STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETEI				
		155637	B. WI	NG		04/10/2025	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ACH 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
F 0000							
Bldg. 00	the Recertification at completed on 2/24/2 to the Investigation and IN00453429 co to the State Residen completed 2/24/25. This visit was in con Investigation of Con IN00455245, IN004 and IN00456087. Complaint IN00453 Complaint IN00453 Complaint IN00455 related to the allegations are completed to the allegations are complaint IN00455 the allegations are complaint IN00455 related to the allegations are complaint IN00456	mplaints IN00454867, 155369, IN00455441, IN00455913, 351 - Not corrected. 429 - Not corrected. 867 - No deficiencies related to ited. 245 - Federal/State deficiencies tions are cited at F677. 369 - Federal/State deficiencies tions are cited at F692.	F 00	000			
	Survey dates: April	7, 8, 9, and 10, 2025					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Natalie Porcaro Administrator 04/21/2025

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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 9SMK12 Facility ID: 001198 If continuation sheet Page 1 of 29

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155637		(X2) MULTIPLE CO A. BUILDING B. WING					
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN 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		
F 0554 SS=D Bldg. 00	Quality review com 483.10(c)(7) Resident Self-Adn Based on record rev failed to ensure a re to self-administer m reviewed for self-ad (Resident 205) Finding includes: Resident 205's reco 8:51 a.m. Diagnose to, chronic obstruct chronic respiratory to the facility on 3/2	reflect State Findings cited in 0 IAC 16.2-3.1. pleted on 4/15/25. nin Meds-Clinically Appropriew and interview, the facility sident had a physician's order redication for 1 of 3 residents liministration of medications. and was reviewed on 4/8/25 at a sincluded, but were not limited ive pulmonary disease and failure. The resident admitted	F 0554	Crown Point Health Campus Annual PSR Survey: 4/10/202 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 ir response to the regulatory requirement. F554 Resident Self Admin Meds-Clinically Appropriate What corrective action(s) will be accomplished for those	an y the		

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 2 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				VEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPLETE	D		
		155637	B. W	. WING 04/10/2025					
				STREET A	ADDRESS, CITY, STATE, ZIP COD				
NAME OF F	PROVIDER OR SUPPLIEF	8	6685 EAST 117TH AVENUE						
CROWN	POINT HEALTH C	AMPUS	CROWN POINT, IN 46307						
(X4) ID	CHMMADV	STATEMENT OF DEFICIENCIE	1	ID	1		(Y5)		
PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) OMPLETION		
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	DATE		
1110	dated 3/31/25, was			1110	residents found to have been	, 	D.11111		
	autu 575 17 2 5, 1145	m progress.			affected by the deficient				
	The Baseline Care	Plan, dated 3/27/25 at 9:19 a.m.,			practice;				
		nt was cognitively intact, had			A self-administration assessm	ent			
		eter, and self-administered			was completed for Resident 2				
	medications.				and an MD order was receive				
					self-administration of PRN rescue				
	A Self-Administrat	ion of Medication Assessment,			inhaler. Resident 205's plan o	f			
dated 3/27/25 8:46 a.m., indicated the resident's					care was updated.				
		ept at bedside and self			How the facility will identify				
administration was appropriate.					other residents having the				
					potential to be affected by the	e			
A Physician's Order, dated 3/24/25, indicated				same deficient practice and					
		nalation solution, 2.5 milligram			what corrective action will be	e			
	inhale orally every	4 hours as needed.			taken;				
					All facility residents with				
		sician's orders to keep the			medication orders have the				
	albuterol inhaler at	the bedside.			potential to be affected by the				
	D	4/10/25 + 0.22 + 1			same alleged deficient practic				
	_	v on 4/10/25 at 9:22 a.m., the			What measures will be put in	ito			
		Nursing indicated the resident ne albuterol inhaler and the			place or what systemic				
		ated for self-administration.			changes will be made to ensure that the deficient				
	oraci would be upa	acca for seir-administration.			practice does not recur;				
	This deficiency was	s cited on 2/24/25. The facility			Staff were educated on not lea	aving			
	1	t a systemic plan of correction			medications at resident bedsic	•			
	to prevent recurrence				unless there is an order for				
	F				self-administration in place.				
	3.1-11				Licensed Nurses were also				
					educated on:				
					Not leaving medications	at			
					bedside unless resident has				
					orders to self-administer				
					If a resident prefers to self				
					-administer medications the				
					following is required:				
					Completion of a medical	tion			
					self-administration assessmer	nt			
					Physicians order for the				
				mediation the resident is to					

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 3 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637 B. WING 00 COMPLETED O4/10/2025 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Self-administer Care plan updated How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
NAME OF PROVIDER OR SUPPLIER CROWN POINT HEALTH CAMPUS (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE REGULATORY OR LSC IDENTIFYING INFORMATION Self-administer Care plan updated How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
NAME OF PROVIDER OR SUPPLIER CROWN POINT HEALTH CAMPUS (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION Self-administer Care plan updated How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDERS PLAN OF CORRECTION CEACHCORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE COMPLETION DATE
TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Self-administer Care plan updated How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
self-administer Care plan updated How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
deficient practice will not recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
recur, i.e., what quality assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
assurance programs will be put into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
into place; Facility Angel's will audit 5 residents 3 days per week to ensure no medication is improperly stored at the bedside
residents 3 days per week to ensure no medication is improperly stored at the bedside
ensure no medication is improperly stored at the bedside
improperly stored at the bedside
and any medication noted at bedside has orders for
self-administration.
The Administrator/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:
4/17/2025
F 0677 483.24(a)(2)
SS=D ADL Care Provided for Dependent Residents Bldg. 00
Based on record review and interview, the facility F 0677 Crown Point Health Campus 04/17/2025
failed to document incontinence care for a Annual PSR Survey: 4/10/2025
resident who was dependent on staff for activities
of daily living (ADLs) for 1 of 4 residents who
were reviewed for ADLs. (Resident B) facility's credible allegation of
compliance. This plan of
Finding includes: correction does not constitute an admission of quilt or liability by the

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 4 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	ETED
		155637	B. W	B. WING 04/10/2025			2025
			<u> </u>	OTEN DEEM	ADDRESS CITY STATE TO SEE		
NAME OF F	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD		
000/4/4/	DOINT LIEALTH O	A A A DUI O			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	(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	DEFICIENCY)		DATE
	Resident B's record	was reviewed on 4/7/25 at			facility and is submitted only ir	n	
	10:20 a.m. Diagnoses included, but were not				response to the regulatory		
	limited to, dementia, hemiplegia and hemiparesis				requirement.		
	(weakness and paralysis) following a cerebral				F677 ADL Care Provided for		
	infarction (stroke).				Dependent Residents		
					What corrective action(s) wil	I	
	The Discharge Min	imum Data Set (MDS)			be accomplished for those		
	assessment, dated 3/12/25, indicated the resident				residents found to have been	n	
	was severely cognitively impaired. She was totally				affected by the deficient		
	dependent on staff for assistance with toileting				practice;		
	and transfers. She was frequently incontinent of				ADL documentation including		
	bladder and always incontinent of bowel.				incontinence care is being		
					completed accordingly for		
	The current Care Plans indicated the resident had				Resident B.		
	episodes of incontir	nence and was at risk for					
	complications. Inter	rventions included, but were			How the facility will identify		
	not limited to, enco	urage fluids, provide			other residents having the		
	incontinence care, a	and toilet at regular intervals or			potential to be affected by th	ie	
	scheduled voiding.				same deficient practice and		
					what corrective action will be	е	
	The CNA Task: Inc	continence Care was reviewed			taken;		
	from 3/17/25 to 4/7	/25. The documentation			All residents requiring assistar	nce	
	frequency was ever	y shift. The following dates			with Activities of Daily Living h	ave	
	and shifts were not	documented:			the potential to be affected by	the	
	- 1st shift on 3/17, 3	3/18, and 3/24/25			same alleged deficient practic	e.	
	- 2nd shift on 3/17,	3/18, 3/31, 4/1, and 4/4/25			What measures will be put in	nto	
	- 3rd shift on 3/17,	3/29, 3/30, 3/31, and 4/3/25			place or what systemic		
					changes will be made to		
	During an interview	on 4/9/25 at 11:30 a.m. the			ensure that the deficient		
	Interim Director of	Nursing indicated the care plan			practice does not recur;		
	for scheduled voidi	ng would be discontinued as			Staff were re-educated of	on	
	she was no longer a	candidate for scheduled			documenting Activities of Daily	y	
	voiding.				Living provided including		
					incontinence care in the medic	cal	
	A policy titled, "Inc	continence," indicated"c. A			record.		
	resident who is inco	ontinent of bladder receives			How the corrective action(s)		
	appropriate treatme	nt and services to maintain			will be monitored to ensure t	the	
	bladder function as	much as possible and prevent			deficient practice will not		
	complications relate	ed to incontinence."			recur, i.e., what quality		
					assurance programs will be	put	

			MULTIPLE CONSTRUCTION (X3) DA BUILDING 00 COM WING 04/		
NAME OF PROVIDER OR SUPPLIER CROWN POINT HEALTH CAMPUS (X4) ID SUMMARY STATEMENT OF DEFICIENCIE		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307			
(EACH DEFICIEN REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE A CTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
failed to implement	a systemic plan of correction		into place; DON/Designee will Audit 5 residents 2 times per week, to ensure Activities of Daily Living with special focus on incontine care is documented in the med record. Director of Nursing/designee w present a summary of the audit to the Quality Assurance committee monthly for 6 month Thereafter, if determined by th 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 4/17/2025	g ence dical vill its ns. e	
483.25 Quality of Care					
failed to ensure a recare in accordance of practice related to a as ordered by the phreviewed for quality. Finding includes: Resident F's record p.m. The diagnoses to neuropathy and a A Physician's Order	sident received treatment and with professional standards of medication not administered sysician for 1 of 3 residents of care. (Resident F) was reviewed on 4/9/25 at 2:04 included, but were not limited orthritis.	F 0684	Crown Point Health Campus Annual PSR Survey: 4/10/202 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. F684 Quality of Care What corrective action(s) will	an the	
	SUMMARY S (EACH DEFICIENCE REGULATORY OR This deficiency was failed to implement to prevent recurrence 3.1-38(a)(2)(c) 483.25 Quality of Care Based on record reversalized to ensure a recare in accordance to practice related to a as ordered by the phereviewed for quality Finding includes: Resident F's record p.m. The diagnoses to neuropathy and a A Physician's Order	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-38(a)(2)(c) 483.25 Quality of Care Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice related to a medication not administered as ordered by the physician for 1 of 3 residents reviewed for quality of care. (Resident F)	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-38(a)(2)(c) 483.25 Quality of Care Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice related to a medication not administered as ordered by the physician for 1 of 3 residents reviewed for quality of care. (Resident F) Finding includes: Resident F's record was reviewed on 4/9/25 at 2:04 p.m. The diagnoses included, but were not limited to neuropathy and arthritis. A Physician's Order, dated 3/29/25, indicated	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-38(a)(2)(c) 3.1-38(a)(2)(c) 3.1-38(a)(2)(c) 1.1-38(a)(2)(c) 1	

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet

Page 6 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155637	B. W	ING		04/10/2025	
				CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF F	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD		
ODOMA:	DOINT LIEALTLY O	AMPLIC		6685 EAST 117TH AVENUE			
CROWN	POINT HEALTH C	AIVIPUS		CROWN 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
	600 mg, one tablet was to be administered every				be accomplished for those		
	12 hours for seven days for a cough. (14 doses)				residents found to have been	n	
					affected by the deficient		
	The Medication Ad	lministration Record (MAR),			practice.		
	dated 3/2025, indicated	ated the guaifenesin had not			Resident F's remains in the		
		on 3/29/25 at 9:00 p.m., 3/30/25			facility. The physician was not	ified	
		00 p.m., and 3/31/25 at 9:00 p.m.			of the undocumented medicat	ion	
		s documented as given on			dose and no furtherer order w	ere	
	3/31/25 at 9:00 a.m	l.			received. Resident F had no		
					adverse reactions.		
	The MAR, dated 4/2025, indicated the guaifenesin						
	had been administered on April 1-4, 2025 at 9:00				How the facility will identify		
a.m. and 9:00 p.m., and April 5, 2025 at 9:00 a.m.				other residents having the			
					potential to be affected by the	ie	
		ot received the medication for			same deficient practice and		
	<u>-</u>	red and had received 9 of the			what corrective action will be	е	
	14 doses ordered.				taken;		
	During an interview	v on 4/10/25 at 9:20 a.m., the			All residents with medication		
	_	Nursing (IDON) acknowledged			orders have the potential to be	Э	
		not been administered as		affected by the alleged deficient			
	ordered.				practice.		
	A facility modication	on administration policy, dated			What magazines will be seed in	***	
	•	yed as current from the IDON,			What measures will be put in	ilO	
		ons were to be administered as			place or what systemic		
	prescribed.	ons were to be administered as			changes will be made to ensure that the deficient		
	preserioeu.				practice does not recur.		
	This deficiency was	s cited on 2/24/25. The facility			practice does not recur.		
	1	t a systemic plan of correction			Staff were educated on:		
	to prevent recurrence	-			Ensuring medications ar	·e	
	provincia recuirent				given as per physician orders	~	
	3.1- 37				Medications are		
					documented at the time of		
					administration in the Medication	on	
					Administration Record (MAR)	=	
					How the corrective action(s)		
					will be monitored to ensure t	the	

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 7 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA				ľ í	TE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155637	B. WIN	ilding <u>00</u> ng		COMPLETED 04/10/2025		
		100001	1 2	_	ADDRESS, CITY, STATE, ZIP COD	0 1/ 10/		
NAME OF	PROVIDER OR SUPPLIE	R			AST 117TH AVENUE			
CROWN	POINT HEALTH C	AMPUS			N POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	F	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE	
					deficient practice will not recur, i.e., what quality assurance programs will be into place.	put		
					DON/designee will review 5 residents with orders 2 times per week to ensure medications a given as per physician orders documented on the Medication Administration Record (MAR). The Administrator/designee were present a summary of the audit to the Quality Assurance committee monthly for 6 mont 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 4/17/2025	re and n ill lits hs.		
F 0689 SS=D Bldg. 00	interview, the facil precautions were in history of falls for accidents. (Resider Findings include:	on, record review, and ity failed to ensure fall a place for residents with a 2 of 3 residents reviewed for	F 06	89	Crown Point Health Campus Annual PSR Survey: 4/10/202 Please accept the following a the facility's credible allegati of compliance. This plan of correction does not constitu an admission of guilt or liabi by the facility and is submitte only in response to the	25 as ion te lity	04/17/2025	

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet

Page 8 of 29

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 04/10/2025 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 observed seated in his wheelchair in his regulatory requirement. bathroom. CNA 2 was shaving the resident's F689 Free of Accident beard at the time. There were no front anti-tippers Hazards/Supervision/Devices noted to the wheelchair. What corrective action(s) will be accomplished for those The record for Resident 34 was reviewed on 4/8/25 residents found to have been at 3:33 p.m. Diagnoses included, but were not affected by the deficient limited to, Alzheimer's Disease, hypertension, and practice; Resident 34's fall care plan has depression. been reviewed and fall The Quarterly Minimum Data Set (MDS) interventions are in place per the assessment, dated 3/17/25, indicated the resident plan of care. was cognitively impaired. He had two or more Resident 59's fall care plan has falls with minor injury since the prior assessment been reviewed and fall and required substantial/maximal assistance from interventions are in place per the staff for transfers. plan of care. How the facility will identify A Care Plan, dated 10/1/24, indicated the resident other residents having the was at risk for falls. An intervention, dated potential to be affected by the 11/9/24, indicated to apply front and rear same deficient practice and anti-tippers to the wheelchair. what corrective action will be taken: During an interview on 4/9/25 at 11:30 a.m., the All residents have the potential to Interim Director of Nursing indicated she had no be affected by the same alleged further information to provide. deficient practice. What measures will be put into place or what systemic 2. On 4/9/25 at 3:22 p.m., Resident 59 was changes will be made to observed in bed. There was a fall mat on the floor ensure that the deficient next to the bed, and there were no bolsters on the practice does not recur; bed. Staff were in-serviced on: Ensuring fall interventions During an interview on 4/9/25 at 3:26 p.m., CNA 1 are in place as per the plan of care indicated there were no bolsters on Resident 59's **Bolsters** bed. Fall mats Lowered bed Resident 59's record was reviewed on 4/9/25 at Reachers 11:09 a.m. Diagnoses included, but were not Anti-tippers limited to, dementia and history of traumatic brain How the corrective action(s) injury. will be monitored to ensure the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ľ í	IULTIPLE CO	(X3) DATE			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 04/10/2025			
		155637	B. W	ING		04/10/	2025
NAME OF P	ROVIDER OR SUPPLIER	.			ADDRESS, CITY, STATE, ZIP COD		
				6685 EAST 117TH AVENUE			
CROWN	POINT HEALTH CA	AIVIPUS		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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	The Questerly Mini	mum Data Set assessment,			deficient practice will not		
		ited the resident was severely			recur, i.e., what quality assurance programs will be	nut	
	cognitively impaired. She required				into place;	put	
		te assistance for transfers and			The DON/Designee will audit	5	
		or mobility. The resident had			residents with fall intervention		
		nce the prior assessment with			times per week to ensure		
	no injuries. The current care plans indicated the resident was at risk for falls. Interventions included, but were not limited to, ensure fall mat is in place, apply body pillow to open side of bed, and bolstered mattress to bed.				interventions are in place per	the	
					plan of care.		
					DON/designee will present a		
					summary of the audits to the		
					Quality Assurance committee	_	
					monthly for 6 months. Therea	ıfter,	
					if determined by the Quality	~	
	During an interview	v on 4/10/25 at 9:23 a.m., the			Assurance committee, auditin and monitoring will be done	9	
	_	Nursing indicated she had no			quarterly and present quarterl	v at	
	further information				the QA meeting. Monitoring v		
		1			be on going.		
	A facility policy, tit	tled "Fall Prevention and					
	Management," indi	cated, "Safety interventions			Date by which systemic		
	_	d for each resident identified			corrections will be complete	d:	
	and documented in	the medical record."			4/17/2025		
	TELL 1 CC .	. 1 2/24/25 TH C 114					
		s cited on 2/24/25. The facility					
	to prevent recurrence	a systemic plan of correction					
	w prevent recurrent						
	3.1-45(a)						
F 0690	483.25(e)(1)-(3)						
SS=D		continence, Catheter, UTI					
Bldg. 00							
	Based on record rev	view and interview, the facility	F 0	690	Crown Point Health Campus		04/17/2025
		nary output was recorded, the			Annual PSR Survey: 4/10/20		·
	physician was notif	ied for low urinary output as			Please accept the following as		
		s orders for void trials were			facility's credible allegation of		
		ician's orders for Foley			compliance. This plan of		
		were implemented, and			correction does not constitute		
	documentation was	completed related to Foley			admission of guilt or liability by	y the	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILD	A. BUILDING 00 COMPLETED			
		155637	B. WING			04/10/20	25
			ST	ΓREET A	DDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	t .	6685 EAST 117TH AVENUE				
CROWN	POINT HEALTH CA	AMPUS	С	CROWN POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TA	AG	DEFICIENCY)		DATE
	catheter changes for 2 of 3 residents reviewed for				facility and is submitted only in	1	
	urinary catheters. (Residents 37 and 205)				response to the regulatory		
	Findings include:				requirement. F690 Bowel/Bladder		
	rindings include.				Incontinence, Catheter, UTI		
	1 Resident 37's red	cord was reviewed on 4/9/25 at			What corrective action(s) wil		
		ses included, but were not			be accomplished for those	•	
	_	er's disease, history of urinary			residents found to have been	,	
	tract infections (UTIs), urethral stricture				affected by the deficient	•	
	(narrowing of the urethra), and obstructive and				practice;		
reflux uropathy (disorders of the bladder causing				Resident 37's physician was			
problems with urine flow).				notified, and orders were upda	ated		
					related to the indwelling cathe		
	The Annual Minimum Data Set (MDS)				and documentation is being		
	assessment, dated 3/21/25, indicated the resident				completed accordingly in the		
	was severely cognit	tively impaired and had an			medical record.		
	indwelling urinary	catheter.			Resident 205's Catheter had b	een	
					discontinued, and a voiding tri	al	
	_	025 Care Plans indicated the			was completed and document	ed	
		welling urinary catheter. An			in the medical record.		
		ed to monitor and document			How the facility will identify		
	intake and output.				other residents having the		
					potential to be affected by th	е	
	-	r, dated 12/23/24, indicated			same deficient practice and		
		eter output every 8 hours. If			what corrective action will be	9	
	*	1 300 milliliters (ml), notify the			taken;		
	pnysician. The orde	er was discontinued on 4/1/25.			All residents with indwelling	ha	
	The Medication Ad	ministration Record (MAR)			catheters have the potential to	be	
		ninistration Record (MAR)			affected by the same alleged deficient practice.		
		ated the Foley output was			What measures will be put in	ıto	
		t on 3/19, 0 milliliter (ml) output			place or what systemic		
	_	ft on 3/23 and evening shift on			changes will be made to		
	3/24, and 240 ml or	2			ensure that the deficient		
					practice does not recur;		
	The record lacked of	locumentation of urinary			Staff were re-educated on:		
		9/25 and for the physician			Initiating voiding trials as	per	
	*	en the Foley output was less			physician orders	r =-	
	than 300 ml.	J 1			Ensuring foley catheter		
					output is documented as per		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00 COMPLETED B. WING 04/10/2025				
		155637	B. WII	NG		04/10/	2025	
NAME OF P	PROVIDER OR SUPPLIEF				ADDRESS, CITY, STATE, ZIP COD			
CDOMA	DOINT HEALTH O	AMDUS	6685 EAST 117TH AVENUE					
CROWN	POINT HEALTH C	HIVIFUO		CROWN POINT, IN 46307				
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG			DATE	
	During an interview on 4/10/25 at 9:23 a.m., the Interim Director of Nursing indicated she had no				physician orders Catheter care and chang	201		
	further information	•			are documented in the medica	-		
	Turiner information	to provide.			record	41		
					Inserting the correct orde	ered		
	2. Resident 205's re	cord was reviewed on 4/8/25 at			catheter size			
		s included, but were not limited		How the corrective action(s)				
	1	e and chronic obstructive			will be monitored to ensure t	he		
		The resident admitted to the			deficient practice will not			
	facility on 3/24/25.				recur, i.e., what quality			
					assurance programs will be	put		
The Admission Minimum Data Set assessment,				into place;				
dated 3/31/25, was still in progress.				DON/designee will review 3				
	The Deseline Cone l	Dlam datad 2/27/25 at 0.10 a m			residents with catheters week	,		
		Plan, dated 3/27/25 at 9:19 a.m., nt was cognitively intact and		ensure the correct catheter size is in place, residents with orders for				
	had an indwelling u			voiding trials have trial initiated and				
	nad an indwennig d	imary cameter.			catheter output and catheter	u anu		
	A Physician's Order	r, dated 3/26/25, indicated the			changes are documented			
		ench (fr) Foley catheter with a		appropriately in the medical				
	30 cc balloon.	() ,			record.			
					The Director of Nursing/design	nee		
	A Nurses' Note, dat	ed 3/25/25 at 9:00 p.m.,			will present a summary of the			
		nt's Foley catheter was leaking			audits to the Quality Assurance	e		
	and the Foley bag v	vas empty. There was a small			committee monthly for 6 mont			
		ted. The nurse practitioner			Thereafter, if determined by the			
		w orders to put in an 18 fr			Quality Assurance committee,			
	Foley catheter and	collect urine for a urinalysis			auditing and monitoring will be)		
	(UA) on 3/26/25.				done quarterly and present			
		1.0/0.6/05			quarterly at the QA meeting.			
		ed 3/26/25 at 3:31 a.m.,			Monitoring will be on going.			
		no urine in the collection bag.			Date by which systemic	.1.		
	· ·	was removed and a new 16 fr			corrections will be complete	a:		
	1	10 cc balloon was inserted and ace. There was a scant amount			4/17/2025			
		e returned, however it was not						
	1	culture and sensitivity (C&S)						
	to be sent out.	Lutture and sensitivity (C&S)						
	to be sent but.							
	A Physician Progre	ss Note, dated 3/26/25 at 1:56						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/10/2025		
	PROVIDER OR SUPPLIEF		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN 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 APPROPR DEFICIENCY)	(X5) COMPLETION DATE	
	p.m., indicated the rebeen leaking since a output. She was strawith good urine returned the catheter staff removed. The catheter staff removed the catheter was resident would need did not void by the post volume residuance. A UA C&S was A Nurses' Note, dat indicated the residenthe Foley catheter. There was no further starting the void triacatheter, Foley catheter, Foley catheter, Foley catheter information Foley catheter used the catheter. A facility policy title Justification and Readmitting nurse will catheter size and obphysician to change Once the indwelling removed the nurse adocument this in the	resident's Foley catheter had arrival with minimal to no hight catheterized on 3/25/25 arn and then the Foley was ter began leaking again and JA was ordered, but not yet eter was leaking again, so the atheter and gave the patient an a void trial in place and the la new Foley catheter if she end of the day shift or if the al (PSR) was greater than 350				

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet

Page 13 of 29

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 04/10/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN 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
F 0692 SS=D Bldg. 00	recommends." This deficiency was failed to implement to prevent recurrence 3.1-41(a)(2) 483.25(g)(1)-(3) Nutrition/Hydration Based on observation interview, the facility supplements as orderintake for meals for 2 of 3 residents review D and H) Findings include: 1. On 4/8/25 at 11:2 taking a lunch tray to cheeseburger, tater as soda. There was not the time. During an observation of the tray can the food. There was the tray. Both CNA resident had not recodictary was responsitarys. Resident D's record 11:16 a.m. Diagnos	on, record review, and ty failed to provide ered and document nutritional residents with weight loss for ewed for nutrition. (Residents ewed for nutrition.) (Residents ewed for nutrition.) (Residents ewed for nutrition ewed at the total expectation of the tray at expectation of the tray at expectation expectation ewed for the tray at expectation expectation.) (Resident D. She received a total expectation expectation ewed for the tray at expectation expectation expectation expectation.) (Resident D. She received a total expectation expectation expectation expectation expectation expectation ewed expectation expectation.) (Resident D. She received a total expectation expectation expectation expectation expectation expectation expectation expectation.) (Residents expectation expectation.) (Residents expectation expectation.) (Residents expectation e	F 0692	Crown Point Health Campus Annual PSR Survey: 4/10/202 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. F692 Nutrition/Hydration Sta Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident D's plan of care was reviewed, and nutritional supplements are being provid per orders. Resident H's meal consumption being documented in the med record per protocol How the facility will identify other residents having the potential to be affected by the	an y the n itus ed as on is iical

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 14 of 29

		X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155637	B. W	ING		04/10/2	2025
NAME OF I	PROVIDER OR SUPPLIER			STREET .	ADDRESS, CITY, STATE, ZIP COD	-	
					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	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					same deficient practice and		
The resident weighed 100.5 pounds on 11/12/24				what corrective action will be	e		
		weight was 96 pounds on			taken;		
	4/7/25.				All residents have the potentia		
	The Oreside Mini				be affected by the same alleg	ea	
		mum Data Set (MDS), dated			deficient practice.		
		he resident was severely			What measures will be put in	nto	
	assistance for eating	d. The resident required setup			place or what systemic		
	assistance for eating	g.			changes will be made to		
	The exament Amil 2	025 Physician Order Summary			ensure that the deficient		
	•	hake twice daily, regular diet,			practice does not recur;		
		• •			Staff were re-educated on:		
	and 1000 milliliter (ml) fluid restriction per day, nursing to provide 215 ml per shift, dietary to				Documenting resident m		
		day, and nursing to provide			consumption in the medical re	cora	
		unces to be given in place of 4			Providing nutritional		
	ounces of fluid at lu				supplements as per orders		
	ounces of fluid at it	inch and dinner.			How the corrective action(s)	II	
	The augment Care Di	ans indicated the resident had			will be monitored to ensure	ine	
		for a diet with fluid restriction.			deficient practice will not		
		led, but were not limited to,			recur, i.e., what quality	n t	
		riate diet as ordered and			assurance programs will be	put	
		ounces per meal and may			into place; Director of Nursing/designee v	a dill	
	provide Mighty Sha	-			audit 5 residents 2 times per v		
	provide Wilging Sile	and twice daily.			to ensure meal consumption is		
	During an interview	v on 4/9/25 at 11:30 a.m., the			being documented in the med		
	_	Nursing indicated she had no			records and supplements with		
	further information	-		special focus on health shakes			
		F			are being provided as per ord		
					The Director of Nursing/design		
	2. Resident H's reco	ord was reviewed on 4/10/25 at			will present a summary of the	II	
		s included, but were not limited			audits to the Quality Assurance		
	to, Alzheimer's dise				committee monthly for 6 mont		
	, : :::::::::::::::::::::::::::::::::::				Thereafter, if determined by the		
	The Quarterly Mini	mum Data Set (MDS)			Quality Assurance committee		
		/10/25, indicated the resident			auditing and monitoring will be		
		tively impaired and was			done quarterly and present	-	
		for all ADLs including eating,			quarterly at the QA meeting.		
		nygiene, and transfers. She			Monitoring will be on going.		
	received hospice ca				mentioning will be on going.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		A. BUILDING <u>00</u> COMPLETI		(X3) DATE SURVEY COMPLETED 04/10/2025	
	PROVIDER OR SUPPLIEF		6685 E	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 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
	The resident weight and 138.8 pounds o	ed 154.8 pounds on 10/15/24 n 4/2/25.		Date by which systemic corrections will be complete 4/17/2025	d:
	unplanned/unexpec need for end of life	ans indicated the resident has ted weight loss related to the care. Interventions included, d to, monitor and record food			
	from 3/17- 4/10/25. meals documented	tritional Intake was reviewed There were no lunch or dinner on 3/21. There were no dinner on 3/25/25, 3/28/25, 3/30/25, 4/5/25.			
	_	on 4/10/25 at 10:45 a.m., the Nursing indicated she had no to provide.			
	indicated, "Ensure diet order, including consistency. Ensure supplements, and for each meal intake to supplement consum	ded, "Nutritional Monitoring," the staff awareness of resident g supplements and food to receipt of correct, diet, tood consistencyMonitor include food, hydration, and toption. Indicate overall the ded by the end of the meal"			
		s cited on 2/24/25. The facility a systemic plan of correction ee.			
	3.1-46(a)				
F 0695 SS=D Bldg. 00	Suctioning Based on observation	eostomy Care and	F 0695	Crown Point Health Campus	04/17/2025
	interview, the facili	ty failed to ensure residents		Annual PSR Survey: 4/10/20	25

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 16 of 29

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	LDING	00	COMPLETED	
		155637	B. WIN	IG		04/10/2	2025
		<u> </u>	'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			AST 117TH AVENUE		
CROWN	POINT HEALTH CA	AMPUS	CROWN POINT, IN 46307				
	Г				, I	ı	OV.5
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5)
	`	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	+	TAG	DEITOLE.		DATE
		ary care and treatment related ration for 1 of 3 residents			Diagon appent the following of	tho	
	, , ,	atory care. (Resident H)			Please accept the following as	strie	
	reviewed for respira	nory care. (Resident H)			facility's credible allegation of		
	Finding includes:				compliance. This plan of correction does not constitute	an	
	Finding includes.					1	
	On 4/8/25 of 11:07	a.m., Resident H was observed			admission of guilt or liability by		
		in her Broda chair. A nasal			facility and is submitted only in	'	
	_	e and oxygen was flowing.			response to the regulatory		
	_	trator was set at 2 liters.			requirement.		
	The oxygen concen	uator was set at 2 liters.			F695 Respiratory/Tracheosto Care and Suctioning	niiy	
	Dagidant Ula ragard	was reviewed on 4/8/25 at 9:46			_		
					What corrective action(s) will be accomplished for those		
a.m. Diagnoses included, but were not limited to, dementia, asthma, and hypertension.				residents found to have been	_		
	dementia, astinia, a	ind hypertension.			affected by the deficient	1	
	The Quarterly Mini	mum Data Set assessment			-		
		25, indicated the resident was			practice; Resident H's oxygen orders w	oro	
		d, dependent on staff for all			clarified and updated. Oxygen		
		ving (ADLs), and received			being administered as per ord		
	oxygen therapy.	ving (ADLs), and received			and documented accordingly.	CIS	
	oxygen merapy.				How the facility will identify		
	A Physician's Order	r, dated 4/1/25, indicated			other residents having the		
	1	via nasal cannula as needed for			potential to be affected by th		
		or shortness of breath.			same deficient practice and	.	
					what corrective action will be	e	
	A Physician's Order	r, dated 4/6/25, indicated			taken;	·	
		asal cannula during sleeping			All residents requiring oxygen		
		parameters, oxygen saturation			have the potential to be affect		
		Physician of oxygen saturation			by the same alleged deficient		
	less than 90%.				practice.		
					What measures will be put in	nto	
	The Medication Ad	ministration Record (MAR)			place or what systemic		
		ninistration Record (TAR),			changes will be made to		
		d any documentation the PRN			ensure that the deficient		
	· ·	gned out as administered, the			practice does not recur;		
		ad been signed out as			Staff were re-educated on:		
		what flow rate, or that the			Ensuring oxygen is		
		aturation had been monitored.			administered as per orders		
]				Oxygen administration is	,	
	During an interview	on 4/9/25 at 11:26 a.m., the			documented appropriately in t	1	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		A. BUILDING 00 COMPLET B. WING 04/10/2		(X3) DATE SURVEY COMPLETED 04/10/2025	
	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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	had been in to see the they had applied the the oxygen orders. provided.	Nursing indicated hospice staff ne resident yesterday and e oxygen. She would clarify No further documentation was a cited on 2/24/25. The facility		clinical record Oxygen saturations are completed per physician order and documented appropriately the clinical record How the corrective action(s)	• • • • • • • • • • • • • • • • • • •
	failed to implement to prevent recurrence	a systemic plan of correction		will be monitored to ensure t deficient practice will not recur, i.e., what quality	
F 0755	3.1-47(a)(6)			assurance programs will be pinto place; Nurse managers will audit 5 residents requiring supplementoxygen 2 times per week to ensure oxygen related documentation is accurate and complete with special focus or oxygen saturations. Director of Nursing/designee with 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 4/17/2025	tal vill ts ns. e
SS=D Bldg. 00	Based on record rev failed to ensure a re routine medications	/Pharmacist/Records riew and interview, the facility sident was provided with in a timely manner by the	F 0755	Crown Point Health Campus Annual PSR Survey: 4/10/20	
	contracted pharmac	y, related to medications not		Please accept the following as	the

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155637	B. W	ING		04/10/2025	
				STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			AST 117TH AVENUE		
CROWN	POINT HEALTH C	AMPHS			N POINT, IN 46307		
CITOVII	TOINT HEALTH O	AWI OO	,	CITOVI			
(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 APPROPRIATE		TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		inistered as ordered by a			facility's credible allegation of		
		residents reviewed for			compliance. This plan of		
	medications. (Resid	lent F)			correction does not constitute		
					admission of guilt or liability by		
	Finding includes:				facility and is submitted only in	1	
	D 11 (E) 1	. 1 4/0/25 + 2.04			response to the regulatory		
		was reviewed on 4/9/25 at 2:04			requirement.		
		included, but were not limited			F755	. .	
	to neuropathy and a	irinritis.	1		Pharmacy/Svcs/Procedures/	rn	
	A A Q 37:-:4 C				armacist/Records		
		mary from the hospital, dated he resident was being treated			What corrective action(s) will	II.	
	· ·	e e			be accomplished for those	_	
	-	nfection. The discharge orders n (antibiotic) 500 mg			residents found to have been	n	
	•	apsule three times a day for			affected by the deficient		
		apsule three times a day for			practice;	•	
	seven days.				Resident F's medications have	е	
	A Nurse's Progress	Note, dated 3/29/25 at 3:32			been received and was	doro	
	_	resident was readmitted to the			administered per physician or How the facility will identify	uers.	
	· ·	sician's Discharge Orders were			other residents having the		
	verified with the ph	_			potential to be affected by th		
	verified with the ph	ysician.			same deficient practice and	i C	
	a) The Physician's	Orders, dated 3/29/25 and			what corrective action will be	۵	
		1/25, indicated cephalexin 500			taken;		
		to be given three times a day			All facility residents that requir	·e	
	-	yen days. The medication was	1		pharmacy services have the	_	
	to be started on 3/2	-			potential to be affected by the		
		r			same alleged deficient practic		
	The Medication Ad	ministration Record (MAR),			What measures will be put in		
		ated the cephalexin 500 mg was			place or what systemic	-	
		29/25 at 10:00 p.m., 3/30/25 at			changes will be made to		
		.,10:00 p.m. and had not been			ensure that the deficient		
	administered on 3/3				practice does not recur;		
					Nurses were educated on:		
	The MAR, dated 3/	2025, indicated the cephalexin			Calling the pharmacy to		
		en given on 3/31/25 at 6:00 a.m.,			inquire about missing medicat	ions	
	2:00 p.m., and 10:0	_			Notifying the physician of		
	• ′	-			unavailable medications and		
	A Medication Adm	inistration Progress Note,			obtaining alternative orders ar	nd/or	
)5 a m indicated the cenhalevin			medication hold orders until	•	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPL	ETED
		155637	B. W	ING		04/10/	2025
				CTD FFT A	ADDRESS OF A STATE SID COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
ODOMAL	DOINT LIE ALTILO	ANADLIO			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	(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	DEFICIENCY)	16	DATE
	was unable to be gi	ven due to a power outage and			medication is available		
	_	otained from the Emergency			Notifying the		
	Drug Kit (EDK).	2 2			DON/ED/Administrator of need	d for	
					authorization for non-covered		
	A Nurse's Progress	Note, dated 3/31/25 at 12:24			medication		
	_	pharmacy was notified in			Nurses were educated o	n l	
	1 -	ery status and informed the			re-ordering medications before		
	~	's insurance would not cover			doses are gone to prevent mis		
	1	they would fax the Director of			doses.	,554	
		an authorization. The Unit			How the corrective action(s)		
	• • •	actitioner, DON, and POA			will be monitored to ensure t		
	(Power of Attorney				deficient practice will not	,,,,,	
	(1 ower of 7 thorney) were notified.			recur, i.e., what quality		
	A Medication Adm	inistration Progress Note,			assurance programs will be	nut	
		2 p.m., indicated the cephalexin			into place;	put	
		vailable due to the insurance			DON/designee will randomly a	audit	
	_	e cost. The Nurse Practitioner,			5 residents' medications 2 time		
		e Unit Manager were notified.			per week to ensure mediations		
	1 071, DOT, and the	c omit Manager were notified.			in the facility and available for		
	Δ Physician's Order	r, dated 3/31/25 at 2:00 p.m.,			administration.		
	1	lexin 500 mg, one tablet was to			The Director of Nursing/design	200	
	_	ee times a day for five days for					
	bronchopneumonia				will present a summary of the audits to the Quality Assurance		
	bronenopheumoma	•					
	The MAD detect 4/	2025, indicated the cephalexin			committee monthly for 6 mont		
		three times a day on 4/1/25 at			Thereafter, if determined by the		
	6:00 a.m.	three times a day on 4/1/23 at			Quality Assurance committee,		
	0:00 a.m.				auditing and monitoring will be	,	
	Duning on intermi	y on 4/0/25 at 4:07 with the			done quarterly and present		
	_	on 4/9/25 at 4:07 p.m., with the N), the Executive Director (ED),			quarterly at the QA meeting.		
	,	* **			Monitoring will be on going.		
		tor, the ED indicated there was			Date by which systemic		
		the generator was working			corrections will be complete	a:	
		I have been functional. The			4/17/2025		
		why the authorization had not					
	been given by the I	JUN.					
	<u> </u>	4/10/05 + 0.00					
	_	y on 4/10/25 at 9:20 a.m., the					
		cephalexin 500 mg was					
		EDK for the 3/29/25 10:00 p.m.					
	dose and the 3/30/2	5 6:00 a.m. dose. She indicated					

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 20 of 29

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	 JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 04/10/	ETED
	PROVIDER OR SUPPLIER		6685 EA	DDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	(X5) COMPLETION
TAG	the 3/30/25 2:00 p.r signed out as given, where they obtained the pharmacy had n and the medication EDK per the EDK r medication order windicating another p the medication. The indicated the insural medication. The nurcontacted the pharm medication had not authorization. b) A Physician's Orgunifenesin (cough	n. and 10:00 p.m. doses were though she was unsure the medications from since of delivered the medication was not removed from the ecords. She indicated the as transcribed incorrectly sharmacy would be supplying facility pharmacy had not not would not pay for the reses and/or DON had not nacy to question why the been sent or about the reder, dated 3/29/25, indicated syrup) extended release (ER) was to be administered every days for a cough.	TAG	DEFICIENCY)	ie .	DATE
	had not been admin 3/30/25 at 9:00 a.m. 9:00 p.m. The guaif given on 3/31/25 at					
	3/29/25 at 10:08 p.r. at 10:00 p.m., and 3 the guaifenesin had	stration Progress Notes, dated m., 3/30/25 at 10:33 a.m., 3/30/25 /31/25 at 8:00 p.m., indicated not been delivered from the not available in the EDK.				
	IDON indicated the incorrectly indicatir supplying the medic had not sent the medic was not available in	on 4/10/25 at 9:20 a.m., the guaifenesin was transcribed ag another pharmacy would be eation. The facility pharmacy dication and the guaifenesin the EDK. She was unsure obtained the guaifenesin for in. dose.				

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet

Page 21 of 29

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/10/2025	
	PROVIDER OR SUPPLIER		6685 E	ADDRESS, 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
F 0757 SS=D Bldg. 00	10/25/14 and receive indicated medication a medication order relectronic medical relectronic medicate the name of the indicate recurrence of the indicate in the indicate in the indicate in the indicate of th	Free from Unnecessary riew and interview, the facility -pharmacological attempted prior to (as needed) pain medication, reviewed for unnecessary ents F and 74) ord was reviewed on 4/9/25 at asses included, but were not	F 0757	Crown Point Health Campus Annual PSR Survey: 4/10/20 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only is response to the regulatory requirement. F757 Drug Regimen is Free from Unnecessary Drugs What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice; Resident F's orders have bee updated to include non-pharmacological interven for pain to be implemented pr providing PRN pain medication	positions ior to

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 22 of 29

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ì í			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		155637	B. WI	NG		04/10/2025	
			•	STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		6685 E	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 DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION	1
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	· ·	/2/25, indicated an intact			Resident 74's orders have been	en	
	-	in was present constantly and			updated to include		
		at frequently effected her sleep			non-pharmacological interven		
	_	and an opioid medication had			for pain to be implemented pri		
	been received.				providing PRN pain medicatio	n.	
					How the facility will identify		
		r, dated 2/25/25 and			other residents having the		
		25/25, indicated Tramadol			potential to be affected by the	e	
		ation) 50 mg (milligrams), one			same deficient practice and		
	tablet every six hou	rs as needed for pain.			what corrective action will be	e	
					taken;		
		ministration Record (MAR),			All residents have the potentia	ıl to	
	dated 3/2025, indica	ated the Tramadol had been			be affected by the same alleg	ed	
	administered as needed for pain on 3/17/25 at 9:05				deficient practice.		
	a.m., 3/18/25 at 11:	57 p.m., 3/19/25 at 10:40 p.m.,			What measures will be put ir	ito	
	3/21/25 at 10:26 p.r	m., 3/22/25 at 11:45 p.m., and			place or what systemic		
	3/24/25 at 10:10 p.r	n.			changes will be made to		
					ensure that the deficient		
	There was a lack of	documentation of any			practice does not recur;		
	non-pharmacologic	al interventions attempted			Staff were re-educated on:		
	prior to the adminis	tration of the Tramadol.			Offering and documentir	ng 3	
					non-pharmacological pain		
	A Physician's Order	r, dated 4/2/25, indicated		interventions prior to administering			
		ne tablet every 24 hours as			PRN pain medication.		
	_	l non-pharmacological					
		to be attempted. The examples			How the corrective action(s)		
	_	ological interventions were			will be monitored to ensure t	he	
	ice, heat, reposition	ing, elevation, massage,			deficient practice will not		
	spiritual/meditation	, visual imagery, and music.			recur, i.e., what quality		
					assurance programs will be	put	
		2025, indicated the Tramadol			into place;		
	50 mg was adminis	tered on 4/5/25 at 4:51 p.m.			DON/Designee will review 5		
					residents with PRN pain		
		documentation of any			medication 2 times per week t	0	
		al interventions attempted			ensure non-pharmacological p	pain	
	prior to the adminis	tration of the Tramadol.			interventions are offered and		
					documented prior to administe	ering	
	During an interview	on 4/9/25 at 4:07 p.m., the			PRN pain medication.		
	Interim Director of	Nursing (IDON), the Executive			Director of Nursing/designee	will	
	Director, and the A	dministrator were informed the			present a summary of the aud		

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	A (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 04/10/2025	
	ROVIDER OR SUPPLIER			6685 EA	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307		
(X4) ID PREFIX TAG	SUMMARY (EACH DEFICIEN REGULATORY OR non-pharmacologic attempted prior to the administered and the medication and non interventions were not attempted policy for dated 10/25/14 and current on 4/10/25 as needed medication and time of the admissymptoms why the	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION al interventions had not been the Tramadol 50 mg being the policies for the as needed -pharmacological		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) to the Quality Assurance committee monthly for 6 month Thereafter, if determined by th 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 4/17/2025	ns. e	(X5) COMPLETION DATE
	Non-pharmacologic administration of the not included in the property of the not included in the notation of the no	ion was received from the of the non-pharmacological exit of the facility on 4/10/25. For was reviewed on 4/9/25 at est included, but were not even heart failure, type 2 diabetes fibrillation. In the resident was a seement of the resident was a seement of the resident was a seement of the resident had pain that the rated 8 out of 10 on the pain of the resident was an ended) pain medications, and any non-medication in. In the resident had pain that the rated 8 out of 10 on the pain of the pain of the resident was an ended) pain medications, and any non-medication in. In the resident had pain that the rated 8 out of 10 on the pain of					

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 24 of 29

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE C A. BUILDING	CONSTRUCTION 00	(X3) DATE SURVEY COMPLETED		
		155637	B. WING		04/10/2025	
	PROVIDER OR SUPPLIER		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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
	dated 3/2025 and 4/ received the hydroc medication on 3/22/ 11:16 p.m., 3/30/25 a.m. There was a la indicate any non-ph had been attempted the pain medication	ministration Records (MARs), (2025, indicated the resident codone-acetaminophen (25 at 11:59 p.m., 3/25/25 at at 1:42 a.m., and 4/7/25 at 2:45 ack of documentation to harmacological interventions prior to the administration of the codonal				
	lacked documentati non-pharmacologic	ed 3/22/25 through 4/7/25, on to indicate any al interventions had been the administration of the pain				
	Interim Director of lack of documentati interventions attempt	y on 4/9/25 at 4:43 p.m., the Nursing was made aware of the ion of non-pharmacological pted prior to the administration ion. No further information				
	1	s cited on 2/24/25. The facility a systemic plan of correction ce.				
	3.1-48(a)(4)					
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4) Infection Prevention					
-	interview, the facili control guidelines v	on, record review, and ty failed to ensure infection were in place and implemented personal protective equipment	F 0880	Crown Point Health Campus Annual PSR Survey: 4/10/202		
	(PPE) worn in an is Finding includes:	olation room. (Resident 59)		Please accept the following as facility's credible allegation of compliance. This plan of		

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

Event ID:

9SMK12 Facility ID: 001198

If continuation sheet Page 25 of 29

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED	
		155637	B. WING			04/10/2025	
				CTDEET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			AST 117TH AVENUE		
CDOWN DOINT HEALTH CAMPUS							
CROWN POINT HEALTH CAMPUS				CROW	N 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 APPROPRIATE			MPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
					correction does not constitute	an	
	On 4/9/25 at 3:18 p	.m., CNA 1 was observed			admission of guilt or liability b	y the	
	providing incontine	ence care to Resident 59. She			facility and is submitted only i	n	
	had on a pair of glo	oves and was not wearing a		response to the regulatory			
	gown at the time.				requirement.		
					F880 Infection Prevention &		
		n the resident's door that			Control		
	indicated Enhanced	Barrier Precautions (EBP)			What corrective action(s) wi	II	
	should be used. Eve	eryone that entered the room			be accomplished for those		
	should wash hands	before entering and when			residents found to have bee	n	
	leaving. Staff must	also: Wear gloves and a gown			affected by the deficient		
	for high-contact res	sident care activities.			practice;		
	č				CNA 1 was immediately		
	Resident 59's record was reviewed on 4/9/25 at				re-educated on donning the		
	11:09 a.m. Diagnoses included, but were not				appropriate PPE in accordance	e	
	limited to, dementia and history of traumatic brain				with Enhanced Barrier Precau	ıtions	
	injury.				and Isolation precautions.		
		r, dated 3/31/25, indicated			How the facility will identify		
		Precautions related to candida			other residents having the		
		side resident's room. Gown and			potential to be affected by the	ie	
	-	ract resident care activities.			same deficient practice and		
		be used for any tasks that			what corrective action will b	e	
	have a high potentia	al of splash or spray.			taken;		
	D	4/10/05 + 0.00			All facility residents have the		
	-	v on 4/10/25 at 9:23 a.m., the			potential to be affected by the		
	Interim Director of Nursing indicated the CNA				same alleged deficient practic	I	
	should have been wearing a gown while providing				What measures will be put in	nto	
	incontinence care.				place or what systemic		
					changes will be made to		
		led, "Infection Prevention and			ensure that the deficient		
	_	indicated " Transmission			practice does not recur;		
	Based Precautions: The facility follows CDC				Staff were re-educated:	.	
	_	ission-based precautions to be			Following Enhanced Ba		
		t spread of infections; which			Precautions/Isolation Precaut	ions	
		and use of PPE and specifies			including:		
		ons for which specific PPE			How to identify who requires		
	should be used"				enhanced barrier precautions		
					(following EBP Signage)		
This deficiency was cited on 2/24/25. The facility				How to identify Isolation			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

	AND PLAN OF CORRECTION AND PLAN OF CORRECTION 155637		(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 04/10/2025				
NAME OF PROVIDER OR SUPPLIER CROWN POINT HEALTH CAMPUS			6685 E	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 B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E COMPLETION DATE				
	failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)			Precautions (following signal What personal protective equipment is required Performing hand hygiene 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 randomly 3 residents requiring Enhance Barrier Precautions 5 times week on alternating shifts to confirm staff are donning the appropriate Personal protect equipment and are performing hand hygiene. The Director of Nursing/desivill present a summary of the audits to the Quality Assurance committee monthly for 6 monomittee monthly for 6 monomittee monthly for 6 monomittee and monitoring will done quarterly and present quarterly at the QA meeting Monitoring will be on going. Date by which systemic corrections will be completed 4/17/2025	e the e put / audit ced per etive ng ignee nce nths. the ee, be				
R 0000									
Bldg. 00	the State Residentia on 2/24/25. This vi	Post Survey Revisit (PSR) to al Licensure Survey completed sit included a PSR to the State Licensure Survey 25 and a PSR to the	R 0000						

State Form Event ID: 9SMK12 Facility ID: 001198 If continuation sheet Page 27 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155637		JILDING			COMPLETED 04/10/2025	
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		(X5) COMPLETION DATE	
	Investigation of Nursing Home Complaints IN00453351 and IN00453429 completed on 2/24/25.							
	This visit was in conjunction with the Investigation of Nursing Home Complaints IN00454867, IN00455245, IN00455369, IN00455441, IN00455913, and IN00456087.							
	Complaint IN00453351 - Not corrected.							
	Complaint IN00453429 - Not corrected.							
	Complaint IN00454867 - No deficiencies related to the allegations are cited.							
	Complaint IN00455245 - Federal/State deficiencies related to the allegations are cited at F677.							
	Complaint IN00455369 - Federal/State deficiencies related to the allegations are cited at F692.							
	Complaint IN00455441 - No deficiencies related to the allegations are cited.							
	Complaint IN00455913 - Federal/State deficiencies related to the allegations are cited at F692.							
	•	5087 - Federal/State deficiencies tions are cited at F580 and						
	Survey dates: April	17, 8, 9, and 10, 2025						
	Facility number: 00	01198						
	Residential Census:							
	compliance with 41	n Campus was found to be in 0 IAC 16.2-5 in regard to the sidential Licensure Survey.						

State Form Event ID: 9SMK12 Facility ID: 001198 If continuation sheet Page 28 of 29

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING			(X3) DATE SURVEY COMPLETED 04/10/2025	
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	SUMMARY S	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 APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Quality review com	pleted on 4/15/25.					

State Form Event ID: 9SMK12 Facility ID: 001198 If continuation sheet Page 29 of 29