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	08/14/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00434830, IN00435059, IN00436631, IN00437372, IN00439224, IN00440267, and IN00440697. Complaint IN00434830 - Federal/State deficiencies related to the allegations are cited at F580, F677, F684, F693, and F695. Complaint IN00435059 - No deficiencies related to the allegations are cited. Complaint IN00436631 - No deficiencies related to the allegations are cited. Complaint IN00437372 - No deficiencies related to the allegations are cited. Complaint IN00439224 - No deficiencies related to the allegations are cited. Complaint IN00440267 - No deficiencies related to the allegations are cited. Complaint IN00440697 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: August 13 & 14, 2024 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 74 SNF: 22	F 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	09/03/2024

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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	Residential: 43 Total: 139 Census Payor Type: Medicare: 14 Medicaid: 62 Other: 20 Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/22/24.			
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must			

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	ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on observation, record review, and interview, the facility failed to notify a resident's physician and responsible party in a timely manner, related to a gastrostomy (g-tube, feeding tube) mechanical malfunction requiring hospital intervention, which resulted in medications and flushes not being given as ordered for 1 of 3 residents reviewed for physician and family notifications. (Resident B) See F693 for additional information on Resident B. Finding includes:	F 0580	**Crown Point Christian Village Complaint Survey 8.14.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F580 Notify of changes (Injuries/Decline/Room, Etc.)**	09/03/2024

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	During an observation on 8/13/24 at 5:24 a.m., the resident was lying in bed with the head of the bed elevated. A liquid tube feeding of Osmolyte 1.5 was infusing at 72 cc (cubic centimeters) per hour. During an observation on 8/13/24 at 11:45 a.m., the resident's tube feeding was turned off. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated a feeding tube was present, the resident received 51% or more calories from the feeding tube and 501 cc's (cubic centimeters) or more of fluids from the feeding tube. A Care Plan, dated 5/15/24, indicated a feeding tube was required for nutrition and fluids. The interventions included, the the tube feeding would be administered as ordered by the Physician. During an observation on 8/13/24 at 1:33 p.m., LPN 3 indicated she was unable to administer the morning medications and the water flush to the resident. She was unable to separate the g-tube from the feeding tube line. The feeding tube line was inserted into the g-tube with a male connector. LPN 3 was unable to remove the feeding tube line. She indicated she had administration nurses and other nurses attempt to get the tube apart and they were also unable to get it apart. LPN 3 indicated she needed to find a syringe so she could see if the second port on the g-tube could be used and left the room.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident B's family and MD were notified of change in status and the need to significantly alter the resident's treatment. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:** LPN 3 and Nurses were in-serviced on timely physician and family notification when a resident has a change of status and the need to significantly alter the resident's treatment. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;**	

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	Cross reference F693. LPN 3 reentered the room on 8/13/24 at 1:50 p.m. with the ADON (Assistant Director of Nursing) and informed the ADON the resident needed to be sent out to the hospital. She indicated she had attempted to administer the morning medications between 9 a.m. and 9:30 a.m. and was unable to get the remove the feeding line from the g-tube. She then attempted to the use flush the second port and the second port on the g-tube was blocked. During an interview on 8/13/24 at 2:00 p.m., LPN 3 indicated she was going to notify the physician and get an order to transfer the resident to the hospital for the tubing removal. During an interview on 8/13/24 at 2:11 p.m., the ADON and the Unit Manager/Infection Control Nurse indicated they had not been notified that the nurse could not remove the feeding line from the g-tube so the medications and flushes could be administered. During an interview on 8/13/24 at 2:53 p.m., LPN 3 indicated she had just paged the physician and was awaiting a return call. She indicated the Wound Nurse, the ADON, and the Unit Manager/Infection Control Nurse also tried to get the feeding line and g-tube separated, and they were unable to do so. The ADON again indicated she had not been notified about the feeding line and g-tube malfunction. The Medication Administration Record (MAR), dated 8/2024, indicated the flush was scheduled for 2:00 a.m., 8:00 p.m., 2:00 p.m., and 8:00 p.m. The 325 cc's of water was not administered at 8 a.m. or		DON/Designee will audit 10 random residents weekly x 2 months, then 10 random resident bi-weekly x 2 months, the 10 residents monthly x 2 months for 6 months, to ensure the timely notification to physicians and families related to the change in residents' change in status and the need to significantly later the resident's treatment. 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: 9.3.24**	

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	at 2 p.m. The morning medications, scheduled for 8:00 a.m. and 9:00 a.m., were marked not given on the MAR on 8/13/24. The Progress Note, written by LPN 3, dated 8/13/24 at 10:52 p.m., indicated the resident's morning medications and water flush were not administered because she was unable to unhook the feeding line from the g-tube. The Wound Nurse, the Unit Manager/Infection Control Nurse and the ADON were unable to separate the line. The Nurse Practitioner was notified and she was waiting on a return call. The resident's family was in the building and made aware of the situation and did not want the resident sent to the hospital and she could get the feeding line apart from the g-tube. The Progress Note from 8/13/24 at 10:52 p.m., when investigated further, indicated it had been created at 3:16 p.m. The Physician had not been notified until after 2:30 p.m. and the family member had not been notified until she arrived at the facility after 2:53 p.m. During an interview on 8/14/24 at 8:20 a.m., the ADON and Unit Manager/Infection Control Nurse acknowledged the Nurse Practitioner/Physician had not been notified until after 2:30 p.m. and the family had not been notified until they came in to the facility. The ADON indicated the resident was sent to the hospital for the g-tube to be changed and had returned to the facility. A facility physician and family notification policy, received from the Administrator on 8/14/24 at			

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	10:44 a.m. as current, indicated the physician and responsible party would be notified with a change in status and the need to significantly alter the resident's treatment. This citation relates to Complaint IN00434830. 3.1-5(a)(3) 3.1-5(a)(4)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who were dependent on staff for activities of daily living (ADL's) received bathing/showers at least twice a week for 2 of 3 dependent residents who were reviewed for ADL's. (Residents B and H) Findings include: 1. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy tube, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated and short and long term memory problem, had no behaviors, and was dependent for ADL's. Shower and bathing status was marked as not assessed. A Care Plan, dated 5/10/23, indicated a self-care performance deficit and all ADL needs would be met.	F 0677	**Crown Point Christian Village Complaint Survey** **8.14.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **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;** Resident B has received bathing/showers on 8/12/24, 8/15/24, 8/19/24, 8/22/24 and 9/2/24. He was in the hospital 8/26/24 and 8/28/24.	09/03/2024

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	The Shower Schedule, located in the Shower Sheets Binder, indicated the resident was to be bathed/showered on Mondays and Thursdays. The Shower Sheets in the binder indicated bathing had occurred on 7/22/24 and 7/29/24. During an interview on 8/13/24 1:33 p.m., CNA 2 indicated the bathing was documented either on the Shower Sheets or in the computer. The computer documentation for bathing was received on 8/14/24 at 10:44 a.m. from the Administrator, and indicated a shower and bed bath had not been received twice a week. The bathing had not occurred on 6/13/24 - the form was left blank, 6/17/24 - the form was documented as non-applicable, 6/24/24 - the form was left blank, 2024, 7/25/24 - the form was left blank, and on 8/1/24 - the form was marked non-applicable. No additional Shower Sheets were received from the facility. 2. Resident H's record was reviewed on 8/14/24 at 2:02 p.m. The diagnoses included, but were not vascular dementia. A Quarterly MDS assessment, dated 6/5/24, indicated an intact cognitive status, no behaviors, and was dependent on staff for bathing. A Care Plan, dated 6/18/24, indicated assistance was required with ADL's and the resident was totally dependent for bathing. The computer documentation for bathing was received on 8/14/24 at 10:44 a.m. from the Administrator, and indicated the showers were scheduled on Wednesday and Saturdays. Bathing had not been received on 7/24/24 - the form was		Resident H has received bathing/showers on 8/14/24, 8/17/24, 8/21/24, 8/24/24, 8/28/24, and 8/31/24. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Staff were re-educated to ensure residents who were dependent on staff for activities of daily living (ADL's) received bathing/showers at least twice a week. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 10 dependent residents weekly x 2 months, then 10 dependent residents bi-weekly x 2 months, then 10 dependent residents monthly x 2 months for 6 months	

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	marked with non-applicable and on 8/3/24 - the form was left blank. No additional Shower Sheets were received from the facility. During an interview on 8/14/24 at 3:05 p.m., the Unit Manager/Infection Control Nurse indicated the residents were to receive bathing twice a week and as needed. This citation relates to Complaint IN00434830. 3.1-38(a)(3) 3.1-38(b)(2)		to ensure residents who were dependent on staff for activities of daily living (ADL's) received bathing/showers at least twice a week. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9.3.24**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary care and services related to medications not administered as ordered by the Physician, for 2 of 15 residents reviewed for quality of care. (Residents B and D)	F 0684	**Crown Point Christian Village Complaint Survey 8.14.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	09/03/2024

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	Finding includes: 1. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. A Care Plan, dated 6/9/23, indicated a diagnosis of anemia. The interventions included the medications would be administered as ordered and laboratory testing would be completed as ordered. The complete blood count laboratory results on 5/10/24 indicated red blood cells (RBC) level was 3.88 (normal 4.7-6.10) and hemoglobin (HGB) was 11.4 (normal 14-18). On 7/15/24, the RBC was 3.46 and HGB 10.5. On 7/31/24, the RBC was 3.24 and HGB 9.7, and on 8/5/24, the RBC was 3.14 and HGB 9.3. The Physician's Orders, dated 6/13/23, indicated five cc's (cubic centimeters) of a liquid multi-vitamin was to be administered daily and seven cc's of ferrous sulfate (iron) liquid 220 milligrams per five cc's was to bed administered through the gastrostomy tube (g-tube) twice a day. The Medication Administration Records (MARs), dated 6/2024 and 7/2024, indicated by initials the multi-vitamin and ferrous sulfate had been administered as ordered. The MAR, dated 8/2024, indicated the multi-vitamin and ferrous sulfate had been administered as ordered on 8/1/24 through 8/12/24. During an observation on 8/13/24 at 2:00 p.m.,		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was immediately assessed and noted with no adverse reaction to not receiving ferrous sulfate and multivitamin. Resident B's family and MD were notified. Resident D was immediately assessed and noted with no adverse reactions related to not receiving Xanax medication. Resident D's family and MD were notified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	LPN 3 indicated there were two bottles of ferrous sulfate for the resident in the medication cart. The labels indicated one bottle was delivered on 6/20/24 and the second bottle was delivered on 8/9/24. The bottle that was delivered on 6/20/24, came with 473 cc's of medication in the bottle and the bottle was 3/4 full of the medication. LPN 3 acknowledged the amount of the medication. The bottle delivered on 8/9/24 was full. The Physician's Orders for the ferrous sulfate, was to administer seven cc's twice a day. Each bottle of the ferrous sulfate would have approximately 33 doses of the medication. The bottle delivered 6/20/24 still had 3/4 of the medication remaining. LPN 3 indicated she was unsure why there was a large amount of ferrous sulfate left in the bottle delivered on 6/20/24. During an interview on 8/13/24 at 2:11 p.m. the Unit Manage/Infection Control Nurse indicated the Nurse Practitioner had spoken with her about the resident's laboratory results and had asked about the ferrous sulfate and if it had been given. She indicated on 8/8/24, she observed the cart and saw there was a bottle of ferrous sulfate that was delivered on 6/1/24 that was almost gone and a full bottle that was delivered on 6/20/24. The 6/1/24 bottle was destroyed and the bottle delivered on 6/20/24 should have been all used or at least almost emptied. A Pharmacy Fill History form, received from the Assistant Director of Nursing (ADON) on 8/13/24 at 3:00 p.m., indicated a 30 day supply of ferrous sulfate, 473 cc's, was delivered on 3/21/24, 5/24/24, 6/20/24, and 8/9/24. She acknowledged a bottle of the ferrous sulfate should last approximately 33 days, with the dosage of seven cc's twice a day.		**practice does not recur;** LPN 3 and Licensed Nurses were re-educated to administer all medications as ordered and sign off on MAR with each medication pass. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 10 residents MARs weekly x 2 months, then 10 residents bi-weekly x 2 months, then 10 residents monthly x 2 months to ensure that nursing is administering all medications as ordered and signing off on MAR with each medication pass for 6 months. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** **9.3.24**	

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

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	During an observation on 8/13/24 at 2:53 p.m., The ADON indicated the bottle of multi-vitamin liquid in the medication cart was delivered on 3/30/24. There was 236 cc's of medication in a full bottle and there was approximately 1/4 of medication remaining in the multi-vitamin bottle that was delivered on 3/30/24. The resident was to receive five cc's of the medication daily. There was 47 doses in each bottle. A Pharmacy Fill History form, received from the ADON on 8/13/24 at 3:38 p.m., indicated the multi-vitamin liquid medication was delivered on 3/3/24 and 3/30/24. There had been no deliveries of the vitamin after 3/30/24. The form indicated each bottle was a 30 day supply. The ADON indicated the multi-vitamin could not have been administered as ordered.2. The record for Resident D was reviewed on 8/13/24 at 9:11 a.m. Diagnoses included, but were not limited to, dementia, general anxiety disorder, and malignant neoplasm of the colon. The Quarterly Minimum Data Set (MDS) assessment, dated 8/3/24, indicated the resident was cognitively impaired and received anti-anxiety medication. A Care Plan, dated 1/4/24, indicated the resident had periods of restlessness and increased anxiety. The interventions included, "administer medications as ordered..." The Physician's Order Summary, dated 8/2024, indicated an order for Xanax (alprazolam, an anti-anxiety medication) 0.5 milligrams (mg) 1 tab every afternoon. The Medication Administration Record (MAR), dated 8/2024, indicated the Xanax medication was			

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	not signed off as given on 8/3/24 and 8/10/24. The Medication Administration Record (MAR), dated 7/2024, indicated the Xanax medication was not signed off as given on 7/11/24. During an interview on 8/14/24 at 10:39 a.m., the Administrator was made aware of the blanks on the MARs. No further information was provided. This citation relates to Complaints IN00434830. 3.1-48(a)(6)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and	F 0693	**Crown Point Christian Village**	09/03/2024

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	interview, the facility failed to provide proper feeding tube (gastrostomy tube) (g-tube) care as per professional standards, related to water flushes not completed as ordered, verification of the g-tube placement not completed prior to medication administration, failure to flush the g-tube after each medication was administered, a liquid feeding bag not labeled, dated or timed, and a piston syringe (used for water flushing and other care for the g-tube) not changed daily, for 2 of 3 residents reviewed for feeding tube care. (Residents B and J) See F580 for additional information on Resident B Findings include: 1. Resident B's record was reviewed on 8/13/24 at 10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated feeding tube was present, he received 51% or more calories from the feeding tube and 501 cc's (cubic centimeters) or more of fluids from the feeding tube. A Care Plan, dated 5/15/24, indicated a feeding tube was required for nutrition and fluids. The interventions included, the placement of the feeding tube would be checked for gastric contents/residual volume and the tube feeding would be administered as ordered by the Physician. During an observation on 8/13/24 at 1:33 p.m., LPN 3 indicated the morning medications and water flush had not been administered because she was unable to separate the g-tube from the		**Complaint Survey** **8.14.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F693 Tube Feeding Management/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was immediately assessed and noted with no adverse reaction to not receiving morning and afternoon medications/ water flushes. Resident B's family, MD and dietician were notified. Resident B did not receive verification of placement of g-tube prior to administering medication, flush/water not used to mix medications, flushes between medications, nor given through gravity. Resident B was assessed, MD, family and dietician notified. Resident J's enteral feeding bag was immediately labeled with the amount of formula hung, the time it was hung, and administered within 8 hours, or if beyond 8 hours, then destroyed. Resident J's family, MD and dietician were	

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	feeding tube line. The feeding tube line was inserted into the g-tube with a male connector. LPN 3 was unable to remove the feeding tube from the g-tube. Cross reference F580. A Physician's Order, dated 4/26/24, indicated the g-tube was to flushed with 325 cc's of water every six hours. The Medication Administration Record (MAR), dated 8/2024, indicated the flush was scheduled for 2:00 a.m., 8:00 p.m., 2:00 p.m., and 8:00 p.m. The 325 cc's of water was not administered at 8:00 a.m. or at 2:00 p.m. on 8/13/24. The morning medications of ascorbic acid (vitamin C) 250 mg (milligrams), one tablet, cholecalciferol (vitamin D3) 1000 units, one tablet, cyanocobalamin (vitamin B12) 2500 micrograms, one tablet, escitalopram (anti-anxiety/anti-depressant) 5 mg, one tab, ferrous sulfate 220 mg/5 cc's, give 7 cc's, twice a day, lorazepam (anti-anxiety) 0.5 mg twice a day, Miralax (laxative) 17 grams daily, memantine (Alzheimer's medication) 10 mg, one tablet daily, multivitamin 5 cc's, and omeprazole (stomach medication) 20 mg, one tablet were marked not given on the MAR on 8/13/24. During an observation on 8/14/24 at 8:35 a.m., LPN 4 was starting to prepare the morning medications for Resident B, which consisted of the above listed medications. She placed each medication in a separate plastic medication cup. She crushed the tablets of medication and placed the powder back into the individual cups. LPN 4 filled three cups with 120 cc's of water each and mixed each medication with 30 cc's of water. The feeding		notified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Clinical staff, LPN 1, LPN 3 and LPN 4 were re-educated to ensure they provide proper feeding tube (gastrostomy tube) (g-tube) care as per professional standards, related to water flushes completed as ordered, verification of the g-tube placement completed prior to medication administration, flush the g-tube after each medication was administered, all liquid feeding bags labeled, dated or timed, and piston syringes (used for water flushing and other care for the g-tube) changed daily. All Residents with g-tubes have orders for x-ray for g-tube placement verification completed. **How the corrective action(s) will be monitored to ensure the**	

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	pump was then turned off, and the feeding line was removed from the g-tube. The g-tube was flushed with 30 cc's of water that was pushed in with a syringe. The g-tube placement was not verified prior to administration of the medications. The syringe was used to administer the first medication dissolved in 30 cc's of water and pushed into the stomach through the g-tube. LPN 4 continued to use this pushing technique with the next medication and then indicated she had forgotten to verify placement of the g-tube, and pulled back on the syringe to check for gastric contents, then the gastric contents were pushed back into the g-tube. Two more medications were dissolved in 30 cc's of water and were pushed separately into the feeding tube, then 30 cc's of water was pushed into the g-tube. The g-tube was not flushed with water until after the fourth medication was administered. After the 30 cc flush, the rest of the medications were pushed into the stomach through the g-tube with the syringe piston. After the last medication was pushed, the g-tube was flushed by pushing 30 cc's of water into the tube. The liquid feeding was then resumed. During an interview on 8/14/24 at 9:47 a.m., LPN 4 indicated there was no order for the amount of water with which to flush the feeding tube or to mix the medications. The policy stated the flush was to be 30 cc's of water and the g-tube should have been flushed with 30 cc's of water after each medication. She indicated she had to push the medications in to the stomach because they would not flow in by gravity. If she attempted to administer the medications by gravity, they would not go in and the feeding would flow out of the stomach. The medications were always pushed into the stomach through the feeding tube.		**deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit/observe 5 nurses administering medications weekly x 2 months, then 5 nurses bi-weekly x 2 months, 5 nurses monthly x 2 months to ensure they provide proper feeding tube care, ensure water flushes completed as ordered, verification of the g-tube placement completed prior to medication administration, flush the g-tube after each medication was administered, all liquid feeding bags labeled, dated or timed, and piston syringes (used for water flushing and other care for the g-tube) changed daily for 6 months. 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: 9.3.24**	

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	A Professional Resource, titled, "Medication Aide Training Curriculum", dated 1/2/24, indicated if more than one medication was being administered, they were to be given separately with a minimum of 10 cc's of warm water or according to facility policy or provider's order before and after each medication. Tube placement was to be verified prior to medication administration. Medications and fluids were not to be forced into the tube. The medications were to be administered by gravity and if necessary, gentle pressure could be applied. The delivery of the medication was to be slow and steady. The fluid was not to be administered too quickly. The g-tube was to be flushed after checking for placement. A facility policy, dated 9/1/2023 and received from the Administrator as current, indicated the medication was to be dissolved in 5-10 cc's of warm water or the prescribed amount. The g-tube was to be verified for placement. The g-tube was to be flushed with 15-30 cc's of water, the preferred amount of flush was 30 cc's, using gravity flow. The medications were to be given and allowed to flow in by gravity and were to be flushed with 15 cc's of water between medications. 2. On 8/14/24 at 9:07 a.m., Resident J was observed lying in his bed with the head of bed elevated. He had a feeding tube connected to a feeding tube bag containing formula. The pump was set to 90 milliliters per hour. The feeding tube bag had no label observed and the formula inside was unidentified. The enteral feeding syringe was placed in a plastic bag hanging on the tube feeding pole and was dated 8/12/24. During an interview on 8/14/24 at 9:17 a.m., LPN 1 indicated the enteral feeding syringe was not available in the stock room on the unit, but it was supposed to be replaced each day. The tube			

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	feeding bag should have been labeled when it was started at 9:00 a.m. that morning. Resident J's record was reviewed on 8/13/24 at 3:26 p.m. The diagnoses included, but were not limited to, dementia, gastrostomy status, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 5/14/24, indicated the resident was moderately impaired for daily decision making. The resident was dependent for all activities of daily living including, but not limited to, oral hygiene, toileting hygiene, personal hygiene, and transfers. The resident received 51% or more of total calories and 501 cc per day or more of fluid intake through a tube feeding. The August 2024 Physician Order Summary indicated the resident received a 150 cc water flush every 6 hours, a pump feeding of Fibersource through a PEG (feeding tube) at 90 milliliters per hour, on at 9:00 a.m. and off at 5:00 a.m., change the feeding syringe and storage bag/canister every night shift, and label the feeding container with the resident's name, formula, date, time hung, and rate every day. During an interview on 8/14/24 at 10:39 a.m., the Assistant Director of Nursing indicated she had no further information to provide. During an interview on 8/14/24 at 10:50 a.m., the Administrator indicated she had no further information to provide. A policy titled, "Enteral Feedings," noted as current, indicated, "Procedures ... 2 ... A new catheter tip syringe and feeding administration set will be utilized and dated daily ...7. Label the			

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	feeding or ready to hang container with the resident's name, formula ordered, and date. If a feeding bag is used, each time a feeding is administered into the bag, the amount of formula hung and the time it was hung must be noted on the feeding bag ....11 ... If using a feeding bag, once a formula is put into a feeding bag, it must be administered within eight hours. If the formula is in the bag beyond 8 hours, it must be discarded...." This citation relates to Complaint IN00434830. 3.1-44(a)(2)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure a resident who required nebulizer breathing treatments was assessed prior to, during, and/or after the treatment for effectiveness of the treatment, lung sounds, pulse, oxygen status, and blood pressure status for 1 of 1 resident reviewed for oxygen therapy. (Resident B) Finding includes; Resident B's record was reviewed on 8/13/24 at	F 0695	**Crown Point Christian Village Complaint Survey 8.14.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F695 Respiratory/Tracheostomy**	09/03/2024

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	10:31 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, gastrostomy, and iron deficiency anemia. An Annual Minimum Data Set (MDS) assessment, dated 5/15/24, indicated a short and long term memory problem, had no behaviors, was dependent for activities of daily living and oxygen was administered. A Care Plan, dated 5/13/24, indicated the resident required oxygen therapy. The interventions included, the medications would be administered as ordered. A Physician's Order, dated 7/5/24, indicated a nebulizer treatment of ipratropium-albuterol (breathing medication) inhalation solution 0.5-2.5 mg (milligrams) per 3 cc's (cubic centimeters) was to be given every six hours due to wheezing. During an observation on 8/14/24 at 8:35 a.m., LPN 4 prepared the resident's morning medication, which included 3 cc's of the ipratropium-albuterol to be administered by a nebulizer. She entered the room and obtained an oximeter reading (oxygen level) of 94 with a pulse of 79. LPN 4 placed the liquid medication in the nebulizer reservoir and placed the mask over the resident's mouth and nose. She then proceeded to administer the other morning medications through the gastrostomy tube. At 9:40 a.m., LPN 4 had finished the administration of the morning medications and then obtained another oximeter reading of 95% with a pulse of 83. She then turned the nebulizer off, removed the mask with the reservoir from the resident and placed it in a plastic bag in the top drawer of the bedside dresser. She did not rinse the reservoir or the mask with water after the treatment. LPN 4 had not assessed lung sounds		**care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was assessed, blood pressure, oxygen saturation level and pulse were taken, no adverse effects noted. Resident B's nebulizer reservoir and mask were cleaned. Resident B's family and MD were notified. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Clinical staff and LPN4 were re-educated to ensure a resident who required nebulizer breathing treatments are assessed prior to, during, and/or after the treatment for effectiveness of the treatment, lung sounds, pulse, oxygen status, and blood pressure status	

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	or monitored the blood pressure before, during or after the treatment. The oxygen saturation level and pulse had not been monitored during the treatment. A facility nebulizer policy, dated 6/2/2009 and received from the Administrator as current, indicated lung sounds were to be auscultated, the respiratory rate/effort and pulse was to be assessed. The mask and reservoir was to be rinsed with water and allowed to dry after each treatment. During an interview on 8/14/24 at 1:48 p.m., the Assistant Director of Nursing indicated the policy had not been followed for the nebulizer medication administration. This citation relates to Complaint IN00434830. 3.1- 47(a)(6)		**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 in place;** DON/designee will audit 5 residents with nebulizers weekly x 2 months, then 5 residents bi-weekly x 2 months, then 5 residents monthly to ensure that nebulizer care and cleaning is being performed according to the physician orders for 6 months. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 9.3.24**	
F 0880 SS=F Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.			

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	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or			

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	their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to provide a safe and sanitary environment to help prevent the potential of transmission of communicable diseases and infections, related to glucometers (blood sugar monitor) used for multiple residents not sanitized before and after each resident use (RN 8) and failed to sanitize an oximeter (oxygen saturation monitor) used for multiple residents after it was used on a resident. (Resident B, LPN 4) This had the potential to affect the 26 residents in the facility who receive glucometer testing and the 25 residents who reside on Eden C Hall. The facility also failed to ensure staff were educated on Enhanced Barrier Precautions (EBP), ensure staff were aware of which residents were on EBP, and correct Personal Protective Equipment (PPE) was used by staff members	F 0880	**Crown Point Christian Village Complaint Survey** **8.14.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F-880 Infection Prevention & Control** **Corrective actions which will**	09/03/2024

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	155637	A. BUILDING 00 B. WING	08/14/2024

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	(CNA 5, CNA 6, CNA 7). This had the potential to affect the 96 residents who reside in the facility. Findings include: 1. During an observation of the Gracepoint Unit on 8/13/24 at 5:32 p.m., RN 9 was in Resident S's room administering a glucometer test. During an observation on 8/13/24 at 5:37 a.m., RN 9 exited Resident S's room and walked down the hallway. RN 9 held a small basket that contained lancets (fingerstick needles) and a glucometer in her hand. RN 9 indicated she was doing the morning blood sugar tests. No sanitizing wipes were observed. She indicated the glucometer was sanitized prior to starting the blood sugar testing and the glucometer was not sanitized after each resident, only before starting the tests and again after everyone was tested. RN 9 indicated bleach wipes were to be used to sanitize the glucometer and was unaware that the glucometers needed to be sanitized after each use. RN 9 indicated she worked on both Gracepoint Unit and Eden Unit. A facility blood glucose monitoring policy, dated 3/26/20 and received as current from the Administrator, indicated the glucometer was to be cleaned after each use. 2. During observations on 8/13/24 at 8:24 a.m., Resident J was observed with a feeding tube, Resident H had a urinary catheter, Resident F had a urinary catheter, Resident T had a feeding tube, and Resident B had a feeding tube. There were no signs on the doors or inside the room that indicated the residents were on EBP. Resident H's room was the only room with gowns in a storage container in the room. CNA 5 was interviewed and indicated she was unsure what EBP was. She		**be accomplished for those residents found to have been affected by the deficient practice:** RN 8 has been in serviced the proper way to sanitize the glucometer before and after each resident use. LPN 4 has been in serviced on the proper way to sanitize an oximeter (oxygen saturation monitor) used for multiple residents after it was used on a resident. CNA 5 was in serviced on following Enhanced Barrier Precautions (EBP), which residents were on EBP, and correct Personal Protective Equipment (PPE) to wear. CNA 6 was in serviced on following Enhanced Barrier Precautions (EBP), which residents were on EBP, and correct Personal Protective Equipment (PPE) to wear. CNA 7 was in serviced on following Enhanced Barrier Precautions (EBP), which residents were on EBP, and correct Personal Protective Equipment (PPE) to wear. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and	

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	looked on the care card in her pocket and indicated there was no information on the care card about EBP. During an interview on 8/13/24 at 8:28 a.m., CNA 7 indicated if the the resident required EBP, there would be a sign on the door and a cart with PPE outside of the door. During an interview on 8/13/24 at 8:39 a.m., LPN 8 indicated she had not received education about EBP and was unsure when EBP was. She indicated gloves were always worn while providing care. During an interview on 8/13/24 at 9:30 a.m., the Unit Manager/Infection Control Nurse indicated there had not been education on EBP since she started employment in July. The Assistant Director of Nursing indicated the facility had not had training for EBP. They were unable to fully explain what the EBP requirements were. During an observation on 8/13/24 at 10:23 a.m., Resident H was lying in bed and CNA 5 was providing care. The resident had a urinary catheter and colostomy. CNA 5 wore gloves and had no gown on to cover her uniform. CNA 5 was observed emptying the urinary catheter drainage bag. A gown was put on after being made aware of the EPB sign on the wall inside by the room entry door. During on observation on 8/13/24 at 1:33 a.m., CNA 6 and CNA 7 were in Resident B's room and indicated they had just finished his daily care. CNA 6 and CNA 7 had gloves on and no gowns were on. CNA 6 indicated she forgot to put a gown on. There was now a sign on the entry door that indicated EBP required to be used when in the room.		medical records to identify other residents having the potential to be affected by the alleged deficient practice. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur:** Regional Nurse and IP Nurse with Infection Preventionist Certification re-educated the facility Administrator, Director of Nursing and Assistant Director of Nursing related to ensure proper infection control practices are followed, i.e. sanitizing the glucometer before and after each resident use, proper way to sanitize an oximeter (oxygen saturation monitor) used for multiple residents after it was used on a resident, and following Enhanced Barrier Precautions (EBP), to ensure they were aware of which residents were on EBP, and correct Personal Protective Equipment (PPE). Clinical staff re-educated on the proper way to sanitize the glucometer before and after each resident use. Clinical staff re-educated on the proper way to sanitize an oximeter (oxygen saturation monitor) used for multiple residents after it was used on a resident. Clinical staff re-educated on following Enhanced Barrier	

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	A facility infection control policy, dated 7/9/24 and received from the Administrator as current, indicated EBP was to be implemented for residents with wounds, indwelling medical devices or targeted multi-drug resistant organisms. High-contact care activities included dressing, bathing, hygiene, changing linens, changing briefs, device care or use, and wound care. PPE was to be stored in an isolation cart immediately outside of the resident's room. 3. During an observation on 8/14/24 at 8:35 a.m., LPN 4 applied an oximeter probe to Resident B's finger and the oxygen saturation level was obtained. The oximeter probe was removed from the finger and placed in the basket attached to the blood pressure/oximeter machine on a rolling pole, on top of the blood pressure cuffs stored in the basket. Resident B's nebulizer treatment was administered. The blood pressure/oximeter machine remained in the room during the nebulizer treatment. During an observation on 8/14/24 at 9:40 a.m., the nebulizer treatment was completed and LPN 4 removed the mask. LPN 4 reapplied the oximeter probe to the resident's finger and obtained the oxygen saturation level. The probe was removed from the resident's finger and placed in the basket attached to the blood pressure/oximeter machines, on top of the blood pressure cuffs stored in the basket. LPN 4 then removed the machine from the room and placed it in the hallway. The oximeter probe, blood pressure cuffs, rolling pole and the machines were not sanitized after it was removed from the room.		Precautions (EBP), which residents were on EBP, and correct Personal Protective Equipment (PPE) to wear. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** The D.O.N. or designee, will conduct surveillance observation audits for 10 residents weekly x 2 months, then bi-weekly x 2 months, then monthly x 2 months to ensure improvement of infection control practices for 6 months. 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. **Dates when corrective action will be completed: 9.3.24**	

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	The rolling pole, machines, and oximeter probe was not used from 9:40 a.m. until 10:55 a.m. During an interview on 8/14/24 at 10:55 a.m., the Wound Nurse indicated the pole, machines, blood pressure cuffs and oximeter probe should have been sanitized after it was used. 3.1-18(b)			