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	04/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crown Point Health Campus	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 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. 32788 Based on observation, record review, and interview, the facility failed to notify the physician and the resident that a medication was unavailable for 1 of 3 residents reviewed for medications. (Resident E) Finding includes: During an interview on 4/8/25 at 11:09 a.m., Resident E indicated she had not received her long-acting insulin this past Saturday and Sunday evening. She had told the nurse where to look for it but apparently she couldn't find it. She was not sure why the nurse had not found it and was not given any further explanation. Record review for Resident E was completed on 4/7/25 at 3:09 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, atrial fibrillation, and multiple sclerosis. The Quarterly Minimum Data Set (MDS) assessment, dated 3/13/25, indicated the resident was cognitively intact. The Physician's Order Summary, dated 4/2025, indicated Lantus (insulin glargine, long-acting insulin) 25 units subcutaneous at bedtime. The Medication Administration Record (MAR), dated 4/2025, indicated the Lantus administrations for 4/5/25 at 8:00 p.m. and 4/6/25 at 8:00 p.m. had been marked with the code 9, which indicated to see the progress notes. An Electronic Medication Administration Record (EMAR) Note, dated 4/5/25 at 8:30 p.m., indicated the Lantus was unavailable and had not been reordered from the pharmacy because it was trying to be refilled too soon. The pharmacy was going to send over a form for the facility to sign in order to get it refilled. The medication was not available in the emergency drug kit (EDK) supply. There was lack of documentation to indicate the physician or the resident had been made aware the insulin was unavailable. An EMAR Note, dated 4/6/25 at 8:53 p.m., indicated the Lantus had not yet been delivered from the pharmacy. There was lack of documentation to indicate the physician or the resident had been made aware the insulin was unavailable. (continued on next page)

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	The Progress Notes, dated 4/5/25 through 4/6/25, lacked any documentation the physician or the resident had been made aware the insulin was unavailable. During an interview on 4/9/25 at 11:26 a.m., the Interim Director of Nursing (DON) indicated the previous DON had identified that the resident had not received the insulin on 4/5/25 and 4/6/25. The DON had spoken with the nurse who worked those shifts. The nurse indicated she had called the pharmacy to reorder the insulin and was told the DON would have to sign a form to get it refilled. She had text messaged the on-call Nurse Practitioner to make them aware and there were no new orders. She had notified the resident that the insulin was unavailable and had to be reordered. The Interim DON was unable to provide any documentation the Nurse Practitioner or the resident had been made aware the insulin was unavailable. This citation relates to Complaint IN00456087. 3.1-5(a)(2) 3.1-5(a)(3)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 45666 Based on record review and interview, the facility failed to document incontinence care for a resident who was dependent on staff for activities of daily living (ADLs) for 1 of 4 residents who were reviewed for ADLs. (Resident B) Finding includes: Resident B's record was reviewed on 4/7/25 at 10:20 a.m. Diagnoses included, but were not limited to, dementia, hemiplegia and hemiparesis (weakness and paralysis) following a cerebral infarction (stroke). The Discharge Minimum Data Set (MDS) assessment, dated 3/12/25, indicated the resident was severely cognitively impaired. She was totally dependent on staff for assistance with toileting and transfers. She was frequently incontinent of bladder and always incontinent of bowel. The current Care Plans indicated the resident had episodes of incontinence and was at risk for complications. Interventions included, but were not limited to, encourage fluids, provide incontinence care, and toilet at regular intervals or scheduled voiding. The CNA Task: Incontinence Care was reviewed from 3/17/25 to 4/7/25. The documentation frequency was every shift. The following dates and shifts were not documented: - 1st shift on 3/17, 3/18, and 3/24/25 - 2nd shift on 3/17, 3/18, 3/31, 4/1, and 4/4/25 - 3rd shift on 3/17, 3/29, 3/30, 3/31, and 4/3/25 During an interview on 4/9/25 at 11:30 a.m. the Interim Director of Nursing indicated the care plan for scheduled voiding would be discontinued as she was no longer a candidate for scheduled voiding. A policy titled, Incontinence, indicated .c. A resident who is incontinent of bladder receives appropriate treatment and services to maintain bladder function as much as possible and prevent complications related to incontinence. This citation relates to Complaint IN00455245. 3.1-38(a)(2)(c)

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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. 20580 Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice related to a medication not administered as ordered by the physician for 1 of 3 residents reviewed for quality of care. (Resident F) Finding includes: Resident F's record was reviewed on 4/9/25 at 2:04 p.m. The diagnoses included, but were not limited to neuropathy and arthritis. A Physician's Order, dated 3/29/25, indicated guaifenesin (cough syrup) extended release (ER) 600 mg, one tablet was to be administered every 12 hours for seven days for a cough. (14 doses) The Medication Administration Record (MAR), dated 3/2025, indicated the guaifenesin had not been administered on 3/29/25 at 9:00 p.m., 3/30/25 at 9:00 a.m. and 9:00 p.m., and 3/31/25 at 9:00 p.m. The guaifenesin was documented as given on 3/31/25 at 9:00 a.m. The MAR, dated 4/2025, indicated the guaifenesin had been administered on April 1-4, 2025 at 9:00 a.m. and 9:00 p.m., and April 5, 2025 at 9:00 a.m. The resident had not received the medication for seven days as ordered and had received 9 of the 14 doses ordered. During an interview on 4/10/25 at 9:20 a.m., the Interim Director of Nursing (IDON) acknowledged the medication had not been administered as ordered. A facility medication administration policy, dated 10/24/14 and received as current from the IDON, indicated medications were to be administered as prescribed. This citation relates to Complaint IN00456087. 3.1-37

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45666 Based on observation, record review, and interview, the facility failed to provide supplements as ordered and document nutritional intake for meals for residents with weight loss for 2 of 3 residents reviewed for nutrition. (Residents D and H) Findings include: 1. On 4/8/25 at 11:24 a.m., CNA 3 was observed taking a lunch tray to Resident D. She received a cheeseburger, tater tots, pickles, and a can of soda. There was no Mighty Shake on the tray at the time. During an observation and interview on 4/8/25 at 11:45 a.m., CNA 3 brought out Resident D's tray to return to the tray cart. The resident had picked at the food. There was no Mighty Shake present on the tray. Both CNA 3 and LPN 1 confirmed the resident had not received the Mighty Shake and dietary was responsible for putting those on the trays. Resident D's record was reviewed on 4/7/25 at 11:16 a.m. Diagnoses included, but were not limited to, dementia, protein-calorie malnutrition, and cognitive communication deficit. The resident weighed 100.5 pounds on 11/12/24 and the most recent weight was 96 pounds on 4/7/25. The Quarterly Minimum Data Set (MDS), dated [DATE], indicated the resident was severely cognitively impaired. The resident required setup assistance for eating. The current April 2025 Physician Order Summary indicated Mighty Shake twice daily, regular diet, and 1000 milliliter (ml) fluid restriction per day, nursing to provide 215 ml per shift, dietary to provide 120 ml per day, and nursing to provide Mighty Shakes, 4 ounces to be given in place of 4 ounces of fluid at lunch and dinner. The current Care Plans indicated the resident had a physician's order for a diet with fluid restriction. Interventions included, but were not limited to, provide the appropriate diet as ordered and dietary to provide 4 ounces per meal and may provide Mighty Shake twice daily. During an interview on 4/9/25 at 11:30 a.m., the Interim Director of Nursing indicated she had no further information to provide. 2. Resident H's record was reviewed on 4/10/25 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 3/10/25, indicated the resident was severely cognitively impaired and was dependent on staff for all ADLs including eating, toileting, personal hygiene, and transfers. She received hospice care. The resident weighed 154.8 pounds on 10/15/24 and 138.8 pounds on 4/2/25. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The current Care Plans indicated the resident has unplanned/unexpected weight loss related to the need for end of life care. Interventions included, but were not limited to, monitor and record food intake at each meal. The CNA Task: Nutritional Intake was reviewed from 3/17- 4/10/25. There were no lunch or dinner meals documented on 3/21. There were no dinner meals documented on 3/25/25, 3/28/25, 3/30/25, 4/2/25, 4/3/25, and 4/5/25. During an interview on 4/10/25 at 10:45 a.m., the Interim Director of Nursing indicated she had no further information to provide. A facility policy titled, Nutritional Monitoring, indicated, .Ensure staff awareness of resident diet order, including supplements and food consistency. Ensure receipt of correct, diet, supplements, and food consistency .Monitor each meal intake to include food, hydration, and supplement consumption. Indicate overall percentage consumed by the end of the meal . This citation relates to Complaint IN00455369 and IN00455913. 3.1-46(a)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 20580 Based on record review and interview, the facility failed to ensure a resident was provided with routine medications in a timely manner by the contracted pharmacy, related to medications not available to be administered as ordered by a physician for 1 of 3 residents reviewed for medications. (Resident F) Finding includes: Resident F's record was reviewed on 4/9/25 at 2:04 p.m. The diagnoses included, but were not limited to neuropathy and arthritis. An After Visit Summary from the hospital, dated 3/28/25, indicated the resident was being treated for a urinary tract infection. The discharge orders included cephalexin (antibiotic) 500 mg (milligrams), one capsule three times a day for seven days. A Nurse's Progress Note, dated 3/29/25 at 3:32 a.m., indicated the resident was readmitted to the facility and the Physician's Discharge Orders were verified with the physician. a) The Physician's Orders, dated 3/29/25 and discontinued on 3/31/25, indicated cephalexin 500 mg, one tablet was to be given three times a day for infection for seven days. The medication was to be started on 3/29/25 at 10 p.m. The Medication Administration Record (MAR), dated 3/2025, indicated the cephalexin 500 mg was administered on 3/29/25 at 10:00 p.m., 3/30/25 at 6:00 a.m., 2:00 p.m.,10:00 p.m. and had not been administered on 3/31/25 at 6:00 a.m. The MAR, dated 3/2025, indicated the cephalexin 500 mg had not been given on 3/31/25 at 6:00 a.m., 2:00 p.m., and 10:00 p.m. A Medication Administration Progress Note, dated 3/31/25 at 6:05 a.m., indicated the cephalexin was unable to be given due to a power outage and was unable to be obtained from the Emergency Drug Kit (EDK). A Nurse's Progress Note, dated 3/31/25 at 12:24 p.m., indicated the pharmacy was notified in regards to the delivery status and informed the facility the resident's insurance would not cover the cephalexin and they would fax the Director of Nursing (DON) for an authorization. The Unit Manager, Nurse Practitioner, DON, and POA (Power of Attorney) were notified. A Medication Administration Progress Note, dated 3/31/25 at 1:42 p.m., indicated the cephalexin 500 mg's was not available due to the insurance would not cover the cost. The Nurse Practitioner, POA, DON, and the Unit Manager were notified. A Physician's Order, dated 3/31/25 at 2:00 p.m., indicated the cephalexin 500 mg, one tablet was to be administered three times a day for five days for bronchopneumonia. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The MAR, dated 4/2025, indicated the cephalexin 500 mg was started three times a day on 4/1/25 at 6:00 a. m. During an interview on 4/9/25 at 4:07 p.m., with the Interim DON (IDON), the Executive Director (ED), and the Administrator, the ED indicated there was a power outage and the generator was working and the EDK would have been functional. The IDON was unsure why the authorization had not been given by the DON. During an interview on 4/10/25 at 9:20 a.m., the IDON indicated the cephalexin 500 mg was obtained from the EDK for the 3/29/25 10:00 p.m. dose and the 3/30/25 6:00 a.m. dose. She indicated the 3/30/25 2:00 p. m. and 10:00 p.m. doses were signed out as given, though she was unsure where they obtained the medications from since the pharmacy had not delivered the medication and the medication was not removed from the EDK per the EDK records. She indicated the medication order was transcribed incorrectly indicating another pharmacy would be supplying the medication. The facility pharmacy had not indicated the insurance would not pay for the medication. The nurses and/or DON had not contacted the pharmacy to question why the medication had not been sent or about the authorization. b) A Physician's Order, dated 3/29/25, indicated guaifenesin (cough syrup) extended release (ER) 600 mg, one tablet was to be administered every 12 hours for seven days for a cough. The MAR, dated 3/2025, indicated the guaifenesin had not been administered on 3/29/25 at 9:00 p.m., 3/30/25 at 9:00 a.m. and 9:00 p.m., and 3/31/25 at 9:00 p.m. The guaifenesin was documented as given on 3/31/25 at 9:00 a.m. Medication Administration Progress Notes, dated 3/29/25 at 10:08 p.m., 3/30/25 at 10:33 a.m., 3/30/25 at 10:00 p.m., and 3/31/25 at 8:00 p.m., indicated the guaifenesin had not been delivered from the pharmacy and was not available in the EDK. During an interview on 4/10/25 at 9:20 a.m., the IDON indicated the guaifenesin was transcribed incorrectly indicating another pharmacy would be supplying the medication. The facility pharmacy had not sent the medication and the guaifenesin was not available in the EDK. She was unsure where the the nurse obtained the guaifenesin for the 3/31/25 9:00 a.m. dose. A facility policy for ordering medications, dated 10/25/14 and received as current from the IDON, indicated medication orders were to be written on a medication order form and entered into an electronic medical record system. Re-admission orders were sent to the pharmacy. The facility was to indicate the name of the pharmacy supplier. This citation relates to Complaint IN00456087. 3.1-25(a)