PRINTED: 01/23/2025

STATEMENT OF DEFICIENCES AND PLAN OF CORRECTION  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  NAME OF PROVIDER OR SUPPLIER  CROWN POINT CHRISTIAN VILLAGE  SUMMARY STATEMENT OF DEFICIENCIE  (ACA) ID  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  This visit was for the Investigation of Complaints IN00442682, IN00442793, IN00442945, IN00443475, IN00447461, IN00448042, IN00449198, and IN00449316.  Complaint IN00442682 - No deficiencies related to the allegations are cited.  Complaint IN00442794 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00442916 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00449198 - Federal/state deficiencies related to the allegations are cited.  Complaint IN0044916 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00449198 - Federal/state deficiencies related to the allegations are cited.  Complaint IN0044916 - Foderal/state deficiencies related to the allegations are cited.  Complaint IN0044916 - Foderal/state deficiencies related to the allegations are cited.  Complaint IN0044916 - Foderal/state deficiencies related to the allegations are cited at F684.  Complaint IN0044916 - No deficiencies related to the allegations are cited at F684.  Complaint IN0044916 - Foderal/state deficiencies related to the allegations are cited.	DEPARTMENT OF HEALTH AND HUMAN SERVICES							RM APPROVED
AND PLAN OF CORRECTION 155637  NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR I.SC IDENTIFYING INFORMATION  TAG REGULATORY OR I.SC IDENTIFYING INFORMATION  FO 0000  Bidg. 00  Complaint IN00442682, IN00449793, IN00442945, IN00443475, IN00443475, IN0044761, IN0044704, IN00447049, Inc.  Complaint IN00442545 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00443475 - No deficiencies related to the allegations are cited.  Complaint IN00443475 - No deficiencies related to the allegations are cited.  Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited.  Complaint IN0044793 - No deficiencies related to the allegations are cited.  Complaint IN004479198 - Federal/state deficiencies related to the allegations are cited.  Complaint IN00449316 - No deficiencies related to the allegations are cited.  Complaint IN00449316 - No deficiencies related to the allegations are cited.	CENTERS FOR	R MEDICARE & MEDIC	CAID SERVICES				OM	B NO. 0938-039
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Survey dates: December 17, 18 and 19, 2024

Facility number: 001198 Provider number: 155637 AIM number: 100471000

Census Bed Type:

TITLE

(X6) DATE

Natalie Porcaro Administrator 01/07/2025

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: UT3E11 Facility ID: 001198 If continuation sheet Page 1 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155637 B. WING 12/19/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 6685 EAST 117TH AVENUE CROWN POINT CHRISTIAN VILLAGE **CROWN POINT. IN 46307** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE SNF/NF: 88 SNF: 13 Residential: 42 Total: 143 Census Payor Type: Medicare: 9 Medicaid: 73 Other: 19 Total: 101 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/26/24. F 0580 483.10(g)(14)(i)-(iv)(15) SS=D Notify of Changes (Injury/Decline/Room, etc.) Bldq. 00 Based on record review and interview, the facility F 0580 **Crown Point Christian Village** 01/07/2025 failed to notify a resident's physician and **Complaint Survey** responsible party in a timely manner related to 12.19.24 abnormal laboratory results for 1 of 3 residents Please accept the following as the reviewed for change in condition (Resident F). facility's credible allegation of compliance. This plan of Finding includes: correction does not constitute an admission of guilt or liability by the Resident F's record was reviewed on 12/17/24 at at facility and is submitted only in 9:42 a.m. The diagnoses included, but were not response to the regulatory limited to, Alzheimer's disease, dementia, requirement. colostomy status, iron deficiency anemia, and F 580 NOTIFY OF CHANGES congestive heart failure. The Quarterly Minimum Data Set (MDS) What corrective action(s) will be assessment, dated 9/12/24, indicated the resident accomplished for those residents was severely cognitively impaired for daily found to have been affected by the decision making. He was dependent on staff for all deficient practice; activities of daily living including, but not limited to, hygiene, toileting, and transfers. The resident Resident F had no adverse effects

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had an ostomy and required oxygen therapy.

Event ID:

UT3E11

Facility ID: 001198

If continuation sheet

from lack of notification. Resident

Page 2 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 12/19/2024
	PROVIDER OR SUPPLIER POINT CHRISTIAN		6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
PREFIX TAG	A Nurses' Note, dat indicated the reside lungs with no impro treatments were adriad A Nurses' Note, dat indicated the reside blood draw for a CI BMP (basic metaborate blood sample w 8/31/24. It was report on 8/31/24. There were follows:  Red blood cells: 2 4.7-6.1)  Hemoglobin: 8.5 ( Hematocrit: 30.9 ( Platelet count: 13/2150-400)  There were no note the family represent results of the laborate A Physician's Order resident was to have were abnormal results. White blood cells: 4.8-10.8)	ed 8/30/24 at 9:23 a.m., and thad audible crackles in the overment after nebulizer ministered per orders.  ed 8/30/24 at 3:43 p.m., and the state of the facility at 3:43 p.m., and the state of the next day.  ed 8/30/24 at 3:43 p.m., and and alcordary.  ed 8/30/	PREFIX TAG	F's MD and family have been notified of abnormal lab result  How the facility will identify off residents having the potential be affected by the same deficipractice and what corrective a will be taken;  The Director of Nursing, Infect Preventionist, unit managers, designees conducted a review residents' physician orders and medical records to identify oth residents having the potential be affected by the alleged defipractice.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur;  Licensed nursing staff were in-serviced to ensure that notification of a resident's physician and responsible par completed in a timely manner related to abnormal laboratory results and to ensure all order including labs, are entered into computer.  How the corrective action(s) we monitored to ensure the deficipractice will not recur, i.e., who quality assurance programs we will assurance programs we wi	s.  ner to lient liction lition litio
	- Hemoglobin: 10.3 (normal reference range: 14-18)			put into place;	

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

Event ID:

UT3E11

Facility ID: 001198

DON/Designee will audit 10

If continuation sheet

Page 3 of 18

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S						
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		A. BUILDING 00			COMPLETED	
		155637	B. WI	NG		12/19/	/2024	
NAME OF F	PROVIDER OR SUPPLIER	· }			ADDRESS, CITY, STATE, ZIP COD			
					AST 117TH AVENUE			
CROWN	POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION s related to the Physician or		TAG			DATE	
		tative being notified of the			random residents weekly x 2 months, then 10 random resid	lont		
	results of the labora				bi-weekly x 2 months, then 10			
	results of the labora	nory testing.			residents monthly x 2 months			
	A Physician's Order	r, dated 12/6/24, indicated the			6 months, to ensure timely	101		
	resident was to have a stool occult blood test.				notification to physicians and			
					families related to the abnorm	al		
		cult Blood test, dated 12/6/24,			laboratory results and the lab			
		s were positive (blood found in			orders are being transcribed to	o the		
	stool).				POS/then notification.			
	There were no note	s to indicate the Physician or			The Director of Nursing/ desig	nee		
	the family representative were notified of the				will present a summary of the			
	abnormal laborator	y results.			interview findings to the Qualit	ty		
					Assurance committee monthly			
		ted 12/6/24 at 6:04 a.m.,			three months. Thereafter, the			
		nt had liquid black stool in his			facility if determined by the Qu	-		
	colostomy bag.				Assurance committee, auditing	g		
	A Nurses' Note dat	ted 12/7/24 at 6:10 a.m.,			and monitoring will be done quarterly and present quarterly	v at		
		nt had liquid black stool noted			the QA meeting. Monitoring w	-		
	in the colostomy ba	-			be on going.			
	A Hematalami Pan	ort, dated 12/7/24, indicated a			Data by which systemic			
		collected on 12/7/24 at 6:15 a.m.			Date by which systemic corrections will be complete	q.		
		ported to the facility on			1.7.25	<b>u</b> .		
		e abnormal results as follows:						
		.08 (normal reference range:						
	4.7-6.1)							
	_	(normal reference range: 14-18)						
	- Hematocrit: 30.4 (	(normal reference range: 42-52)						
	There were no orde	ers in the Electronic Health						
	Record (EHR) for t	he testing or any						
	corresponding notes	s related to notification to the						
	Physician or family	representative of the abnormal						
	laboratory results.							
	A Nurses' Note, dat	ted 12/9/24 at 10:26 a.m.,						
		rs were received to obtain a						

AND PLAN OF CORRECTION  IDENTIFICATION NUMBER  A BUILDING  N WING  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT CHRISTIAN VILLAGE  CX4 ID  SIMMARY STATEMENT OF DEFICIENCIE  FREER  GRACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  SREGULATORY OR ISC IDENTIFIVATION NUMBER  AND POINT, IN 46307  STATE CLOCKWIN POINT CHRISTIAN VILLAGE  STATE CLOCKWIN POINT CHRISTIAN VILLAGE  ID  PROPERLY  GRACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CX6MIP  STATE CLOCKWIN POINT, IN 46307  TAG  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  STREET ADDRESS, CITY, STATE, ZIP COD  GROWN POINT, IN 46307  CX5)  CROWN POINT, IN 46307  CX5)  CX5  CROWN POINT, IN 46307  CX5  CX5  CX5  CX5  CX5  CX5  CX5  CX	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
STREET ADDRESS, CITY, STATE, ZIP COD 6885 EAST 1177TH AVENUE CROWN POINT CHRISTIAN VILLAGE  (X4] ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX TAG REGULATORY OR IS CIDENTIFYING HINFORMATION stat CBC/BMP and stool occult blood test. Stool was collected and placed in the refrigerator for collection.  A Nurses' Note, dated 12-9/24 at 1:29 p.m., indicated new orders were received to send the resident to the Emergency Department for further evaluation due to abnormal laboratory results and dark turry stools. The resident's family representative was made aware.  During an interview on 12/19/24 at 10:05 a.m., the Director of Nursing (DON) indicated there was an order placed on 12/6/24 for the stool occult blood and lab draw for CBC/BMP, however the lab draw order did not get put into the FIRR and was only on a laboratory sip. This was due to the nurse on duty getting COVID-19 and having to leave the facility. When labs were completed when running her daily reports. This instance for Resident Focurred on a weekend, so the DON was responsible for maning the report and sending any notifications out to the Physician regarding lab values. The laboratory values were reported to the Physician on 12/9/24 but should have been reported immediately.  A facility policy titled, "Diagnostic Testing Services," and noted as current, indicated, "I. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physicians or orders. No diagnostic tests (laboratory and radiology) in accordance with the physicians orders. No diagnostic tests will be performed without specific physician orders in accordance with State law to include scope of practice laws. 2. Qualified nursing personnel will receive and review the diagnostic test reports and communicate the results to the	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
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		_						
ordering Physician. 3. Documentation of		_						

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UT3E11

Facility ID: 001198

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637	
NAME OF PROCESSION P	4
(X4) ID PREFIX TAG	(X5) COMPLETION DATE
5 0684 SS=D Bldg. 00	
	01/07/2025 the an the
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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>		COMPLETED	
		155637	B. W	ING		12/19/2	2024
				_	_		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD		
					AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	NT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	osteomyelitis of the	osteomyelitis of the vertebra, and neoplasm of the			administered as ordered.		
	spinal cord.						
	•				Resident M's family and MD w	/ere	
	The Admission Minimum Data Set (MDS)				notified of orders for neck colla		
	assessment, dated 10/26/24, indicated the resident				guidance on when the residen		
		act and dependent on staff for			should wear it and monitoring		
	ADLs (activities of daily living).				the skin under the neck collar		
	TIDES (decivities of daily fiving).				place. New orders for the necl		
	A Care Plan, dated 10/23/24, indicated the resident				collar, guidance on when the	`	
	had surgical sites to her neck and throat. There				resident should wear it, and		
	were no interventions related to the neck collar.				monitoring to the skin under the		
	were no interventions related to the neek contain				neck collar are in place for	16	
	A Nurse Practitioner Note, dated 12/11/24 at 7:18				Resident M's.		
	p.m., indicated the resident had a cervical				Resident W.S.		
	laminectomy (spinal surgery) on 10/16/24. The				How the facility will identify at	or	
		on 10/19/24 and the staples			How the facility will identify oth		
		0/31/24. "Soft cervical collar in			residents having the potential to be affected by the same deficient		
	place x [for] 3 weel	KS.			practice and what corrective a will be taken;	ction	
	The Physician's Or	der Summary, dated 12/2024,			will be taken,		
		or a neck collar, guidance on			The Director of Nursing, Infect	tion	
	-	hould wear it, or monitoring to			Preventionist, unit managers,		
	the skin under the r	_			designees conducted a review		
					residents' physician orders an		
	During an interview	v on 12/18/24 at 3:28 p.m., the			medical records to identify oth		
		g was made aware there were no		residents having the potential to			
	_	collar, guidance on when the			be affected by the alleged defi		
		ar it, or monitoring to the skin			practice.		
		ar. She indicated she would			What measures will be put ir	ıto	
		ther information was received.2.			place or what systemic		
		was reviewed on 12/17/24 at at			changes will be made to		
		noses included, but were not			ensure that the deficient		
	_	ner's disease, dementia,			practice does not recur;		
		ron deficiency anemia, and			practice does not recur,		
	congestive heart fai	-			LPN2, Wound nurse and licen	<sub>bea</sub>	
	congestive heart fai	nuic.			nursing staff have been in-ser		
	The Overtants Minimum Data Car (MDC)				to ensure residents receive the		
	The Quarterly Minimum Data Set (MDS)					E	
	assessment, dated 9/12/24, indicated the resident was severely cognitively impaired for daily				necessary care and services		
					related to orders and monitori	_	
	i decision making. H	le was dependent on staff for all	- [		place for a neck collar, preven	ıta I	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTI A. BUILD B. WING		onstruction  00	(X3) DATE COMPI 12/19	LETED
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE	-	
CROWN	POINT CHRISTIAN	N VILLAGE	С	ROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE	II		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	``	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		EFIX AG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
		ving including, but not limited			delay in treatment after notific	ation	
	to, hygiene, toiletin	g, and transfers. The resident			of critical laboratory results,		
	had an ostomy and	required oxygen therapy.			medication to be administere		
	The exament Cone Di	long indicated the manident had			ordered by the Physician and		
		lans, indicated the resident had . Interventions included, but			ensure assessments and	lition	
	I -	, administer medications as			monitoring of a new skin cond in place, and complete labs a		
		ostics as ordered, and			ordered by the Physician.	5	
	_	report any signs or symptoms			oracioa by the r riyololari.		
of anemia. The resident had gastroesophageal				How the corrective action(s) v	vill be		
reflux disorder (GERD). Interventions included,					monitored to ensure the defic		
but were not limited to, administer medications as					practice will not recur, i.e., wh	ıat	
ordered, monitor/document side effects and				quality assurance programs v	vill be		
	effectiveness, labs/	diagnostics as ordered, and			put into place;		
		any signs or symptoms of					
	GERD.				DON/Designee will audit 10		
	431 131 4 1	1.0/01/04 + 4.20			residents MARs weekly x 2		
		ted 8/21/24 at 4:39 p.m.,			months, then 10 residents		
		order for complete blood sic metabolic profile (BMP)			bi-weekly x 2 months, then 10		
		laced for 8/23/24. The family			residents monthly x 2 months ensure nursing is administeri		
	was aware.	laced 101 6/23/24. The family			medications as ordered,	iy ali	
	was aware.				assessments and monitoring		
	A Physician's Progr	ress note, dated 8/23/24 at			orders in place for new skin		
		ed the resident was seen for			conditions including neck coll	ars,	
		umonia. The patient had			and labs completed timely an		
	rhonchi anteriorly v	with wheezing. His oxygen			results and treatments are re	ayed	
		tween 91-94%. He had a cough			timely as ordered by Physicia	n for	
		congestion. The staff denied			6 months.		
	1	ults were still pending. Staff			<u></u>		
	reported no issues.				The Director of Nursing/ design		
	The Hematology D	eport, dated 8/24/24, indicated			will present a summary of the interview findings to the Qual		
		eted at 6:15 a.m. on 8/24/24.			Assurance committee monthl	-	
		emoglobin and hematocrit were			three months. Thereafter, the	-	
		back) and faxed to a nurse at			facility if determined by the Q		
	the facility at 3:33 j				Assurance committee, auditir	-	
					and monitoring will be done	-	
		ted 8/24/24 at 5:57 p.m.,			quarterly and present quarter	ly at	
	indicated the reside	ent was sent to the hospital for			the QA meeting. Monitoring	will	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155637	B. W	ING	_	12/19/	2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	t .			AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE	CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	a critical hemoglobin of 4.4 via 911. Before the				be on going.		
		projectile emesis with blood					
		actitioner, Director of Nursing,			Date by which systemic		
		umily representative were all			corrections will be complete	ed:	
	aware. All of the paper work was sent with the				1.7.25		
	resident and report called to the emergency						
	department.						
	A Nurses' Note, dated 8/28/24 at 10:58 a.m.,						
	indicated the reside	nt was in the hospital. He was					
	tested again for hen	noglobin with a result of 4.14.					
	He received 2 units	of blood. He had labs redrawn					
	on 8/25/24 at the ho	ospital with a hemoglobin of					
	6.45.						
	A Physician Progre	ss Note, dated 8/29/24 at 11:59					
		resident admitted back into the					
	_	on 8/29/24 following a					
		to severe anemia with dark					
	-	omy and vomiting blood clots					
	on 8/24/24. The res	ident had a transfusion and					
	was determined to l	nave an esophageal ulcer.					
	During an interview	v on 12/18/24 at 3:27 p.m., the					
	_	; indicated the lab had called					
	_	en a nurse the report of the					
	, ,	values. The nurse had the labs					
		When the Director of Nursing					
	-	the desk, she immediately					
		d got orders to send the					
		nospital 911. The nurse should					
		ent the resident out to the					
	_	new the labs were critical. The					
	_	indicated she did not believe					
		wed the report understood that					
		al and how to proceed.					
	A Physician's Order	r, dated 8/29/24, indicated					
	_	r, dated 8/29/24, indicated aspension 3 milligrams/milliliter					
	_	g via G-Tube twice daily for 54					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE S				SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	A. BUILDING <u>00</u>			COMPLETED	
		155637	B. WING			12/19/	2024	
	PROVIDER OR SUPPLIER		66	85 EA	DDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE N POINT, IN 46307			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	, [			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL	PREI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TA	.G	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE.	DATE	
	days							
	at 6:47 p.m., indicat suspension 3 mg/ml  A Medication Adm at 6:06 a.m., indicat was ordered to be g  A Nurses' Note, dat indicated the back-uand informed the fa was going to go to to medication had been the medication was tonight (9/2/24). If to pharmacy, it would	inistration Note, dated 9/2/24 ted the lansoprazole medication						
	indicated the back-t lansoprazole would tonight (9/2/24). Th representative was in A Nurses' Note, da indicated the lansop found.  The Medication Ad August, September, the resident receive at 6:00 a.m., 8/31/2- 9/1/24 at 6 a.m., and medication was not	ministration Record (MAR) for and October 2024 indicated the lansoprazole on 8/30/24 at 6:00 a.m. and 6:00 p.m., d 9/2/24 at 6 p.m. The administered as ordered on ., 9/1/24 at 6:00 p.m., 9/2/24 at 6						

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UT3E11

Facility ID: 001198

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED	
		155637	B. W	ING		12/19/2024	
				CTREET	ADDRESS CITY STATE ZID COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP COD		
CDOWN	POINT CHRISTIAN	1)/   1 4 6 5			AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	During an interview	v on 12/18/24 at 2:20 p.m., the					
	Director of Nursing	indicated she contacted the					
	pharmacy to determ	nine when the medication was					
	actually delivered.	The pharmacy indicated it was					
	delivered very late	on 9/2/24 because the					
	pharmacy did not h	ave the medication available.					
	_	of the medication would have					
		g of 9/3/24. She could not					
	provide any rationa	le as to why the medications					
		ninistered on the MAR					
	between 8/30-9/2/2	4 since they had not yet been					
	delivered at those ti	mes.					
		ed 9/22/24 at 11:05 a.m.,					
		nt's colostomy bag and wafer					
		l as per policy and order. The					
	_	areas and one vesicle located					
	-	left hip and above groin area,					
		s brief got wrapped and					
	_	ne first and most distal open					
		centimeter (cm) x 1 cm. The					
	_	ocated on top of the first,					
		0.5 cm. The third area was a					
		op of second open area, which					
		x 0.25 cm. Monitoring would					
	take place throughout	out the shift.					
		r Nurses' Notes or wound					
	assessments related	to the new skin conditions.					
	_	v on 12/18/24 at 3:15 p.m., LPN					
		changed the colostomy bag					
		three areas on Resident F.					
		in condition was observed,					
		o write a progress note and					
		e about the area. When LPN 2					
		ift, the areas were no longer					
		not recall when her next shift					
		actly. She did not receive					
	notification in repor	rt about the areas either, so she					

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155637	B. WING		12/19/2024		
NAME OF F	PROVIDER OR SUPPLIER	₹		ET ADDRESS, CITY, STATE, ZIP C EAST 117TH AVENUE	OD		
CROWN	POINT CHRISTIAN	N VILLAGE	CRO	WN POINT, IN 46307			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF COR			
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SECTION SECTIO	APPROPRIATE CONT. EL TION		
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
	conditions.	nything further about the skin					
	conditions.						
	During an interview	v on 12/18/24 at 3:17 p.m., the					
	_	g indicated any time a new skin					
	condition was ident	ified, the staff were					
	_	ng out a form that was created					
	1 -	Nurse. The Wound Care					
		l ever receiving information					
	out at the time.	s, and no form was ever filled					
	out at the time.						
	A facility policy title	led, "Wound Assessment,"					
	and noted as current indicated, "3. New wounds						
	and/or other skin in	npairments/abnormalities will					
	be assessed and doc	cumented using the Skin and					
	_	the electronic medical record					
		d. 4. Wounds will be					
	I	complications and intact					
		pleted wound assessment will					
	_	ly for all wounds and skin malities using the Skin and					
	_	the electronic medical					
	record"	the electronic medical					
		ress note, dated 8/29/24 at					
	_	ed the resident had an upper					
	l -	norrhage, acute blood loss					
		ulcer, and iron deficiency					
		nic blood loss. The plan of					
		the resident had been ceived high-dose proton pump					
	_	nt for gastroesophageal reflux					
	· ·	d transfusion. The serial					
	· '	ant (CBC) had been stable and					
		g the CBC results weekly for 4					
		veeks for 1 month, and then					
	1	y laboratory routine.					
	The Hematology Ro	eports were reviewed from	1				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155637		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 12/19/2024	
	POINT CHRISTIAN		6685 E	ADDRESS, CITY, STATE, ZIP COD AST 117TH AVENUE IN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	draws on the follow	rent. There were laboratory ring dates: 8/31/24, 9/6/24, 0/2/24, 10/14/24, 10/16/24, 4.			
	indicated the resident about if the resident and last week. Ther the specified dates of Practitioner was conreceived for labs, the requested a lab draw (9/19/24) as well as dates with orders for daughter was inform.  There were no labout between 9/6-9/19/22. November.  During an interview Director of Nursing of the Physician ore facility's Nurse Practical and put their own on not normal for this swrite orders for labs.  A facility policy titt Services" and proving Facility will maintatests (laboratory and with the physician's will be performed with the performed with the performed with the proving the same proving the performed with the physician's will be performed with the performed wit	ded, "Diagnostic Testing ded as current, indicated "1. in a schedule of diagnostic d radiology) in accordance orders. No diagnostic tests without specific physician e with State law to include			
		to Complaints IN00442945,			

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l '		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155637	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY  COMPLETED  12/19/2024	
	PROVIDER OR SUPPLIEI		<u> </u>	6685 E	ADDRESS, CITY, STATE, ZIP COD EAST 117TH AVENUE /N POINT, IN 46307	<u> </u>	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE.	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE
	3.1-37(a)						
F 0761 SS=E							
Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals  Based on observation and interview, the facility failed to ensure a controlled substance was double locked at all times for 1 of 2 medication rooms observed (Grace Point). This had the potential to affect the residents on Grace Point who had the ability to access the storage room.  Finding includes:  On 12/18/24 at 10:45 a.m., the Grace Point Medication Room was observed with LPN 1. Inside the unlocked refrigerator was a clear tackle box. The box was not locked. Inside the box was 2 medication cards of Dronabinol (Marinol) pills. Interview with LPN 1 at that time, indicated the clear box key was lost and the box should be locked.  During an interview on 12/18/24 at 10:48 a.m., LPN 1 indicated the box should be locked and they lost they keys to the box.  During an interview on 12/18/24 at 11:45 a.m., the Assistant Director of Nursing indicated the box should be lock at all times and she would locate the key to ensure the narcotic box was locked and stored correctly.  A current facility policy, titled, "Medication, Ordering, Receiving, and Storage," indicated, "4. Controlled substances will be stored in the medication room in a locked container, separate		F 07	761	Crown Point Christian Villag Complaint Survey 12.19.24 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F 761 LABEL/STORE DRUGS AND BIOLOGICALS  What corrective action(s) will accomplished for those reside found to have been affected by deficient practice;  The facility has ensured contrasubstances have been double locked at all times on Grace Point's storage room.  How the facility will identify off residents having the potential be affected by the same deficient practice and what corrective a will be taken;  The Director of Nursing, Infect Preventionist, unit managers, designees conducted a review	s the  an y the n S be ents by the olled c her to ient action tion and y of	01/07/2025
1	from containers for any non-controlled medications. This container will always remain				residents' physician orders an		

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

PRINTED: 01/23/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>			COMPLETED	
155637			B. WI	NG		12/19/2024	
		-	-	STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		6685 E	AST 117TH AVENUE		
CROWN	POINT CHRISTIAI	N VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ιΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)		DATE
	locked, except when it is accessed with a key or				medical records to identify oth		
	access code to obtain medications for residents"				residents having the potential		
	The U.S. Department of Justice Drug Enforcement				be affected by the alleged def	cient	
	_	ags of Abuse Guide, dated		practice.  What measures will be pu			
		onabinol was a Schedule III			place or what systemic		
	medication.			changes will be made to			
	medication.				ensure that the deficient		
	This citation relate			practice does not recur;			
	3.1-25(m)				LPN 1 and Licensed nursing s	staff	
					have been in-serviced to ensu	ıre all	
					controlled substances will be		
					double locked at all times.		
					How the corrective action(s) w	<i>i</i> ill be	
					monitored to ensure the defici	ent	
					practice will not recur, i.e., who		
					quality assurance programs will be		
					put into place;		
					The DON/designee will compl	ete	
					audit of medication storage ro	oms	
				5x/weekly to ensure all contro	lled		
					substances are double locked		
					6 months. The facility will follo		
				the storage policy for all control	olled		
					substances.		
					The Director of Nursing/ desig		
					will present a summary of the		
					interview findings to the Qualit	-	
					Assurance committee monthly	•	
					three months. Thereafter, the		
					facility if determined by the Qu	· · · · · · · · · · · · · · · · · · ·	
					Assurance committee, auditing	g	
					and monitoring will be done	v ot	
					quarterly and present quarterly the QA meeting. Monitoring w	-	
					be on going.	/111	
1	1		1		pe on going.		1

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA		ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BU	A. BUILDING <u>00</u>		COMPLETED		
155637		B. W.	12/19/2024				
NAME OF F	AD CLUBED OD CLUBBLIER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER				6685 E	AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	I VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)	DATE	
					Date by which systemic		
					corrections will be complete	.d.	
					1.7.25	,u.	
F 0776	483.50(b)(1)(i)(ii)						
SS=D	Radiology/Other [	Diagnostic Services					
Bldg. 00				77.6	One on Beint Obeinties Wille	01/07/2025	
	Based on observation, record review, and interview, the facility failed to ensure an x-ray was			776	Crown Point Christian Villag	ge 01/07/2025	
	completed as ordered by the Physician in a timely				Complaint Survey		
	manner for 1 of 3 residents reviewed for change in condition. (Resident M)				Please accept the following a	s the	
					facility's credible allegation of		
					compliance. This plan of		
	Finding includes:				correction does not constitute	an l	
					admission of guilt or liability b		
	On 12/18/24 at 12:0	05 p.m., Resident M was			facility and is submitted only i	•	
		ed in her room. She had a soft			response to the regulatory		
	-	around her neck. During an			requirement.		
		esident's family at that time,			F 776 RADIOLOGY/ OTHER		
		esident recently had neck			DIAGNOSTIC SERVICES		
		why she was wearing the neck			\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	h -	
	collar. She was supposed to have a neck x-ray done last week to compare with the previous x-ray, but it was not completed until this week and they were unsure why there was a delay.				What corrective action(s) will accomplished for those reside		
					found to have been affected b		
					deficient practice;	/y tile	
	,	, and the second			a concionary actions,		
	Record review for I	Resident M was completed on			Resident M's family and MD v	were	
	12/18/24 at 2:11 p.m. Diagnoses included, but were not limited to, fusion of the spine,				notified the facility failed to en	sure	
					an X-ray was completed as		
		vertebra, and neoplasm of the			ordered by the Physician in a		
	spinal cord.				timely manner. Resident M di		
	AN N 1. 110/10/04 . 0.51				suffer any adverse effects from	m	
	A Nursing Note, dated 12/10/24 at 8:51 p.m.,				lack of timely X-ray.		
	indicated a new order was received from the resident's surgeon for an x-ray of the cervical				How the facility will identify ot	her	
		ractitioner was made aware.			residents having the potential		
		placed with the facility's			be affected by the same defic	l l	
	radiology services p				practice and what corrective a		
					will be taken;		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPP		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	a. building <u>00</u>		COMPLETED	
155637		155637	B. WING			12/19/2024	
				CERTE	A DODDEGG CHTM CTATE THE COD	<u> </u>	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
CROWN POINT CHRISTIAN VILLAGE					AST 117TH AVENUE		
CROWN	POINT CHRISTIAN	N VILLAGE		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	A Physician's Orde	r, dated 12/16/24, indicated and					
	order for a cervical	spine x-ray 2 views, status			The Director of Nursing, Infect	ion	
	post-surgery.				Preventionist, unit managers, and		
	1 -8-7.				designees conducted a review		
	A Radiology Exam Order Form, dated 12/16/24,				residents' physician orders an		
	indicated an order f	for a cervical spine x-ray.			medical records to identify oth		
					residents having the potential		
	A Nursing Note, da	ated 12/16/24 at 10:52 p.m.,			be affected by the alleged defi		
	indicated the radiol	ogy report had been received,			practice.		
	all parties were awa	are, and there were no new			What measures will be put in	ito	
	orders at this time.				place or what systemic		
					changes will be made to		
	The cervical spine x-ray results, dated 12/16/24 at				ensure that the deficient		
	7:45 p.m., indicated intact orthopedic hardware				practice does not recur;		
	and mild degenerative changes without acute						
	findings.				Licensed nursing staff were		
					in-serviced to ensure all X-ray	s are	
	There was lack of documentation to indicate why				completed as ordered by the		
	the cervical spine x-ray had not been completed				Physician in a timely manner.		
	until 12/16/24.						
					All residents with X-ray orders		
	During an interview	v on 12/18/24 at 3:28 p.m., the			have been assessed.		
	Director of Nursing	g indicated the x-ray had not					
	been completed unt	til 12/16/24. She was unsure			How the corrective action(s) w	ill be	
	why the orders had not been put in until 12/16. The x-ray was considered non-emergent so				monitored to ensure the defici-	ent	
					practice will not recur, i.e., who	at	
	radiology services would have come to complete			quality assurance programs will be			
	it as soon as they were available. A radiology				put into place;		
	services policy was requested.						
	A facility policy, titled "Diagnostic Testing Services," indicated, "1. Facility will maintain a				DON/designee will audit 5		
					residents with X-ray orders we	ekly	
					x 2 months, then 5 residents		
	schedule of diagnostic tests (laboratory and				bi-weekly x 2 months, then 5		
	radiology) in accordance with the physician's			residents monthly to ensure all			
	orders"				X-rays have been completed i	n	
					timely manner, as Physician		
	This citation relates	s to Complaint IN00442945.			ordered for 6 months.		
	3.1-49(g)				The Director of Nursing/design	nee	
3.1-49(h)					will present a summary of the		

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/23/2025 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 12/19/2024			
NAME OF PROVIDER OR SUPPLIER CROWN POINT CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP COD 6685 EAST 117TH AVENUE CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX C		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	COMPLETION DATE
mo	TAG REGULATORY OR LSC IDENTIFYING INFORMATION  3.1-49(i)				interview findings to the Quality Assurance committee monthly three months. Thereafter, the facility if determined by the Quy Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going.  Date by which systemic corrections will be completed 1.7.25	for ality d / at rill	

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