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	12/19/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666 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. 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) (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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: - [NAME] 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) 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 [DATE]. 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. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurses' Note, dated 12/9/24 at 10:26 a.m., indicated new orders were received to obtain a 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 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)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32788 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, 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. 45666 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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. 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. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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 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. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaints IN00442945, IN00447461 and IN00449198. 3.1-37(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 48055 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 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)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 32788 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. 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. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-49(g) 3.1-49(h) 3.1-49(i)