STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	04/10/2025

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

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F 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 2/24/25. This visit included a PSR to the Investigation of Complaints IN00453351 and IN00453429 completed on 2/24/25 and a PSR to the State Residential Licensure Survey completed 2/24/25. This visit was in conjunction with the Investigation of 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. Complaint IN00456087 - Federal/State deficiencies related to the allegations are cited at F580, F684, and F755. Survey dates: April 7, 8, 9, and 10, 2025	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	04/21/2025

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 90 SNF: 15 Residential: 39 Total: 144 Census Payor Type: Medicare: 23 Medicaid: 53 Other: 29 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/15/25.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on record review and interview, the facility failed to ensure a resident had a physician's order to self-administer medication for 1 of 3 residents reviewed for self-administration of medications. (Resident 205) Finding includes: Resident 205's record was reviewed on 4/8/25 at 8:51 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease and chronic respiratory failure. The resident admitted to the facility on 3/24/25. The Admission Minimum Data Set assessment,	F 0554	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those**	04/17/2025

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	dated 3/31/25, was still in progress. The Baseline Care Plan, dated 3/27/25 at 9:19 a.m., indicated the resident was cognitively intact, had an indwelling catheter, and self-administered medications. A Self-Administration of Medication Assessment, dated 3/27/25 8:46 a.m., indicated the resident's inhaler was to be kept at bedside and self administration was appropriate. A Physician's Order, dated 3/24/25, indicated albuterol sulfate inhalation solution, 2.5 milligram inhale orally every 4 hours as needed. There were no physician's orders to keep the albuterol inhaler at the bedside. During an interview on 4/10/25 at 9:22 a.m., the Interim Director of Nursing indicated the resident self-administered the albuterol inhaler and the order would be updated for self-administration. This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-11		**residents found to have been affected by the deficient practice;** A self-administration assessment was completed for Resident 205 and an MD order was received for self-administration of PRN rescue inhaler. Resident 205's plan of care was updated. **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;** All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were educated on not leaving medications at resident bedside unless there is an order for self-administration in place. 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 medication self-administration assessment Physicians order for the mediation the resident is to	

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			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 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 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on record review and interview, the facility failed to document incontinence care for a resident who was dependent on staff for activities of daily living (ADLs) for 1 of 4 residents who were reviewed for ADLs. (Resident B) Finding includes:	F 0677	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the	04/17/2025

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	Resident B's record was reviewed on 4/7/25 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis (weakness and paralysis) following a cerebral infarction (stroke). The Discharge Minimum Data Set (MDS) assessment, dated 3/12/25, indicated the resident was severely cognitively impaired. She was totally dependent on staff for assistance with toileting and transfers. She was frequently incontinent of bladder and always incontinent of bowel. The current Care Plans indicated the resident had episodes of incontinence and was at risk for complications. Interventions included, but were not limited to, encourage fluids, provide incontinence care, and toilet at regular intervals or scheduled voiding. The CNA Task: Incontinence Care was reviewed from 3/17/25 to 4/7/25. The documentation frequency was every shift. The following dates and shifts were not documented: - 1st shift on 3/17, 3/18, and 3/24/25 - 2nd shift on 3/17, 3/18, 3/31, 4/1, and 4/4/25 - 3rd shift on 3/17, 3/29, 3/30, 3/31, and 4/3/25 During an interview on 4/9/25 at 11:30 a.m. the Interim Director of Nursing indicated the care plan for scheduled voiding would be discontinued as she was no longer a candidate for scheduled voiding. A policy titled, "Incontinence," indicated ..."c. A resident who is incontinent of bladder receives appropriate treatment and services to maintain bladder function as much as possible and prevent complications related to incontinence."		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 affected by the deficient practice;** ADL documentation including incontinence care is being completed accordingly for Resident B. **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;** All residents requiring assistance with Activities of Daily Living have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on documenting Activities of Daily Living provided including incontinence care in the medical record. **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**	

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	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)		**into place;** DON/Designee will Audit 5 residents 2 times per week, to ensure Activities of Daily Living with special focus on incontinence care is documented in the medical record. 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: 4/17/2025**	
F 0684 SS=D Bldg. 00	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 guaifenesin (cough syrup) extended release (ER)	F 0684	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F684 Quality of Care** **What corrective action(s) will**	04/17/2025

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	600 mg, one tablet was to be administered every 12 hours for seven days for a cough. (14 doses) The Medication Administration Record (MAR), dated 3/2025, indicated the guaifenesin had not been administered on 3/29/25 at 9:00 p.m., 3/30/25 at 9:00 a.m. and 9:00 p.m., and 3/31/25 at 9:00 p.m. The guaifenesin was documented as given on 3/31/25 at 9:00 a.m. The MAR, dated 4/2025, indicated the guaifenesin had been administered on April 1-4, 2025 at 9:00 a.m. and 9:00 p.m., and April 5, 2025 at 9:00 a.m. The resident had not received the medication for seven days as ordered and had received 9 of the 14 doses ordered. During an interview on 4/10/25 at 9:20 a.m., the Interim Director of Nursing (IDON) acknowledged the medication had not been administered as ordered. A facility medication administration policy, dated 10/24/14 and received as current from the IDON, indicated medications were to be administered as prescribed. This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1- 37		**be accomplished for those residents found to have been affected by the deficient practice.** Resident F's remains in the facility. The physician was notified of the undocumented medication dose and no furtherer order were received. Resident F had no adverse reactions. **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;** All residents with medication orders have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Staff were educated on: Ensuring medications are given as per physician orders Medications are documented at the time of administration in the Medication Administration Record (MAR) **How the corrective action(s) will be monitored to ensure the**	

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			deficient practice will not recur, i.e., what quality assurance programs will be put into place. DON/designee will review 5 residents with orders 2 times per week to ensure medications are given as per physician orders and documented on the Medication Administration Record (MAR). 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 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review, and interview, the facility failed to ensure fall precautions were in place for residents with a history of falls for 2 of 3 residents reviewed for accidents. (Residents 34 and 59) Findings include: 1. On 4/9/25 at 10:38 a.m., Resident 34 was	F 0689	**Crown Point Health Campus Annual PSR Survey: 4/10/2025 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the**	04/17/2025

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

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	The Quarterly Minimum Data Set assessment, dated 2/3/25, indicated the resident was severely cognitively impaired. She required substantial/moderate assistance for transfers and used a wheelchair for mobility. The resident had two or more falls since the prior assessment with 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. During an interview on 4/10/25 at 9:23 a.m., the Interim Director of Nursing indicated she had no further information to provide. A facility policy, titled "Fall Prevention and Management," indicated, "...Safety interventions will be implemented for each resident identified and documented in the medical record." This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-45(a)		**deficient practice will not recur, i.e., what quality assurance programs will be put into place;** The DON/Designee will audit 5 residents with fall interventions 2 times per week to ensure 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. 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 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on record review and interview, the facility failed to ensure urinary output was recorded, the physician was notified for low urinary output as ordered, physician's orders for void trials were implemented, physician's orders for Foley (urinary) catheters were implemented, and documentation was completed related to Foley	F 0690	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the	04/17/2025

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	catheter changes for 2 of 3 residents reviewed for urinary catheters. (Residents 37 and 205) Findings include: 1. Resident 37's record was reviewed on 4/9/25 at 11:09 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, history of urinary tract infections (UTIs), urethral stricture (narrowing of the urethra), and obstructive and reflux uropathy (disorders of the bladder causing problems with urine flow). The Annual Minimum Data Set (MDS) assessment, dated 3/21/25, indicated the resident was severely cognitively impaired and had an indwelling urinary catheter. The current April 2025 Care Plans indicated the resident had an indwelling urinary catheter. An intervention indicated to monitor and document intake and output. A Physician's Order, dated 12/23/24, indicated monitor Foley catheter output every 8 hours. If output was less than 300 milliliters (ml), notify the physician. The order was discontinued on 4/1/25. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 3/2025, indicated the Foley output was blank for night shift on 3/19, 0 milliliter (ml) output during morning shift on 3/23 and evening shift on 3/24, and 240 ml output on 3/27/25. The record lacked documentation of urinary outputs from 4/1-4/9/25 and for the physician being contacted when the Foley output was less than 300 ml.		facility and is submitted only in response to the regulatory requirement. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 37's physician was notified, and orders were updated related to the indwelling catheter and documentation is being completed accordingly in the medical record. Resident 205's Catheter had been discontinued, and a voiding trial was completed and documented in the medical record. **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;** All residents with indwelling catheters have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on: Initiating voiding trials as per physician orders Ensuring foley catheter output is documented as per	

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	During an interview on 4/10/25 at 9:23 a.m., the Interim Director of Nursing indicated she had no further information to provide. 2. Resident 205's record was reviewed on 4/8/25 at 8:51 a.m. Diagnoses included, but were not limited to, retention of urine and chronic obstructive pulmonary disease. The resident admitted to the facility on 3/24/25. The Admission Minimum Data Set assessment, dated 3/31/25, was still in progress. The Baseline Care Plan, dated 3/27/25 at 9:19 a.m., indicated the resident was cognitively intact and had an indwelling urinary catheter. A Physician's Order, dated 3/26/25, indicated the resident had a 18 french (fr) Foley catheter with a 30 cc balloon. A Nurses' Note, dated 3/25/25 at 9:00 p.m., indicated the resident's Foley catheter was leaking and the Foley bag was empty. There was a small amount of blood noted. The nurse practitioner was notified and new orders to put in an 18 fr Foley catheter and collect urine for a urinalysis (UA) on 3/26/25. A Nurses' Note, dated 3/26/25 at 3:31 a.m., indicated there was no urine in the collection bag. The Foley catheter was removed and a new 16 fr Foley catheter with 10 cc balloon was inserted and then anchored in place. There was a scant amount of dark yellow urine returned, however it was not enough for a urine culture and sensitivity (C&S) to be sent out. A Physician Progress Note, dated 3/26/25 at 1:56		physician orders Catheter care and changes are documented in the medical record Inserting the correct ordered catheter size **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will review 3 residents with catheters weekly to ensure the correct catheter size is in place, residents with orders for voiding trials have trial initiated and catheter output and catheter changes are documented appropriately in the medical record. The 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: 4/17/2025**	

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	155637	A. BUILDING 00 B. WING	04/10/2025

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	p.m., indicated the resident's Foley catheter had been leaking since arrival with minimal to no output. She was straight catheterized on 3/25/25 with good urine return and then the Foley was replaced. The catheter began leaking again and was exchanged. A UA was ordered, but not yet collected. The catheter was leaking again, so the staff removed the catheter and gave the patient an opportunity to void. The Assessment/Plan indicated there was a void trial in place and the resident would need a new Foley catheter if she did not void by the end of the day shift or if the post volume residual (PSR) was greater than 350 cc. A UA C&S was to be collected. A Nurses' Note, dated 3/27/25 at 12:41 a.m., indicated the resident had no urine output from the Foley catheter. There was no further documentation related to starting the void trials, PSR amounts, the straight catheter, Foley catheter changes, and the physician notification related to the UA C&S not being collected. During an interview on 4/10/25 at 9:22 a.m., the Interim Director of Nursing indicated she had no further information related to the incorrect size Foley catheter used and documentation related to the catheter. A facility policy titled, "Indwelling Catheter Justification and Removal," indicated "...2. The admitting nurse will document the indwelling catheter size and obtain an order from the physician to change the catheter as needed...5. Once the indwelling urinary catheter has been removed the nurse removing the catheter will document this in the record and may initiate the 3-day tracking and trending for the nursing			

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	assistant to document voiding or as physician recommends." This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-41(a)(2)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on observation, record review, and interview, the facility failed to provide supplements as ordered and document nutritional intake for meals for residents with weight loss for 2 of 3 residents reviewed for nutrition. (Residents D and H) Findings include: 1. On 4/8/25 at 11:24 a.m., CNA 3 was observed taking a lunch tray to Resident D. She received a cheeseburger, tater tots, pickles, and a can of soda. There was no Mighty Shake on the tray at the time. During an observation and interview on 4/8/25 at 11:45 a.m., CNA 3 brought out Resident D's tray to return to the tray cart. The resident had picked at the food. There was no Mighty Shake present on the tray. Both CNA 3 and LPN 1 confirmed the resident had not received the Mighty Shake and dietary was responsible for putting those on the trays. Resident D's record was reviewed on 4/7/25 at 11:16 a.m. Diagnoses included, but were not limited to, dementia, protein-calorie malnutrition, and cognitive communication deficit.	F 0692	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F692 Nutrition/Hydration Status Maintenance** **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 provided as per orders. Resident H's meal consumption is being documented in the medical record per protocol **How the facility will identify other residents having the potential to be affected by the**	04/17/2025

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	The resident weighed 100.5 pounds on 11/12/24 and the most recent weight was 96 pounds on 4/7/25. The Quarterly Minimum Data Set (MDS), dated 2/18/25, indicated the resident was severely cognitively impaired. The resident required setup assistance for eating. The current April 2025 Physician Order Summary indicated Mighty Shake twice daily, regular diet, and 1000 milliliter (ml) fluid restriction per day, nursing to provide 215 ml per shift, dietary to provide 120 ml per day, and nursing to provide Mighty Shakes, 4 ounces to be given in place of 4 ounces of fluid at lunch and dinner. The current Care Plans indicated the resident had a physician's order for a diet with fluid restriction. Interventions included, but were not limited to, provide the appropriate diet as ordered and dietary to provide 4 ounces per meal and may provide Mighty Shake twice daily. During an interview on 4/9/25 at 11:30 a.m., the Interim Director of Nursing indicated she had no further information to provide. 2. Resident H's record was reviewed on 4/10/25 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/10/25, indicated the resident was severely cognitively impaired and was dependent on staff for all ADLs including eating, toileting, personal hygiene, and transfers. She received hospice care.		**same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on: Documenting resident meal consumption in the medical record Providing nutritional supplements as per orders **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;** Director of Nursing/designee will audit 5 residents 2 times per week to ensure meal consumption is being documented in the medical records and supplements with special focus on health shakes are being provided as per orders. The 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.	

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	The resident weighed 154.8 pounds on 10/15/24 and 138.8 pounds on 4/2/25. The current Care Plans indicated the resident has unplanned/unexpected weight loss related to the need for end of life care. Interventions included, but were not limited to, monitor and record food intake at each meal. The CNA Task: Nutritional Intake was reviewed from 3/17- 4/10/25. There were no lunch or dinner meals documented on 3/21. There were no dinner meals documented on 3/25/25, 3/28/25, 3/30/25, 4/2/25, 4/3/25, and 4/5/25. During an interview on 4/10/25 at 10:45 a.m., the Interim Director of Nursing indicated she had no further information to provide. A facility policy titled, "Nutritional Monitoring," indicated, "...Ensure staff awareness of resident diet order, including supplements and food consistency. Ensure receipt of correct, diet, supplements, and food consistency...Monitor each meal intake to include food, hydration, and supplement consumption. Indicate overall percentage consumed by the end of the meal..." This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-46(a)		**Date by which systemic corrections will be completed: 4/17/2025**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure residents	F 0695	**Crown Point Health Campus Annual PSR Survey: 4/10/2025**	04/17/2025

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	received the necessary care and treatment related to oxygen administration for 1 of 3 residents reviewed for respiratory care. (Resident H) Finding includes: On 4/8/25 at 11:07 a.m., Resident H was observed in her room sitting in her Broda chair. A nasal cannula was in place and oxygen was flowing. The oxygen concentrator was set at 2 liters. Resident H's record was reviewed on 4/8/25 at 9:46 a.m. Diagnoses included, but were not limited to, dementia, asthma, and hypertension. The Quarterly Minimum Data Set assessment (MDS), dated 3/10/25, indicated the resident was cognitively impaired, dependent on staff for all activities of daily living (ADLs), and received oxygen therapy. A Physician's Order, dated 4/1/25, indicated oxygen 2 L (liters) via nasal cannula as needed for difficulty breathing or shortness of breath. A Physician's Order, dated 4/6/25, indicated oxygen 2-5 L via nasal cannula during sleeping hours per vital sign parameters, oxygen saturation every shift. Notify Physician of oxygen saturation less than 90%. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 4/2025, lacked any documentation the PRN oxygen had been signed out as administered, the nighttime oxygen had been signed out as administered and at what flow rate, or that the resident's oxygen saturation had been monitored. During an interview on 4/9/25 at 11:26 a.m., the		Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F695 Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident H's oxygen orders were clarified and updated. Oxygen is being administered as per orders and documented accordingly. **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;** All residents requiring oxygen have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on: Ensuring oxygen is administered as per orders Oxygen administration is documented appropriately in the	

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	Interim Director of Nursing indicated hospice staff had been in to see the resident yesterday and they had applied the oxygen. She would clarify the oxygen orders. No further documentation was provided. This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-47(a)(6)		clinical record Oxygen saturations are completed per physician orders and documented appropriately in the clinical record **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;** Nurse managers will audit 5 residents requiring supplemental oxygen 2 times per week to ensure oxygen related documentation is accurate and complete with special focus on oxygen saturations. 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: 4/17/2025**	
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure a resident was provided with routine medications in a timely manner by the contracted pharmacy, related to medications not	F 0755	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the	04/17/2025

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	available to be administered as ordered by a physician for 1 of 3 residents reviewed for medications. (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. An After Visit Summary from the hospital, dated 3/28/25, indicated the resident was being treated for a urinary tract infection. The discharge orders included cephalexin (antibiotic) 500 mg (milligrams), one capsule three times a day for seven days. A Nurse's Progress Note, dated 3/29/25 at 3:32 a.m., indicated the resident was readmitted to the facility and the Physician's Discharge Orders were verified with the physician. a) The Physician's Orders, dated 3/29/25 and discontinued on 3/31/25, indicated cephalexin 500 mg, one tablet was to be given three times a day for infection for seven days. The medication was to be started on 3/29/25 at 10 p.m. The Medication Administration Record (MAR), dated 3/2025, indicated the cephalexin 500 mg was administered on 3/29/25 at 10:00 p.m., 3/30/25 at 6:00 a.m., 2:00 p.m.,10:00 p.m. and had not been administered on 3/31/25 at 6:00 a.m. The MAR, dated 3/2025, indicated the cephalexin 500 mg had not been given on 3/31/25 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A Medication Administration Progress Note, dated 3/31/25 at 6:05 a.m., indicated the cephalexin		facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F755** **Pharmacy/Svcs/Procedures/Pharmacist/Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F's medications have been received and was administered per physician orders. **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;** All facility residents that require pharmacy services have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were educated on: Calling the pharmacy to inquire about missing medications Notifying the physician of unavailable medications and obtaining alternative orders and/or medication hold orders until	

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	was unable to be given due to a power outage and was unable to be obtained from the Emergency Drug Kit (EDK). A Nurse's Progress Note, dated 3/31/25 at 12:24 p.m., indicated the pharmacy was notified in regards to the delivery status and informed the facility the resident's insurance would not cover the cephalexin and they would fax the Director of Nursing (DON) for an authorization. The Unit Manager, Nurse Practitioner, DON, and POA (Power of Attorney) were notified. A Medication Administration Progress Note, dated 3/31/25 at 1:42 p.m., indicated the cephalexin 500 mg's was not available due to the insurance would not cover the cost. The Nurse Practitioner, POA, DON, and the Unit Manager were notified. A Physician's Order, dated 3/31/25 at 2:00 p.m., indicated the cephalexin 500 mg, one tablet was to be administered three times a day for five days for bronchopneumonia. The MAR, dated 4/2025, indicated the cephalexin 500 mg was started three times a day on 4/1/25 at 6:00 a.m. During an interview on 4/9/25 at 4:07 p.m., with the Interim DON (IDON), the Executive Director (ED), and the Administrator, the ED indicated there was a power outage and the generator was working and the EDK would have been functional. The IDON was unsure why the authorization had not been given by the DON. During an interview on 4/10/25 at 9:20 a.m., the IDON indicated the cephalexin 500 mg was obtained from the EDK for the 3/29/25 10:00 p.m. dose and the 3/30/25 6:00 a.m. dose. She indicated		medication is available Notifying the DON/ED/Administrator of need for authorization for non-covered medication Nurses were educated on re-ordering medications before all doses are gone to prevent missed doses. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit 5 residents' medications 2 times per week to ensure mediations are in the facility and available for administration. The 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: 4/17/2025**	

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	the 3/30/25 2:00 p.m. and 10:00 p.m. doses were signed out as given, though she was unsure where they obtained the medications from since the pharmacy had not delivered the medication and the medication was not removed from the EDK per the EDK records. She indicated the medication order was transcribed incorrectly indicating another pharmacy would be supplying the medication. The facility pharmacy had not indicated the insurance would not pay for the medication. The nurses and/or DON had not contacted the pharmacy to question why the medication had not been sent or about the authorization. b) A Physician's Order, dated 3/29/25, indicated guaifenesin (cough syrup) extended release (ER) 600 mg, one tablet was to be administered every 12 hours for seven days for a cough. The MAR, dated 3/2025, indicated the guaifenesin had not been administered on 3/29/25 at 9:00 p.m., 3/30/25 at 9:00 a.m. and 9:00 p.m., and 3/31/25 at 9:00 p.m. The guaifenesin was documented as given on 3/31/25 at 9:00 a.m. Medication Administration Progress Notes, dated 3/29/25 at 10:08 p.m., 3/30/25 at 10:33 a.m., 3/30/25 at 10:00 p.m., and 3/31/25 at 8:00 p.m., indicated the guaifenesin had not been delivered from the pharmacy and was not available in the EDK. During an interview on 4/10/25 at 9:20 a.m., the IDON indicated the guaifenesin was transcribed incorrectly indicating another pharmacy would be supplying the medication. The facility pharmacy had not sent the medication and the guaifenesin was not available in the EDK. She was unsure where the the nurse obtained the guaifenesin for the 3/31/25 9:00 a.m. dose.			

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	A facility policy for ordering medications, dated 10/25/14 and received as current from the IDON, indicated medication orders were to be written on a medication order form and entered into an electronic medical record system. Re-admission orders were sent to the pharmacy. The facility was to indicate the name of the pharmacy supplier. This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-25(a)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to administering PRN (as needed) pain medication, for 2 of 3 residents reviewed for unnecessary medications. (Residents F and 74) Findings include: 1. 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 Care Plan, dated 7/25/24, indicated a risk for pain. The interventions included pain relieving method examples of positioning, relaxation therapy, progressive relaxation, bathing, heat and cold application, muscle stimulation, and ultra sound would be attempted to help relieve the pain. A Quarterly Minimum Data Set (MDS)	F 0757	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F757 Drug Regimen is Free from Unnecessary Drugs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F's orders have been updated to include non-pharmacological interventions for pain to be implemented prior to providing PRN pain medication.	04/17/2025

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	assessment, dated 2/2/25, indicated an intact cognitive status, pain was present constantly and was rated at a 10 that frequently effected her sleep and daily activities, and an opioid medication had been received. A Physician's Order, dated 2/25/25 and discontinued on 3/25/25, indicated Tramadol (opioid pain medication) 50 mg (milligrams), one tablet every six hours as needed for pain. The Medication Administration Record (MAR), dated 3/2025, indicated the Tramadol had been administered as needed for pain on 3/17/25 at 9:05 a.m., 3/18/25 at 11:57 p.m., 3/19/25 at 10:40 p.m., 3/21/25 at 10:26 p.m., 3/22/25 at 11:45 p.m., and 3/24/25 at 10:10 p.m. There was a lack of documentation of any non-pharmacological interventions attempted prior to the administration of the Tramadol. A Physician's Order, dated 4/2/25, indicated Tramadol 50 mg, one tablet every 24 hours as needed for pain and non-pharmacological interventions were to be attempted. The examples of the non-pharmacological interventions were ice, heat, repositioning, elevation, massage, spiritual/meditation, visual imagery, and music. The MAR, dated 4/2025, indicated the Tramadol 50 mg was administered on 4/5/25 at 4:51 p.m. There was a lack of documentation of any non-pharmacological interventions attempted prior to the administration of the Tramadol. During an interview on 4/9/25 at 4:07 p.m., the Interim Director of Nursing (IDON), the Executive Director, and the Administrator were informed the		Resident 74's orders have been updated to include non-pharmacological interventions for pain to be implemented prior to providing PRN pain medication. **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;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated on: Offering and documenting 3 non-pharmacological pain interventions prior to administering PRN pain medication. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will review 5 residents with PRN pain medication 2 times per week to ensure non-pharmacological pain interventions are offered and documented prior to administering PRN pain medication. Director of Nursing/designee will present a summary of the audits	

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	155637	A. BUILDING 00 B. WING	04/10/2025

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	non-pharmacological interventions had not been attempted prior to the Tramadol 50 mg being administered and the policies for the as needed medication and non-pharmacological interventions were requested. A facility policy for medication administration, dated 10/25/14 and received from the IDON as current on 4/10/25 at 9:20 a.m., indicated, when an as needed medication was administered, the date and time of the administration, complaints or symptoms why the medication was given, and the results achieved from the medication would be documented. Non-pharmacological interventions prior to the administration of the as needed medications were not included in the policy received. No further information was received from the facility in regards to the non-pharmacological interventions upon exit of the facility on 4/10/25. 2. Resident 74's record was reviewed on 4/9/25 at 3:55 p.m. Diagnoses included, but were not limited to, congestive heart failure, type 2 diabetes mellitus, and atrial fibrillation. The Quarterly Minimum Data Set assessment (MDS), dated 1/9/25, indicated the resident was cognitively intact. The resident had pain that occurred frequently rated 8 out of 10 on the pain scale, received PRN (as needed) pain medications, and had not received any non-medication interventions for pain. A Physician's Order, dated 9/27/24, indicated to give hydrocodone-acetaminophen (Norco, an opioid pain medication) 5-325 mg (milligrams), every six hours as needed for pain.		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**	

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	The Medication Administration Records (MARs), dated 3/2025 and 4/2025, indicated the resident received the hydrocodone-acetaminophen medication on 3/22/25 at 11:59 p.m., 3/25/25 at 11:16 p.m., 3/30/25 at 1:42 a.m., and 4/7/25 at 2:45 a.m. There was a lack of documentation to indicate any non-pharmacological interventions had been attempted prior to the administration of the pain medication. The Electronic Medication Administration Record (EMAR) Notes, dated 3/22/25 through 4/7/25, lacked documentation to indicate any non-pharmacological interventions had been attempted prior to the administration of the pain medication. During an interview on 4/9/25 at 4:43 p.m., the Interim Director of Nursing was made aware of the lack of documentation of non-pharmacological interventions attempted prior to the administration of the pain medication. No further information was provided. This deficiency was cited on 2/24/25. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-48(a)(4)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to improper personal protective equipment (PPE) worn in an isolation room. (Resident 59) Finding includes:	F 0880	**Crown Point Health Campus Annual PSR Survey: 4/10/2025** Please accept the following as the facility's credible allegation of compliance. This plan of	04/17/2025

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	On 4/9/25 at 3:18 p.m., CNA 1 was observed providing incontinence care to Resident 59. She had on a pair of gloves and was not wearing a gown at the time. There was a sign on the resident's door that indicated Enhanced Barrier Precautions (EBP) should be used. Everyone that entered the room should wash hands before entering and when leaving. Staff must also: Wear gloves and a gown for high-contact resident care activities. Resident 59's record was reviewed on 4/9/25 at 11:09 a.m. Diagnoses included, but were not limited to, dementia and history of traumatic brain injury. A Physician's Order, dated 3/31/25, indicated Enhanced Barrier Precautions related to candida auris. EBP sign outside resident's room. Gown and glove for high contract resident care activities. Face shield should be used for any tasks that have a high potential of splash or spray. During an interview on 4/10/25 at 9:23 a.m., the Interim Director of Nursing indicated the CNA should have been wearing a gown while providing incontinence care. A facility policy titled, "Infection Prevention and Control Program," indicated "... Transmission Based Precautions: The facility follows CDC protocol for transmission-based precautions to be followed to prevent spread of infections; which includes selection and use of PPE and specifies the clinical conditions for which specific PPE should be used..." This deficiency was cited on 2/24/25. The facility		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F880 Infection Prevention & Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** CNA 1 was immediately re-educated on donning the appropriate PPE in accordance with Enhanced Barrier Precautions and Isolation precautions. **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;** All facility residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated: Following Enhanced Barrier Precautions/Isolation Precautions including: How to identify who requires enhanced barrier precautions (following EBP Signage) How to identify Isolation	

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	failed to implement a systemic plan of correction to prevent recurrence. 3.1-18(b)		Precautions (following signage) What personal protective equipment is required Performing hand hygiene **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit 3 residents requiring Enhanced Barrier Precautions 5 times per week on alternating shifts to confirm staff are donning the appropriate Personal protective equipment and are performing hand hygiene. The 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: 4/17/2025**	
R 0000 Bldg. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 2/24/25. This visit included a PSR to the Recertification and State Licensure Survey completed on 2/24/25 and a PSR to the	R 0000		

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	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. Complaint IN00456087 - Federal/State deficiencies related to the allegations are cited at F580 and F755. Survey dates: April 7, 8, 9, and 10, 2025 Facility number: 001198 Residential Census: 39 Crown Point Health Campus was found to be in compliance with 410 IAC 16.2-5 in regard to the PSR to the State Residential Licensure Survey.			

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	Quality review completed on 4/15/25.			