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	05/09/2024

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 IN00432891, IN00433279, and IN00433545. Complaint IN00432891 - Federal/state deficiencies related to the allegations are cited at F677 and F692. Complaint IN00433279 - Federal/state deficiencies related to the allegations are cited at F692. Complaint IN00433545 - Federal/state deficiencies related to the allegations are cited at F677. Survey dates: May 8 and 9, 2024. Facility number: 001198 Provider number: 155637 AIM number: 100471000 Census Bed Type: SNF/NF: 81 SNF: 22 Residential: 49 Total: 152 Census Payor Type: Medicare: 16 Medicaid: 56 Other: 31 Total: 103 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/14/24.	F 0000	The facility kindly requests a desk review	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure dependent residents received the necessary ADL (activities of daily living) care, related to lack of documentation of incontinence care for 3 of 4 residents reviewed for ADL care. (Residents F, G, and H) Findings include: 1. Resident F's record was reviewed on 5/8/24 at 9:00 a.m. Diagnoses included, but were not limited to Alzheimer's disease, gastrostomy and colostomy status, and traumatic brain injury. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/24, indicated the resident was severely cognitively impaired for daily decision making. He was dependent on staff for ADL care including, but not limited to, oral hygiene, toileting hygiene, and personal hygiene. 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 assistance 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	F 0677	**Crown Point Christian Village Complaint Survey** **5.9.24** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F now has documentation of incontinence care every shift. Resident G now has documentation of incontinence care every shift. Resident H now has documentation of incontinence care every 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 taken;**	05/24/2024

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	reviewed for the last 21 days. The frequency was every shift. Incontinence care was documented once daily on 4/20/24, 4/24/24, 5/2/24, 5/5/24, and 5/7/24. Incontinence care was documented twice daily on 4/18/24, 4/25/24, 4/27/24, 4/28/24, 4/29/24, and 5/3/24. During an interview on 5/9/24 at 11:23 a.m., the Director of Nursing indicated staff should have documentation of incontinence care at least every shift. 2. Resident G's record was reviewed on 5/8/24 at 1:08 p.m. Diagnosis included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/24, indicated the resident was severely cognitively impaired. He was dependent on staff for activities of daily living (ADLs) including, but not limited to, oral hygiene, toileting hygiene, and personal hygiene. A Care Plan, dated 9/11/20, indicated the resident had bladder incontinence. Interventions included, but were not limited to, check and change. A Care Plan, dated 10/26/21, indicated the resident had an ADL self-care performance deficit. Interventions included, but were not limited to, the resident required extensive assistance for toileting. The CNA Task - Bladder Continence was reviewed for the last 21 days. The frequency was every shift. Incontinence care was documented once daily on 4/24/24 and 5/5/24. Incontinence care was documented twice daily on 4/17/24, 4/20/24, 4/22/24, 4/25/24, 4/27/24, 4/30/24, 5/1/24, 5/3/24, and 5/7/24.		All dependent 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 assistance with ADLs per resident's plan of care including documenting at least once per shift that incontinence care has been provided. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit 10 dependent residents 2xs/week for 6 months to ensure they have documentation of incontinence care at least every shift. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 5.24.24**	

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	During an interview on 5/9/24 at 11:23 a.m., the Director of Nursing indicated staff should have documentation of incontinence care at least every shift. 3. Resident H's record was reviewed on 5/8/24 at 2:52 p.m. Diagnoses included, but were not limited to, dementia, anxiety, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated the resident was cognitively intact for daily decision making. She was dependent on staff for toilet hygiene. A Care Plan, dated 10/5/23, indicated the resident needed assistance with ADLs. Interventions included, but were not limited to, the resident required extensive assistance for toileting. A Care Plan, dated 4/1/24, indicated the resident had incontinence and was at risk for complications. Interventions included, but were not limited to, incontinence care with each incontinence episode. The CNA Task - Bladder Continence was reviewed for the last 21 days. The frequency was every shift. There was no incontinence care documented on 4/22/24. Incontinence care was documented once daily on 4/20/24, 4/24/24, 4/25/24, 4/27/24, 5/2/24, and 5/5/24. Incontinence care was documented twice daily on 4/19/24, 4/28/24, 4/29/24, 5/1/24, 5/4/24, and 5/8/24. During an interview on 5/9/24 at 11:23 a.m., the Director of Nursing indicated staff should have documentation of incontinence care at least every shift.			

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	This citation relates to Complaint IN00432891 and IN00433545. 3.1-38(2)(C)			
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §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 record review, and interview, the facility failed to ensure physician's orders were followed related to an incorrect amount of enteral feeding documented and incomplete meal consumption logs for residents with a history of weight loss for 3 of 4 residents reviewed for nutrition. (Residents F, G, and H) Findings include:	F 0692	**Crown Point Christian Village Complaint Survey** **5.9.24** 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	05/24/2024

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	1. Resident F's record was reviewed on 5/8/24 at 9:00 a.m. Diagnoses included, but were not limited to Alzheimer's disease, gastrostomy and colostomy status, and traumatic brain injury. The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/24, indicated the resident was severely cognitively impaired for daily decision making. He had a feeding tube. He received 51% or more of his total calories and 501 cc per day or more fluids through the feeding tube. A Care Plan, dated 6/7/23, indicated the resident required a tube feeding. Interventions included, but were not limited to, feed via tube feed pump per Physician's order. A Physician's Order, dated 8/9/23, indicated Osmolite 1.5 at 72 milliliter per hour for 20 hours, on at 1:00 p.m. and off at 9:00 a.m. A Physician's Order, dated 6/13/23, indicated monitor enteral feeding intake every shift and document amount administered. The April 2024 Medication Administration Record (MAR) indicated the resident received the following total enteral feeding amounts per day: - 4/17/24: 1,590 milliliter (ml) - 4/18/24: 1,441 ml - 4/19/24: 1,185 ml - 4/20/24: 1,543 ml - 4/21/24: 1,953 ml - 4/22/24: 1,396 ml - 4/23/24: 976 ml - 4/24/24: 882 ml - 4/25/24: 976 ml - 4/26/24: 2,456 ml - 4/27/24: 1,586 ml		requirement. **F692 Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F had an incorrect documented amount of enteral feeding documented and incomplete meal consumption logs. Resident F's documentation for enteral feeding and meal consumption is now updated and accurate, RD continues to follow for Nutrition at Risk. Resident G had incomplete meal consumption logs. Resident G's documentation for meal consumption is now updated and complete, RD continues to follow for Nutrition at Risk. Resident H had incomplete meal consumption logs. Resident H's documentation for meal consumption is now updated and complete, 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 with a history of weight loss have the potential to be affected by the same alleged deficient practice. **What measures will be put into**	

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	- 4/28/24: 1,303.5 ml - 4/29/24: 1,446 ml - 4/30/24: 975 ml During an interview on 5/9/24 at 12:35 p.m., the Director of Nursing indicated the staff had probably not reset the feeding pump which led to inaccurate documentation of the enteral feeding. 2. Resident G's record was reviewed on 5/8/24 at 1:08 p.m. Diagnosis included, but were not limited to, Alzheimer's disease, dementia, and gastrostomy status. The Quarterly Minimum Data Set (MDS) assessment, dated 3/7/24, indicated the resident was severely cognitively impaired. He received feedings through a feeding tube and also had a mechanically altered and therapeutic diet. The May 2024 Physician Order Summary indicated the resident was on a mechanical soft diet with thin liquids. A Care Plan, dated 4/25/22, indicated the resident had a potential nutrition problem. Interventions included, but were not limited to, provide diet per order, monitor intake and record. The CNA Task - Eating ADL (activity of daily living) indicated there was no breakfast meal documented on 4/24/24, 4/26/24, 4/27/24, and 5/1/24. There was no lunch meal documented on 4/24/24 and 4/27/24. There was no dinner meal documented on 4/18/24, 4/20/24, 4/22/24, 4/24/24, 4/25/24, 4/30/24, 5/1/24, and 5/5/24. During an interview on 5/9/24 at 11:23 a.m., the Director of Nursing indicated she was unable to provide any further information.		**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 to ensure that all accurate documentation of meal consumptions and enteral feedings are completed daily. **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 10 residents' meal consumption documentation and all tube feeing documentation on MAR 5x/week for 6 months. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 5.24.24**	

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	3. Resident H's record was reviewed on 5/8/24 at 2:52 p.m. Diagnoses included, but were not limited to, dementia, anxiety, and cognitive communication deficit. The Quarterly Minimum Data Set (MDS) assessment, dated 3/28/24, indicated the resident was cognitively intact for daily decision making. The resident's weight log indicated the resident weighed 101.8 pounds on 4/7/24. She weighed 96.4 pounds on 5/7/24. The May 2024 Physician Order Summary indicated the resident received a regular diet with fortified food with all meals due to weight loss and a wound that returned. A current Care Plan, indicated the resident had a nutritional problem related to increased needs for wound healing. Interventions included, but were not limited to, provide and service diet as ordered and monitor intake and record each meal. The CNA Task - Eating ADL (activity of daily living) indicated there was no breakfast meal documented on 4/18/24, 4/22/24, 4/24/24, 4/25/24, 4/29/24, and 5/2/24. There was no lunch meal documented on 4/20/24, 4/22/24, 4/24/24, 4/25/24, 4/29/24, and 5/2/24. There was no dinner meal documented on 4/20/24, 4/24/24, 4/25/24, 4/27/24, 4/28/24, 5/2/24, 5/4/24, 5/5/24, and 5/6/24. During an interview on 5/9/24 at 11:23 a.m., the Director of Nursing indicated she had no further information to provide. This citation relates to Complaint IN00432891 and IN00433279.			

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	3.1-46(a)(1)			