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	07/24/2025

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 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. Based on interview and record review, the facility failed to develop and/or implement policies and procedures for ensuring the reporting of a reasonable suspicion of a crime in accordance with section 1150B of the Act related to an allegation of physical and sexual abuse for 1 of 1 resident reviewed for abuse. (Resident E) Finding includes:Resident E's closed record was reviewed on 7/22/25 at 9:09 a.m. The diagnoses included, but were not limited to dementia, bipolar with current manic episodes with psychotic features, and unsteadiness on her feet. The admission date was 6/20/25. A Nurse's Progress Note, dated 6/20/25 at 11:30 p.m., indicated the resident voiced an allegation that she had been both physically and sexually assaulted the day earlier.During an interview on 7/22/25 at 11:35 a.m., the Administrator indicated the allegation had not been investigated or reported immediately to the Administrator, Indiana Department of Health (IDOH), the resident's previous facility, physician, responsible party, or local law enforcement.A Reported IDOH Incident, dated 7/22/25, indicated the Administrator was notified of a Progress Note that indicated an allegation of physical and sexual abuse. LPN 4 had indicated she thought the resident was in a manic state and the allegation was related to the mental state at the time the allegation was voiced. The Resident's family and Physician were notified on 7/22/25.The facility abuse policy, dated 9/1/24 and received as current from the Administrator, indicated the employees were required to report any allegation of abuse to the Administrator immediately or to the immediate supervisor. Any allegation of abuse was to be investigated and reported to the IDOH.3.1-28(c)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, record review and interview, the facility failed to ensure residents received necessary care and services, related to, treatments to surgical sites were not completed, glucometer monitoring (blood sugar checks) were not completed and orders not clarified for the glucometer monitoring, a thorough admission assessment was not completed, a elopement risk assessment was not completed accurately, insulin was not administered as ordered, and bruising un unknown cause was not investigated and monitored, for 4 of 12 residents reviewed for quality of care. (Residents D, E, F, and M)Findings include:1. During an observation on 7/23/25 at 2:42 p.m., the Wound Nurse indicated Resident D had two surgical wounds located on the left ischium and on the sacral area. There was a dressing on each of the areas with the date of 7/21/25. Both areas were washed and patted dried, covered with calcium alginate (wound treatment) and covered with foam dressings. She indicated the wounds were improving. Resident D’s record was reviewed on 7/24/25 at 10:13 a.m. The diagnoses included, but were not limited to, osteomyelitis, stroke, and post-surgical closure and debridement of stage four (full thickness) pressure ulcers. The admission date was 6/20/25. A Care Plan, dated 6/24/25 and revised on 7/17/25, indicated there were surgical wounds on the left ischium and sacrum area. The interventions included the treatment would be completed as ordered. An admission Minimum Data Set assessment, dated 6/26/25, indicated an intact cognitive assessment, surgical wounds were present, was receiving an antibiotic, and had intravenous (IV) medications and access. a. A Skin/Wound Note, dated 6/20/25 at 4:30 p.m., indicated the resident had been admitted from an acute care facility. A head-to-toe assessment was completed. There was an IV line in the left upper arm, a feeding tube, colostomy, and urinary catheter present. There was a surgical site observed on the right hip with 10 sutures and 24 staples. The coccyx and left ischium both had six sutures, and the right ischium had eight sutures. There were pressure ulcers on the bilateral heels. New orders were received from the Nurse Practitioner and skin would be re-assessed in a week. There was no admission Assessment completed at the time of admission other than the Skin and Wound Note. A facility policy for the admission assessments, dated 9/1/24, and received from the Administrator as current, indicated the residents were to have a comprehensive assessment upon admission to identify each resident’s physical, emotional, psychological, and social needs. b. The Physician’s admission Orders indicated an order on 6/20/25 to monitor the blood glucose four times a day and on 6/21/25 there was also an order to complete blood sugar glucose testing twice a day. There was no clarification of the blood sugar monitoring orders. The blood sugars had not been completed on the Medication and Treatment Administration Records from 6/21/25 to 7/24/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	c. A Physician’s Order, dated 6/21/25 and discontinued on 7/8/25, indicated the coccyx (sacrum) surgical site was to be cleansed with normal saline, patted dry, and a foam dressing was to be applied every day shift and as needed for dislodgement/soilage. The Treatment Administration Record (TAR), dated 7/2025, indicated the treatment had not been completed on 7/5/25 A Physician’s Order, dated 6/21/25 and discontinued on 7/8/25, indicated the left ischium surgical site was to be cleansed with normal saline, patted dry, and a foam dressing was to be applied every day shift and as needed for soilage/dislodgement. The TAR, dated 7/2025, indicated the treatment had not been completed on 7/8/25. During an interview on 7/24/25 at 1:33 p.m., the Director of Nursing indicated the blood sugar monitoring had not been completed. The order had not been transcribed correctly so it had not been transferred over to the Medication Administration Record. She indicated the resident was not diabetic. She acknowledged the treatment had not been completed as ordered and an admission Assessment should have been completed. 2. Resident E’s closed record was reviewed on 7/22/25 at 9:09 a.m. The diagnoses included, but were not limited to dementia, bipolar with current manic episodes with psychotic features, and unsteadiness on her feet. The admission date was 6/20/25. A Nurse’s Progress Note, dated 6/20/25 at 11:30 p.m., indicated the resident packed her belongings and stated she was leaving the facility. An admission Clinical Observation was dated 6/20/25 at 11:45 p.m. The Neurological Observation indicated the resident was oriented to person. The Elopement section indicated she was able to ambulate independently, was not oriented to person, place, time. Statements were made by the resident of dissatisfaction or intention to leave. The resident was physically able to leave the facility independently. A Skilled Evaluation, dated 6/21/25 at 10:36 a.m., indicated the resident was oriented to person, place, and time (x3), though was disoriented to person and time. During an interview on 7/23/24 at 11:33 a.m., LPN 5 indicated the resident had periods of confusion and she was forgetful at times. She was not oriented at all times and the “oriented x3” may have been marked by accident. LPN 5 could not recall the status of the resident on 6/21/25. A Nurse’s Progress Note, dated 6/21/25 at 11:59 a.m., indicated the resident had packed her belongings and was wanting to leave. A family member indicated the resident was confused. A Nurse’s Progress Note, dated 6/21/25 at 4:15 p.m., indicated she had attempted to exit the facility using the Emergency Exit due to wanting to get a soda and candy bar and the alarm was activated. A Nurse’s Progress Note, dated 6/21/25 at 8:20 p.m., indicated she had packed her belonging and thought someone was stealing from her. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Nurse’s Note, dated 6/21/25 at 8:56 p.m., indicated she was pulling plates from a cabinet in the Bistro and telling staff they were hers and someone had stolen them. A Nurse’s Note, dated 6/22/5 at 9:30 p.m., indicated the resident was in the front foyer area and had aggressive and destructive behavior. A Cognitive Status Assessment, dated 6/23/25 at 7:06 a.m., indicated an intact cognition status. A Skilled Evaluation, dated 6/23/25 at 12:57 p.m., indicated the resident was agitated, anxious, and restless. She had confusion and was forgetful. A Nurse Practitioner’s Progress Note, dated 6/23/25 at 1:25 p.m., indicated the resident had a flight of ideas, seemed anxious and was ready to go home. She had dementia and needed to be monitored for any exit seeking behaviors. The Elopement Risk Assessment, dated 6/23/24 at 4:04 p.m. and completed by the Social Service Director, included the following questions: - Is there a history (prior to admission) of wandering/elopement and/or does the resident verbalize a strong desire to leave? This was marked no. - Is there a diagnosis of dementia and/or severe mental illness? This was marked yes - Was there any reported/documented episodes of elopement and/or attempts to elope? This was marked no. - Are there signs of compromised decision capacity and substantially impaired judgement and/or physical status limitations that would place the resident at risk in the community? This was marked no. The Behavioral Observations indicated if 6 or more triggers, makes the resident a possible elopement risk: - Does the resident, hang around the facility exits and/or stairways? (if yes, score 2 points). This was marked no - Does the resident verbalize a serious/strong intent to leave the facility in the absence of an appropriate discharge plan? (if, yes, score 3 points). This was marked no - Does the resident have the physical ability to leave the building? (if yes, score 1 point). This was marked yes. - Does the resident become agitated, confused, and/or disoriented or displays consistently poor judgement (i.e would not be able to safely care for hi/herself outside of the facility)? (if yes, score 2 points) This was marked no. The assessment indicated the combined score was 2 and the resident was not a risk for elopement. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Nurse’s Progress Notes indicated the above questions would have been a yes, making the score 8 and the resident was at risk for elopement. During an interview on 7/22/25 at 11:35 a.m., the Social Service Director indicated she did not recall if she reviewed the Nurses’ Progress and Skilled Notes prior to the completion of the Elopement Risk Assessment. 3. Resident F’s record was reviewed on 7/23/25 at 9:23 a.m. The diagnoses included, but were not limited to, dementia, long term use of insulin, depression, diabetes, and hypertension (high blood pressure). The 5/27/25 admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and he received insulin. A Care Plan, dated 6/3/25, indicated the resident was at risk for complications related to diagnosis of diabetes. Interventions included, but were not limited to, administer diabetes medication as ordered and monitor/document for side effects and effectiveness. A Physician’s Order, dated 5/21/25, indicated the resident was Insulin Dependent. A Physician’s Order, dated 5/23/25, indicated the resident received a Humalog Injection (insulin injection) per sliding scale (amount of medication needed is based on blood sugar levels) subcutaneously (applied under the skin) before meals and at bedtime. A Physician's Order, dated 7/1/25, indicated the resident received 5 units of Insulin Glargine subcutaneously at bedtime. The June 2025 Medication Administration Record (MAR) indicated the Humalog was not signed out as given and no blood sugar level was documented on 6/24/25 at 11:00 a.m., and 6/27/25 at 9:00 p.m. The July 2025 Medication Administration Record (MAR) indicated the Insulin Glargine was not signed out as given and no blood sugar level was documented on 7/1/25 at 9:00 p.m. During an interview on 7/23/25 at 4:00 p.m., the nurse consultant indicated she had no answer as to why insulin was not given or documented on 6/24, 6/27, and 7/1/25. 4. Resident M’s record was reviewed on 7/24/25 at 9:00 a.m. The diagnoses included, but were not limited to, dysphagia (difficulty swallowing), parkinsonism, gastrostomy status, diabetes, and chronic respiratory failure. The 5/19/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident was severely impaired for daily decision making. A Care Plan, dated 6/2/25, indicated the resident had diabetes. Interventions included, but were not limited to, administer diabetes medication as ordered and monitor for adverse effects, monitor/document/report signs of hyperglycemia and hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A Physician’s Order, dated 7/3/25, indicated the resident received 20 units of Lantus insulin subcutaneously two times a day. The June 2025 Medication Administration Record (MAR) indicated the Lantus was not signed out as given on 6/6, 6/7, 6/13, 6/14, and 6/15/2025 for the 8:00 p.m. dose. The July 2025 Medication Administration Record (MAR) indicated the Lantus was not signed out as given on 7/12/25 for the 8:00 p.m. dose. During an interview on 7/24/25 at 10:18 a.m., the Director of Nursing indicated she did not have an answer to why Resident M’s insulin was not given and signed out. No further information was provided. This citation relates to Complaints 1810989, 1811010, and 1811012. 3.1-37(a)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure adequate supervision was in place to prevent elopement of a resident with diagnoses of dementia and bipolar in a manic state with psychotic features. The resident had indicators of being an elopement risk and behaviors of wanting to exit the facility. The facility was unaware of the resident's where abouts and the resident was found by a Good Samaritan standing in the road, approximately 0.15 miles from the facility, on a highly traveled road. The resident was returned to the facility by the Good Samaritan. (Resident E) The Immediate Jeopardy began on 6/24/25, when the facility was unaware the resident had exited the facility without supervision. The resident walked independently and was found standing on the road that runs in front of the facility at approximately 4:50 a.m. by a Good Samaritan, who assisted the resident back to the facility. The Administrator, Executive Director (ED), and the Director of Nursing (DON), were notified of the immediate jeopardy on 7/22/25 at 2:52 p.m. The immediate jeopardy was removed on 7/23/25, but noncompliance remained at the lower scope and severity level of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy. The facility also failed to ensure a resident who had falls had documentation of a fall, assessments after the fall, family and Physician notification, investigation of the fall, assessments and follow up assessments after the falls, for 1 of 1 resident reviewed for falls. (Resident H) Findings include:1. During an interview on 7/22/25 at 5:05 a.m., the Administrator and DON indicated there had been no current elopements from the facility. The Administrator indicated if there had been an elopement, she would have reported it to the Indiana Department of Health (IDOH). During an interview on 7/22/25 at 5:21 a.m., RN 1 indicated a person from the outside community had found Resident E outside of the building on 6/24/25 and brought her back to the facility. She had not been the nurse assigned to the resident that night. The resident was last seen in the lounge across from the Nurses' Station drinking coffee and was gone from the facility approximately 30 minutes. The DON had been notified of the incident. During an interview on 7/22/25 at 5:24 a.m., LPN 2 indicated she had been the nurse assigned to Resident E. On 6/24/25, early morning, the resident was in the Dining Room/Lounge, across from the Nurses' Station, and requested coffee. She drank the coffee and said she was going back to her room. The resident was brought back to the facility through the [NAME] Unit Doors by a community person. LPN 2 indicated one of the staff members from the [NAME] Unit called the DON and the DON called the Grace Unit and directed her to go to the [NAME] Unit to assist the resident back up to the Grace Unit. There were no injuries observed. She was missing from the building about 30 minutes from the last time she was observed. She left through the front door. The Front door had been slid open and would not close when attempts were made to reset the door. LPN 1 indicated she was instructed not to document the incident. The resident had not been at the facility very long and kept her belongings packed and made statements she was going home. She also had other behaviors. During an interview on 7/22/25 at 5:33 a.m., CNA 3 indicated Resident E would make comments she was ready to go and she was not going to stay at the facility. She would wander the hallways and was exit-seeking. She never stayed in her room very long. The staff had to keep a close eye on the resident. During an interview on 7/22/25 at 6:20 a.m., the Executive Director (ED) indicated the incident had not been reported to the Indiana Department of Health (IDOH). They had not considered this event an elopement. The resident was oriented to person, place and time and was assessed as safe to be out in the community. The Administrator indicated the resident was not off the facility grounds and she had been found at the edge of the parking lot. During a telephone interview on 7/22/25 at 8:17 a.m., the Good Samaritan indicated she was driving west on the road in front of the facility about 4:50 a.m. on 6/24/25 and saw a woman who was kind of hunched over standing in the road. She indicated it was just getting light outside. She turned her car around and came back to get the resident. She indicated the resident was about a quarter of a mile down the road from the main entrance and was at the end of the turn in lane into the facility parking lot. The resident was not hesitant about getting in the car and just wanted a cup of coffee. The resident gave her a home address and informed her she did not want to go back to the facility. The resident was returned to the unit at the back of the building and the Good Samaritan indicated she had spoken to the DON on the phone. The resident had indicated her knees were hurting. On 7/22/25 at 8:45 a.m., the pathway from the front door to the approximate area where the resident was found, through the grass and not the parking lot, was walked. Once in the grassy area, it was downhill, then uphill closer to the road. The distance was measured with a sports watch and registered at 0

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observations, record review, and interview, the facility failed to ensure a resident's tube feeding was infusing at the correct flow rate for 1 of 3 residents reviewed for feeding tube usage. (Resident H)Finding includes:During an observation on 7/22/25 at 3:03 p.m., the liquid tube feeding for Resident H was not infusing.During an observation on 7/23/25 at 11:51 a.m., the liquid tube feeding of Jevity 1.5 was infusing at 60 cc/hr (cubic centimeters per hour).Resident H's record was reviewed on 7/23/25 at 1:56 p.m. The diagnoses included, but were not limited to, gastrostomy tube and dysphagia.A Care Plan, dated 5/26/25, indicated a feeding tube was present. The interventions indicated the tube feeding and water flushes were to be administered as ordered by the Physician.An admission Minimum Data Set assessment, dated 5/28/25, indicated a severely impaired cognitive status and had a feeding tube and it provided 51% or more of daily nutrition and 502 milliliters or more of fluids daily. A Physician's Order, dated 7/17/25, indicated a liquid feeding of Jevity 1.5 at 60 cc/hr for 18 hours. Turn the feeding off at 8:00 a.m. and turn the feeding on at 2:00 p.m. The Medication Administration Record, dated 7/2025, indicated the enteral feeding order was one time per day of Jevity 1.5 at 60 cc/hr for 18 hours for a total of 1350 cc's. Turn feeding off at 8:00 a.m. and on at 2:00 p.m. The time was documented as 5:30 p.m. and was being checked off as done. During an interview on 7/23/25 at 4:46 p.m., the Director of Nursing indicated she would re-write the feeding tube orders to make the orders clearer. This citation relates to Complaint 1811010.3.1-44(a)(2)

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and interview, the facility failed to ensure a PICC (peripherally inserted central catheter) line had physician's orders for the care and monitoring and the dressing was changed once weekly for 1 of 1 resident reviewed for PICC line care. (Resident D)Finding includes:During an observation on 7/23/25 at 2:42 p.m., a PICC line was observed in the resident's left upper arm. The date on the dressing covering the PICC line was 7/13/25. The Wound Nurse indicated the dressing was to be changed weekly. Resident D's record was reviewed on 7/24/25 at 10:13 a.m. The diagnoses included, but were not limited to, osteomyelitis, stroke, and post-surgical closure and debridement of stage four (full thickness) pressure ulcers. The admission date was 6/20/25.A Skin/Wound Note, dated 6/20/25 at 4:30 p.m., indicated an intravenous (IV) line was observed on the left upper arm.A Physician's Order, dated 6/21/25, indicated ceftriaxone (antibiotic) 2 grams was to be administered daily for osteomyelitis until 7/17/25.There were no physician's orders for the flushes, dressing changes, nor other care of the PICC line.The Medication and Treatment Administration Records, dated 6/2025 and 7/2025, lacked instructions for the flushes, dressing changes, and other care of the PICC line.A Nurse's Progress Note, dated 6/24/25 at 6:26 a.m., indicated the PICC line was intact and was flushed with 10 cc's (cubic centimeters) of normal saline. The site of insertion was clean, dry and intact and there was no signs or symptoms of infection.An admission Minimum Data Set (MDS) assessment, dated 6/26/25, indicated an intact cognitive status, received an antibiotic, had an intravenous (IV) access and received IV medications.Nurses' Progress Notes, dated 6/29/25 at 12:01 p.m. and 9:15 p.m., indicated the IV site was patent and there were no signs and symptoms of infection. The notes had not indicated the IV was flushed.A Nurse's Progress Note, dated 6/30/25 at 12:50 a.m., indicate the IV was flushed with 10 cc's of sterile normal saline, flushes easily and the insertion site was without signs of infection.A Nurse's Progress Note, dated 7/1/25 at 2:27 a.m., indicated the IV was flushed with normal saline and the site was with signs of infection.A Nurse's Progress Note, dated 7/2/25 at 12:17 a.m., indicated the IV site had no symptoms of infection.A Nurse's Progress Note, dated 7/3/25 at 1:52 a.m., indicated no signs of infection at the insertion site.There were no other assessments of the PICC line or indications the PICC was flushed until 7/8/25 at 7:22 p.m.A Nurse's Progress Note, dated 7/8/25 at 6:15 a.m., indicated the PICC was flushed with normal saline and the site was without signs of infection.A Nurse's Progress Note, dated 7/8/25 at 11:15 p.m., indicated the PICC flushed easily and there was no sign of infection.The next documentation on the PICC was 7/12/25 at 1:52 a.m., that indicated the PICC was flushed and no signs of infection at the insertion site.A Nurse's Progress Note, dated 7/13/25 at 2:57 p.m., indicated the PICC line dressing had been changed with sterile technique.A Nurse's Progress Note, dated 7/14/25 at 12:09 a.m., indicated the PICC was flushed and there was no sign of infection at the insertion site.The Medication Administration Records, dated 7/2025, indicated the last dose of the antibiotic was on 7/16/25.A Nurse's Progress Note, dated 7/18/25 at 2:25 a.m., indicated the antibiotic treatment continued and there was no signs of infection at the PICC insertion site.A Care Plan, revised on 7/18/25, indicated an IV in the left upper arm was present. The interventions indicated the insertion site would be assessed during the infusions and at least every shift when not in use and the line would be flushed with 10 cc's (cubic centimeters) of normal saline and follow with 5 cc's of heparin - 10 units per cc.A Nurse's Progress Note, dated 7/19/25 at 6:30 a.m., indicated the resident was still receiving the antibiotic.A Nurse's Progress Note, dated 7/20/25 at 12:32 a.m. (late entry on 7/22/25 at 1:51 a.m.), indicated the PICC was flushed with normal saline, the dressing was clean, dry, and intact, and there was no signs of infection at the insertion site. There were no further Nurses' Progress Notes that indicated the PICC had been flushed, assessed, and dressing had been changed per the Care Plan interventions.During an interview on 7/24/25 at 1:33 p.m., the Director of Nursing (DON), indicated the PICC line was to be removed today. There were no order for the flush, dressing change, nor other care of the PICC.A facility policy for flushing the PICC line, dated 9/1/16 and received from the Corporate Regional RN as current, indicated the lines would be flushed to maintain patency. The catheters were to be flushed at regular intervals to maintain patency and before and after medication administration.A facility policy for PICC dressing changes, received from the Corporate Regional RN as current, indicated dressing changes were to be completed every five to seven days or as needed.3.1-47(a)(2)

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	07/24/2025

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. Based on observation and interview, the facility failed to ensure medications were stored properly for 2 of 2 medication carts observed. (B wing medication cart and C wing medication cart)Findings include:1. On 7/23/25 at 8:04 a.m., LPN 1 was observed in Resident C's room. The C Wing medication cart was in the hallway and the following medications were sitting on top of the cart unsupervised and accessible to anyone in the hallway:a. 1 bottle of amoxicillin labeled for Resident T.b. 2 Nystatin bottles labeled for Resident U and Resident V.c. 1 tube of wound paste and 1 tube of cooling gel labeled for Resident W.During an interview on 7/23/25 at 8:36 a.m., LPN 1 indicated the medications on top of her cart belonged in the treatment cart and not in the medication cart. LPN 1 indicated the treatment cart was at the end of the hallway and those medications did not belong in her cart. 2. On 7/23/25 at 8:38 a.m., the B wing medication cart was observed with LPN 3 during a medication administration pass for Resident Y. LPN 3 was out of a medication and left her cart to check for it. The medication cards that she had previously pulled were sitting on top of the medication cart. There was 1 resident walking in the hallway at the time. The following medications were on top of the cart and accessible to anyone in the hallway: a. pantoprazoleb. carvedilolc. digoxind. Acetaminophene. ferrosolDuring an interview on 7/23/25 at 3:10 p.m., the Nurse Consultant indicated she understood the med storage concern and had no further information to provide.3.1-25(m)

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure medical records were complete and accurately documented related to an elopement incident and antibiotic administration for 2 of 24 residents reviewed for medical record documentation. (Residents E and D)Findings include: 1. During an interview on 7/22/25 at 5:24 a.m., LPN 2 indicated she had been the nurse assigned to Resident E on 6/23-6/24/25 night shift. On 6/24/25 in the early morning, the resident was in the Dining Room/Lounge, across from the Nurses’ Station, and requested coffee. She drank the coffee and said she was going back to her room. The resident was brought back to the facility through the [NAME] Unit Doors by a community person a little while later. LPN 2 indicated one of the staff members from the [NAME] Unit called the DON and the DON called the Grace Unit and directed her to go to the [NAME] Unit to assist the resident back up to the Grace Unit. There were no injuries observed. The resident was missing from the building for about 30 minutes from the last time she was observed. The resident left through the front door. The front door had been slid open and would not close when attempts were made to reset the door afterwards. LPN 2 indicated she was instructed not to document the incident. The resident had not been at the facility for very long and kept her belongings packed and made statements she was going home. She also had other behaviors. During a telephone interview on 7/22/25 at 8:17 a.m., the Good Samaritan indicated she was driving west on the road in front of the facility about 4:50 a.m. on 6/24/25 and saw a woman who was “kind of hunched over” standing in the road. She indicated it was just getting light outside. She turned her car around and came back to get the resident. She indicated the resident was about a quarter of a mile down the road from the main entrance and was at the end of the turn-in lane into the facility parking lot. The resident was not hesitant about getting in the car and just wanted a cup of coffee. The resident gave her a home address and informed her she did not want to go back to the facility. The resident was returned to the unit at the back of the building and the Good Samaritan indicated she had spoken to the DON on the phone. The resident had indicated her knees were hurting. Resident E’s closed record was reviewed on 7/22/25 at 9:09 a.m. The diagnoses included, but were not limited to dementia, bipolar with current manic episodes with psychotic features, and unsteadiness on her feet. The admission date was 6/20/25. Cross reference F689. There were no Nurses’ Progress Notes for 6/24/25 written by LPN 2 related to the elopement incident. A Nurse’s Progress Note, dated 6/24/25 at 7:30 a.m. and written by the DON (Director of Nursing) on 6/24/25 at 1:51 p.m., indicated the resident was banging on the front door and tried to open the door. She was verbalizing she wanted to leave. The staff were unable to redirect. One-on-one care was provided, the family was notified and arrived at the facility. The Nurse Practitioner was notified and the resident was transferred to the hospital for further evaluation. During an interview on 7/22/25 at 9:16 a.m., the DON indicated no one had told her not to document the event but she was told what to document. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interviews on 7/22/25 at 11:35 a.m., the Executive Director indicated the Nurse was told not to document at that time because they wanted to make sure the documentation was, “factual”. The Administrator indicated they wanted to discuss the event and “ensure the documentation was objective and not subjective”. The DON indicated the note for 6/24/25 at 7:30 a.m. was her documentation, but she had not witnessed what had happened prior to or after the resident left the building. She assumed the resident had been pounding on the door and saying she wanted to go home. She indicated it was the family who wanted the resident transferred to the hospital. 2. Resident D’s record was reviewed on 7/24/25 at 10:13 a.m. The diagnoses included, but were not limited to, osteomyelitis, stroke, and post-surgical closure and debridement of stage four (full thickness) pressure ulcers. The admission date was 6/20/25. A Physician’s Order, dated 6/21/25, indicated ceftriaxone (antibiotic) 2 grams was to be administered daily for osteomyelitis until 7/17/25. The Medication Administration Records, dated 7/2025, indicated the last dose of the antibiotic was on 7/16/25. A Nurse’s Progress Note, dated 7/18/25 at 2:25 a.m., indicated the antibiotic treatment continued and there was no signs of infection at the PICC insertion site. A Care Plan, revised on 7/18/25, indicated an IV in the left upper arm was present. The interventions indicated the insertion site would be assessed during the infusions and at least every shift when not in use and the line would be flushed with 10 cc’s (cubic centimeters) of normal saline and follow with 5 cc’s of heparin - 10 units per cc. A Nurse’s Progress Note, dated 7/19/25 at 6:30 a.m., indicated the resident was still receiving the antibiotic. There were no additional physician’s orders to indicate the antibiotic was to continue past 7/17/25 and no or MAR documentation that the antibiotic was given past 7/16/25. During an interview on 7/24/25 at 11:43 a.m., the Director of Nursing (DON) acknowledged the antibiotic was completed on the MAR on 7/16/25 and had no further information to provide regarding the documentation discrepancies. Cross reference F694. This citation relates to Complaint 1811008. 3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure infection control practices were in place related to hand hygiene during medication pass for 3 random medication pass observations. (LPN 1 and LPN 3, Residents Z, X and Y)Findings include:1. On 7/23/25 at 8:18 a.m., LPN 1 was observed leaving Resident C's room after administering medication. She then began a medication pass for Resident Z. She popped out all the medication required into a medicine cup and then donned a gown and gloves prior to entering resident Z's room. The residents' blood pressure was checked and pills were administered. She did not wash her hands or use hand sanitizer upon leaving resident C's room prior to preparing resident Z's medication or before donning the gloves upon entering Resident Z's room.2. On 7/23/25 at 8:29 a.m., LPN 1 was observed preparing a medication pass for Resident X. LPN 1 entered the resident's room and checked the blood pressure. She exited the room and prepared the resident's medication. She then re-entered Resident X's room and administered her medication. LPN 1 completed the medication pass and went back to her treatment cart. At that time, she realized she had not given the resident a pain patch. The pain patch was out of the packaging and was lying flat on the treatment cart. LPN 1 then re-entered the resident's room and applied the pain patch. She did not wash her hands or use hand sanitizer upon leaving Resident Z's room, upon entering Resident X's room, after she checked Resident X's blood pressure, before preparing Resident X's medication, or prior to applying the pain patch.3. On 7/23/25 at 8:38 a.m., LPN 3 was observed during a medication pass. LPN 3 did not have one medication and went to the medication room. She returned and completed preparing the medication pass. She entered Resident Y's room and administered the medication. She did not wash her hands or use hand sanitizer upon entering Resident Y's room.During an interview at the time, LPN 3 indicated she had used hand hygiene in the medication room and hadn't realized she needed to use hand hygiene again prior to entering Resident Y's room. During an interview on 7/23/25 at 3:10 p.m., the Nurse Consultant indicated she understood the infection control concern and indicated the staff members were nervous. She had no additional information to provide. The facility policy titled Hand Hygiene/Handwashing was provided on 7/23/25 at 3:10 p.m. by the Nurse Consultant and identified as current. The policy indicated hand hygiene should be performed, .Before and after having direct contact with a patient's intact skin (taking a blood pressure, performing physical examinations, lifting a patient in bed), after glove removal.3.1-18(b)