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	12/19/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00442682, IN00442793, IN00442945, IN00443475, IN00447461, IN00448042, IN00449198, and IN00449316. Complaint IN00442682 - No deficiencies related to the allegations are cited. Complaint IN00442793 - No deficiencies related to the allegations are cited. Complaint IN00442945 - Federal/state deficiencies related to the allegations are cited at F580, F684, F761, and F776. Complaint IN00443475 - No deficiencies related to the allegations are cited. Complaint IN00447461 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00448042 - No deficiencies related to the allegations are cited. Complaint IN00449198 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00449316 - No deficiencies related to the allegations are cited. Survey dates: December 17, 18 and 19, 2024 Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type:	F 0000	The facility kindly requests a desk review.	

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

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	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 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify a resident's physician and responsible party in a timely manner related to abnormal laboratory results for 1 of 3 residents reviewed for change in condition (Resident F). Finding includes: Resident F's record was reviewed on 12/17/24 at at 9:42 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, colostomy status, iron deficiency anemia, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 9/12/24, indicated the resident was severely cognitively impaired for daily decision making. He was dependent on staff for all activities of daily living including, but not limited to, hygiene, toileting, and transfers. The resident had an ostomy and required oxygen therapy.	F 0580	**Crown Point Christian Village Complaint Survey** **12.19.24** 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 580 NOTIFY OF CHANGES What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident F had no adverse effects from lack of notification. Resident	01/07/2025

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	A Nurses' Note, dated 8/30/24 at 9:23 a.m., indicated the resident had audible crackles in the lungs with no improvement after nebulizer treatments were administered per orders. A Nurses' Note, dated 8/30/24 at 3:43 p.m., indicated the resident was to have a laboratory blood draw for a CBC (complete blood count) and BMP (basic metabolic profile) the next day. The Hematology Report, dated 8/31/24, indicated the blood sample was collected at 5:15 a.m. on 8/31/24. It was reported to the facility at 5:00 p.m. on 8/31/24. There were abnormal results as follows: - Red blood cells: 2.97 (normal reference range: 4.7-6.1) - Hemoglobin: 8.5 (normal reference range: 14-18) - Hematocrit: 30.9 (normal reference range: 42-52) - Platelet count: 134 (normal reference range: 150-400) There were no notes related to the Physician or the family representative being notified of the results of the laboratory testing. A Physician's Order, dated 9/5/24, indicated the resident was to have a CBC and BMP on 9/6/24. The Hematology Report, dated 9/6/24, indicated the blood sample was collected at 4:15 a.m. There were abnormal results as follows: - White blood cells: 4.14 (normal reference range: 4.8-10.8) - Red blood cells: 3.53 (normal reference range: 4.7-6.1) - Hemoglobin: 10.3 (normal reference range: 14-18) - Hematocrit: 37.6 (normal reference range: 42-52)		F's MD and family have been notified of abnormal lab results. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nursing staff were in-serviced to ensure that notification of a resident's physician and responsible party is completed in a timely manner related to abnormal laboratory results and to ensure all orders, including labs, are entered into the computer. 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	

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	There were no notes related to the Physician or the family representative being notified of the results of the laboratory testing. A Physician's Order, dated 12/6/24, indicated the resident was to have a stool occult blood test. The Laboratory Occult Blood test, dated 12/6/24, indicated the results were positive (blood found in stool). There were no notes to indicate the Physician or the family representative were notified of the abnormal laboratory results. A Nurses' Note, dated 12/6/24 at 6:04 a.m., indicated the resident had liquid black stool in his colostomy bag. A Nurses' Note, dated 12/7/24 at 6:10 a.m., indicated the resident had liquid black stool noted in the colostomy bag. A Hematology Report, dated 12/7/24, indicated a blood sample was collected on 12/7/24 at 6:15 a.m. The results were reported to the facility on 12/7/24. There were abnormal results as follows: - Red blood cells: 3.08 (normal reference range: 4.7-6.1) - Hemoglobin: 9.3 (normal reference range: 14-18) - Hematocrit: 30.4 (normal reference range: 42-52) There were no orders in the Electronic Health Record (EHR) for the testing or any corresponding notes related to notification to the Physician or family representative of the abnormal laboratory results. A Nurses' Note, dated 12/9/24 at 10:26 a.m., indicated new orders were received to obtain a		random residents weekly x 2 months, then 10 random resident bi-weekly x 2 months, then 10 residents monthly x 2 months for 6 months, to ensure timely notification to physicians and families related to the abnormal laboratory results and the lab orders are being transcribed to the POS/then notification. The Director of Nursing/ designee will present a summary of the interview findings to the Quality Assurance committee monthly for three months. Thereafter, the facility if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 1.7.25**	

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	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 tarry 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 EHR and was only on a laboratory slip. This was due to the nurse on duty getting COVID-19 and having to leave the facility. When labs were completed without an order entered in the computer, the DON did not receive a notification they were completed when running her daily reports. This instance for Resident F occurred on a weekend, so the DON was responsible for running 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, "1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's 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 ordering Physician. 3. Documentation of			

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	diagnostic tests, the results, and date/time of Physician notification will be maintained in the resident's clinical record." This citation relates to Complaint IN00442945. 3.1-5(a)(2)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure a resident received the necessary care and services related to a lack of orders or monitoring in place for a neck collar, a delay in treatment after notification of critical laboratory results, medications not administered as ordered by the Physician, lack of assessment or monitoring of a new skin condition, and labs not completed as ordered by the Physician for 2 of 3 residents reviewed for change of condition. (Residents M and F) Findings include: 1. On 12/18/24 at 12:05 p.m., Resident M was observed lying in bed in her room. She had a soft neck collar in place around her neck. During an interview with the resident's family at that time, they indicated the resident recently had neck surgery which was why she was wearing the neck collar. On 12/19/24 at 11:13 a.m., Resident M was observed lying in bed in her room. She had a soft neck collar in place around her neck. Record review for Resident M was completed on 12/18/24 at 2:11 p.m. Diagnoses included, but were not limited to, fusion of the spine,	F 0684	**Crown Point Christian Village Complaint Survey 12.19.24** 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 684 QUALITY OF CARE What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident F's family and MD were notified of a delay in treatment after notification of critical laboratory results, medications not administered as ordered by the Physician, lack of assessment or monitoring of a new skin condition, and labs not completed as ordered by the Physician. Resident F's treatments, skin assessment and monitoring orders completed, medications have been	01/07/2025

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	osteomyelitis of the vertebra, and neoplasm of the spinal cord. The Admission Minimum Data Set (MDS) assessment, dated 10/26/24, indicated the resident was cognitively intact and dependent on staff for ADLs (activities of daily living). A Care Plan, dated 10/23/24, indicated the resident had surgical sites to her neck and throat. There were no interventions related to the neck collar. A Nurse Practitioner Note, dated 12/11/24 at 7:18 p.m., indicated the resident had a cervical laminectomy (spinal surgery) on 10/16/24. The drain was removed on 10/19/24 and the staples were removed on 10/31/24. "Soft cervical collar in place x [for] 3 weeks." The Physician's Order Summary, dated 12/2024, lacked any orders for a neck collar, guidance on when the resident should wear it, or monitoring to the skin under the neck collar. During an interview on 12/18/24 at 3:28 p.m., the Director of Nursing was made aware there were no orders for the neck collar, guidance on when the resident should wear it, or monitoring to the skin under the neck collar. She indicated she would look into it. No further information was received.2. Resident F's record was reviewed on 12/17/24 at at 9:42 a.m. The diagnoses included, but were not limited to, Alzheimer's disease, dementia, colostomy status, iron deficiency anemia, and congestive heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 9/12/24, indicated the resident was severely cognitively impaired for daily decision making. He was dependent on staff for all		administered as ordered. Resident M's family and MD were notified of orders for neck collar, guidance on when the resident should wear it and monitoring to the skin under the neck collar in place. New orders for the neck collar, guidance on when the resident should wear it, and monitoring to the skin under the neck collar are in place for Resident M's. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** LPN2, Wound nurse and licensed nursing staff have been in-serviced to ensure residents receive the necessary care and services related to orders and monitoring in place for a neck collar, prevent a	

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	activities of daily living including, but not limited to, hygiene, toileting, and transfers. The resident had an ostomy and required oxygen therapy. The current Care Plans, indicated the resident had a history of anemia. Interventions included, but were not limited to, administer medications as ordered, labs/diagnostics as ordered, and monitor/document/report any signs or symptoms of anemia. The resident had gastroesophageal reflux disorder (GERD). Interventions included, but were not limited to, administer medications as ordered, monitor/document side effects and effectiveness, labs/diagnostics as ordered, and monitor/document any signs or symptoms of GERD. A Nurses' Note, dated 8/21/24 at 4:39 p.m., indicated a new lab order for complete blood count (CBC)and basic metabolic profile (BMP) were ordered and placed for 8/23/24. The family was aware. A Physician's Progress note, dated 8/23/24 at 10:05 p.m., indicated the resident was seen for follow up with pneumonia. The patient had rhonchi anteriorly with wheezing. His oxygen saturations were between 91-94%. He had a cough that was loose with congestion. The staff denied any fevers. Lab results were still pending. Staff reported no issues. The Hematology Report, dated 8/24/24, indicated the labs were collected at 6:15 a.m. on 8/24/24. Critical values of hemoglobin and hematocrit were phoned (with read back) and faxed to a nurse at the facility at 3:33 p.m. on 8/24/24. A Nurses' Note, dated 8/24/24 at 5:57 p.m., indicated the resident was sent to the hospital for		delay in treatment after notification of critical laboratory results, medication to be administered as ordered by the Physician and ensure assessments and monitoring of a new skin condition in place, and complete labs as ordered by the Physician. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; DON/Designee will audit 10 residents MARs weekly x 2 months, then 10 residents bi-weekly x 2 months, then 10 residents monthly x 2 months to ensure nursing is administering all medications as ordered, assessments and monitoring orders in place for new skin conditions including neck collars, and labs completed timely and results and treatments are relayed timely as ordered by Physician for 6 months. The Director of Nursing/ designee will present a summary of the interview findings to the Quality Assurance committee monthly for three months. Thereafter, the facility if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will	

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	a critical hemoglobin of 4.4 via 911. Before the resident left, he had projectile emesis with blood clots. The Nurse Practitioner, Director of Nursing, and the resident's family representative were all aware. All of the paper work was sent with the resident and report called to the emergency department. A Nurses' Note, dated 8/28/24 at 10:58 a.m., indicated the resident was in the hospital. He was tested again for hemoglobin with a result of 4.14. He received 2 units of blood. He had labs redrawn on 8/25/24 at the hospital with a hemoglobin of 6.45. A Physician Progress Note, dated 8/29/24 at 11:59 p.m., indicated the resident admitted back into the facility at 2:09 p.m. on 8/29/24 following a hospitalization due to severe anemia with dark blood in the colostomy and vomiting blood clots on 8/24/24. The resident had a transfusion and was determined to have an esophageal ulcer. During an interview on 12/18/24 at 3:27 p.m., the Director of Nursing indicated the lab had called the facility and given a nurse the report of the critical laboratory values. The nurse had the labs sitting on the desk. When the Director of Nursing saw them sitting on the desk, she immediately called the doctor and got orders to send the resident out to the hospital 911. The nurse should have immediately sent the resident out to the hospital once she knew the labs were critical. The Director of Nursing indicated she did not believe the nurse that received the report understood that the labs were critical and how to proceed. A Physician's Order, dated 8/29/24, indicated lansoprazole oral suspension 3 milligrams/milliliter (mg/ml), give 30 mg via G-Tube twice daily for 54		be on going. **Date by which systemic corrections will be completed: 1.7.25**	

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	days A Medication Administration Note, dated 8/30/24 at 6:47 p.m., indicated the lansoprazole oral suspension 3 mg/ml was reordered. A Medication Administration Note, dated 9/2/24 at 6:06 a.m., indicated the lansoprazole medication was ordered to be given later today. A Nurses' Note, dated 9/2/24 at 9:44 p.m., indicated the back-up Pharmacist was contacted and informed the facility the Pharmacy Supervisor was going to go to the pharmacy to check if the medication had been delivered to the pharmacy. If the medication was there, it would be delivered tonight (9/2/24). If the medication was not at the pharmacy, it would be delivered tomorrow (9/3/24). The resident's family representative was informed. A Nurses' Note, dated 9/2/24 at 11:24 p.m., indicated the back-up Pharmacist indicated the lansoprazole would be sent out stat to the facility tonight (9/2/24). The resident's family representative was informed. A Nurses' Note, dated 10/5/24 at 5:45 p.m., indicated the lansoprazole medication was not found. The Medication Administration Record (MAR) for August, September, and October 2024 indicated the resident received the lansoprazole on 8/30/24 at 6:00 a.m., 8/31/24 at 6:00 a.m. and 6:00 p.m., 9/1/24 at 6 a.m., and 9/2/24 at 6 p.m. The medication was not administered as ordered on 8/30/24 at 6:00 p.m., 9/1/24 at 6:00 p.m., 9/2/24 at 6 a.m., and 10/5/24 at 6:00 p.m.			

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	During an interview on 12/18/24 at 2:20 p.m., the Director of Nursing indicated she contacted the pharmacy to determine when the medication was actually delivered. The pharmacy indicated it was delivered very late on 9/2/24 because the pharmacy did not have the medication available. The first dose given of the medication would have been on the morning of 9/3/24. She could not provide any rationale as to why the medications were marked as administered on the MAR between 8/30-9/2/24 since they had not yet been delivered at those times. A Nurses' Note, dated 9/22/24 at 11:05 a.m., indicated the resident's colostomy bag and wafer were being changed as per policy and order. The nurse noted 2 open areas and one vesicle located laterally beside the left hip and above groin area, where the resident's brief got wrapped and secured in place. The first and most distal open area measured 1.2 centimeter (cm) x 1 cm. The second open area, located on top of the first, measured 0.5 cm x 0.5 cm. The third area was a vesicle located on top of second open area, which measured 0.25 cm x 0.25 cm. Monitoring would take place throughout the shift. There were no other Nurses' Notes or wound assessments related to the new skin conditions. During an interview on 12/18/24 at 3:15 p.m., LPN 2 indicated she had changed the colostomy bag and discovered the three areas on Resident F. Whenever a new skin condition was observed, she was supposed to write a progress note and tell the wound nurse about the area. When LPN 2 worked her next shift, the areas were no longer there. LPN 2 could not recall when her next shift worked occurred exactly. She did not receive notification in report about the areas either, so she			

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	did not document anything further about the skin conditions. During an interview on 12/18/24 at 3:17 p.m., the Director of Nursing indicated any time a new skin condition was identified, the staff were responsible for filling out a form that was created by the Wound Care Nurse. The Wound Care Nurse did not recall ever receiving information about the three areas, and no form was ever filled out at the time. A facility policy titled, "Wound Assessment," and noted as current indicated, "...3. New wounds and/or other skin impairments/abnormalities will be assessed and documented using the Skin and Wound Program in the electronic medical record upon being observed. 4. Wounds will be monitored daily for complications and intact dressing. 5. A completed wound assessment will be completed weekly for all wounds and skin impairments/abnormalities using the Skin and Wound Program in the electronic medical record..." A Physician's Progress note, dated 8/29/24 at 11:59 p.m., indicated the resident had an upper gastrointestinal hemorrhage, acute blood loss anemia, esophageal ulcer, and iron deficiency anemia due to chronic blood loss. The plan of treatment indicated the resident had been hospitalized and received high-dose proton pump inhibitors (treatment for gastroesophageal reflux disease) and a blood transfusion. The serial complete blood count (CBC) had been stable and continual following the CBC results weekly for 4 weeks, every two weeks for 1 month, and then back on the monthly laboratory routine. The Hematology Reports were reviewed from			

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	155637	A. BUILDING 00 B. WING	12/19/2024

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	August 2024 to current. There were laboratory draws on the following dates: 8/31/24, 9/6/24, 9/19/24, 9/25/24, 10/2/24, 10/14/24, 10/16/24, 12/3/24, and 12/7/24. A Nurses' Note, dated 9/18/24 at 2:38 p.m., indicated the resident's daughter called to inquire about if the resident's labs were done for today and last week. There were no orders for labs for the specified dates of 9/13 or 9/18/24. The Nurse Practitioner was contacted regarding orders received for labs, then called the lab and requested a lab draw for the following day (9/19/24) as well as filled out lab slips for future dates with orders from the Nurse Practitioner. The daughter was informed of the new orders. There were no laboratory results provided between 9/6-9/19/24 and for the month of November. During an interview on 12/19/24 at 3:41 p.m., the Director of Nursing indicated she was not aware of the Physician ordering the labs. Usually the facility's Nurse Practitioners would order the labs and put their own orders in the computer. It was not normal for this specific doctor to come in and write orders for labs. A facility policy titled, "Diagnostic Testing Services" and provided as current, indicated "1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders. No diagnostic tests will be performed without specific physician orders in accordance with State law to include scope of practice laws." This citation relates to Complaints IN00442945, IN00447461 and IN00449198.			

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F 0761 SS=E Bldg. 00	3.1-37(a) 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 from containers for any non-controlled medications. This container will always remain	F 0761	**Crown Point Christian Village** **Complaint Survey** **12.19.24** 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 761 LABEL/STORE DRUGS AND BIOLOGICALS What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The facility has ensured controlled substances have been double locked at all times on Grace Point's storage room. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and	01/07/2025

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	locked, except when it is accessed with a key or access code to obtain medications for residents..." The U.S. Department of Justice Drug Enforcement Administration Drugs of Abuse Guide, dated 2020, indicated Dronabinol was a Schedule III medication. This citation relates to Complaint IN00442945. 3.1-25(m)		medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** LPN 1 and Licensed nursing staff have been in-serviced to ensure all controlled substances will be double locked at all times. 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; The DON/designee will complete audit of medication storage rooms 5x/weekly to ensure all controlled substances are double locked for 6 months. The facility will follow the storage policy for all controlled substances. The Director of Nursing/ designee will present a summary of the interview findings to the Quality Assurance committee monthly for three months. Thereafter, the facility if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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			Date by which systemic corrections will be completed: 1.7.25	
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services Based on observation, record review, and interview, the facility failed to ensure an x-ray was completed as ordered by the Physician in a timely manner for 1 of 3 residents reviewed for change in condition. (Resident M) Finding includes: On 12/18/24 at 12:05 p.m., Resident M was observed lying in bed in her room. She had a soft neck collar in place around her neck. During an interview with the resident's family at that time, they indicated the resident recently had neck surgery which was why she was wearing the neck 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. Record review for Resident M was completed on 12/18/24 at 2:11 p.m. Diagnoses included, but were not limited to, fusion of the spine, osteomyelitis of the vertebra, and neoplasm of the spinal cord. A Nursing Note, dated 12/10/24 at 8:51 p.m., indicated a new order was received from the resident's surgeon for an x-ray of the cervical spine. The Nurse Practitioner was made aware. The order would be placed with the facility's radiology services provider.	F 0776	**Crown Point Christian Village Complaint Survey 12.19.24** 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 776 RADIOLOGY/ OTHER DIAGNOSTIC SERVICES What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident M's family and MD were notified the facility failed to ensure an X-ray was completed as ordered by the Physician in a timely manner. Resident M did not suffer any adverse effects from lack of timely X-ray. 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;	01/07/2025

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	A Physician's Order, dated 12/16/24, indicated and order for a cervical spine x-ray 2 views, status post-surgery. A Radiology Exam Order Form, dated 12/16/24, indicated an order for a cervical spine x-ray. A Nursing Note, dated 12/16/24 at 10:52 p.m., indicated the radiology report had been received, all parties were aware, and there were no new orders at this time. The cervical spine x-ray results, dated 12/16/24 at 7:45 p.m., indicated intact orthopedic hardware and mild degenerative changes without acute findings. There was lack of documentation to indicate why the cervical spine x-ray had not been completed until 12/16/24. During an interview on 12/18/24 at 3:28 p.m., the Director of Nursing indicated the x-ray had not been completed until 12/16/24. She was unsure why the orders had not been put in until 12/16. The x-ray was considered non-emergent so radiology services would have come to complete it as soon as they were available. A radiology services policy was requested. A facility policy, titled "Diagnostic Testing Services," indicated, "...1. Facility will maintain a schedule of diagnostic tests (laboratory and radiology) in accordance with the physician's orders..." This citation relates to Complaint IN00442945. 3.1-49(g) 3.1-49(h)		The Director of Nursing, Infection Preventionist, unit managers, and designees conducted a review of residents' physician orders and medical records to identify other residents having the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nursing staff were in-serviced to ensure all X-rays are completed as ordered by the Physician in a timely manner. All residents with X-ray orders have been assessed. 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 5 residents with X-ray orders weekly x 2 months, then 5 residents bi-weekly x 2 months, then 5 residents monthly to ensure all X-rays have been completed in timely manner, as Physician ordered for 6 months. The Director of Nursing/designee will present a summary of the	

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	3.1-49(i)		interview findings to the Quality Assurance committee monthly for three months. Thereafter, the facility if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 1.7.25**	