STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST INDIANAPOLIS, IN 46219

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included the Investigation of Complaint IN00353230 and IN00354989. Complaint IN00353230 - Substantiated. No state residential findings related to the allegations were cited. Complaint IN00354989 - Substantiated. No state residential findings related to the allegations were cited. Survey dates: June 28, 29, and 30, 2021 Facility number: 5729 Residential Census: 47 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on July 7, 2021	R 0000		
R 0050 Bldg. 00	410 IAC 16.2-5-1.2(t)(1-10) Residents' Rights - Noncompliance (t) Residents have the right to manage their personal affairs and funds. When the facility manages these services, a resident may, by written request, allow the facility to execute all or part of their financial affairs. Management does not include the safekeeping of personal items. If the facility agrees to manage the resident ' s funds, the facility must: (1) provide the resident with a quarterly accounting of all financial affairs handled by the facility; (2) provide the resident, upon the resident ' s			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	request, with reasonable access, during normal business hours, to the written records of all financial transactions involving the individual resident ' s funds; (3) provide for a separation of resident and facility funds; (4) return to the resident, upon written request and within no later than fifteen (15) calendar days, all or any part of the resident ' s funds given the facility for safekeeping; (5) deposit, unless otherwise required by federal law, any resident ' s personal funds in excess of one hundred dollars ($100) in an interest-bearing account (or accounts) that is separate from any of the facility ' s operating accounts and that credits all interest earned on the resident ' s funds to his or her account (in pooled accounts, there must be a separate accounting for each resident ' s share); (6) maintain resident ' s personal funds that do not exceed one hundred dollars ($100) in a noninterest-bearing account, interestbearing account, or petty cash fund; (7) establish and maintain a system that assures a full, complete, and separate accounting, according to generally accepted accounting principles, of each resident ' s personal funds entrusted to the facility on the resident ' s behalf; (8) provide the resident or the resident ' s legal representative with reasonable access during normal business hours to the funds in the resident ' s account; (9) provide the resident or the resident ' s legal representative upon request with reasonable access during normal business hours to the written records of all financial transactions involving the individual resident ' s funds;			

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	(10) provide to the resident or his or her legal representative a quarterly statement of the individual financial record and provide to the resident or his or her legal representative a statement of the individual financial record upon the request of the resident or the resident ' s legal representative; and (11) convey, within thirty (30) days of the death of a resident who has personal funds deposited with the facility, the resident ' s funds and a final accounting of those funds to the individual or probate jurisdiction administering the resident ' s estate.			
	Based on interview and record review, the facility failed to provide reasonable access to resident funds during normal business hours for 1 of 1 resident reviewed for resident funds. (Resident B) Findings include: The clinical record for Resident B was reviewed on 6/28/21 at 1:30 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and bipolar disease. An interview was conducted with Resident B on 6/28/21 at 1:45 p.m. He indicated he had a personal funds account with the facility. The BOM (Business Office Manager) was in charge of the accounts. The banking hours were 2:00 p.m. to 4:00 p.m. Monday through Friday, and he was not okay with that schedule. He stated, "They should be open more than 2 hours Monday through Friday. It should be normal banking hours." An interview was conducted with the BOM on 6/29/21 at 10:30 a.m. She indicated the facility's banking hours were 2:00 p.m. to 4:00 p.m. Monday through Friday. They'd had an incident on a Sunday, when Resident B took a cab to the facility	R 0050	**R – 050** **Corrective action taken:** On 06/29/21 banking hours were immediately changed to 9 am to 4 pm, Monday –Friday to make resident funds available for the affected resident. **How facility will identify other residents:** All residents have the potential to be affected. On 6/29/21 banking hours were changed to 9 am – 4 pm Monday - Friday to make resident funds available to all residents that have a resident fund account. **What measures will be put in place:** Banking hours were changed to 9am until 4pm Monday – Friday Business Office Manager or	06/30/2021

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	and didn't have access to his money to pay for it. The cab driver left his name and number, and on Monday, the cab driver came back to the facility and received payment. She indicated, if a resident wanted access to their funds at 1:00 p.m., she'd tell them to wait until 2:00 p.m. An interview was conducted with the ED on 6/29/21 at 10:44 a.m. He indicated he considered normal business hours 9:00 a.m. to 5:00 p.m. Monday through Friday. The residents' banking hours were 2:00 p.m. and 4:00 p.m. Monday through Friday, and "that's how it's always been." If a resident needed funds before 2:00 p.m., they would make arrangements for an emergency, but if it wasn't an emergency they'd need to wait until 2:00 p.m. The Management of Personal Funds policy was provided by the BOM on 6/29/21 at 10:15 a.m. It read, "The facility shall provide reasonable access during normal business hours to the funds in the account."		designee will be available to disperse resident funds when requested by residents.. **How will the corrective actions be monitored:** Administrator or designee will monitor the banking hours daily Monday – Friday to ensure there is an employee available to disperse resident funds when requested by residents. This will be ongoing.	
R 0091 Bldg. 00	410 IAC 16.2-5-1.3(h)(1-4) Administration and Management - Noncompliance (h) The facility shall establish and implement a written policy manual to ensure that resident care and facility objectives are attained, to include the following: (1) The range of services offered. (2) Residents' rights. (3) Personnel administration. (4) Facility operations. The policies shall be made available to residents upon request.			
	Based on interview and record review, the facility failed to follow their abuse policy for 1 of 2 residents reviewed for abuse. (Resident B)	R 0091	**R-091** **Corrective Actions:**	07/18/2021

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	Findings include: The clinical record for Resident B was reviewed on 6/28/21 at 1:30 p.m. The diagnoses included, but were not limited to, chronic obstructive pulmonary disease and bipolar disease. An interview was conducted with Resident B on 6/28/21 at 1:45 p.m. He indicated a night shift CNA (Certified Nursing Assistant,) CNA 5, called him a mean person and a trouble maker back in November or December, 2020. He thought he'd reported it, but wasn't sure. An interview was conducted with the ED (Executive Director) on 6/28/21 at 3:15 p.m. after being informed of Resident B's above allegation. He indicated he did not have any reportable allegations involving CNA 5 and would look into Resident B's allegation. An interview was conducted with the ED on 6/29/21 at 10:49 p.m. He indicated he was still investigating Resident B's allegation against CNA 5. He'd spoken with Resident B about it the afternoon of 6/28/21. He'd spoken with CNA 5 about it a few minutes ago, approximately 10:00 a.m. on 6/29/21. He was unsure if CNA 5 worked the night shift on 6/28/21 into the morning of 6/29/21. An interview was conducted with the DHS (Director of Health Services) on 6/29/21 at 10:55 a.m. She indicated CNA 5 worked the night shift last night and was still at the facility when LPN (Licensed Practical Nurse) 6 arrived this morning. An interview was conducted with LPN 2 on 6/29/21 at 11:03 a.m. She indicated CNA 5 was at		Suspended C.N.A 5 was 6/29/21 pending further investigation. Employee brought back on 7/1/2021 after abuse and resident right trianing. **How facility will identify other residents:** All residents have the potential to be affected. **What means will be but in place:** Abuse policy will be strictly followed to insure compliance. Employees have been in-serviced 7/14/ 21 and ongoing as needed **How will the corrective actions be monitored:** All incidents are discussed in morning stand-up Mon thru Friday	

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	the facility when she arrived that morning, shortly after 7:00 a.m. An interview was conducted with the ED on 6/29/21 at 11:10 a.m. He indicated he considered the allegation made by Resident B against CNA 5 an allegation of verbal abuse, and guessed he should have suspended CNA 5 last night. He stated, "I didn't realize she worked yesterday, so I will suspend her today and make sure she knows she can't work." The Abuse policy was provided by the DHS on 6/28/21 at 1:26 p.m. It read, "Verbal Abuse is define (sic) as the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability....PROCEDURES: ...The alleged violation shall be thoroughly investigated by the Administrator or designee. The facility must prevent further potential abuse while the investigation is in process. The alleged employee exhibiting abusive behavior should not be permitted to continue to provide care until the investigation is completed and the allegation is found to be unsubstantiated."			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency (k) The facility shall keep all kitchens, kitchen areas, common dining areas, equipment, and utensils clean, free from litter and rubbish, and maintained in good repair in accordance with 410 IAC 7-24.			
	Based on observation, interview and record review, the facility failed to ensure kitchen appliances, storage containers, walls, floors, and ceiling vents were free of dirt and grease. This had	R 0154	**R – 154** **Corrective action:**	07/30/2021

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	a potential to affect 47 of 47 residents that eat food prepared in the kitchen. Findings include: A kitchen tour was conducted with the Dietary Manager on 6/29/21 at 10:39 a.m. The flooring in the food prep area was observed to have crumbs lying along the back wall of the appliances with ants crawling on the crumbs. The walls by the stove had brown-yellow substance splattered. The ceiling vents above a cart of clean dishes and a 3-compartment sink was observed with a gray furry substance hanging from the covered vents. The deep fryer and stove had grease splatter on the front and the sides of the appliances, and the dry storage area had wrappers and food crumbs lying along the back wall. An observation was made of the kitchen with the DM on 6/29/21 at 2:11 p.m. The flooring in back of the stove area was observed with ants crawling over small food particles lying on the floor. The walls had yellow-brown substance splattered and dripped down the wall. The deep fryer and stove had grease splatter on the sides and front of the appliances. A plastic container was observed to have oven mitts sitting inside with food crumbs lying inside the bottom of the container. The air vents on the ceilings above a cart of clean dishes and the 3- compartment sink were observed with a gray furry substance hanging on the cover of the vents. The flooring in the dry storage area had food crumbs and wrappers lying on it. An interview was conducted with the DM on 6/29/21 at 2:15 p.m. He indicated the walls had debree from the cleaning service that had cleaned the range hoods and fire extinguisher. It had been a couple of months, since they had been out. The		All residents could have been affected. Vents in question were immediately cleaned and put on a cleaning schedule to be cleaned every 2 weeks. The deep fryer, stove and wall have been cleaned. The exterminator was in on 7/1/2021 and treated the kitchen for ants. The kitchen floor has been cleaned, patched and painted. All food items that were removed from the original packaging and all opened food containers in the freezer, refrigerator and on the shelf have been dated. All employees have been notified not to place unlabeled food in the medication refrigerator. **How facility will identify potential deficient practice:** Dietary Manager will do inspections daily of the appliances, floor and vents and monitor the cleaning logs to be sure cleaning was done and just sign off. Dietary manager or designee will check food storage area twice weekly to ensure all opened items removed from original packaging are dated. DM or designee will check the refrigerator and freezer daily to ensure all opened food containers are dated. Health Service Director or designee will monitor medication refrigerator daily for unlabeled food/meals. Dietary	

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	Maintenance Department was responsible for cleaning the ceiling vents. The daily cleaning logs were provided by the DM on 6/29/21 at 2:20 p.m. The deep fryer, stove, walls and flooring had been signed off by the staff the daily cleaning had been conducted. An interview was conducted with the Maintenance Supervisor on 6/29/21 at 2:20 p.m. He indicated it had been a couple of months since he had been in the kitchen and cleaned the ceiling vents. An interview was conducted with the DM and Executive Director on 6/29/21 at 2:42 p.m. They do not have policies related to the cleanliness of the kitchen, but they follow the food manual titled 410 IAC 7-24.		employees will report to maintenance if they see any ants in the kitchen. Maintenance will call the exterminator as necessary. **What measures will be but in place:** Dietary employees have been in-serviced on cleaning of appliances, mopping of floor and the importance of dating all food item that are removed from the original packaging. Dietary manager will do follow up in-services with employees. Medication refrigerator will be monitor by Health Services Director or designee daily. **How will the corrective actions be monitored:** DM and HSA or designees will report to the Administrator daily at the morning meetings that compliance is being maintained. Administrator or designee will do a weekly walk through of the kitchen to ensure compliance. Monitoring will be ongoing.	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure food stored in a walk-in	R 0273	R- 273	07/30/2021

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	refrigerator, freezer and dry storage area were dated and that food items were not stored with medications. This had a potential to affect 47 of 47 residents that eat food prepared in the kitchen. Findings include: A kitchen tour was conducted with the Dietary Manager on 6/29/21 at 10:39 a.m. During the tour, the walk-in refrigerator, freezer and dry storage area was observed. The following stored food items were undated in the following areas: Walk-in refrigerator: 2 containers of unopened pasta salad, 1 opened pasta salad and 1 container of ricotta cheese, The freezer: 1 banana cream pie, a box of opened pork patties and a porkloin, The dry storage: 3 bags of brown sugar, 6 cans of ketchup, 1 opened box of fruit loops An interview was conducted with the Dietary Manager on 6/29/21 at 10:45 a.m. He indicated all food stored in walk-in refrigerator, freezer and dry storage area should be dated. On 6/30/21 at 2:14 p.m., the medication refrigerator was observed with LPN 2. A frozen meal was located in the freezer section of the medication refrigerator. It was unlabled. During an interview on 2:14 p.m., LPN 2 indicated that food items should not be stored in the medication refrigerator. An interview was conducted with the DM and Executive Director on 6/29/21 at 2:42 p.m. They do not have policies related to food stored in the kitchen, but they follow the food manual titled 410 IAC 7-24.		**Corrective Actions:** Packages found unlabeled were labeled as needed. Food in medication fridge unlabeled was disposed of immediately. **How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** Kitchen staff was in-serviced by dietary manager on proper marking and dating procedures. **What measures will be put into place or what systematic changes will the facility make to ensure the deficient practice does not recur:** Food items will be dated upon arrival, anything placed in refrigerator and / or freezer will be dated. **How corrective actions will be monitored to ensure the deficient practice does not recur:** Refrigerators and freezer to be checked by DM or designee daily. Kitchen to be inspected by DM or designee weekly.	

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R 0301 Bldg. 00	410 IAC 16.2-5-6(c)(5) Pharmaceutical Services - Deficiency (5) Labeling of prescription drugs shall include the following: (A) Resident ' s full name. (B) Physician ' s name. (C) Prescription number. (D) Name and strength of the drug. (E) Directions for use. (F) Date of issue and expiration date (when applicable). (G) Name and address of the pharmacy that filled the prescription. If medication is packaged in a unit dose, reasonable variations that comply with the acceptable pharmaceutical procedures are permitted.			
	Based on observation and interview the facility failed to label a vial of Apisol with the date opened with the potential to affect 47 of 47 residents residing at the facility Findings include: On 6/30/21 at 2:14 p.m., the medication refrigerator was observed with LPN 2. A bottle the facility's stock of Aplisol solution was in the refrigerator. The vial was open and there was no open date on the vial or the bottle that the vial was stored. The vial had a label in which to place the date opened which indicated that the solution should be discarded 28 days after opening. During an interview on 6/30/21 at 2:14 p.m., LPN 2 indicated the vial should have been dated when it was opened.	R 0301	**R – 301** **Corrective action:** Aplisol solution was disposed of and a new bottle ordered with physician order 6/30/21. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**: An in- service will be done with all	07/30/2021

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			nurses and QMA’s on the procedure for dating refrigerated medications upon opening. See policy **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DHS or designee will monitor the refrigerator for opened medications to ensure all are dated and will document on the refrigerator monitoring form daily. This will ensure that the open medications in refrigerator are properly dated. See log.	
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview the facility failed to label over the counter medications with Resident's names and Physician's names for 2 randomly observed medications in a medication cart. Findings include:	R 0302	R – 302 **Corrective action:** Over the Counter medications were removed from the200 hall med cart on 6/30/21.	07/30/2021

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	On 6/30/21 at 2:10 p.m., the 200-hall medication cart was observed with LPN 2. The bottom drawer of the medication cart contained a box of Avinol PM (sleep aid) and a box of over -the -counter laxative tablets which had no label indicating a resident's name or the prescribing physician. During an interview on 6/30/21 at 2:10 p.m., LPN 2 indicated that the medications should have a resident's name and the boxes should be destroyed. She did not know who the medications belonged to. On 6/30/21 at 2:50 p.m., the DHS (Director of Health Services) provided the current Over-The-Counter Medication Policy which read "...Policy: This facility shall respect the right of each resident to obtain medications per the pharmacy of choice, including the purchasing of over-the-counter medications from an alternative source other than a pharmacy. Should this occur, all over-the counter medications will be appropriately identified....3. The handwritten or typed legible lave placed by the licensed facility staff on container shall include the following: Resident name, Physician name"		**How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** All residents have the potential to be affected. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**: An in- service will be done with all nurses and QMA's on the procedure for over the counter medications. The in-service will consist of educating the licensed nursing staff on the procedure for labeling and proper storage of all medication that are on the medication carts. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** The DHS or designee will monitor the medication carts via audit weekly x 4 weeks then bi- monthly x 4 then monthly and will document on a cart audit form see form. This will ensure that the medication on the carts are all properly labeled with resident's	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	06/30/2021

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			and physician's name.	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities.			
	Based on interview and record review, the facility failed to prevent and/or contain COVID-19 with ensuring staff screened and obtained temperatures when entering in the facility for 2 of 3 staff members reviewed for infection control. (Dietary Aides (DA) 2 and 3) Findings include: 1. A June 2021 staff schedule was provided by the Executive Director on 6/39/21 at 2:51 p.m. It indicated the following days DA 2 had worked in the building: 6/2/21, 6/3/21, 6/4/21, 6/7/21, 6/8/21, 6/9/21, 6/10/21, 6/12/21, 6/13/21, 6/14/21, 6/16/21, 6/17/21, 6/18/21, 6/21/21, 6/22/21, 6/23/21, 6/24/21, 6/26/21, 6/27/21, and 6/28/21 The employee screening and temperature binder did not include a screen tool with screenings and temperatures obtained for DA 2 on the days in the month of June 2021 she had worked in the	R 0407	**R – 407** **Corrective action:** Employees in question immediately spoken with on 6/30 about importance of proper documentation. **How facility will Identify potential deficient practice:** The sign – in log will be monitored daily for compliance By ED or designee. going. **What measures will be put in place:** Employees in-serviced as to the importance of proper documentation on 7/14/2021 **How will the corrective action be monitored**: The sign-in log will be monitored by the ED or Designee and reported as to the compliance in Morning Stand-up Mon. thru	07/29/2021

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		A. BUILDING 00 B. WING	06/30/2021

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	building. 2. A June 2021 staff schedule was provided by the Executive Director on 6/29/21 at 2:51 p.m. It indicated the following days DA 3 had worked in the building: 6/1/21, 6/2/21, 6/4/21, 6/5/21, 6/6/21, 6/8/21, 6/9/21, 6/10/21, 6/11/21, 6/14/21, 6/15/21, 6/16/21, 6/18/21, 6/19/21, 6/20/21, 6/22/21, 6/23/21, 6/24/21, 6/25/21, 6/28/21, 6/29/21 and 6/30/21 The employee screening and temperature binder indicated the following days DA 3 had not utilized a screen tool with screening or obtaining his temperature the days in the month of June 2021 he had worked in the building: 6/1/21, 6/4/21, 6/5/21, 6/9/21, 6/10/21, 6/11/21, 6/14/21, 6/15/21, 6/16/21, 6/18/21, 6/19/21, 6/20/21, 6/22/21, 6/23/21, 6/24/21, 6/25/21, 6/28/21 and 6/29/21 An interview was conducted with the Executive Director on 6/30/21 at 2:51 p.m. He was unable to locate any additional screen tools for DA 2 or DA 3. A "COVID 19 Infection Surveillance Policy" was provided by the Director of Nursing on 6/30/21 at 3:24 p.m. It indicated "Employees: Employees will be monitored for COVID19 when entering the facility, temperatures will be taken and employee will fill out the facility questionnaire..."		Friday.	