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	03/22/2024

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 a Recertification and State Licensure Survey and Investigation of Complaints IN00429849, IN00429448, IN00429192, and IN00428708. This visit included a State Residential Licensure Survey. Complaint IN00429849 - Federal/State deficiencies related to the allegations are cited at F940. Complaint IN00429448 - No deficiencies related to the allegations are cited. Complaint IN00429192 - Federal/State deficiencies related to the allegations are cited at F940. Complaint IN00428708 - No deficiencies related to the allegations are cited. Survey dates: March 18, 19, 20, 21, and 22, 2024 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 93 SNF: 13 Residential: 48 Total: 154 Census Payor Type: Medicare: 19 Medicaid: 63 Other: 24 Total: 106 These deficiencies reflect State Findings cited in	F 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	04/16/2024

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on 4/1/24.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications, for 2 of 2 residents reviewed for self-administration of medication. (Residents 35 and 101) Findings include: 1. On 3/18/24 at 2:13 p.m., a Breo Ellipta inhaler (asthma treatment) and an albuterol inhaler (asthma treatment) were both observed on Resident 35's bedside table. The resident indicated she administered the Breo Ellipta inhaler every morning and the albuterol inhaler only when she needed it. On 3/19/24 at 10:30 a.m., a Breo Ellipta inhaler (asthma treatment) and an albuterol inhaler (asthma treatment) were both observed on Resident 35's bedside table. Resident 35's record was reviewed on 3/21/24 at 8:55 a.m. Diagnoses included, but were not limited to, asthma and type 2 diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 1/23/24, indicated the resident was cognitively intact for daily decision making.	F 0554	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** 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 554 Resident Self-Administration Medications-Clinically Approp** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 101 had medications bedside. A self-administration assessment was completed, medications removed from the bedside. Resident 101 is discharged from the facility. Resident 35 had medications bedside. The self-administration assessment was completed and orders for the self-administration of	04/16/2024

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	A Physician's Order, dated 2/17/24, indicated Breo Ellipta inhalation aerosol powder breath activated 100-25 microgram/actuation, 1 puff inhale orally one time a day. A Physician's Order, dated 6/9/23, indicated albuterol sulfate 108 microgram/actuation, 2 puff inhale orally every 8 hours as needed. There were no orders for self-administration of the medications. There were no assessments completed for self-administration of the medications. During an interview, on 3/20/24 at 1:20 p.m., the Director of Nursing (DON) indicated she should have had orders to keep the medications at bedside and an assessment completed. 2. On 3/19/24 at 10:02 a.m., a calcitonin salmon nasal spray (osteoporosis treatment) was observed on Resident 101's bedside table and a box of lidocaine 4% patches were observed on another table in the resident's room. On 3/20/24 at 9:16 a.m., a calcitonin salmon nasal spray was observed on Resident 101's bedside table and a box of lidocaine 4% patches were observed on another table in the resident's room. The resident indicated he wasn't sure what the nasal spray was for. Resident 101's record was reviewed on 3/20/24 at 9:31 a.m. Diagnoses included, but were not limited to, osteoporosis, osteoarthritis, and collapsed vertebra in the thoracic region. The Admission Minimum Data Set (MDS)		the medications. There were no adverse effects noted. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents who self-administer medications 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 re-educated on completing self-administration medication assessments and orders for self-administration in PCC for residents who desire to have medications in room/ bedside. If a resident is unable to pass the assessment, there should be no medications left bedside. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit 5 residents 2x's/week for 6 months, to ensure there are no medications left bedside, and if resident is able to pass medication, they have completed a self-administration medication	

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	assessment, dated 2/15/24, indicated the resident was moderately cognitively impaired for daily decision making. A Physician's Order, dated 2/10/24, indicated lidocaine external patch 4%, apply to back topically one time a day for pain. There was no order for the calcitonin salmon nasal spray. There were no orders for self-administration of the medications or a self-administration of medication assessment completed for either of the medications. During an interview on 3/20/24 at 9:32 a.m., the 200 Unit Manager indicated the resident should not have either of the medications at the bedside. During an interview on 3/20/24 at 11:27 a.m., the Director of Nursing indicated the resident should not have had the medications at the bedside. 3.1-11(a)		assessment and orders for the self-administration of the medications is in PCC. 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 will be presented quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 4.16.24**	
F 0576 SS=D Bldg. 00	483.10(g)(6)-(9) Right to Forms of Communication w/ Privacy §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable			

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	access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law.			
	Based on interview, the facility failed to ensure a resident's right to privacy, related to facility staff opening a resident's personal mail, for 1 of 1 residents reviewed for residents' rights. (Resident 35). Finding includes: During an interview on 3/19/24 at 9:14 a.m., Resident 35 indicated within the last week, she had ordered a new debit card. She had received a	F 0576	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** 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	04/16/2024

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	notification on her cell phone that indicated her card was going to be delivered to the facility soon. She had gone to see the Business Office Manager (BOM) upstairs regarding another matter, and asked if she had received any mail addressed to her. The BOM indicated she had received a letter the day before, and gave the letter to the resident. The letter had already been opened by the BOM. Resident 35 indicated she had never received a call from the BOM indicating the letter had arrived the day before. In the meantime, Resident 35 had canceled the card because she was afraid it had been lost, and now had to wait for another card to be delivered. Resident 35's record was reviewed on 3/21/24 at 8:55 a.m. The Quarterly Minimum Data Set (MDS) assessment, dated 1/23/24, indicated the resident was cognitively intact for daily decision making. During an interview, on 3/20/24 at 2:14 p.m., the Business Office Manager indicated she had opened Resident 35's mail last week. The facility had received a letter in the mail addressed to Resident 35. The envelope was blank with no return address. The BOM indicated she would open any resident letters that appeared to be for insurance, as anything that was insurance-related had to be scanned into the resident's chart or sent in with check deposits. Once she determined the letter was a personal letter, she gave it to the resident the following day when she saw her. During an interview, on 3/20/24 at 3:38 PM, the Administrator indicated she was not aware of any mail being opened prior to delivery to the resident. All of the residents in the facility had the right to receive all of their mail unopened.		requirement. **F 576 Right to Forms or Communication with Privacy** **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The administrator met with Resident 35. Resident 35 suffered no psychosocial distress. Staff member who opened Resident 35's mail was counseled regarding maintaining resident's right to privacy. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** All residents have the potential to be affected by alleged deficient practice. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** Staff member who opened Resident 35's mail was counseled regarding maintaining resident's right to privacy.	

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	3.1-3(s)(1)		Facility staff have been in-serviced on residents' right to receive mail unopened. How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Administrator/designee will audit 5 residents' mail to ensure it has been delivered unopened 2 times a week for 6 months. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for six months. After six months, it will be determined by the Quality Assurance committee if further monitoring should continue and for what time. Monitoring will be ongoing. **Date of Completion: 4.16.24**	
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 observation, record review, and interview, the facility failed to ensure dependent residents received the necessary ADL (activities of daily living) care, related to unshaven facial hair, lack of incontinence care, and long fingernails, for 3 of 3	F 0677	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** Please accept the following as the facility's credible allegation of compliance. This plan of	04/16/2024

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	residents reviewed for ADL care. (Residents 17, B, and 27) Findings include: 1. On 3/18/24 at 10:13 a.m., Resident 17 was observed in bed. She had long facial hair on her chin. On 3/19/24 at 1:26 p.m., the resident was again observed in bed, with long facial hair on her chin. She indicated she did not like the facial hair and the staff would sometimes shave her. Resident 17's record was reviewed on 3/19/24 at 1:50 p.m. Diagnoses included, but were not limited to, atherosclerotic heart disease, lymphedema and low back pain. The Quarterly Minimum Data Set (MDS) assessment, dated 1/4/24, indicated the resident had moderate cognitive impairment and required extensive staff assistance for bed mobility and transfers. The current ADL Care Plan indicated the resident needed assistance with ADLs due to immobility. Shower sheets for the past 30 days indicated the following: 2/26/24 - bed bath, not shaved 2/29/24 - refused 3/4/24 - bed bath, shave not needed 3/7/24 - refused 3/11/24 - refused 3/14/24 - bed bath, not shaved 3/18/24 - refused During an interview, on 3/19/24 at 3:20 p.m., the Infection Prevention Nurse indicated the resident		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 17 was assisted with all needed ADL's, which included shaving facial hair per care plan. Resident B was assisted with all needed ADL's, which included providing incontinence care as per care plan. Resident 27 was assisted with all needed ADL's, which included providing nail care as per care plan. Resident 27 is discharged from the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** 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 providing residents with	

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	would often refuse care. She indicated there were no notes or refusals documented on the shower sheets to indicate shaving had been offered or provided in the past 30 days. 2. During an interview, on 3/19/24 at 1:17 p.m., Resident B's Power of Attorney (POA) indicated the resident was not getting checked for incontinence and changed every two hours. She had arrived to the facility to visit the resident, and when staff got him up, his brief was so saturated it was dripping onto the floor. A continuous observation of Resident B was started on 3/21/24 at 9:50 a.m. The resident was observed in bed asleep at the time, with both heels elevated. On 3/21/24 at 10:42 a.m., LPN 2 entered the room to check on the resident's roommate. She did not check or change Resident B. Resident B was observed awake in bed with his heels elevated. On 3/21/24 at 11:35 a.m., QMA 1 was observed entering Resident B's room to administer medications to the resident's roommate. On 3/21/24 at 11:48 a.m., Agency CNA 1 was observed delivering the roommate's lunch tray. She placed the tray on Resident B's bedside table and exited the room. On 3/21/24 at 11:51 a.m., CNA 1 entered Resident B's room, picked up the roommate's tray from Resident B's bedside table and proceeded to assist the roommate with his lunch. The continuous observation concluded at 11:54 a.m. on 3/21/24. No staff were observed checking or changing Resident B's brief.		assistance with ADLs per resident's plan of care including shaving facial hair, providing incontinence care and nail care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 10 residents 2xs/week for 6 months, with a focus on resident's requiring ADL assistance to ensure they are providing residents with assistance per resident's plan of care including shaving facial hair, providing incontinence care and nail care. 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 will be presented quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 4.16.24**	

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	On 3/21/24 at 1:07 p.m., CNA 1 indicated she had just changed Resident B's brief and it was moderately wet. She typically went thru her line-up the same way as time allowed, and that was the soonest she could get to Resident B's incontinence check and change. She tried to check and change him every two hours. Resident B's record was reviewed on 3/21/24 at 10:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, pressure ulcer of left heel, colostomy status, and benign prostatic hyperplasia (an enlarged prostate). The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/23, indicated the resident was severely cognitively impaired for daily decision making. A Care Plan, dated 5/10/23, indicated the resident had an ADL self-care performance deficit. Interventions included, but were not limited to, the resident required total assist for toileting and colostomy care. A Care Plan, dated 5/18/23, indicated the resident was incontinent of bladder. Interventions included, but were not limited to, check and change. The CNA Task - Bladder continence was reviewed for the last 30 days. The frequency was every shift. All documented care was marked for incontinence. There was no documented incontinence care on 2/22/24, 2/27/24, 3/1/24, 3/3/24, 3/12/24, 3/14/24, and 3/16/24. Incontinence care was documented once daily on 2/21/24, 2/23/24, 2/25/24, 2/26/24, 2/28/24, 2/29/24, 3/4/24, 3/5/24, 3/8/24, 3/10/24, 3/11/24, 3/15/24, 3/17/24, 3/18/24, and 3/19/24.			

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	Incontinence care was documented twice daily on 3/2/24, 3/6/24, 3/7/24, 3/9/24, 3/13/24, and 3/20/24. During an interview, on 3/21/24 1:54 p.m., the Director of Nursing indicated staff should have documentation of incontinence care every two hours. 3. During an interview, on 3/18/24 at 10:50 a.m., Resident 27 indicated he wanted his fingernails trimmed and had asked staff to help him, but they had not assisted him with it. On 3/20/24 at 9:05 a.m., Resident 27 indicated he still wanted his fingernails trimmed. Resident 27's record was reviewed on 3/20/24 at 9:51 a.m. Diagnoses included, but were not limited to, heart failure and chronic respiratory failure. The State Optional MDS, dated 2/2/24, indicated he was cognitively intact for daily decision making. He required extensive assistance with one person physical assist for bed mobility and limited assistance for transfers and toilet use. A Care Plan, dated 12/18/23, indicated the resident needed assistance with ADLs. During an interview, on 3/20/24 at 1:20 p.m., the Director of Nursing indicated staff would address his nails when he returned from an appointment. 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that			

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	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 residents received the necessary care and treatment, related to compression stockings not in place as ordered, a non-pressure skin treatment not completed as ordered, and a fall assessment not completed, for 1 of 1 residents reviewed for edema, 1 of 2 residents reviewed for non-pressure skin conditions, and 1 of 1 resident reviewed for falls. (Residents 64, 52 & 27) Findings include: 1. On 3/18/24 at 1:14 p.m., Resident 64 was observed seated in her Broda chair near the Nurses' Station. She was fully dressed with regular socks and tennis shoes on her feet. There were no compression stockings on her legs. On 3/19/24 at 9:30 a.m., the resident was in her room seated. There were no compression stockings on her legs. A family member was present in the room and indicated she frequently did not have them on. Staff said she would take them off, but she wasn't able to do so herself. On 3/19/24 at 1:25 p.m., the resident was observed again seated by the Nurses' Station. She had shoes and socks on her feet with no compression stockings. Resident 64's record was reviewed on 3/19/24 at	F 0684	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** 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. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 52 was assessed, fall assessment has been completed. Resident 64 was assessed, and no abnormalities were noted related to not wearing ted hose as ordered. Res.is on hospice, order has been discontinued. Resident 27 was discharged from the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;**	04/16/2024

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	155637	A. BUILDING 00 B. WING	03/22/2024

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	10:05 a.m. Diagnoses included, but were not limited to, unspecified dementia and congestive heart failure. The Quarterly Minimum Data Set assessment, dated 2/7/24, indicated the resident was severely cognitively impaired and required extensive staff assistance for bed mobility, transfers, and toileting. A Physician's Order, dated 8/5/23, indicated to apply TED hose (compression stockings) in the morning and remove at bedtime. Document if the resident refuses. The March 2024 Treatment Administration Record indicated the TED hose were applied 3/19/24 and the entry for 3/18/24 was blank. During an interview, on 3/19/24 at 1:34 p.m., LPN 1 indicated the previous shift had documented the resident's TED hose were on. 2. On 3/18/24 at 2:59 p.m., Resident 52 was observed sitting in her wheelchair in the lounge area. She had a sling in place to her left arm. She indicated she fell and hurt her shoulder a few months ago and had to wear the sling until it healed. The record for Resident 52 was reviewed on 3/20/24 at 9:35 a.m. Diagnoses included, but were not limited to, dementia, hypertension, and anxiety disorder. The Significant Change Minimum Data Set (MDS) assessment, dated 1/18/24, indicated the resident was moderately cognitively impaired, had one fall with major injury since the prior assessment, and impaired range of motion to the upper extremity on one side.		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;** Licensed Nurses were re-educated on the need to document their fall assessments in PCC and Risk Management. Licensed Nurses were re-educated to ensure they are following all physician 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;** DON/Designee will audit all residents with falls, weekly for 6 months, to ensure fall assessments are completed in PCC and Risk Management. If any assessments were not completed, DON to follow up with Nursing staff to complete and document missing assessments for 6 months. DON/Designee will audit 5 Wound MD orders weekly for 6 months, for any changes noted to residents' treatment orders. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee,	

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	A Progress Note, dated 12/29/23 at 12:23 p.m., indicated the resident complained of left arm pain and bruising was noted to the clavicle and shoulder area. An order was received for an x-ray. A Progress Note, dated 12/29/23 at 5:55 p.m., indicated the x-ray results indicated an acute left clavicle fracture. There was a lack of a post fall assessment or any fall documentation. A Nurse Practitioner (NP) Note, dated 12/29/23 at 7:39 p.m., indicated "...She is seen today for staff reporting that patient was complaining of pain to left shoulder...The patient reports she fell a few days ago, staff were not aware. The patient is now complaining of left arm/shoulder pain and had a fading bruise to left chest area...Left shoulder/clavicle pain. X-ray revealed acute distal left clavicle fracture..." An IDT (Interdisciplinary Team) Note, dated 12/29/23 at 6:24 p.m., indicated "...This resident complained of left shoulder pain approximately 12:20 p.m. The resident was assessed by the nurse and noted to have pain and bruising/yellow discoloration to her left shoulder area. She scored a 2/10 for pain. She received acetaminophen 650 mg (milligrams) for the discomfort. The NP was notified, and an x-ray was ordered. The x-ray revealed an acute left clavicle fracture. An investigation was immediately initiated, and interviews were conducted. Upon further investigation, it was determined the resident had an incident a week before where she was observed on the floor. There were no witnesses on how the resident got to the floor. Resident was not able to recall if she fell or what occurred.		auditing and monitoring will be done quarterly and will be presented quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 4.16.24**	

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	Probable cause of fracture is likely a result from incident of resident on the floor where she was observed lying on her left side. This was the same side where she was complaining of pain, had the bruising/yellow discoloration and where the clavicle fracture is located..." An IDOH (Indiana Department of Health) reportable incident investigation, dated 12/20/23, indicated the CNA who was working on 12/29/23 indicated she had received in report, approximately 1 week prior, that this resident had a fall during the midnight shift. The CNA who was working on 12/23/23 on the 12 a.m. to 6 a.m. shift was interviewed, and indicated the resident was observed lying on her left side on the floor next to her bed at approximately 4:45 a.m. The CNA had informed the nurse that the resident was on the floor. The nurse came into the room and asked the resident if she was ok. According to the CNA's statement, the resident indicated she was ok, but her shoulder hurt. The nurse was not observed doing any assessment and the resident was assisted back to bed. When the nurse was interviewed during the investigation, he indicated he did not recall the fall. The nurse was suspended. During an interview with the Administrator, on 3/20/24 at 1:25 p.m., she indicated the nurse was no longer employed by the facility. They had completed an inservice regarding fall documentation and put a performance improvement plan in place.3. On 3/20/24 at 2:35 p.m., LPN 3 was observed during a wound dressing change for Resident 27. She washed her hands and donned clean gloves. She removed the old dressing from his left medial calf, which was dated 3/19/24 on 7 a.m. to 3 p.m. shift. She removed her gloves and donned clean gloves. She			

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	did not perform hand hygiene between changing her gloves. She washed the wound with normal saline and applied a Vaseline dressing to the wound and then wrapped the calf with kerlix. Resident 27's record was reviewed on 3/20/24 at 9:51 a.m. Diagnoses included, but were not limited to, hypertensive heart disease with heart failure, chronic respiratory failure, and peripheral vascular disease. The State Optional MDS, dated 2/2/24, indicated he was cognitively intact for daily decision making. A Care Plan, dated 3/18/24, indicated the resident had a traumatic hematoma to his left medial calf. Interventions included, but were not limited to, observe area at least daily, document weekly until resolved, and render treatment per order. A Physician's Order, dated 3/17/24, indicated apply Vaseline dressing to the left inner calf and wrap with kerlix every day shift and as needed. A Wound Evaluation and Management Summary, dated 3/15/24, indicated a new order for the non-pressure wound of the left, medial calf for betadine, apply once daily for 30 days. During an interview, on 3/20/24 at 2:51 p.m., LPN 3 indicated she was following the order on the current Physician's Order Summary, and the Wound Nurse had not updated the order in the system for the betadine. During an interview on 3/20/24 at 3:23 p.m., the Director of Nursing indicated the order should have been updated and followed for wound care.			

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F 0686 SS=D Bldg. 00	3.1-37(a) 483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure ulcer care was provided as ordered and a pressure ulcer was correctly assessed, for 2 of 4 residents reviewed for pressure ulcers. (Residents 49 and B) Findings include: 1. On 3/20/24 at 1:26 p.m., Resident 49's wound care was observed with LPN 4. The LPN removed a Flagyl (antibiotic) 500 milligram (mg) tablet from the cart, crushed it and poured it into a medicine cup. She gathered additional supplies, then indicated she had not seen the wound before and did not know if there were one or two areas. She removed another Flagyl 500 mg tablet, crushed it and poured it into the same medicine cup. The resident was positioned on her side. The old dressing was removed from her sacral area. There	F 0686	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** 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. **F686- Treatments/Svcs to Prevent/Heal Pressure Ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 49 was assessed for any	04/16/2024

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	was a full thickness wound with reddened edges, approximately 10 centimeters (cm) wide by 10 cm long. The area was cleansed with normal saline and gauze. The nurse then sprinkled all the crushed Flagyl over the area, applied calcium alginate and covered with a dry dressing. Resident 49's record was reviewed on 3/19/24 at 2:10 p.m. Diagnoses included, but were not limited to, heart disease, macular degeneration and a stage 3 pressure ulcer to the sacral region. The Admission Minimum Data Set (MDS) assessment, dated 1/14/24, indicated the resident was cognitively intact and required extensive staff assistance for bed mobility and transfers. A Physician's Order, dated 3/11/24, indicated Flagyl 500 mg, crush and sprinkle medication to wound bed every Monday, Wednesday and Friday. Cleanse with normal saline, sprinkle medication, apply calcium alginate and cover with a dry dressing. During an interview on 3/20/24 at 1:45 p.m., LPN 4 indicated she had crushed two tablets because she didn't know if it was one or two areas, and she should have clarified the treatment order. 2. During a wound care treatment observation for Resident B, on 3/22/24 at 9:35 a.m., the Wound Nurse performed hand hygiene and donned clean gloves. She removed the old dressing, dated 3/21/24. She removed her gloves, performed hand hygiene, and donned clean gloves. She washed the wound with normal saline and a 4x4 gauze. She removed her gloves, performed hand hygiene, and donned clean gloves. She used a phone camera and took a picture of the wound to retrieve measurements for her documentation and open the assessment. The Wound Nurse indicated the		additional skin alterations, and none were noted. Wound assessments have been completed. Resident 49 no longer resides in the facility. Resident B was assessed for any additional skin alterations, and none were noted. Wound assessments have been completed. **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;** Nursing staff were re-educated to ensure wound treatments and skin care are completed using proper techniques and wound assessments are completed correctly. **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 3 wound dressing changes and ensure that the wound assessments have been completed 3x's/week for 6	

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	camera captured the measurements, but took the measurement of his whole heel and not just the wound. She performed hand hygiene, donned new gloves, and measured the wound using a paper tape measure. The wound measured 3.4 cm by 3.0 cm. She measured the small reddened open area in the middle of the wound about the size of a pencil eraser. The medial heel had an area that was discolored, however the nurse indicated that was not part of the heel wound, and it was only the reddened open area. She then poured betadine into a cup. The betadine had no patient label or instructions for use on it. The Wound Nurse indicated it was house stock. She then placed a 4x4 gauze into the cup to soak up the betadine. She wiped the 4x4 soaked gauze from the most distal portion of the wound across the middle towards the most proximal part of the wound. She applied a clean 4x4 gauze to the wound bed and wrapped the wound with kerlix. She removed her gloves and washed her hands. Resident B's record was reviewed on 3/21/24 at 10:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, pressure ulcer of left heel, colostomy status, and benign prostatic hyperplasia (an enlarged prostate). The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/23, indicated the resident was severely cognitively impaired for daily decision making. He had 1 stage 4 pressure ulcer. A Physician's Order, dated 6/14/23, indicated evaluate left lateral heel wound/peri-wound for complications, including symptoms of infection, every day shift. A Physician's Order, dated 9/29/23, indicated cleanse left heel stage 4 pressure injury with		months, to ensure proper wound dressing techniques are being practiced. The nurse manager/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 will be presented quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 4.16.24**	

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	normal saline, apply betadine to wound bed, cover with 4x4 gauze and wrap with kerlix, with no compression, daily and as needed. A Care Plan, dated 5/10/23, indicated the resident admitted with a stage 4 pressure injury to his left heel. Interventions included, but were not limited to, administer treatments as ordered and assess and document appearance of the area at least weekly and as needed. A Skin and Wound Evaluation, dated 2/16/24 at 4:45 a.m., indicated the resident had a pressure injury stage 4 to the left heel measuring 3.9 cm by 3.0 cm by 1.8 cm. The wound bed description, exudate description, periwound description, and wound pain description were left blank. A Skin and Wound Evaluation, dated 2/27/24 at 1:06 p.m., indicated the resident had a pressure injury stage 4 to the left heel measuring 0.6 cm by 0.7 cm by 2.2 cm. The notes section indicated the wound measured 3.0 cm by 1.8 cm. The wound bed description, exudate description, periwound description, and wound pain description were left blank. A Skin and Wound Evaluation, dated 2/28/24 at 7:44 a.m., indicated the resident had a pressure injury stage 4 to the left heel measuring 8.5 cm by 3.1 cm by 3.9 cm. The treatment was intact,. It was cleansed with normal saline, painted with betadine, and wrapped with kerlix. The wound was stable. The wound bed description, exudate description, periwound description, and wound pain description were left blank. A Skin and Wound Evaluation, dated 3/8/24 at 1:18 p.m., indicated the assessment was still in progress.			

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	A Skin and Wound Evaluation, dated 3/15/24 at 8:15 a.m., indicated the resident had a pressure injury stage 4 to the left heel measuring 0.1 centimeters (cm) by 0.6 cm by 0.3 cm. The treatment was intact,. It was cleansed with normal saline, painted with betadine, and wrapped with kerlix. The wound was stable. The wound bed description, exudate description, periwound description, and wound pain description were left blank. During an interview on 3/22/24 at 9:25 a.m., the Wound Nurse indicated she was never instructed that she had to fill out the entire assessment. She just did the measurements with the camera. She would have to clarify with the Physician what he would like her to do weekly. The other Wound Physician usually did the full assessment when he came to evaluate the residents, and she would use his notes for the weekly assessment. During an interview, on 3/22/24 at 9:33 a.m., the Interim Director of Nursing (DON) indicated the Wound Nurse should have done a thorough assessment and included all of the information on the wound documentation, including, but not limited to, the wound bed, periwound, and exudate descriptions. There was a discrepancy with wound measuring because the assessments were only opened once they used a camera to measure the wounds. The nurse could not override the measurements on the assessment. The nurse also should have applied the betadine using betadine swabs. 3.1-40(a)(2)			
F 0692 SS=D	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance			

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Bldg. 00	§483.25(g) Assisted nutrition and hydration. (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)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. Based on observation, record review, and interview, the facility failed to complete meal consumption logs for a resident with a history of weight loss, for 1 of 1 resident reviewed for nutrition. (Resident 78) Finding includes: On 3/19/24 at 9:45 a.m., Resident 78 was observed in the dining area eating breakfast, but falling asleep during breakfast time. The resident ate about 40% of her breakfast. The resident picked up a small piece of food and put it in her mouth, then fell asleep. The resident's breakfast tray was removed from in front of the resident. On 03/21/24 at 9:21 a.m., Resident 78 was asleep in bed. The resident's breakfast tray was on the food	F 0692	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** 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. **F692 Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	04/16/2024

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	cart in the hallway and was untouched by the resident. Breakfast service time was at 7:00 a.m. The record for Resident 78 was reviewed on 3/18/24 at 9:39 a.m. Diagnoses included, but were limited to, unspecific dementia, behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. The 1/25/24 State Optional Minimum Data Set (MDS) assessment indicated the resident required supervision and set up help for eating. The resident was cognitively impaired. A Care Plan, dated 2/6/24, indicated the resident required a regular diet and the resident was noted to have had a significant weight loss in 3 months. The approaches were to monitor food consumption, supervise and set up the resident for meals. A Nutritional Intake Assessment, dated 2/21/24 through 3/20/24, indicated the resident's meal consumption logs were not being monitored daily for three meals per day. No refusals of meals were documented for the period of 2/21/24 through 3/20/24. During an interview, on 3/21/24 at 10:42 a.m., the Director of Nursing indicated the staff should properly document every meal the resident consumes or refuses, especially for a resident with weight loss. 3.1-46(a)		Resident 78's meal logs were incomplete at times; RD continues to follow for Nutrition at Risk. **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;** Nurses, QMA's and CNAs were in-serviced on obtaining accurate weights and documentation of meal consumption. **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 the PCC residents' meal consumption report 3x/week for 6 months, to monitor meal intake trends. The DON/designee will communicate meal intake reductions to the dietician and MD/NP for review and intervention. 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	

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	155637	A. BUILDING 00 B. WING	03/22/2024

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			Quality Assurance committee, auditing and monitoring will be done quarterly and will be presented quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 4.16.24**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure food was stored under sanitary conditions, related to unlabeled and undated food and beverages, and a scoop stored in the dry food storage bin, for 2 of 4 refrigerators reviewed (Main Kitchen), as well as unlabeled and undated staff	F 0812	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** Please accept the following as the facility's credible allegation of compliance. This plan of	04/16/2024

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	beverages in 1 of 2 unit refrigerators (Grace Point 2 Unit) observed. This had the potential to affect 103 residents who received food from the kitchen. Findings include: 1. During the initial tour of the kitchen, with Chef 1 on 3/18/24 at 9:12 a.m., the following observations were made: a. There was an unlabeled and undated beverage in the dessert refrigerator. b. There was an unlabeled and undated pan of rice in the cook's refrigerator. c. In the dry storage room, there was a scoop stored in the rice bin. During an interview, on 3/18/24 at 9:15 a.m., Chef 1 indicated food and drinks should be labeled and dated and there should not be scoops stored in the bins. 2. During an observation of the Grace Point 2 Unit refrigerator, with LPN 4 on 3/21/24 at 2:55 p.m., there were unlabeled and undated staff beverages stored in the refrigerator. During an interview at the time, LPN 4 indicated the staff should not use the unit refrigerators for their personal use. 3.1-21(i)(3)		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F812 Food Procurement, Store/Prepare/Serve-Sanitary** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** The unlabeled and undated beverages found in the kitchen's dessert refrigerator have been labeled and dated. The unlabeled and undated pan of rice found in the cook's refrigerator in the kitchen have been labeled and dated. The scoop in the rice bin in the kitchen's dry storage room has been removed and put back into the scoop holder. The unlabeled and undated staff beverages stored in the Gracepoint 2-unit refrigerator have been removed. **How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice?**	

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			The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Dietary staff were educated on ensuring food and beverages are labeled and dated in the kitchen and ensuring the scoops are stored in the appropriate location and not in the food bins. All staff were re-educated to ensure no staff foods/drinks are stored in the Resident designated refrigerators. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Culinary Manager/designee will audit the kitchen and GracePoint's refrigerators to ensure all foods and beverages are labeled and dated, and rice scoops are stored in the appropriate location 5x's/week for 6 months. 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	

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			done quarterly and will be presented quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 4.16.24**	
F 0880 SS=D 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. 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 §483.70(e) 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			

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	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 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	F 0880	**Crown Point Christian Village**	04/16/2024

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	interview, the facility failed to ensure infection control practices and standards were maintained, related to staff touching pills during medication administration, for 2 of 5 residents observed during the medication administration observation, and lack of hand hygiene during wound care, for 1 of 4 residents reviewed for pressure ulcers. (Residents 67, 47, and 27) Finding includes: 1. On 3/19/24 at 9:57 a.m., LPN 1 was observed preparing Resident 67's medications. She opened the pre-packaged medication pouch and poured the pills in to her hand, then placed them in a medicine cup. She then administered the medications. During an interview with LPN 1 at that time, she indicated she wasn't aware she was touching the pills and was not aware she shouldn't touch the medications with her hands. During an interview, on 3/19/24 at 10:15 a.m., the Director of Nursing (DON) indicated the nurse should not have been putting the pills in her hand and then administering them. 2. On 3/20/24 at 8:59 a.m., QMA 1 was observed preparing Resident 47's medications. She popped one hydrocodone/acetaminophen 5/325 mg (milligram) tablet from the medication card into her hand and then put it in a medication cup. She dispensed 1 capsule of Linzess 290 mcg (micrograms) from the bottle into her hand. She opened the capsule with her hands, and poured the medication into a medication cup. She then administered the medications. During an interview with QMA 1 at that time, she		**Annual/ Complaint Survey: 3.22.24** 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. **POC F-880 Infection Prevention & Control** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** QMA was immediately re-educated related to dispensing medications into gloved hand rather than bare hand during med pass. LPN was immediately re-educated related to dispensing medications into gloved hand rather than bare hand during med pass. LPN was immediately re-educated related to hand washing in between each glove change during resident wound care. **How the facility will identify other residents having the potential to be affected by the**	

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	indicated she was not aware she couldn't touch the medications with her hands. During an interview on 3/20/24 at 9:14 a.m., the Assistant Director of Nursing (ADON) indicted the QMA should have put on gloves before touching any pills.3. On 3/20/24 at 2:35 p.m., LPN 3 was observed during wound dressing changes for Resident 27. She washed her hands and donned clean gloves. She removed the old dressing from his left medial calf, which was dated 3/19/24 on the 7 a.m. to 3 p.m. shift. She removed her gloves and donned clean gloves. She did not perform hand hygiene between changing her gloves. She washed the wound with normal saline and applied a Vaseline dressing to the wound, and then wrapped the calf with kerlix. She removed her gloves and donned clean gloves. She did not perform hand hygiene. She removed the dressing to the right calf, dated 3/19/24. She removed her gloves and applied new gloves without performing hand hygiene. She then wrapped the right calf with kerlix. She removed her gloves and performed hand hygiene. She washed the wound on the resident's coccyx with normal saline and patted dry with gauze. She removed her gloves and donned clean gloves. She did not perform hand hygiene between glove use. She applied maxorb alginate to the wound and then applied a padded foam dressing. She removed her gloves and washed her hands. During an interview, on 3/20/24 at 2:51 p.m., LPN 3 indicated she should have washed her hands between glove changes. During an interview, on 3/20/24 at 3:23 p.m., the Director of Nursing indicated the nurse should		**same deficient practice:** All residents have 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:** Christian Horizons Clinical Nurse Consultant with Infection Preventionist Certification re-educated the facility Administrator, Director of Nursing and Assistant Director of Nursing related to dispensing medications into gloved hand rather than bare hand and hand washing in between glove changes during resident wound care. Clinical staff re-educated related to dispensing medications into gloved hand rather than bare hand during med pass. Clinical staff re-educated related to hand washing in between each glove change during resident wound care. **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	

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	have performed hand hygiene between glove use. 3.1-18(b)		observation audits for 5 med pass/ wound treatments 3 times weekly for 3 months, then 5 med pass/wound treatments weekly for 3 months, to ensure compliance of infection control practices. 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 will be presented quarterly at the QA meeting. Monitoring will be on going. **Dates when corrective action will be completed: 4.16.24**	
F 0940 SS=D Bldg. 00	483.95 Training Requirements §483.95 Training Requirements A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their			

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	expected roles. A facility must determine the amount and types of training necessary based on a facility assessment as specified at § 483.70(e). Training topics must include but are not limited to- Based on observation and record review, the facility failed to ensure agency staff were provided adequate orientation to the facility and residents care needs, related to Agency CNA 1 delivering a meal tray to a resident who was NPO (nothing by mouth), for a random observation on the 200 C hall. This had the potential to affect 3 residents residing in the facility who were NPO. Finding includes: On 3/21/24 at 11:48 a.m., Agency CNA 1 was observed delivering Resident C's lunch tray. She placed Resident C's tray on Resident B's bedside table and exited the room. Resident B was observed sitting in his bed with his eyes open. On 3/21/24 at 11:51 a.m., CNA 1 entered Resident B's room, picked up Resident C's tray from Resident B's bedside table and proceeded to assist Resident C with his lunch. Resident B's record was reviewed on 3/21/24 at 10:32 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, pressure ulcer of left heel, colostomy status, and benign prostatic hyperplasia (an enlarged prostate). The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/23, indicated the resident was severely cognitively impaired for daily decision making. A Physician's Order, dated 6/13/23, indicated	F 0940	**Crown Point Christian Village Annual/ Complaint Survey 3.22.24** 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 940 Training Requirements** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Agency CNA 1 provided a tray to NPO resident. The tray was removed immediately, the resident did not touch/eat any of the food. Agency CNA 1 has not returned to work at the facility. The facility failed to provide orientation for agency staff. The facility has implemented an orientation checklist and binder with policies and procedures to be completed prior to the start of the new agency staff's shift. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	04/16/2024

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	Resident B was on an NPO diet. A Care Plan, dated 5/10/23, indicated Resident B required a tube feeding related to oral and pharyngeal dysphagia. Interventions included, but were not limited to, resident is NPO. During an interview, on 3/21/24 at 1:44 p.m., CNA 1 indicated she had provided Agency CNA 1 a short orientation using a cheat sheet that she had made. The sheet provided information on residents who required assistance, were NPO (not eating or drinking by mouth), and other special care instructions. Agency CNA 1 had placed Resident C's lunch tray on Resident B's bedside table. She had gone into the room to assist Resident C with his lunch, and observed the tray on the wrong bedside table. She indicated Resident B was NPO and should not have received a tray. She had spoken to Agency CNA 1 and she did not know which resident was in bed 1 or 2. Both residents in the room were non-interviewable. CNA 1 indicated she was having to provide orientation to a lot of agency staff, as they would come work for a short amount of time and not return. She had to follow behind the agency staff and provide the care for the residents, as the agency staff did not know the residents and/or they just did not perform their job duties. They often were leaving their work for the next shift to complete. During an interview, on 3/21/24 at 1:54 p.m., the Director of Nursing indicated the agency staff should be oriented to the unit that they are working on and should know the residents who were NPO. She was unable to provide documentation of Agency CNA 1 receiving any orientation to the building and the residents care needs.		**taken;** All NPO 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;** Facility staff were re-educated to ensure prior to agency staff beginning their first shift with facility, they will orientate to facility's policies and procedures and complete facility tour. The completed sheets will be kept in a binder with the scheduler. **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 conduct a weekly audit to ensure all new agency staff have completed their onboarding orientation papers and have reviewed the facility's policies and procedures and completed facility tour. 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 will be presented quarterly at the QA meeting. Monitoring will be on going.	

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	This citation relates to Complaint IN00429849 and IN00429192. 3.1-13(b)(1)		**Date of completion: 4.16.24**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00429849, IN00429448, IN00429192, and IN00428708. Complaint IN00429849 - Federal/State deficiencies related to the allegations are cited at F940. Complaint IN00429448 - No deficiencies related to the allegations are cited. Complaint IN00429192 - Federal/State deficiencies related to the allegations are cited at F940. Complaint IN00428708 - No deficiencies related to the allegations are cited. Survey dates: March 18, 19, 20, 21, and 22, 2024 Facility number: 001198 Residential Census: 48 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/1/24.	R 0000	The facility kindly requests a desk review.	
R 0045	410 IAC 16.2-5-1.2(r)(6-9) Residents' Rights - Deficiency			

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Bldg. 00	(6) Before an interfacility transfer or discharge occurs, the facility must, on a form prescribed by the department, do the following: (A) Notify the resident of the transfer or discharge and the reasons for the move, in writing, and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident ' s clinical record and transmit a copy to the following: (i) The resident. (ii) A family member of the resident if known. (iii) The resident ' s legal representative if known. (iv) The local long term care ombudsman program (for involuntary relocations or discharges only). (v) The person or agency responsible for the resident ' s placement, maintenance, and care in the facility. (vi) In situations where the resident is developmentally disabled, the regional office of the division of disability, aging, and rehabilitative services, who may assist with placement decisions. (vii) The resident ' s physician when the transfer or discharge is necessary under subdivision (4)(C), (4)(D), (4)(E), or (4)(F). (B) Record the reasons in the resident ' s clinical record. (C) Include in the notice the items described in subdivision (9). (7) Except when specified in subdivision (8), the notice of transfer or discharge required under subdivision (6) must be made by the facility at least thirty (30) days before the resident is transferred or discharged. (8) Notice may be made as soon as practicable before transfer or discharge when:			

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	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	(A) the safety of individuals in the facility would be endangered; (B) the health of individuals in the facility would be endangered; (C) the resident ' s health improves sufficiently to allow a more immediate transfer or discharge; (D) an immediate transfer or discharge is required by the resident ' s urgent medical needs; or (E) a resident has not resided in the facility for thirty (30) days. (9) For health facilities, the written notice specified in subdivision (7) must include the following: (A) The reason for transfer or discharge. (B) The effective date of transfer or discharge. (C) The location to which the resident is transferred or discharged. (D) A statement in not smaller than 12-point bold type that reads, " You have the right to appeal the health facility ' s decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing with the Indiana state department of health postmarked within ten (10) days after you receive this notice. If you request a hearing, it will be held within twenty-three (23) days after you receive this notice, and you will not be transferred from the facility earlier than thirty-four (34) days after you receive this notice of transfer or discharge unless the facility is authorized to transfer you under subdivision (8). If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Indiana state department of health at the number listed below. " . (E) The name of the director and the address,			

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	155637	A. BUILDING 00 B. WING	03/22/2024

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	telephone number, and hours of operation of the division. (F) A hearing request form prescribed by the department. (G) The name, address, and telephone number of the state and local long term care ombudsman. (H) For health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection and advocacy services commission. Based on record review and interview, the facility failed to ensure a transfer form was completed and a discharge was documented, for 1 of 7 records reviewed. (Resident 8) Finding includes: The closed record for Resident 8 was reviewed on 3/21/24 at 2:58 p.m. Diagnoses included, but were not limited to, dementia and anxiety. A Progress Note, dated 2/15/24 at 2:30 p.m., indicated the resident was found on the floor in his room and complained of neck pain. 911 was called and the resident was sent to the hospital for evaluation. There was no transfer form or discharge paperwork available for review. The resident had not returned to the facility. During an interview with the Wellness Director, on 3/21/24 at 3:33 p.m., she indicated the resident had a fall and was sent to the hospital. From the hospital he was discharged home with his family. She was unable to provide any transfer form, discharge paperwork, or documentation that the resident would not be returning to the facility and his belongings were picked up.	R 0045	**Crown Point Christian Village Annual Survey 03/22/24** 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. R 045 Residents' Rights **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R8 is no longer a resident of the facility. Transfers forms and discharges are now being documented in the clinical records. **How will facility identify other residents who have the potential to be affected by the**	04/16/2024

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			same alleged deficient practice? The deficient practice has the potential to affect all residents, but no other residents were identified. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** The AL Nurses were educated on ensuring transfer forms and discharges are completed and documented in the clinical records. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The AL Nurse Manager and/or designee will complete random audit on residents to ensure transfer forms and discharges are completed and there is documentation in the clinical records. The AL Nurse Manager and/or designee will review the audit/log to ensure compliance for the next six months. A summary of the audits will be presented to the Quality Assurance committee for review.	

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	155637	A. BUILDING 00 B. WING	03/22/2024

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			By what date the systemic changes will be completed? April 16, 2024	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure fire drills were conducted each shift per quarter, failed to document who participated in the fire drills, and also failed to invite the fire department to participate in fire drills every six months as required. This had the potential to affect all 48 residents in Assisted	R 0092	**Crown Point Christian Village Annual Survey 03/22/24** 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	04/16/2024

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	Living. Findings include: 1. The annual fire drill documents were reviewed on 3/22/24. There was no fire drill conducted on the night shift during the first quarter (January, February and March) of 2023. There was no fire drill conducted on the evening or night shift during the second quarter (April, May and June) of 2023. 2. The fire drills conducted in March and September, 2023 included the signatures of the staff members who participated in the fire drill. There was no documentation of the participants in the fire drills the remaining ten months of 2023. 3. The fire drill records lacked documentation the fire department had participated in any of the drills. An e-mail, dated 3/13/23, indicated the local fire department had been to the facility and participated in a fire drill. There was no documentation of another invitation to the fire department in 2023. During an interview, on 3/22/24 at 11:28 a.m., the Maintenance Director indicated he had not invited the fire department to participate in fire drills every six months last year, just the one time in March as indicated in the e-mail. He had no additional information related to the fire drills not conducted each shift per quarter, and indicated he would include participants names from now on.		facility and is submitted only in response to the regulatory requirement. R 092 Administration and Management **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Fire drills are now being completed on each shift per quarter. Fire drill participation are now being documented. The fire department was invited to participate in fire drills every six months as required. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** The maintenance team was educated on following the facility's fire drill policy and ensuring all	

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			associates who participates in the fire drill signs the participation form. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The Maintenance Manager and/or designee will complete a monthly audit of all fire drills to ensure the participation forms are signed by associates who were present for the drill and compliance with the fire drill policy. The Maintenance Manager and/or designee will review the audit to ensure compliance for the next six months. A summary of the audits will be presented to the Quality Assurance committee for review. **By what date the systemic changes will be completed?** April 16, 2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food was stored under sanitary	R 0273	**Crown Point Christian Village Annual Survey 03/22/24**	04/16/2024

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	conditions, related to unlabeled and undated food and beverages, and a scoop stored in the dry food storage bin, for 2 of 4 refrigerators reviewed. (Main Kitchen) This had the potential to affect 48 residents who received food from the kitchen. Findings include: During the initial tour of the kitchen, with Chef 1 on 3/18/24 at 9:12 a.m., the following observations were made: a. There was an unlabeled and undated beverage in the dessert refrigerator. b. There was an unlabeled and undated pan of rice in the cook's refrigerator. c. In the dry storage room, there was a scoop stored in the rice bin. During an interview, on 3/18/24 at 9:15 a.m., Chef 1 indicated food and drinks should be labeled and dated and there should not be scoops stored in the bins.		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. R 273 Food and Nutritional Services **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All beverages and food items were labeled and dated. The scoop was removed from the rice bin. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** All dietary staff were educated on ensuring that food was stored under sanitary conditions and	

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			food. All beverages and food items must be labeled and dated. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The Dietary Manager and/or designee will conduct 3 random inspections weekly in the kitchen to ensure compliance. The Dietary Manager and/or designee will review the inspections to ensure compliance for the next six months. A summary of the audits will be presented to the Quality Assurance committee for review. **By what date the systemic changes will be completed?** April 16, 2024	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible.			

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	(4) Systematically organized. Based on record review and interview, the facility failed to ensure Physician's orders were in place for a wound treatment, for 1 of 7 records reviewed. (Resident 5) Finding includes: Resident 5's record was reviewed on 3/21/24 at 1:37 p.m. The resident was readmitted to the facility on 2/26/24. Diagnoses included, but were not limited to, neuropathy, spinal stenosis and hypertension. He had wounds on both feet that required treatments by home health. The Admission Service Plan, dated 2/26/24, indicated home health would provide wound care to bilateral feet. Physician's Orders lacked a treatment order for the wounds on the feet. During an interview with the Wellness Director, on 3/21/24 at 2:45 p.m., she indicated the resident had arterial wounds on the tops of both feet. Home health was coming in to provide treatment twice weekly and they were wrapping the feet. She indicated if the dressing became loose or soiled, the facility nurses could replace the dressing. She was made aware there was no treatment order in place, and indicated she would contact home health to obtain the treatment order.	R 0349	**Crown Point Christian Village Annual Survey 03/22/24** 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. R 349 Clinical Records **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R5 treatment orders were transcribed to the POS. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all residents, but no other residents were identified. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** AL Nurses were educated on ensuring treatment orders were transcribed to POS.	04/16/2024

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	03/22/2024

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			What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent? The AL Nurse Manager and/or designee will complete 3 random audits weekly to ensure all treatment orders were transcribed to POS. The AL Nurse Manager and/or designee will review the audit to ensure compliance for the next six months. A summary of the audits will be presented to the Quality Assurance committee for review. **By what date the systemic changes will be completed?** April 16, 2024	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance (i) A current emergency information file shall be immediately accessible for each resident, in case of emergency, that contains the following: (1) The resident ' s name, sex, room or apartment number, phone number, age, or date of birth. (2) The resident ' s hospital preference. (3) The name and phone number of any legally authorized representative. (4) The name and phone number of the			

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	155637	A. BUILDING 00 B. WING	03/22/2024

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CROWN POINT CHRISTIAN VILLAGE	6685 EAST 117TH AVENUE CROWN POINT, IN 46307

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	resident ' s physician of record. (5) The name and telephone number of the family members or other persons to be contacted in the event of an emergency or death. (6) Information on any known allergies. (7) A photograph (for identification of the resident). (8) Copy of advance directives, if available. Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information, for 4 of 5 residents reviewed. (Residents 2, 3, 5 and 6) Findings include: The resident Emergency Binder was reviewed on 3/21/24. The following information was missing: a. Resident 2 - missing allergies and hospital preference. b. Resident 3 - missing hospital preference. c. Resident 5 - missing birthdate/ age, address, phone number, sex, physician and hospital preference. d. Resident 6 - missing allergies, birthdate/ age, address, phone number, sex, physician and hospital preference. During an interview with the Wellness Director, on 3/21/24 at 2:45 p.m., she was made aware of the missing items and had no additional information.	R 0356	**Crown Point Christian Village Annual Survey 03/22/24** 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. R 356 Clinical Records **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** All the necessary information for all residents were updated in the emergency binder as needed. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all residents.	04/16/2024

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	155637	A. BUILDING 00 B. WING	03/22/2024

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			What corrective measures will the facility take or will alter to ensure that the problem will not recur? AL associates were re-educated on updating and revising the emergency binder as needed. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The AL Nurse Manager and/or designee will complete random audits weekly to ensure the emergency sheets are being updated and revised as needed. The AL Nurse Manager and/or designee will review the audit to ensure compliance for the next six months. A summary of the audits will be presented to the Quality Assurance committee for review. **By what date the systemic changes will be completed?** April 16, 2024	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to			

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	155637	A. BUILDING 00 B. WING	03/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation and interview, the facility failed to ensure infection control measures were in place and implemented, related to hand hygiene during medication pass, for 1 of 2 staff observed during medication pass. (QMA 2) Finding includes: On 3/21/24 at 12:35 p.m., QMA 2 was observed passing medications. She prepared and passed medications to Resident 9, then returned to her cart. She did not perform hand hygiene. She prepared and passed medications to Resident 10, then returned to her cart. She did not perform hand hygiene. She then prepared and passed medications to Resident 11, then returned to her cart and again did not perform hand hygiene. During an interview with the QMA after the observation, she indicated she thought she only had to perform hand hygiene every third person on assisted living during medication pass.	R 0407	**Crown Point Christian Village Annual Survey 03/22/24** 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. R 407 Infection Control **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** QMA 2 was educated on hand hygiene during medication pass. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all residents.	04/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
			What corrective measures will the facility take or will alter to ensure that the problem will not recur? AL nursing staff were re-educated on hand hygiene during medication pass. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The AL Nurse Manager and/or designee will conduct 2 random inspections weekly on nursing staff to ensure hand hygiene during medication pass. The AL Nurse Manager and/or designee will review the audit/log to ensure compliance for the next six months. A summary of the audits will be presented to the Quality Assurance committee for review. **By what date the systemic changes will be completed?** April 16, 2024	