STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Christian Village	6685 East 117th Avenue Crown Point, IN 46307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. 20580 Based on interview and record review, the facility failed to ensure a resident's privacy was respected, related to RN 2 using her private cell phone to take pictures of bruising on the left arm and left breast of a cognitively impaired resident (Resident B) without the approval of the resident's Responsible Party, for 1 of 1 resident reviewed for privacy. See F609 for additional information regarding Resident B. Finding includes: Resident B's record was reviewed on 9/5/24 at 9:47 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 6/22/24, indicated a moderately impaired cognitive status. A Nurse's Progress Note, dated 8/24/24 at 5:46 a.m. and signed by RN 2, indicated a large bruised area was observed on the left breast and left upper arm and the left ankle was slightly swollen. The resident complained of pain with movement of the ankle and was unable to remember how she received the bruises. Cross reference F609. During an interview on 9/5/24 at 1:16 p.m., RN 1 indicated the bruising of the left arm and breast area was purple when she first observed them on the morning of 8/24/24. The DON had asked her to take pictures and the pictures were sent to the Director of Nursing (DON). The pictures were taken on her personal cell phone and sent to the DON. During an interview on 9/5/24 at 1:30 p.m., the DON indicated the pictures were sent to her personal cell phone. The only facility cell phone available was the on-call cell phone. During an interview on 9/5/24 at 2:04 p.m., the Administrator indicated taking pictures of the residents on a cell phone was against the facility policy. (continued on next page)

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

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Resident's Authorization to Disclose Resident Photographs and Voices consent, signed by the Responsible Party on 2/14/19, indicated photographs could be used for marketing or promoting the community. The facility's Employee Handbook, dated 9/2019, indicated cell phone cameras or any cameras were not to be used in any resident areas nor to capture photos of the residents. This citation relates to Complaint IN00442079.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 20580 Based on observation, record review, and interview, the facility failed to ensure an injury of unknown source was immediately reported to the Administrator/Abuse Coordinator and the Indiana Department of Health (IDOH) and failed to ensure the injury was investigated/assessed thoroughly for 1 of 3 residents reviewed for injuries and abuse. (Resident B) Finding includes: During an observation on 9/5/24 at 1:50 p.m., CNA 1 lifted up Resident B's shirt and removed her left arm from the sleeve of the shirt. There was a fading purplish/red bruised area from the underarm to the elbow, approximately 20 centimeters (cm) by 13 cm. The entire side and underneath the left breast had a purple bruise. CNA 1 indicated she was unsure how the injury occurred. The resident was unable to recall how the bruise occurred. Resident B's record was reviewed on 9/5/24 at 9:47 a.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Quarterly Minimum Data Set assessment, dated 6/22/24, indicated a moderately impaired cognitive status, no behaviors, no impaired movements of the upper and lower extremities, was dependent on staff for toileting, showers, dressing, hygiene, bed mobility, transfers and wheelchair mobility, and was not receiving blood thinners or anticoagulant medications. A Care Plan, dated 12/31/23, indicated assistance was required for activities of daily living. The interventions included two staff members and a mechanical lift was required for all transfers. A Nurse's Progress Note, dated 8/24/24 at 5:46 a.m. and signed by RN 2, indicated a large bruised area was observed on the left breast and left upper arm and the left ankle was slightly swollen. The resident complained of pain with movement of the ankle and was unable to remember how she received the bruises. There were no measurements of the bruising of the left arm or breast documented. A Nurse's Progress Note, dated 8/24/24 at 7:31 a.m., indicated the Nurse Practitioner ordered STAT X-rays for the left ankle and chest. The X-ray results, received by the facility on 8/24/24 at 11:46 a.m., indicated there were no fractures observed on the left ankle and there were no rib fractures. During an interview on 9/5/24 at 11:16 a.m., the Director of Nursing (DON), indicated the staff from 8/22/24, 8/23/24, and 8/24/24 had been interviewed. The interviews and the investigation had not been typed up. None of the staff had reported the resident had fallen. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/14 at 1 p.m., the DON indicated the bruising had not been measured when it was found. The policy indicated the the nurse who initially observed the bruising was to measure the bruise. The bruising had been observed by the DON on 8/24/24 and the bruise on the left arm went from the shoulder area to the mid arm and was approximately 7 cm by 4 cm. The left chest bruising went from under the arm to the left side of the breast and was about 4 cm by 4 cm. The DON indicated the following staff had been interviewed after the bruising was reported on 8/24/24: CNA 3 and CNA 4, who had worked night shift on 8/22/24 through the morning of 8/24/24, and they were unaware of the bruising and of a fall. They indicated CNA 5 had taken care of the resident. CNA 5 indicated she had been floated to another area and had not taken care of the resident. CNA 2 had reported there was gossip the resident had been dropped and was transferred off the floor without the incident being reported to the nurse. None of the other staff interviewed had indicated they heard the resident had been dropped. CNA 6 had indicated the bruises were observed on 8/23/24 on the evening shift while night time care was provided. The bruising was not reported at this time because she thought it had already been reported. During an interview on 9/5/24 at 1:16 p.m., RN 1 indicated the bruising of the left arm and breast area was purple when they were first observed on the morning of 8/24/24. The DON had asked her to take pictures of the areas and send them to her. The bruising was observed on the whole side of the left breast and the left arm had bruising from the elbow up to the shoulder. She had not measured the bruising and would estimate the bruising on the left arm at 20 cm by 7 cm. The ankle was a little puffy and Resident B complained of pain with movement. CNA 6 had worked a double shift and notified her. CNA 6 informed RN 1 she had seen the bruising earlier and had forgotten to report the bruising. CNA 7 came into work on 8/24/24 and indicated she had seen the bruises on the morning of 8/23/24. During an interview on 9/5/24 at 1:30 p.m., the DON indicated she forgot about the pictures. The pictures from 8/24/24 were observed on the cell phone. The left arm bruising was from under the arm at the shoulder to the elbow and the whole side of the left breast had purple bruising. The DON estimated the bruising of the breast to be 20 cm by 7 cm, and then indicated she was not good at estimating the size. The bruising had not been reported to the IDOH. During an interview on 9/5/24 at 1:35 p.m., CNA 7 indicated the bruises on the left arm and breast were observed when the resident was assisted with dressing on the morning of 8/23/24. She was unable to locate the nurse and went back to work and had not reported the bruising until she left for day around 11 a.m. The bruising was reported to LPN 8. During an interview on 9/5/24 at 1:44 p.m., LPN 8 indicated CNA 7 reported the bruising of the left arm and breast. CNA 7 had informed her the bruising had been reported to another nurse. LPN 8 had not followed up/assessed the bruising. During an interview on 9/5/24 at 2:04 p.m., the Administrator indicated the bruising had just been reported to IDOH. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/5/24 at 2:05 p.m., CNA 2 indicated the bruises were observed on 8/24/24. There had been rumors the resident had rolled out of bed on the night of 8/22/24 and was placed back into bed without the nurse being notified. During an interview on 9/5/24 at 2:11 p.m., the DON indicated CNA 3 had reported the resident was turned and repositioned. The resident had not been transferred from the bed the morning of 8/23/24. CNA 4 had indicated CNA 5 had taken care of the resident. CNA 5 was interviewed and had been floated to another unit and had not been in the resident's room. During an interview on 9/5/24 at 2:32 p.m., CNA 3 indicated CNA 5 had been assigned to the resident until she was moved to another unit around 1:00 a.m. The resident had not screamed out or fallen during the night and was unable to move around in the bed independently. During an interview on 9/5/24 at 3:25 p.m., CNA 6 indicated a report was given by CNA 7 on 8/23/24 about the bruising. There was a nurse sitting at the desk and CNA 6 was unsure if the nurse heard CNA 7 report the bruising. CNA 6 indicated she had not reported the bruising because she thought CNA 7 had already reported it. The facility abuse policy, dated 5/30/17 and received as current from the DON, indicated when an incident of neglect or abuse of a resident was suspected, the Abuse Coordinator was to be be notified immediately. An initial report was to be sent to IDOH. All alleged violations involving abuse, neglect and injuries of unknown source were to be reported immediately but no later than two hours. Injuries of unknown origin will be investigated. An injury of unknown origin would be an injury that was not observed and was suspicious because of the extent or the injury or the location of the injury. A facility wound assessment policy, dated 1/2024 and received as current from the Administrator, indicated bruising would be assessed if considered significant in size, location or characteristics. This citation relates to Complaint IN00442079. 3.1-28(c) 3.1-28(d)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident who required respiratory care received care consistent with profession standards and was administered oxygen as ordered by the physician, for 1 of 1 resident reviewed for respiratory care. (Resident E) Finding includes: During an observation on 9/5/24 at 9:38 a.m., LPN 8 responded to an activated call light activated by Resident F. Resident F indicated Resident E's oxygen concentrator was alarming and it was driving him crazy. LPN 8 indicated she needed to administer medications then she would take care of the concentrator, said she would be back, then left the room. During an observation on 9/5/24 at 9:42 a.m., Resident E was lying in bed with the head of the bed elevated. A nasal cannula for the oxygen was in place. The oxygen concentrator was alarming and a lit picture of a wrench was flashing on the concentrator. The concentrator was set at less than 0.5 liters per minute. During an interview on 9/5/24 at 9:59 a.m., Minimum Data Set (MDS) Nurse 9 indicated she was unsure what the wrench meant. She acknowledged the alarm continued and the concentrator was setting for oxygen administration at a little bit over zero. Another concentrator would be needed and she would also report this to the resident's nurse. During an observation on 9/5/24 at 10:06 a.m., LPN 8 entered the room and indicated all the other concentrators were broken. MDS Nurse 9 had brought an oxygen cylinder into the room. LPN 8 obtained the resident's oxygen saturation at 83% and indicated the resident was still wheezing and he had just received a nebulizer treatment. The oxygen had been working during the night shift and the setting would not go higher than the 0.5 liters per minute. MDS Nurse 9 applied the oxygen at 2 liters per minute through the oxygen cylinder and the resident's oxygen saturation result was 93%. LPN 8 indicated she had been in the room about 30-40 minutes ago and had turned the concentrator on and off and it still beeped. No one else had been notified and the oxygen cylinder had not been used because they have never used them. During an interview on 9/5/24 at 10:12 a.m., the Administrator indicated the concentrator not working was just reported to her and there were other concentrators in the building. A different nurse had retrieved another concentrator was taking it to the resident's room There were also cylinders in the building the staff could have used. Resident B's record was reviewed on 9/5/24 at 4:10 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. A Care Plan, dated 8/23/24, indicated a diagnosis of pneumonia. The interventions included medications would be administered as ordered. A current Physician's Order indicated oxygen to be delivered at two liters per nasal cannula. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse Practitioner's Progress Note, dated 8/22/24, indicated wheezing and congestion. The oxygen saturation had been low the past week and oxygen was started at two liters by nasal cannula. There was difficulty obtaining a good oxygen saturation reading due to clenching of hands. A facility oxygen administration policy, dated 9/2009 and received as current, indicated oxygen would be provided to the resident as ordered by the attending physician. 3.1-47(a)(6)