiencies ations are cited at F677. 3429 - Federal/State deficiencies ations are cited at F880 ruary 17, 18, 19, 20, 21, and 24, 01198 155637 471000	F 0000	The facility kindly requests a creview.	desk	
LABORATOR	V DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE	

Natalie Porcaro Administrator 03/17/2025

Any defiency statement 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 disclodays 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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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPI	LETED
		155637	B. W	ING		02/24	/2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t.			AST 117TH AVENUE		
CROWN	POINT HEALTH CA	AMPUS		CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Quality review com	pleted on 2/28/25.					
F 0554 483.10(c)(7)							
SS=D	, , , ,	nin Meds-Clinically Approp					
Bldg. 00	rtesident cen-rtan	Till Weds-Oll lloany Approp					
ug. 00	Based on observation	on, record review and	F 0:	554	Crown Point Christian Villag	e	03/17/2025
		ty failed to ensure residents) J	Annual/ Complaint Survey	_	
	were assessed to self-administer medication and				2.24.25		
	had a physician's or	der to self-administer					
	medication for 2 of	2 residents observed			Please accept the following as	s the	
	self-administering r	nedications. (Residents 41 and			facility's credible allegation of		
	201)				compliance. This plan of		
					correction does not constitute	an	
	Findings include:				admission of guilt or liability by		
					facility and is submitted only in	า	
	_	observation on 2/17/25 at 9:09			response to the regulatory		
		ras observed seated in her			requirement.		
		oom. There was a medicine cup			F 554 Resident		
	_	her overbed table in front of			Self-Administration		
		es later, the pills were again ident's table. The resident			Medications-Clinically Appro	-	
		take all of them. RN 1 entered			What corrective action(s) will be accomplished for those	II.	
		assisted the resident with			residents found to have been	1	
	taking the medication				affected by the deficient		
	tuning the interior				practice;		
	During an interview	on 2/17/25 at 9:13 a.m., the			Resident 41 had medications		
	_	had left them with the resident			bedside. The medications rem	noved	
	because she was tak	ring her time, and she should			from the bedside. There were	no	
	not have left the me	edications with the resident.			adverse effects noted. Reside	nt's	
					family and MD have been noti	fied.	
		d was reviewed on 2/17/25 at			Resident 201 had medications	6	
		s no self-medication			bedside. The medications rem	noved	
		ssment and no Physician's			from the bedside. There were		
	order to self-admini	ster medications.			adverse effects noted. Reside	nt	1
					201's significant other was		
	2 0 2/17/25 (0)	25 DN 1 1 1			educated that all medications		
		35 a.m., RN 1 was observed			needed to have a physician's		1
		s to Resident 201. The resident			order. Resident 201 no longer	-	
		her nightstand, there was a ntment and loperamide tablets			resides at the facility.		
	i table of antibiotic of	nument and roperannue tablets	1		How the facility will identify		1

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPLE	TED
		155637	B. WIN	IG		02/24/2	2025
		<u> </u>	' 1	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	8			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307		
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE		ID	Τ		(Y5)
PREFIX		ICY MUST BE PRECEDED BY FULL		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	1	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		cation). The resident indicated		1110	other residents having the		DITTE
	`	om the antibiotics she was			potential to be affected by th	_	
	taking. The RN did not remove the medications.				same deficient practice and	Ĭ	
					what corrective action will be	.	
	The resident's recor	rd was reviewed on 2/17/25 at			taken;		
	10:00 a.m. There v	vas no self-medication			The Director of Nursing, Infect	ion	
	assessment, physician's order to self-administer				Preventionist, unit managers,	and	
	medications, or ord	ers for the antibiotic ointment			designees conducted a review	of	
	or loperamide.				residents' physician orders an		
					medical records to identify oth		
	_	on 2/18/25 at 8:45 a.m., the			residents having the potential		
		g indicated the resident's			be affected by the alleged defi	cient	
	•	ught the medications and had			practice.		
		all medications needed to			What measures will be put in	ito	
	have a physician's of	order.			place or what systemic		
	2111				changes will be made to		
	3.1-11				ensure that the deficient		
					practice does not recur;	iith	
					RN1 was in-serviced to stay we each resident until the entire	'lu'i	
					medication administration is		
					completed.		
					Nurses were re-educated on		
					completing self-administration		
					medication assessments and		
					orders for self-administration i	n	
					PCC for residents who desire	to	
					have medications in room/		
					bedside. If a resident is unable	e to	
					pass the assessment, there		
					should be no medications left		
					bedside.		
					How the corrective action(s)	.	
					will be monitored to ensure t	ne	
					deficient practice will not		
					recur, i.e., what quality		
					assurance programs will be	put	
					into place; DON/designee will randomly a	udit	
					5 residents 2x's/week for 6	iuuit	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/24/2025
NAME OF P	ROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE	
CROWN	POINT HEALTH C	AMPUS		N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				months, to ensure there are needications left bedside, and resident is able to pass medication, they have comple a self-administration medication assessment and orders for the self-administration of the medications is in PCC. Director of Nursing/designee or present a summary of the audito the Quality Assurance committee monthly for 6 month 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 complete 3.17.25	if sted on e will dits ths. ne
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Impleme	nt Comprehensive Care Plan			
-	failed to ensure a codeveloped and in plus ignificant weight be reviewed. (Resident Findings include: 1. Resident 75's reconsistent 10:55 a.m. Diagnool limited to, heart fail deficiency anemia at The Quarterly Minimals.)	oriew and interview, the facility omprehensive care plan was ace for residents with coss for 2 of 24 care plans at 75 and 85) ord was reviewed on 2/18/25 at sees included, but were not ture, spinal stenosis, iron and atrial fibrillation.	F 0656	Crown Point Christian Village Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability be facility and is submitted only is response to the regulatory requirement. F 656 Develop/Implement Comprehensive Care Plan What corrective action(s) will be accomplished for those	s the an y the

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING		02/24/	2025
		l .		CTDEET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			AST 117TH AVENUE		
CDOWN	POINT HEALTH C	AMBUS			N POINT, IN 46307		
CROWN	POINT HEALTH C	AMPUS		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	ļ	TAG	DEFICIENCY)		DATE
	1 -	nd was dependent on staff			residents found to have been	n	
	_	and bed mobility. He had a			affected by the deficient		
	_	or more in a month or 10% or			practice;		
	more in 6 months a				Resident 75 no longer resides	in	
	physician-prescribe	ed weight loss regimen.			this facility.		
					Resident 85 had care plan		
		ssion weight on 8/8/24 was			updated related to significant		
		resident's weight on 11/5/24			weight loss. No adverse effect		
	•	and on 2/5/25, was 246.5			from not having care plan wer		
	pounds. This was a weight loss of 30.8 pounds, a				noted. Resident 85's family ar	nd	
	24% change, in six months.				MD were notified.		
					How the facility will identify		
	A Dietary Note, dated 2/13/25, indicated the				other residents having the		
	_	ficant weight loss. The			potential to be affected by th	e	
	_	ed difficulty chewing foods			same deficient practice and		
		His diet had been downgraded			what corrective action will be	е	
	to pureed and Speed	ch and Occupational Therapy			taken;		
	had been ordered.				The Director of Nursing, Infect	tion	
					Preventionist, unit managers,	and	
		re plan in place to related to the			designees conducted a review	v of	
	significant weight l	oss.			residents' physician orders an		
					medical records to identify oth		
	_	v on 2/21/25 at 2:50 p.m., the			residents having the potential		
	_	g indicated there was no care			be affected by the alleged def	icient	
		significant weight loss.			practice.		
		Resident 85 was reviewed on			What measures will be put in	nto	
		. Diagnoses included, but were			place or what systemic		
		eimer's Disease, general anxiety			changes will be made to		
	disorder, and major	depressive disorder.			ensure that the deficient		
					practice does not recur;		
		mum Data Set (MDS)			Licensed nursing staff and the	;	
		/24/25, indicated the resident			dietician were re-educated to		
		paired and had a significant			ensure a comprehensive care	-	
	weight loss.				was developed and in place for		
		1-100/04/1			residents with significant weig	ht	
		d 7/30/24, indicated the			loss.		
		egular diet. The interventions			How the corrective action(s)		
	_	supplements per orders.			will be monitored to ensure t	the	
		plan related to significant			deficient practice will not		
	weight loss.				recur, i.e., what quality		

JENTERS FOR	R MEDICARE & MEDIC	AID SERVICES				ОМ	B NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING		02/24/	/2025
	PROVIDER OR SUPPLIER		•	6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROWIDERIC DI ANI OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	and on 2/3/25 was 1 The Culinary Nutrit Assessment, dated 1 had a significant we The Culinary Nutrit dated 1/29/25, indic significant weight to During an interview Director of Nursing	tional Comprehensive 11/1/24, indicated the resident eight loss x 90 days. tional Quarterly Assessment, eated the resident had a			assurance programs will be into place; DON/designee will audit 5 residents with significant weight loss weekly x 2 months, then 8 residents bi-weekly x 2 months then 5 residents monthly to ensure a comprehensive care was developed and in place for residents with significant weight loss for 6 months. Director of Nursing/designee was present a summary of the audit to the Quality Assurance committee monthly for 6 month. 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	ht 5 s, plan or ht vill its hs.	
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing						
	interview, the facility were updated for 1 or reviewed. (Resident Finding includes: On 2/17/25 at 2:46 pin a wheelchair. Her contracted (a condit	p.m., Resident 7 was observed r left hand appeared to be cion where the fingers or palm oluntarily bent or curled in).	F 00	557	Crown Point Christian Village Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.	s the an / the	03/17/2025

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The resident was unable to communicate if she

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F 657 Care Plan Timing and

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING _		02/24/	2025
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307		
			1		I		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	er hand or if she wore any			Revision		
	splinting devices.				What corrective action(s) wi		
	T 10 D				be accomplished for those		
		ident 7 was reviewed on 2/20/25			residents found to have bee	n	
	_	noses included, but were not			affected by the deficient		
		palsy, mild intellectual			practice;	al £ a	
		miplegia and hemiparesis			Resident 7 has been assesse		
	(paralysis and weakness) following a stroke				therapy for recommendations		
	affecting the left side.				regarding splinting device.		
	The Quarterly Minimum Data Set (MDS)				Resident 7's family and MD aware, no adverse effects.		
assessment, dated 11/19/24, indicated the resident					How the facility will identify		
	was moderately cognitively impaired, had a				other residents having the		
	1	n in range of motion on one			potential to be affected by the		
		stremities, and required			same deficient practice and	ie	
		ff with toileting, showering,			what corrective action will b	_	
	and transfers.	ir with tonethig, showering,			taken;	`	
				The Director of Nursing, Infection			
	The February 2025	Physician Order Summary			Preventionist, unit managers,		
	I	ent may participate in			designees conducted a review		
	restorative program				residents' physician orders ar		
					medical records to identify oth		
	A Care Plan, dated	8/22/24, indicated the resident			residents having the potential		
	had an ambulation	activity of daily living (ADL)			be affected by the alleged def		
	self-care performan	nce deficit. Interventions			practice.		
	included, but were	not limited to, ambulation			What measures will be put in	nto	
		rative to assist resident by			place or what systemic		
	ambulating up to 50	0 feet with platform walker and			changes will be made to		
	gait belt.				ensure that the deficient		
					practice does not recur;		
		8/30/24, indicated the resident			Staff were re-educated to ens	ure	
		nge of motion. Interventions			that care plans were updated	and	
	included, but were not limited to, restorative to				reviewed, including for restora	ative	
	instruct and supervise active range of motion				therapy.		
	(AROM) to the bilateral lower extremities (BLE), 10				How the corrective action(s)		
	repetitions twice daily for 6 to 7 days per week.				will be monitored to ensure	the	
					deficient practice will not		
		t indicated restorative was to			recur, i.e., what quality		
		ent up to 50 feet as tolerated			assurance programs will be	put	
	with left hand platf	orm walker and restorative was	1		into place;		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/24/2025	
	ROVIDER OR SUPPLIER POINT HEALTH CA		6685 E	ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	to instruct and super repetitions twice da There was no restor the last 30 days review During an interview Director of Nursing had restorative there the Care Plan should resident had cerebra	rvise AROM to the BLE 10 ily for 6 to 7 days per week. ative therapy documented for		DON/Designee will audit 5 residents 2xs/week for 6 monto to ensure that care plans were updated and reviewed, includit for restorative therapy. Director of Nursing/designee was present a summary of the audito the Quality Assurance committee monthly for 6 monto 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 complete 3.17.25	ths, end of the state of the st
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provide	d for Dependent Residents			
	failed to document is resident who was do of daily living (ADI were reviewed for A Finding includes: During an interview Resident C's Power she had come to the and found the resident resident was fully dactivities of daily living a comment of the second	riew and interview, the facility incontinence care for a rependent on staff for activities and the staff for activities are for 1 of 7 residents who and the staff for activities and the staff for activities are for 1 of 7 residents who and the staff for 1 of 2/18/25 at 9:14 a.m., of Attorney (POA) indicated facility on multiple occasions and in a soaking wet brief. The ependent on the staff for all wing (ADLs) including, but not eating, and drinking.	F 0677	Crown Point Christian Villag Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by 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	s the an y the n

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155637	B. W	ING		02/24	/2025
		1	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	8			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307		
		-	1		,		OV.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	1	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION iewed on 2/20/25 at 11:20 a.m.		TAG	affected by the deficient		DATE
		but were not limited to,			practice;		
	Alzheimer's disease				Resident C was assisted with	ااد	
	7 Hzhenner 5 disease	and demondia.			needed ADL's, which included		
	The Quarterly Mini	mum Data Set (MDS)			providing incontinence care. A		
		2/8/24, indicated the resident			care has been documented.	(DL	
		tively impaired and was			How the facility will identify		
		for all ADLs including eating,			other residents having the		
	toileting, personal hygiene, and transfers. She was				potential to be affected by th	ie	
	always incontinent of bowel and bladder and				same deficient practice and		
	received hospice care.				what corrective action will be	е	
					taken;		
	The current Care Plans indicated the resident				The Director of Nursing, Infect	tion	
	needed assistance with ADLs due to cognitive				Preventionist, unit managers,	and	
	deficit and was tota	lly dependent on staff for all			designees conducted a review	v of	
	ADL care. The resi	dent was incontinent of			residents' physician orders an	d	
	bladder due to decr	eased mobility and cognition.			medical records to identify oth	er	
	She had a diagnosis	s of Alzheimer's disease and			residents having the potential	to	
	did not alert staff of	f her need to use the bathroom.			be affected by the alleged def	icient	
	Interventions include	led, but were not limited to,			practice.		
		nd incontinence care with each			What measures will be put ir	nto	
	incontinence episod	le.			place or what systemic		
					changes will be made to		
		continence Care was reviewed			ensure that the deficient		
		(1/23-2/20/25). The			practice does not recur;		
		uency was every shift. The			Staff were re-educated to ens	ure	
		shifts were not documented:			that the facility will document		
	· ·	2/11, 2/17, and 2/18/25			incontinence care for resident		
		2/4, 25, 2/6, 2/8, 2/9, 2/11, 2/14,			who are dependent on staff fo		
	2/16, 2/17, and 2/18				activities of daily living (ADLs)		
	- 3rd shift on 1/23,	1/26, 1/28, 2/2, 2/10, and 2/19/25			How the corrective action(s)		
	D	0/01/05 + 0.17			will be monitored to ensure t	the	
	During an interview on 2/21/25 at 8:17 a.m., the				deficient practice will not		
	Director of Nursing had no further information to		1		recur, i.e., what quality	4	
	provide.				assurance programs will be	put	
	This citation relates to Complaint IN00453351.				into place;		
	This challon relates	to Complaint 11100455551.			DON/Designee will audit 10	tho	
					residents 2xs/week for 6 mont	uis,	
					to ensure that the facility	aro	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155637		(X2) MULTIPI A. BUILDIN B. WING	LE CONSTRUCTION G 00	(X3) DATE SURVEY COMPLETED 02/24/2025	
	PROVIDER OR SUPPLIER		668	EET ADDRESS, CITY, STATE, ZIP COD 55 EAST 117TH AVENUE OWN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFI TAG	CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation interview, the facility orders were followed condition treatment were assessed and respectively.	on, record review, and ty failed to ensure physician's ed for non-pressure skin s and non-pressure skin areas nonitored for 2 of 5 residents onditions, non-pressure	F 0684	for residents who are depends on staff for activities of daily li (ADLs). Director of Nursing/designee or present a summary of the audito the Quality Assurance committee monthly for 6 month 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 complete 3.17.25 Crown Point Christian Village Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability be facility and is submitted only in the present and the present activities of the survey and the present activities of the	ent ving will dits ths. the , e et
	1. During an intervi at 9:42 a.m., Reside area on her right up last couple of weeks night before. The ar	ew and observation on 2/17/25 ent 1 indicated she had a sore per chest. She had it for the s and told the staff about it the rea was observed to be a large anding skin red in color.		response to the regulatory requirement. F684 Quality of Care What corrective action(s) wi be accomplished for those residents found to have bee	ш
	On 2/20/25 at 11:09	a.m., Resident 1 had a 4 by 4 ring the area on her right upper		affected by the deficient practice; Resident 1 was assessed, an MD orders were followed for s	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/24/2025 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT HEALTH CAMPUS CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE chest. The resident indicated the staff put a cream condition treatments. R1's plan of on it the night before and was keeping it covered care has been updated. Resident so her top would not rub the area. 1's family and MD were notified, no adverse effects identified. Resident 1's record was reviewed on 2/19/25 at Resident 16 was assessed: 11:10 a.m. Diagnoses included, but were not wound assessments have been limited to, hereditary motor and sensory completed. Resident 16's TAR neuropathy (affecting the peripheral nerves) and was reviewed, and care plan has diabetes mellitus. been updated. Resident 16's family and MD have been notified; The Ouarterly Minimum Data Set (MDS) no adverse effects have been assessment, dated 2/2/25, indicated the resident noted. was cognitively intact for daily decision making. How the facility will identify She had an impairment to range of motion on one other residents having the side of the upper extremities. She was totally potential to be affected by the dependent for toileting and transfers and required same deficient practice and maximal assistance with showering/bathing. what corrective action will be The Skin Check Assessment, dated 2/14/25, The Director of Nursing, Infection indicated there were no skin concerns. Preventionist, unit managers, and designees conducted a review of During an interview on 2/19/25 at 2:59 p.m., the residents' physician orders and Wound Nurse indicated she was unaware of the medical records to identify other scabbed area until Tuesday (2/18/25) when the residents having the potential to resident told her about the area, she was then be affected by the alleged deficient assessed by the Nurse Practitioner (NP) and practice. received orders for a treatment to the area. What measures will be put into place or what systemic During an interview on 2/21/25 at 1:40 p.m., the changes will be made to Director of Nursing indicated she would follow up ensure that the deficient with the Wound Nurse regarding the scabbed practice does not recur; area. There was no further information provided. Licensed Nurses and the Wound Nurse were re-educated to ensure the physician's orders were 2. Resident 16's record was reviewed on 2/18/25 at followed for non-pressure skin 3:11 p.m. Diagnosis included, but were not limited condition treatments and to, lymphedema, venous insufficiency, and non-pressure skin areas were non-pressure chronic ulcer of the right and left assessed and monitored. calf. How the corrective action(s) will be monitored to ensure the

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	COMP	E SURVEY PLETED 4/2025	
	PROVIDER OR SUPPLIEI		6685 E	ADDRESS, CITY, STATE, ZIP CO EAST 117TH AVENUE /N POINT, IN 46307	DD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
	assessment, dated I was moderately cogassistance from state (ADL) care. The current Care Pinon-pressure woun venous ulcers to the and a history of an shin. Interventions to, observe the area weekly until resolv treatments as ordered. A Physician's Orde cleanse the left low pat dry, apply hydrand cover with a dr Wednesday, and Fr. The December 202 Administration Receive treatment was not continued to the pat dry. A Physician's Orde cleanse the left possaline, apply calciuncover with an abdokerlix and secure wi	r, dated 10/24/24, indicated to er shin area with normal saline, ofera blue to the wound bed y dressing every Monday, iday and as needed. 4 and January 2025 Treatment cords (TARs) indicated the ompleted as ordered on 1/1/25, 1/17/25, 1/22/25, and r, dated 12/6/24, indicated to terior calf area with normal malginate to the wound bed, minal (ABD) pad, wrap with ith tape every Monday,		deficient practice will recur, i.e., what quality assurance programs winto place; DON/Designee will audi residents with non-pressure skin areas for 6 months, to ensure physician's orders were for non-pressure skin cotreatments and non-presareas were assessed at monitored. DON/Designee will audi records weekly for 6 money changes noted to retreatment orders. Director of Nursing/desi present a summary of the tothe Quality Assurance committee monthly for 6 Thereafter, if determined Quality Assurance committee quarterly and presequarterly at the QA meek Monitoring will be on go Date by which systemi corrections will be conducted.	vill be put it all sure skin d s, weekly the followed ondition ssure skin nd it 5 TARs onths, for esidents' gnee will ne audits e 6 months. d by the mittee, will be sent eting. ing.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		l í	UILDING	instruction 00	(X3) DATE COMPL 02/24 /	ETED	
	PROVIDER OR SUPPLIER			6685 EA	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
	SUMMARY: (EACH DEFICIEN REGULATORY OR saline, pat dry, appl wound bed, cover w kerlix, and secure w Wednesday, and Fr. The December 2024 indicated the treatm ordered on 12/18/24 A Physician's Order cleanse the right shi apply hydrofera blu with a dry dressing and Friday. The December 2024 indicated the treatm ordered on 12/18/24 A Physician's Order cleanse the right po pat dry, apply xerof with an ABD pad, w with tape every Mo The January 2025 T was not completed a 1/24/25. A Physician's Order cleanse the left post pat dry, apply xerof with an ABD pad, w with tape and the post pat dry, apply xerof with an ABD pad, w with an ABD pad, w	AMPUS STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION by calcium alginate to the with an ABD pad, wrap with with tape every Monday, iday. 4 and January 2025 TARs ent was not completed as 4, 12/25/24, 1/1/25, and 1/8/25. 5, dated 12/9/24, indicated to n with normal saline, pat dry, the to the wound bed and cover every Monday, Wednesday, 4 and January 2025 TARs ent was not completed as 1, 12/25/24, 1/1/25, 1/8/25, 5. 5, dated 1/10/25, indicated to esterior calf with normal saline, form to the wound bed, cover every with kerlix, then secure enday, Wednesday, and Friday. 6 AR indicated the treatment as ordered on 1/17, 1/22, and 7, dated 1/10/25, indicated to erior calf with normal saline, form to the wound bed, cover every with kerlix and secure with enday with kerlix and secure with		6685 EA	AST 117TH AVENUE	NE	(X5) COMPLETION DATE
	The January 2025 T	Wednesday, and Friday. AR indicated the treatment as ordered on 1/17, 1/22, and					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 155637 B. WING			(X3) DATE SURVEY COMPLETED 02/24/2025		
	PROVIDER OR SUPPLIER		668	EET ADDRESS, CITY, STATE, ZIP COD 5 EAST 117TH AVENUE DWN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	CROSS-REFERENCED TO THE APPR	D BE COMPLETION
F 0686 SS=D Bldg. 00	Wound Nurse indic progress note correstresident refused a transfer frequently refused to the During an interview Director of Nursing provide. A facility policy titl indicated "3. New impairments/abnorm documented in the robserved." 3.1-37(a) 483.25(b)(1)(i)(ii) Treatment/Svcs to Ulcer Based on observation interview, the facility with pressure ulcerstreatment and service to weekly wound as a physician's treatment 2 residents reviewed (Residents D and 4) Findings include: 1. On 2/19/25 at 10 observed providing Resident D's left hed dime-sized scabbed nurse indicated it wulcer.	on 2/19/25 at 1:40 p.m., the ated there should have been a sponding to any day the seatment. The resident had reatments in the past. on 2/21/25 at 1:50 p.m., the had no further information to ed, "Wound Assessment," of wounds and/or other skin malities will be assessed and medical record upon being Prevent/Heal Pressure on, record review and try failed to ensure residents areceived the necessary bees to promote healing related assessments not completed and tent order not updated for 2 of differ pressure ulcers. et 2 a.m., the Wound Nurse was care for a pressure ulcer on the left heel. The as a healing stage 4 pressure	F 0686	Crown Point Christian V Annual/ Complaint Surve 2.24.25 Please accept the followir facility's credible allegatio compliance. This plan of correction does not consti admission of guilt or liabili facility and is submitted or response to the regulatory requirement. F686- Treatments/Svcs t Prevent/Heal Pressure U What corrective action(s be accomplished for tho residents found to have affected by the deficient practice; Resident D no longer resi	ng as the n of tute an ty by the nly in / o Icers) will se been

STATEME?	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING		02/24/	2025
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	₹			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	es included, but were not limited			the facility.		
	to, Alzheimer's dementia, depression and chronic				Resident 4 was assessed. We	ound	
	respiratory failure.				assessments have been		
					completed. Resident 4's famil	У	
		imum Data Set assessment,			and MD have been notified, n		
	· ·	icated the resident had severe			adverse effects have been no	ted.	
		ent, was dependent for toileting,			How the facility will identify		
		y and transfers and had a stage			other residents having the		
	4 pressure ulcer.				potential to be affected by the	ne	
					same deficient practice and		
		Care Plan, dated 5/29/24,			what corrective action will b	е	
		ent had a history of pressure			taken;		
	_	ntial to develop additional			The Director of Nursing, Infec		
	_	erventions included, but were			Preventionist, unit managers,	and	
	_	ide daily skin monitoring and			designees conducted a review	v of	
	weekly skin checks	.			residents' physician orders ar	nd	
					medical records to identify oth	ner	
	A Skin and Wound	Evaluation, dated 12/19/24,			residents having the potential	to	
	indicated there was	a stage 4 pressure ulcer on the			be affected by the alleged det	icient	
	left heel that measu	red 0.9 centimeters (cm) x 1.4			practice.		
	cm, scab, no draina	ge. There were no additional			What measures will be put in	nto	
	skin and wound eva	aluations.			place or what systemic		
					changes will be made to		
	_	v on 2/19/25 at 2:56 p.m., the			ensure that the deficient		
		cated she did not do weekly			practice does not recur;		
	wound assessments	because it was just a scab.			Nursing staff and Wound nurs	se	
					were re-educated to ensure		
		v on 2/21/25 at 2:50 p.m., the			residents with pressure ulcers	5	
	_	g indicated there should be			received the necessary treatn	nent	
	weekly wound asse	essments.			and services to promote heali	ng	
					related to weekly wound		
		"Wound Assessment",			assessments completed, and		
		omplete wound assessment			ensure that physician's treatm	nent	
	_	weekly for all wounds and skin			orders are completed and upo	dated	
	_	malities using the Skin and			for pressure ulcers as ordered	d.	
	Wound Program in	the electronic medical			Wound Nurse completed a sk	in	
	record"				sweep audit for the facility to		
					identify any new or worsened		
					areas.		
	2. On 2/19/25 at 2:	16 p.m., the Wound Nurse was			How the corrective action(s)		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155637	B. W	ING		02/24/	/2025
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
IAU	observed providing on Resident 4's right removed the old drewound with normal calcium alginate (at the wound bed and border dressing. The resident's record 9:53 a.m. Diagnose to, diabetes mellitus. The Significant Charassessment, dated 1 had moderate cognidependent on bed mastage 4 pressure under a stage 4 pressure under a stage 4 pressure under ight lower leg treat saline and pat dry, a antimicrobial wound cover with a dry drewed wednesday and Fried During an interview Wound Nurse indicing changed the order a	treatment to a pressure ulcer t lower leg. The nurse essing. She cleansed the saline and gauze, then applied a absorbent wound material) to covered the wound with a d was reviewed on 2/19/25 at sincluded, but were not limited and schizophrenia. Inge Minimum Data Set //30/25, indicated the resident tive impairment, was nobility and toileting, and had leer. It, dated 12/27/24, indicated the ment was to clean with normal apply Hydrofera Blue (and d foam) to the wound bed and essing every Monday, day. If on 2/19/25 at 2:56 p.m., the ated the physician had couple weeks ago and she nging it in the medical record,		IAU	will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance programs will be into place; DON/Designee will audit to all residents with pressure ulcers weekly, to ensure residents with pressure ulcers received the necessary treatment and serv to promote healing, wound assessments completed, and ensure that physician's treatm orders are completed and upof for pressure ulcers as ordered 6 months. Director of Nursing/designee with the Quality Assurance committee monthly for 6 mont Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 3.17.25	the put ith ices ent lated I for will its hs.	DATE
F 0688 SS=D Bldg. 00	3.1-40 483.25(c)(1)-(3) Increase/Prevent	Decrease in ROM/Mobility					
Diag. 00	interview, the facili a palmar guard and	on, record review, and ty failed to ensure an order for a resting hand splint device n place for a resident with a	F 00	688	Crown Point Christian Villag Annual/ Complaint Survey 2.24.25 Please accept the following as		03/17/2025

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 02/24/2025 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT HEALTH CAMPUS CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE right hand contracture for 1 of 1 resident reviewed facility's credible allegation of for range of motion. (Resident 42) compliance. This plan of correction does not constitute an Finding includes: admission of guilt or liability by the facility and is submitted only in During random observations on 2/17/24 at 2:17 response to the regulatory p.m., on 2/19/25 at 9:26 a.m., and on 2/20/25 at requirement. 10:35 a.m., Resident 42 was observed lying in bed. F688- Increase/Prevent At those times, the resident was observed with Decrease in ROM/Mobility her right hand clenched against her chest. What corrective action(s) will be accomplished for those On 2/19/25 at 2:01 p.m., CNA 1 indicated the residents found to have been resident could not open her right hand without affected by the deficient forcing her hand open or using a hot water towel practice; to open the resident's hand. She had never used a Resident 42 was assessed, palm protector and did not know if the resident palmar guard and resting hand was supposed to have a palm protector applied to splint device was provided. her right hand. Resident 42's family and MD have been notified, no adverse effects The record for Resident 42 was reviewed on have been noted. 2/17/25 at 2:17 p.m. Diagnoses included, but were How the facility will identify not limited to. Alzheimer's disease with late onset. other residents having the generalized muscle weakness, and stiffness. potential to be affected by the same deficient practice and The Quarterly Minimum Data Set (MDS) what corrective action will be assessment, dated 1/29/25, indicated the resident taken: was cognitively impaired. The Director of Nursing, Infection Preventionist, unit managers, and An Occupational Therapy (OT) Plan and designees conducted a review of Treatment Note, dated 1/7/25-2/17/25, indicated residents' physician orders and Resident 42 was recommended to wear a palmar medical records to identify other guard and a resting hand splint on the right hand residents having the potential to and on the right wrist at all times except bathing be affected by the alleged deficient and exercise in order to develop and establish a practice. wearing schedule, reduce pain caused by joint What measures will be put into deformity, and reduce pain caused by muscle place or what systemic tightening. changes will be made to ensure that the deficient During an interview on 2/21/25 at 2:37 p.m., practice does not recur; Physical Therapist (PT) 1 indicated that the Nursing staff, Restorative nurse

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 02/24/2025
	PROVIDER OR SUPPLIEI		6685 E	ADDRESS, CITY, STATE, ZIP COD FAST 117TH AVENUE IN POINT, IN 46307	
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIENT REGULATORY OF nursing staff were of splinting was support Resident 42. The soft protector was to we showers and baths, program that was well buring an interview Assistant Director of thought therapy has found her hand to be attempting to possi	STATEMENT OF DEFICIENCIE SCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION educated and a schedule for osed to be implemented for chedule for the splint/soft palm ear daily and take off for There was also a restorative viritten for the resident. V on 2/21/25 at 3:02 p.m., the of Nursing indicated she d tried to apply the splint and be too tight, so they were bly discontinue the splint d that the nursing staff did not	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPEDEFICIENCY) and CNA-1 were re-educate ensure that all palmar guard resting hand splint devices a place for residents with contractures. Restorative Nurse completed for the facility to ensure all sipalmar protectors are in place ordered. How the corrective action(swill be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; DON/Designee will audit to a residents with contractures weekly, to ensure that all pal guards and resting hand splind devices are in place for residents. Director of Nursing/designeed months. Director of Nursing/designeed present a summary of the auto the Quality Assurance committee monthly for 6 mon Thereafter, if determined by Quality Assurance committee auditing and monitoring will adone quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed 3.17.25	ENATE COMPLETION DATE d to s and are in d audit plints/ ce as s) e the e put all lmar int dents d
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervis	sion/Devices			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/O		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) D		(X3) DATE) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155637	B. WI	NG		02/24/	2025
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF I	PROVIDER OR SUPPLIER	8		l	ADDRESS, CITY, STATE, ZIP COD		
CDOWN	POINT HEALTH C	AMDUS		6685 EAST 117TH AVENUE CROWN POINT, IN 46307			
CROWN	POINT REALTH CA	AMPUS		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Based on observation, record review, and		F 06	589	Crown Point Christian Village	е	03/17/2025
	interview, the facili	ty failed to ensure fall			Annual/ Complaint Survey		
	precautions were in	place for a resident with a			2.24.25		
	history of falls for 1	of 5 residents reviewed for			Please accept the following as	the	
	accidents. (Residen	t 34)			facility's credible allegation of		
					compliance. This plan of		
	Finding includes:				correction does not constitute	an	
					admission of guilt or liability by	/ the	
		p.m., Resident 34 was observed			facility and is submitted only ir	1	
		chair in the unit dining room.			response to the regulatory		
		rollback bars or anti-tippers			requirement.		
	noted to the wheelchair.				F689-Free of Accident		
					Hazards/Supervision/Devices		
		p.m., Resident 34 was observed			What corrective action(s) wil	I	
		chair propelling himself around			be accomplished for those		
		n. There were no anti-rollback			residents found to have beer	1	
	bars or anti-tippers	noted to the wheelchair.			affected by the deficient		
					practice;		
		a.m., Resident 34 was			Resident 34 is in the correct		
		his wheelchair and was			wheelchair with appropriate fa		
		dining room by a CNA. There			interventions. Resident 34's fa	•	
		ck bars or anti-tippers noted to			and MD have been notified, no		
	the wheelchair.				adverse effects have been not	ted.	
					How the facility will identify		
		dent 34 was reviewed on			other residents having the		
		. Diagnoses included, but were			potential to be affected by th	е	
		eimer's Disease, hypertension,			same deficient practice and		
	and depression.				what corrective action will be	•	
		D + C + (MDC)			taken;		
		mum Data Set (MDS)			The Director of Nursing, Infect		
		2/26/24, indicated the resident			Preventionist, unit managers,		
		paired. He had two or more			designees conducted a review		
	1	ury since the prior assessment			residents' physician orders an		
	and was dependent	on staff for transfers.			medical records to identify oth		
	A Cara Dlam data 1	10/1/24 indicated the resident			residents having the potential		
		10/1/24, indicated the resident			be affected by the alleged defi	cient	
		An intervention, dated o apply front and rear			practice.	· • •	
	anti-tippers to the w				What measures will be put in	itO	
	anu-uppers to the w	viicciciiaii.			place or what systemic		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/24/2025 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT HEALTH CAMPUS CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A Care Plan Note, dated 11/11/24 at 2:51 p.m., ensure that the deficient indicated the resident had a fall on 11/9/24 while practice does not recur; attempting to self-transfer. Anti-tippers were put Nursing staff and Restorative in place to the resident's wheelchair as an nurse were re-educated to ensure intervention. all resident with history of falls have appropriate fall interventions During an interview on 2/21/25 at 1:51 p.m., the in place. Director of Nursing (DON) indicated anti-tippers Restorative Nurse completed audit were added to the resident's wheelchair on for the facility to ensure all fall 11/11/24 per the completed work order. She had interventions are in place as determined staff had been putting the resident in ordered. his roommate's wheelchair by mistake, which did How the corrective action(s) not have anti-tippers. He was now in the correct will be monitored to ensure the wheelchair. deficient practice will not recur, i.e., what quality A facility policy, titled "Fall Prevention," assurance programs will be put indicated, "...Residents are identified as at risk for into place; falls, clinically appropriate interventions will be DON/Designee will audit 10 put into place to reduce the risk for falls and/or to residents weekly, to ensure that prevent recurrence of falls..." residents with history of falls have all fall interventions in place as 3.1-45(a) 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 483.25(e)(1)-(3) SS=D Bowel/Bladder Incontinence, Catheter, UTI

FORM CMS-2567(02-99) Previous Versions Obsolete

Bldg. 00

Event ID:

9SMK11

Facility ID: 001198

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED			
		155637	B. Wl	ING		02/24/2025	
			•	STREET.	ADDRESS, CITY, STATE, ZIP COD		\neg
NAME OF P	PROVIDER OR SUPPLIEF	R			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS		CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		view and interview, the facility	F 06	590	Crown Point Christian Villag	e 03/17/2025	
		nary output was recorded and			Annual/ Complaint Survey		
		otified for low urinary output			2.24.25		
		1 resident reviewed for urinary			Please accept the following as		
	catheters. (Resident	(37)			facility's credible allegation of		
	T: 1: 1 1 1				compliance. This plan of		
	Finding includes:				correction does not constitute		
	TEI 10 TO 1	1			admission of guilt or liability by		
		dent 37 was reviewed on			facility and is submitted only in	۱	
		m. Diagnoses included, but were			response to the regulatory		
		eimer's disease, history of			requirement.		
		ons (UTIs), urethral stricture			F690 Bowel/Bladder		
		rethra), and obstructive and			Incontinence, Catheter, UTI		
		sorders of the bladder causing			What corrective action(s) will		
	problems with uring	e flow).			be accomplished for those		
					residents found to have been	n	
		mum Data Set (MDS)			affected by the deficient		
	· ·	2/22/24, indicated the resident			practice;		
		tively impaired and had an			Resident 37 was assessed, a	nd	
	indwelling urinary	catheter.			all urinary outputs have been		
					recorded since 2.24.25 and		
		ry 2025 Care Plans indicated			notified MD for low urinary out		
		indwelling urinary catheter.			Resident 37's family and MD		
		icated to monitor and			been notified; no adverse effe	cts	
	document intake an	d output.			have been noted.		
	m	2025 N			How the facility will identify		
		ry 2025 Physician Order			other residents having the		
	-	monitor Foley catheter output			potential to be affected by th	ie	
		at was less than 300 milliliters			same deficient practice and		
	(ml), notify the phy	sician.			what corrective action will be	e	
		D Jane			taken;		
		ministration Record (MAR)			The Director of Nursing, Infec		
		ninistration Record (TAR),			Preventionist, unit managers,		
		ated the Foley output was not			designees conducted a review		
		following dates and shifts:			residents' physician orders an		
	- 1st shift: 2/4/25	1.2/0/25			medical records to identify oth		
	- 2nd shift: 2/1, 2/2,				residents having the potential		
	- 3rd shift: 2/1 and 2	2/11/25			be affected by the alleged def	icient	
					practice.		
	I The Medication Ad	ministration Record (MAR)	1		What measures will be put in	nto I	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		A. BUILDING <u>00</u> COMPLE		X3) DATE SURVEY COMPLETED 02/24/2025	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
	and Treatment Adm dated 2/2025, indicathan 300 ml on the sense of the shift: 2/2, 2/9, 2nd shift: 2/3, 2/6, 3rd shift: 2/5, 2/6, There was no docur being contacted whethan 300 milliliters. During an interview Director of Nursing information to prove 3.1-41(a)(2)	ninistration Record (TAR), ated the Foley output was less following shifts: 2/10, and 2/16/25, 2/8, 2/10, 2/11, and 2/17/25 and 2/9/25 mentation of the physician en the Foley output was less of on 2/21/25 at 1:45 p.m., the indicated she had no further		place or what systemic changes will be made to ensure that the deficient practice does not recur; Nursing staff were re-educated ensure residents with indwelling catheters have the urinary outprecorded and notify the physici for low urinary output as ordered thow the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be printo place; DON/Designee will audit 5 residents with indwelling catheters/week to ensure urinate output was recorded and notify physician for low urinary output ordered for 6 months. Director of Nursing/designee we present a summary of the audite to the Quality Assurance committee monthly for 6 month. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed 3.17.25	to g but an ed. ne ry the t as till ts ss.
F 0692 SS=D Bldg. 00	-	n Status Maintenance	F 0692	Crown Point Christian Village	03/17/2025

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING		02/24/	/2025
		ı		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIE	₹			AST 117TH AVENUE		
CRUMM	POINT HEALTH C	AMPLIS			N POINT, IN 46307		
CKOWN	I OINT HEALTH G	AIVII UU		CROW	N 1 OHN 1, HN 4000 <i>1</i>		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	failed to monitor weekly weights and document				Annual/ Complaint Survey		
		or fluids, meals, and			2.24.25		
		ered for residents with			Please accept the following as		
	-	oss for 3 of 3 residents			facility's credible allegation of		
	reviewed for nutriti	on. (Residents 75, 85 and C)			compliance. This plan of		
					correction does not constitute		
	Findings include:				admission of guilt or liability by	•	
					facility and is submitted only in	n	
		cord was reviewed on 2/18/25 at			response to the regulatory		
		ses included, but were not			requirement.		
		lure, spinal stenosis, iron			F692 Nutrition/Hydration Sta	itus	
	deficiency anemia	and atrial fibrillation.			Maintenance		
					Please accept the following as		
	•	imum Data Set assessment			facility's credible allegation of		
		5, indicated the resident was			compliance. This plan of		
		nd was dependent on staff			correction does not constitute		
	_	and bed mobility. He had a			admission of guilt or liability by	-	
	-	or more in a month or 10% or			facility and is submitted only in	n	
	more in 6 months a				response to the regulatory		
	physician-prescribe	ed weight loss regimen.			requirement.		
					What corrective action(s) wil	II	
		ssion weight on 8/8/24 was			be accomplished for those		
	-	resident's weight on 11/5/24			residents found to have beer	n	
	-	and on 2/5/25, was 246.5			affected by the deficient		
	-	weight loss of 30.8 pounds, a			practice;		
	24% change, in six	months.			Resident 75 no longer resides	at	
	l . mi	1 . 111/10/04			the facility.		
		r, dated 11/19/24, indicated to			Resident 85 was assessed; al		
	check a weekly we	ight.			supplement consumptions have		
	E 202535 11 1				been documented since 2.24.	-	
		on Administration Record			Resident 85's family and MD I		
		ne following weekly weights:			been notified; no adverse effe		
	1/13/25: n/a				noted and care plan has been	1	
	1/20/25: n/a				updated accordingly.		
	1/27/25: 256 pound	ls			Resident C was assessed, all		
	2/3/25: n/a				supplement consumptions, me	eals	
	2/10/25: 246.5 pour	nds			and fluid intakes have been		
	2/17/25: blank				documented since 2.24.25.		
					Resident C's family and MD h		
	During an interview	v on 2/21/25 at 1:55 p.m., the			been notified; no adverse effe	cts	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155637	B. W	ING		02/24/2	2025
		1	<u> </u>	STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307		
		-			1	-	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	1	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		g indicated there were no			noted.		
additional weekly weights available. 2. On 2/20/25 at 11:36 a.m. Resident 85 was				How the facility will identify			
					other residents having the		
		a table in the unit dining room			potential to be affected by the	ie	
		ad a mighty shake open in front			same deficient practice and		
	of him but was not	urmkilig it.	1		what corrective action will be	t	
	The record for Dogi	dent 85 was reviewed on			taken; The Director of Nursing, Infect	tion	
		. Diagnoses included, but were			Preventionist, unit managers,		
		eimer's Disease, general anxiety			designees conducted a review		
		depressive disorder.			residents' physician orders an		
	disorder, and major	depressive disorder.			medical records to identify oth		
	The Quarterly Mini	imum Data Set (MDS)			residents having the potential		
		/24/25, indicated the resident			be affected by the alleged def		
		paired and had a significant			practice.	loiont	
	weight loss.	panea ana naa a sigimmaan			What measures will be put in	nto	
	Weight less.				place or what systemic		
	A Care Plan, update	ed 7/30/24, indicated the			changes will be made to		
	_	egular diet. The interventions			ensure that the deficient		
		supplements per orders.			practice does not recur;		
	_	olan related to significant			Nursing staff and the Register	ed	
	weight loss.	- -			Dietician have been re-educat		
					ensure weekly weights will be		
	The resident's weig	ht on 7/19/24 was 154 pounds			monitored and document		
	and on 2/3/25 was 1	135 pounds.			nutritional intake for fluids, me	als	
					and supplements as ordered f	for	
	The Culinary Nutri	tional Comprehensive			residents with significant weig	ht	
	Assessment, dated	11/1/24, indicated the resident			loss.		
	had a significant we	eight loss x 90 days.			The IDT has reviewed resider	nts	
					POC charting to ensure all		
		er (NP) Note, dated 12/31/24 at			documentation is completed for		
	_	I the resident's weight was			residents with significant weig	ht	
		ne. The mighty shake was			loss during the weekly NARS		
		to three times a day and a 2 cal			meetings.		
	supplement was add	ded twice a day.	1		How the corrective action(s)		
			1		will be monitored to ensure t	the	
	1 7	r, dated 9/16/24, indicated			deficient practice will not		
		ron, an antidepressant			recur, i.e., what quality		
		ed as an appetite stimulant) 45	1		assurance programs will be	put	
	milligrams at bedting	me for insomnia and appetite			into place;		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155637	B. W	/ING		02/24/	2025
				CTREET	ADDRESS CITY STATE ZIR COR		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
0001471	DOINT LIEATTILO	AMDUC			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AIVIPUS		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	stimulant.				DON/Designee will audit 10		
					residents/weekly to ensure we	ekly	
	Physician's Orders,	dated 12/31/24, indicated to			weights will be monitored and	-	
	1 -	ent twice a day and a mighty			document nutritional intake for		
	shake with meals for				fluids, meals and supplements		
		S			ordered for residents with		
	The Culinary Nutri	tional Quarterly Assessment,			significant weight loss for 6		
		cated the resident had a			months.		
	significant weight l				Director of Nursing/designee v	vill	
		•			present a summary of the aud		
	The Medication Ad	ministration Record (MAR),			to the Quality Assurance	-	
		ated the mighty shake and 2 cal			committee monthly for 6 mont	hs.	
		een administered, however,			Thereafter, if determined by the		
	there was no amount or percentage consumed				Quality Assurance committee,		
		e was only a check mark			auditing and monitoring will be		
	documented with ea	-			done quarterly and present		
					quarterly at the QA meeting.		
	During an interview	v on 2/21/25 at 1:44 p.m., the			Monitoring will be on going.		
	_	g indicated the supplement			Date by which systemic		
		put in the computer correctly			corrections will be complete	d:	
		the percentage consumed to			3.17.25		
		ne had now updated the					
		C's record was reviewed on					
		m. Diagnoses included, but were					
		eimer's disease and dementia.					
	,						
	The Quarterly Mini	mum Data Set (MDS)					
		2/8/24, indicated the resident					
		tively impaired and was					
		for all ADLs including eating,					
		nygiene, and transfers. She					
	received hospice ca						
	The resident weigh	ed 155.4 pounds on 8/1/24 and					
	139 pounds on 2/1/2	-					
	1						
	The current Care Pl	lans indicated the resident					
		with ADLs due to cognitive					
		lly dependent on staff for all					
		dent had a nutritional problem					
ı	1	proorein	1		I	J	

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Event ID:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	, ,	JILDING	nstruction <u>00</u>	(X3) DATE COMPL 02/24/	ETED
	PROVIDER OR SUPPLIER POINT HEALTH C		-	6685 EA	DDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
		o hospice. Interventions not limited to, monitor intake					
	indicated the reside	Physician's Order Summary ent received super cereal in the hty Shake with meals for					
	Administration Rec Shake was adminis	Medication and Treatment cords indicated the Mighty tered with meals, but did not of the supplement was					
	for the last 30 days meals were not doc - Breakfast: 1/28, 2 - Lunch: 1/28, 2/17	/17, and 2/18/25					
	last 30 days (1/23-2 documentation was	/17, and 2/18/25 , and 2/18/25					
	~	y on 2/21/25 at 9:27 a.m., the g indicated she had no further ride.					
	3.1-46(a)						
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mg	mt/Restore Eating Skills					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED
		155637	B. W	ING		02/24/2025
				STREET .	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	t .		6685 E	AST 117TH AVENUE	
CROWN	POINT HEALTH CA	AMPUS		CROW	N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
		view and interview, the facility	F 00	593	Crown Point Christian Villag	e 03/17/2025
	failed to provide pro	-			Annual/ Complaint Survey	
	(gastrostomy tube)				2.24.25	- 41
	_	rds, related to a lack of			Please accept the following as	
		abe feeding administration for			facility's credible allegation of	
		story of weight loss for 1 of 2			compliance. This plan of	an
	residents reviewed	for tube feeding. (Resident 47)			correction does not constitute	
	Finding includes:				admission of guilt or liability by	-
	Finding menues:				facility and is submitted only in	11
	Resident 17's record	d was reviewed on 2/20/25 at			response to the regulatory requirement.	
		s included, but were not limited			F693 Tube Feeding	
	to, vascular dement				Mgmt/Restore Eating Skills	
	to, vasculai demeni	14.			What corrective action(s) will	
	The Quarterly Mini	mum Data Set (MDS)			be accomplished for those	11
		/7/25, indicated the resident			residents found to have been	n
		tively impaired. She had a			affected by the deficient	
		as receiving hospice care.			practice;	
					Resident 47 was assessed, al	ll the
	The current Care Pl	ans indicated the resident was			tube feedings have been mark	
		ion related to the g-tube use.			as administered since 2.24.25	
		led, but were not limited to,			Resident 47's family and MD	
		feedings and fluids via g-tube			been notified, no adverse effe	
		dent had a g-tube related to			have been noted.	
	_	roke. Interventions included,			How the facility will identify	
		d to, registered dietician (RD) to			other residents having the	
		and as needed and tube			potential to be affected by the	ne
		The resident had a potential			same deficient practice and	
	nutritional problem	. Interventions included, but			what corrective action will be	e
	were not limited to,	RD to evaluate and make diet			taken;	
	changes as needed,	supplements as ordered, and			The Director of Nursing, Infec	tion
	monitor signs and s	ymptoms of malnutrition such			Preventionist, unit managers,	
	as significant weigh	nt loss: 3 lbs in 1 week, >5% in			designees conducted a reviev	v of
	1 month, >7.5% in	3 months, >10% in 6 months.			residents' physician orders an	nd
					medical records to identify oth	ner
	-	ted 1/15/2025 at 6:20 p.m.,			residents having the potential	to
		nt was not receiving any food			be affected by the alleged def	icient
	I -	received tube feeding. She			practice.	
	weighted 151.8 pou	ands (lbs) on 10/11/24, 146.8 lbs			What measures will be put in	nto
	on 12/1/24 and 140	.2 lbs on 12/18/24. With			place or what systemic	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE S	URVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLE	ETED
		155637	B. W	'ING		02/24/2	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			AST 117TH AVENUE		
CROWN	POINT HEALTH CA	AMPUS			N POINT, IN 46307		
					,	Т	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	significant weight l				changes will be made to		
		crease the duration of the tube			ensure that the deficient		
	_	at 45 ml per hour with Jevity			practice does not recur;		
	1.5 formula.				Nursing staff were re-educate		
	TEI (T. I	2025 Pl			ensure that all documentation		
		ry 2025 Physician's Order			tube feeding administration for		
	Summary indicated enteral feed of Jevity 1.5 per				resident with a history of weig	nt	
	g-tube via pump at 45 milliliters per hour. Start the				loss has been completed as		
		n. and turn off at 8:00 a.m. or			ordered and provide the prope	er	
		vas infused for 18 hours.			feeding tube care as per		
		ministered through the g-tube			professional standards.		
	every shift.				How the corrective action(s)		
	El E 1 2025	3.6.12.22.17			will be monitored to ensure t	he	
	-	Medication and Treatment			deficient practice will not		
		ords indicated the tube			recur, i.e., what quality		
		ministered on the following			assurance programs will be	put	
	days:	2/0.2/10			into place;		
		p.m.: 2/9, 2/10, and 2/13/25			DON/Designee will audit all		
	- 11:00 p.m. to 7:00	a.m.: 2/11 and 2/17/25			residents on feeding tubes we	-	
	Duning on interview	y on 2/21/25 at 1.24 m m tha			to ensure that all documentation		
	_	on 2/21/25 at 1:34 p.m., the indicated the nurse had just			tube feeding administration for		
	_	·			resident with a history of weight	nı	
	administration.	f on the tube feeding			loss has been completed as		
	aummstration.				ordered and provide the proper	71	
	3.1-44(a)				feeding tube care as per		
	5.1 -44 (a)				professional standards for 6 months.		
					Director of Nursing/designee v	_{vill}	
					present a summary of the aud		
					to the Quality Assurance	າເວ	
					committee monthly for 6 mont	he	
					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.		
					with be on going.		
					Date by which systemic		
					corrections will be complete	_d .	
			1		1 221122112112 Hill De complete	∽ .	

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	` ′	ULTIPLE CO JILDING	ONSTRUCTION 00	(X3) DATE COMPI	
		155637	B. W			02/24	
	PROVIDER OR SUPPLIER			6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307	•	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDENCE WAS A CONTRACTOR		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					3.17.25		
F 0695 SS=D Bldg. 00	Suctioning Based on observation interview, the facility received the necessate to incorrect oxygen an oxygen level for respiratory care. (Reference of the findings include: 1. On 2/17/25 at 11: Resident 75 was obtain asal cannula in rate of 3 liters per marked of 3 liters per marked of the findings include: Resident 75's record 10:55 a.m. Diagnost limited to, heart fail deficiency anemia at the Quarterly Minit (MDS), dated 1/2/2 cognitively intact an assist for toileting at A Physician's Order administer oxygen at On 2/19/25 at 10:05	served lying in his bed with place and oxygen flowing at a ninute (lpm). If was reviewed on 2/18/25 at ses included, but were not ture, spinal stenosis, iron and atrial fibrillation. In the service of the service o	F 00	695	Crown Point Christian Villag Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F695 Respiratory/Tracheoste 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 the facility. Resident 74 was assessed, oxygen has been provided at correct rate 2L, oxygen satural orders have been clarified. Resident 74's family and MD is been notified, no adverse effer have been noted. How the facility will identify other residents having the	an y the n omy II n s at the	03/17/2025
	1	ctly set between 2.5 and 3 lpm			potential to be affected by th	ie	
		to 2 lpm at that time.			same deficient practice and		
		:33 a.m., Resident 74 was			what corrective action will be	е	
		elchair wearing oxygen per			taken;	tion	
	was set at 2.5 liters	dent 74's oxygen concentrator			The Director of Nursing, Infect Preventionist, unit managers.		
l .	was set at 2.3 mers	OI OAYKUII.	1		i Fieventionist, unit managers.	aliu	1

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING		02/24/	2025
NAME OF F	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
CDOWN	DOINT LIEALTH C	ANADIJO			AST 117TH AVENUE		
CROWN	POINT HEALTH CA	AMPUS		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					designees conducted a review	v of	
	On 2/19/25 at 2:51	p.m., Resident 74 was observed			residents' physician orders an	d	
	in his wheelchair, h	is oxygen was set to 2.5 liters.			medical records to identify oth	er	
					residents having the potential	to	
	On 2/20/25 at 10:52	2 a.m., the resident was			be affected by the alleged def		
	observed with the A	ADON. She indicated the			practice.		
	oxygen was set to 4	liters. She adjusted the			What measures will be put ir	nto	
	oxygen to 2 liters at that time.				place or what systemic		
					changes will be made to		
	The record for Resident 74 was reviewed on				ensure that the deficient		
	2/18/25 at 10:33 a.r.	n. Diagnoses included, but were			practice does not recur;		
	not limited to, chronic combined systolic				Nursing staff, LPN 2 and ADC	N	
	congestive and diastolic heart failure.				were re-educated to ensure th		
					residents receive the necessa	rv	
	The Quarterly Mini	mum Data Set (MDS)			care and treatment related to	,	
		/9/25, indicated the resident			correct oxygen flow rates and		
	was cognitively inta				monitoring an oxygen level as		
					ordered.		
	A Physician's Order	r, dated 10/10/24, indicated			How the corrective action(s)		
		rs via nasal cannula to be			will be monitored to ensure t		
	administered every	24 hours as needed for			deficient practice will not		
	hypoxia. Administe	r oxygen if oxygen saturation			recur, i.e., what quality		
	falls below 92%.				assurance programs will be	put	
					into place;		
	An Assessment of I	Resident 74's vital record tasks			DON/Designee will audit 10		
	indicated Resident	74's oxygen saturation levels			residents/weekly to ensure that	at	
	were last checked o	n 1/20/25, and the resident was			residents receive the necessa		
	saturating at 98% ro	oom air.			care and treatment related to		
					correct oxygen flow rates and		
	During an interview	on 2/20/25 at 10:57 a.m., the			monitoring an oxygen level as		
	Assistant Director of	of Nursing verified that			ordered for 6 months.		
	Resident 74 should	be on 2 liters of oxygen. She			Director of Nursing/designee v	will	
	indicated she would	turn the concentrator to the			present a summary of the aud		
	correct rate immedi	ately. The ADON indicated			to the Quality Assurance		
		xygen saturation levels were			committee monthly for 6 mont	hs.	
		1/20/25. She indicated she			Thereafter, if determined by the		
	would get a current	oxygen saturation level on the			Quality Assurance committee,		
	resident immediatel				auditing and monitoring will be		
					done quarterly and present		
	3.1-47(a)(6)				quarterly at the QA meeting.		
	````				l , ,		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		l í	(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING 00 COMPLET				
THILD TENT	or condition	155637	B. WI			02/24/	
	PROVIDER OR SUPPLIED			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Monitoring will be on going.		
					Date by which systemic corrections will be complete 3.17.25	d:	
F 0755 SS=D	483.45(a)(b)(1)-(3	3)					
	Pharmacy	//Pharmacist/Pacards					
Bldg. 00	Based on observati interview, the facility emergency drugs wand procedures for provided for 2 of 2 pharmacy services.  Findings include:  1. On 2/17/25 at 2:00 observed seated in indicated she had a and her left leg for requested to see the The resident's reconducted 1:30 p.m. Diagnose	s/Pharmacist/Records on, record review and ity failed to ensure routine and were received in a timely manner accurate dispensing were residents reviewed for (Residents 32 and 77)  00 p.m., Resident 32 was her recliner in her room. She in tiching rash on both arms about a week. She had e Nurse Practitioner.  rd was reviewed on 2/20/25 at es included, but were not limited	F 07	755	Crown Point Christian Villag Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F755 Pharmacy Srvcs/Procedures/Pharmacisecords What corrective action(s) will be accomplished for those residents found to have been	s the an y the n	03/17/2025
	The Quarterly Mindated 1/25/25, indicognitively intact a toileting, transfers,  A Physician's Progindicated the reside complaint of itchin patches to her upper	imum Data Set assessment, cated the resident was nd was independent for bed mobility and eating.  ress Note, dated 2/18/25, ent was seen that day for a g. She had about five red er arms and left leg. An order actinolone cream twice daily for eted areas.			affected by the deficient practice; Resident 32 was assessed; all medications have been given ordered. Resident 32's family MD were notified, no adverse effects noted. Resident 77 was assessed; all medications have been given ordered. Resident 77's family MD have been notified; no adreffects have been noted. How the facility will identify other residents having the	as and II as and	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155637	B. WI	ING		02/24/2025
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>
NAME OF F	PROVIDER OR SUPPLIEF	8			AST 117TH AVENUE	
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307	
	Г		1		, T	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
TAG		R LSC IDENTIFYING INFORMATION		TAG		DATE
	_	ated 2/21/25 at 6:15 a.m., nt was upset the triamcinolone			potential to be affected by the	ie
		ed yet. The pharmacy was			same deficient practice and what corrective action will b	
		I they would check on it.			taken;	e
	caned and indicated	they would check on it.			The Director of Nursing, Infec	tion
	During an interview	y on 2/21/25 at 0.25 a.m. the			Preventionist, unit managers,	
	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				designees conducted a review	
					residents' physician orders ar	
	within 24 hours. At 3:43 p.m., the DON indicated				medical records to identify oth	
		ved the order on 2/18/25 and			residents having the potential	
		every service on 2/19/25. There			be affected by the alleged def	
		macy for emergency			practice.	ICIETIL
		esident received the medication			What measures will be put in	nto
	on 2/21/25.	sident received the inedication			place or what systemic	
	_	35 a.m., a family interview was			changes will be made to	
		77's son. He indicated that he			ensure that the deficient	
		torney for his mother and he			practice does not recur;	
		other may have been receiving			Nursing staff and LPN 2 were	
		ication named Sertraline			re-educated to ensure that ro	
		o treat depression, panic			and emergency drugs are rec	
	,	ompulsive disorder,			in a timely manner and proceed	
		s disorder, and social anxiety			for accurate dispensing were	
		ated that he believed the			provided as ordered.	
	/	he medication cart and was			Medication cart audit was	
		inistered to his mother during			completed, all medications are	e
	daily medication pa				current in med carts since	
	'				2.24.25.	
	The record for Resi	dent 77 was reviewed on			New pharmacy in place as of	
		. Diagnoses included, but were			2.28.25.	
		ety disorder, unspecified, other			How the corrective action(s)	
		nspecified dementia,			will be monitored to ensure	
	unspecified severity	without behavioral			deficient practice will not	
	disturbance, psycho	otic disturbance, and mood			recur, i.e., what quality	
	disturbance.				assurance programs will be	put
					into place;	
	The Admission Min	nimum Data Set assessment,			DON/Designee will audit 10	
	dated 11/20/24, ind	icated the resident was			residents/weekly to ensure the	at
	cognitively impaire	d.			routine and emergency drugs	are
					received in a timely manner a	nd
	A Physician's Orde	r. dated 1/23/25, indicated			procedures for accurate	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	X3) DATE SURVEY COMPLETED 02/24/2025
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, CITY, STATE, ZIP COD FAST 117TH AVENUE IN POINT, IN 46307	
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)  dispensing were provided as ordered for 6 months. Director of Nursing/designee w present a summary of the audit to the Quality Assurance committee monthly for 6 month Thereafter, if determined by the	ill ts
	Resident 77's Sertra medications to the r  During an interview indicated she had catimes to inform therorder. She indicated be delivered, so she	esident.  y on 2/21/25 at 9:41 a.m., LPN 2 alled the pharmacy several m to stop sending the Sertraline I the medication continued to wrote a note to inform 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	
	During an interview DON indicated the the facility and rece medication orders. S and the pharmacist medication was orig another pharmacy s	not to administer the line medication to Resident 77.  Y on 2/21/25 at 3:48 p.m., the pharmacy was interfaced with rived all new and discontinued She spoke with the pharmacy informed her that the ginally discontinued, however taff member reordered the sused the Sertraline to be dility weekly.			
F 0757 SS=D Bldg. 00	Drugs Based on record rev failed to ensure non interventions were a narcotic pain medic	Free from Unnecessary view and interview, the facility -pharmacological attempted prior to giving ation for 1 of 5 residents essary medications. (Resident	F 0757	Crown Point Christian Village Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/24/2025 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT HEALTH CAMPUS CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE correction does not constitute an Finding includes: admission of guilt or liability by the facility and is submitted only in Resident 75's record was reviewed on 2/18/25 at response to the regulatory 10:55 a.m. Diagnoses included, but were not requirement. limited to, heart failure, spinal stenosis, iron F757 Drug Regimen is Free deficiency anemia and atrial fibrillation. from Unnecessary Drugs What corrective action(s) will The Quarterly Minimum Data Set assessment be accomplished for those (MDS), dated 1/2/25, indicated the resident was residents found to have been cognitively intact and was dependent on staff affected by the deficient assist for toileting and bed mobility. The resident practice; had pain that occurred almost constantly, did not Resident 75 no longer resides in receive prn (as needed) pain medication or the facility. non-medication interventions for pain. How the facility will identify other residents having the A Pain Care Plan, dated 8/8/24, indicated the potential to be affected by the resident had chronic pain due to spinal stenosis. same deficient practice and Interventions included, but were not limited to, what corrective action will be encourage resident to try different pain-relieving taken: methods such as positioning, relaxation therapy, The Director of Nursing, Infection progressive relaxation, bathing, heat and cold Preventionist, unit managers, and application, ultra sound, muscle stimulation. designees conducted a review of residents' physician orders and A Physician's Order indicated to give Norco (an medical records to identify other opioid pain medication) 5 milligrams (mg)/325 mg, residents having the potential to every six hours as needed for pain. be affected by the alleged deficient practice. A Physician's Order, dated 11/19/24, indicated to What measures will be put into monitor pain: non-pharmacological interventions place or what systemic documentation as follows: ice; heat; reposition; changes will be made to elevate; massage; spiritual /meditation; visual ensure that the deficient imagery; music; other. practice does not recur: Nursing staff were re-educated to The 2025 Medication Administration Record ensure non-pharmacological (MAR) indicated the resident received seven interventions have been attempted Norco in January and eight in February. prior to giving narcotic pain medications. The January and February 2025 MARs lacked How the corrective action(s) documentation to indicate any will be monitored to ensure the

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PRINTED: 03/24/2025

	Γ OF HEALTH AND HU! R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039	
STATEMEN	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/24/2025	
NAME OF I	PROVIDER OR SUPPLIEF			r ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE		
CROWN	POINT HEALTH CA	AMPUS		VN POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 0880	attempted prior to the During an interview	een attempted.		deficient practice will not recur, i.e., what quality assurance programs will be pinto place; DON/Designee will audit 10 residents/ weekly to ensure non-pharmacological intervent have been attempted prior to gnarcotic pain medications for 6 months. Director of Nursing/designee wpresent a summary of the audit to the Quality Assurance committee monthly for 6 month 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	cions giving S vill its ns. e	
SS=D Bldg. 00	Based on observation interview, the facility control guidelines were related to improper (PPE) worn in an is	on & Control  on, record review and ty failed to ensure infection were in place and implemented personal protective equipment olation room and lack of a room on contact isolation.	F 0880	Crown Point Christian Village Annual/ Complaint Survey 2.24.25 Please accept the following as facility's credible allegation of compliance. This plan of	03/17/2025	

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

correction does not constitute an admission of guilt or liability by the

facility and is submitted only in

response to the regulatory

	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		155637	B. W	ING		02/24/2	2025
NAME OF F	PROVIDER OR SUPPLIER	}	-		ADDRESS, CITY, STATE, ZIP COD		
					AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPUS		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	-	TAG	DEFICIENCY)		DATE
		oves, assessed the g-tube for sked residual. She then			requirement.		
	1 ^	edication dissolved in water			POC F-880 Infection	n	
	into the g-tube.	edication dissolved in water			<b>Prevention &amp; Cont</b>	rol	
		the resident's door that					
	indicated Enhanced Barrier Precautions should be				Corrective actions which wil	il .	
	· ·	t entered the room should			be accomplished for those		
		entering and when leaving.			residents found to have bee	n	
		ear gloves and a gown for the tact resident care activities.			affected by the deficient		
					practice:		
	Activities included, but were not limited to, device care or use: central line, urinary catheter, feeding tube, tracheostomy.						
					LPN 1 was immediately		
	,				re-educated related to ensure		
	During an interview	on 2/19/25, immediately after			infection control guidelines are	ı	
	the observation, the	LPN indicated the resident			place and implemented relate	I .	
		any longer. The sign on the			wearing protective equipment		
		and she again indicated the			properly in an isolation room f	or	
	resident was no lon	ger on isolation.			Resident D during g-tube		
	During an interview	on 2/19/25 at 3:54 p.m., the			medication administration.		
	_	; indicated the nurse should			Resident B's contact isolation	haa	
	_	a gown during the g-tube			been rehung on her door. Res		
		stration and she would speak to			B's family and MD were notific	I .	
		rvations on 2/18/25 at 3:06 p.m.,			no adverse effects were repor		
		., and 2/20/25 at 3:25 p.m.,					
		he day room and her room was			How the facility will identify		
		olation bin next to the			other residents having the		
	l .	gnage posted on or near the			potential to be affected by the	ne l	
	door.				same deficient practice:		
	Resident B's record	was reviewed on 2/24/25 at			The Director of Nursing, Infec	tion	
		s included, but were not limited			Preventionist, unit managers,		
		and breast cancer, and			designees conducted a review	I .	
	traumatic brain inju	ıry.			residents' physician orders an	I .	
					medical records to identify oth	I .	
	I	Physician's Order Summary			residents having the potential	I .	
		nt was in contact isolation			be affected by the alleged def	icient	
	related to candida a	uris.			practice.	l	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155637	A. BU B. W.		<u>UU                                   </u>	02/24/2025	
		100001	<i>D.</i> W.	_	ADDRESS SIEV SELECT STREET	02/2 <del>4</del> /.	2020
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE		
CROWN	POINT HEALTH CA	AMPUS			N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	During an interview Infection Prevention contact isolation pro auris. She believed contact isolation sig	on 2/20/25 at 4:05 p.m., the nist indicated the resident was ecautions as she had candida the family had removed the m.  to Complaint IN00453429.		TAG	The measures the facility will take or systems the facility walter to ensure that the problem will be corrected an will not recur:  Christian Horizons Clinical Nuc Consultant with Infection Preventionist Certification re-educated the facility Administrator, Director of Nurse to ensure infection control guidelines are in place and implemented related to wearing protective equipment properly an isolation room and ensuring that all signage is in place for resident room on contact isolated Clinical staff re-educated to enthey are wearing proper PPE Enhanced Barrier Precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.  Clinical staff re-educated to enthey are wearing proper precaution rooms.	vill  Ind  Irse  Ising  Ing  Ing  Insure  Insure  Inct  Insure  Inct  Insure  Inct  Insure  Inct  Insure  Inct  Insure	DATE

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE ( A. BUILDING B. WING	CONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/24/2025
	PROVIDER OR SUPPLIEF		6685	FADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				for 3 months, then 5 g-tube me 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 signs on their doors 5x/weekly for 6 months.	
				Director of Nursing/designee varies and to the Quality Assurance committee monthly for 6 month. 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.	ns. e
				Date by which systemic corrections will be completed 3.17.25	d:
F 0887 SS=E Bldg. 00	483.80(d)(3)(i)-(vii COVID-19 Immun	•			
5	failed to ensure the included documentare representative was plenefits and potentic COVID-19 vaccinathe vaccine was not	riew and interview, the facility residents' medical records ation the resident or resident provided education on the al risk associated with the tion and documentation why administered for 4 of 5 for COVID-19 vaccinations.	F 0887	Crown Point Christian Village Annual/ Complaint Survey 2.24.25  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory	an o the

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155637	B. W	ING		02/24/2025
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF 1	PROVIDER OR SUPPLIEF	₹			AST 117TH AVENUE	
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307	
	TOTAL TILALITIO	,		J. COW	11. 3111, 11. 40007	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					F 887 COVID-19 Immunization	
		ecord was reviewed on 2/21/25			What corrective action(s) wi	II
	at 9:55 a.m.				be accomplished for those	
					residents found to have bee	n
	The COVID-19 vaccination had not been				affected by the deficient	
	documented as offered or administered since				practice;	
	9/22/22. There was no documentation education				Resident B was assessed,	
	on the benefits and potential risk of the the				COVID-19 vaccine was provide	<b>I</b>
		had been provided to the			Resident B's family and MD v	vere
	resident or the resid	lent's representative.			notified.	
					Resident 53 was assessed,	
					COVID-19 vaccine was offered	ed,
	2. Resident B's record was reviewed on 2/21/25 at				declined at this time. Residen	ıt
		dent received the first			53's family and MD were noti	fied.
	COVID-19 vaccina	ation on 2/26/22.			Resident 201 no longer resident	es in
					the facility.	
		ecination had not been			Resident 300 was assessed,	
		ered or administered since			COVID-19 vaccine was provide	ded.
		s no documentation education			Resident 300's family and MI	)
		potential risk of the the			were notified.	
		had been provided to the			How the facility will identify	
	resident or the resid	lent's representative.			other residents having the	
					potential to be affected by the	ne
					same deficient practice and	
	-	ecord was reviewed on 2/21/25			what corrective action will b	e
	at 10:00 a.m.				taken;	
					The Director of Nursing, Infec	
		ccination had not been			Preventionist, unit managers,	
		ered or administered. There			designees conducted a review	
		ion education on the benefits			residents' physician orders ar	
	_	f the the COVID-19 vaccine			medical records to identify oth	<b>I</b>
	_	to the resident or the resident's			residents having the potential	
	representative.				be affected by the alleged de	ficient
					practice.	
	,				What measures will be put i	nto
		ecord was reviewed on 2/21/25			place or what systemic	
	at 10:05 a.m.				changes will be made to	
					ensure that the deficient	
		ecination had not been			practice does not recur;	
	documented as offe	ered or administered. There			Licensed nursing staff and the	e

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 02/24/2025 155637 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT HEALTH CAMPUS CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE was no documentation education on the benefits Infection Preventionist Nurse were and potential risk of the the COVID-19 vaccine re-educated to ensure that the had been provided to the resident or the resident's COVID-19 vaccination has been representative. offered and/or administered; will document education on the During an interview on 2/20/25 at 2:42 p.m., the benefits and potential risk of the Infection Preventionist (IP) indicated she had COVID-19 vaccine given to the offered vaccinations at the time of admission. She resident or the resident's did not offer vaccinations at other times. The representative. COVID-19 vaccination was not available from their Infection Preventionist Nurse has pharmacy, so she had been trying to set up a scheduled a COVID-19 clinic on clinic with the county health department, but she March 27, 2025. was having difficulty getting it completed. She How the corrective action(s) was not aware she needed to periodically ask the will be monitored to ensure the long term residents if they were interested in deficient practice will not receiving the COVID-19 vaccinations when recur, i.e., what quality eligible, she had only been offering the influenza assurance programs will be put vaccine when those were available. into place; DON/designee will audit 10 During an interview on 2/24/25 at 1:22 p.m., the residents/weekly to ensure that Director of Nursing indicated the IP had been the COVID-19 vaccination has trying to get things set up and in place so that been offered and/or administered they could have a COVID-19 vaccination clinic. and that there is documentation of They had not hosted a clinic lately. She did not education on the benefits and provide any further information. potential risk of the COVID-19 vaccine given to the resident or the A policy titled "COVID-19 Vaccination Policy," resident's representative for 6 indicated "...Procedure...4.2 COVID-19 months. vaccinations will be offered as per CDC (ACIP) Director of Nursing/designee will and/or FDA guidelines unless such immunization present a summary of the audits is medically contraindicated. This will include to the Quality Assurance additional doses or booster doses when committee monthly for 6 months. appropriate and available...4.5 Prior to Thereafter, if determined by the administration of the vaccine, the person Quality Assurance committee, receiving the immunization, or representative, will auditing and monitoring will be be provided with a copy of the CDC's current done quarterly and present vaccine information statement...4.9 The resident's quarterly at the QA meeting. medical record will include documentation that the Monitoring will be on going. resident was provided education regarding the Date by which systemic benefits and potential side effects of the corrections will be completed:

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	l í	ILDING	nstruction 00	(X3) DATE : COMPL <b>02/24</b> /	ETED
	PROVIDER OR SUPPLIER			6685 EA	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	]	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
R 0000	immunization"				3.17.25		
Bldg. 00	Survey. This visit in State Licensure Sur Nursing Home Com IN00453351, and IN		R 00	000	The facility kindly requests a dreview.	esk	
	the allegations are c Complaint IN00453 related to the allega Complaint IN00453 related to the allega	257 - No deficiencies related to ited.  351 - Federal/State deficiencies tions are cited at F677.  429 - Federal/State deficiencies tions are cited at F880  pary 17, 18, 19, 20, 21, and 24,					
	2025 Facility number: 00 Residential Census: These State Resider accordance with 410	42 atial Findings are cited in					
R 0217	Quality review com 410 IAC 16.2-5-2( Evaluation - Defici	e)(1-5)					
Bldg. 00	failed to ensure serv updated with change	riew and interview, the facility rice plans were signed and/ or es related to a urinary catheter 7 service plans reviewed.	R 02	217	Crown Point Christian Village Annual/ Complaint Survey 2.24.25  Please accept the following as		03/17/2025
	, , , , , , , , , , , , , , , , , , ,		1		l ·		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED			
		155637	B. WING		02/24/2025			
			<u> </u>	OTT DET	IDDREGG CHTV GT TE TO COP			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
					AST 117TH AVENUE			
CROWN	POINT HEALTH C	AMPUS		CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
					facility's credible allegation of			
	Findings include:				compliance. This plan of			
					correction does not constitute	an		
	1. On 2/24/25 at 12	2:01 p.m., Resident 4 was			admission of guilt or liability by	/ the		
	observed in the hall	lway outside his room. A			facility and is submitted only ir	า		
		g was observed hanging from		response to the regulatory				
	the side of his whee	elchair in a dignity bag. He		requirement.				
	indicated he had a t	urinary catheter and was able			R217			
	to empty the draina	ge bag himself.			What corrective action(s) wil	I		
					be accomplished for those			
		was reviewed on 2/24/25 at			residents found to have been	า		
	_	ses included, but were not			affected by the deficient			
		ention and neuromuscular			practice;			
	1 -	oladder. The resident was		Service plans have been updated				
	admitted to the facility on 2/18/23.				for residents 4 and 3 to ensure			
					that they are reflective of the			
	The Physician's Order Summary, dated 2/2025,				resident.			
	indicated to monitor the urinary catheter insertion				How the facility will identify			
	site twice a day and drain the catheter bag every				other residents having the			
	shift.				potential to be affected by th	е		
					same deficient practice and			
		ed 9/17/24, lacked any			what corrective action will be	9		
	documentation the resident had a urinary ca				taken;			
if he needed assistance taking car		_			The Director of Nursing, Infect			
	and who was to change the urinary catheter.				Preventionist, unit managers,			
				designees conducted a review of				
	During an interview on 2/24/25 at 2:37 p.m., the				residents' physician orders an			
	Assisted Living Director indicated the resident			medical records to identify other				
	took care of the urinary catheter himself. He would				residents having the potential			
	go out to the physician's office to have the				be affected by the alleged def	icient		
	catheter changed and had an appointment coming				practice.			
	up. She would update the service plan.				What measures will be put in	ito		
	2. Resident 3's record was reviewed on 2/24/25 at				place or what systemic			
	10:28 a.m. Diagnoses included, but were not				changes will be made to			
	limited to, hypothyroidism and vitamin D				ensure that the deficient			
	deficiency.				practice does not recur;	·h o		
	The Desident C.	as Diam dated 2/6/25 :1:4-1			Staff have been educated on the			
		ce Plan, dated 2/6/25, indicated			requirements to ensure servic			
	the resident was severely cognitively impaired.				plans are reflective of the resident			
She had a 24 hour per day, 7 day a week caregiver.					and include oxygen therapy a	nd		

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STATEMENT OF DEFICIENCIES  AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00		(X3) DATE SURVEY COMPLETED		
		155637		B. WING		02/24/2025	
NAME OF PROVIDER OR SUPPLIER  CROWN POINT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
	She was receiving here. The February 2025 indicated 2 liters per cannula as needed.  The Resident Service applicable for oxygon During an interview Assisted Living Dirinad a current order.	EGULATORY OR LSC IDENTIFYING INFORMATION  was receiving hospice care.  Catheter use.  How the corrective action(s)  will be monitored to ensure the deficient practice will not		or to s vill its ns. e			
R 0356 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -						
3	failed to ensure the contained all the ne residents reviewed.  Findings include:	riew and interview, the facility resident Emergency Binder cessary information for 3 of 5 (Residents 2, 4, and 6)  ency Binder was reviewed on	R 03	356	Crown Point Christian Village Annual/ Complaint Survey 2.24.25  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in	the an	03/17/2025

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155637		A. BUILDING B. WING	00	COMPLETED 02/24/2025			
NAME OF PROVIDER OR SUPPLIER  CROWN POINT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR a. Resident 2 was maddress.  b. Resident 4 was maddress.  b. Resident 4's record 10:54 a.m. His allersulfate.  c. Resident 6 was maddress.  c. Resident 6's record 1:54 p.m. Her allermetformin, spironol sulfamethoxazole/trlatex, mold, and address.	imethoprim, green beans, cats,	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION MEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  response to the regulatory requirement.  R356  What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; The emergency forms for Res 2, 4, and 6 have been update 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, Infect Preventionist, unit managers, designees conducted a review residents' physician orders are medical records to identify oth residents having the potential be affected by the alleged definition practice.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; AL Director and nursing staff been educated on the require information for the emergency binder.  How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be	II  n  sident ed to  e  tion and v of ad ner to cicient  have d		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  02/24/2025		
NAME OF PROVIDER OR SUPPLIER CROWN POINT HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP COD 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 emergence binder. The checklist will be completed when creating an emergency form for each new resident. Additionally, the AL director will audit the emerger binder monthly to ensure all required components are president a summary of the audit of the Quality Assurance committee monthly for 6 month 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 complete 3.17.25	oncy sent. will dits ths. he		

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