STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	06/04/2026

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES...	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION...	(X5) COMPLETION DATE
R 0000	INITIAL COMMENTS This visit was for the Investigation of Intakes 469884 and 470064. Intake 469884 - State deficiencies related to the allegations are cited at R247. Intake 470064 - No deficiencies related to the allegations are cited. Survey date: June 4 and 5, 2026 Facility number: 005729 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on June 12, 2026.	R 0000	Preparation and or execution of This Plan of Correction in general or any correct set forth herein, in particular, does not constituent admission or agreement by CrownPointe of the facts alleged or the conclusion set forth in the statement of deficiencies. The Plan of Correction and specific corrective actions are prepared and/or executed solely because the provisions of the Federal and State/laws. CrownPointe desires the Plan of Correction to be considered the facility's allegation of compliance.	
R 0247	Health Services - Deficiency 410 IAC 16.2-5-4(e)(7)	R 0247	• Resident E's medication error was identified and reported to the Director of	06/26/2026

(7) Any error in medication administration shall be noted in the resident ' s record. The physician shall be notified of any error in medication administration when there are any actual or potential detrimental effects to the resident.

Based on interview and record review, the facility failed to ensure a resident was not administered an excess dosage of hydrocodone (controlled pain reliever for severe pain) medication for 1 of 3 residents medication's reviewed. (Resident E)

Findings include:

The clinical record for Resident E was reviewed on 6/4/26 at 1:30 p.m. The diagnoses included, but were not limited to, dementia (decline in mental abilities) and chronic pain.

A service plan, dated 3/29/26, indicated Resident E needed assistance by the staff with the administration of medications due to her inability to safely administer the correct medication and proper dosage.

A physician order, dated 4/20/26, indicated Resident E was to receive 1 tablet of 10-325 milligrams of hydrocodone three times a day.

The April 2026 Medication Administration Record (MAR)

Nursing. The resident's Nurse Practitioner was notified, and the resident was monitored for adverse effects for 24 hours per NP’s direction. No adverse effects were observed. The medication error report was completed, documented in the resident record, and reviewed by the Director of Nursing.

- The Director of Nursing completed an audit of all medication administration records (MARs), controlled substance records, and medication error reports for the previous 30 days to identify any additional medication administration discrepancies involving controlled substances or medications administered without proper documentation. Any identified concerns were immediately investigated and addressed.
- The facility revised and reinforced its medication administration process to ensure medications are documented on the electronic MAR immediately following administration and prior to shift change whenever possible.

	indicated Resident E was to receive 1 tablet of 10-325 milligrams of hydrocodone daily at 11:00 a.m., 3:00 p.m., and 7:00 p.m. The Controlled Substance Record, dated 4/1/26, indicated on 4/23/26 Resident E had received the hydrocodone at the following times and the amount of tablets: 11:00 a.m. - 1 tablet of 10-325 milligrams of hydrocodone 3:00 p.m. - 2 tablets of 10-325 milligrams of hydrocodone, and 7:00 p.m., 1 tablet of 10-325 milligrams of hydrocodone A medication error report, dated 4/23/26, indicated Qualified Medication Aide (QMA) 1 had reported to the Director of Nursing she had administered an additional dosage of 10-325 milligrams of hydrocodone to Resident E. The electronic MAR had not shown the nurse prior had already administered the resident's 3:00 p.m. 10-325 milligrams of hydrocodone dosage. The medical provider was notified. The interventions were to monitor the resident for 24 hours. The resident had not shown any side effects of receiving excess dosage. An interview was conducted with the Director of Nursing on		All licensed nurses and Qualified Medication Aides (QMAs) received re-education on: • The five rights of medication administration. • Proper documentation of medication administration. • Controlled substance accountability procedures. • Verification of medication administration status before administering medications. • Reporting and documentation requirements for medication errors. The Director of Nursing or designee will review all medication error reports and controlled substance discrepancies to ensure appropriate follow-up, physician notification when indicated, and corrective action. • The Director of Nursing or designee will conduct weekly audits of medication administration records, controlled substance documentation records, and medication	

	6/5/26 at 9:35 p.m. She indicated QMA 1 had notified her of the medication error on 4/23/26. QMA 1 had reported, she had administered an additional tablet 10-325 milligrams of hydrocodone. The day shift nurse had administered Resident E's 10-325 milligrams of hydrocodone medication prior to her shift ending. On 2nd shift, QMA 1 had also administered the resident's 3:00 p.m. dosage unaware the nurse had already administered the 3:00 p.m. dosage. The nurse had not signed off on the electronic MAR she had already given the 3:00 p.m. dosage. Then, QMA 1 had administered the 7:00 p.m. dosage of 10-325 milligrams of hydrocodone to the resident. QMA 1 had not recognized the medication error had occurred until after she signed out the 7:00 p.m. dosage on the controlled substance record sheet. At that time, QMA 1 notified her of the medication error. A medication administration policy was provided by the Director of Nursing on 6/4/26 at 4:00 p.m. It indicated, "...Residents of the facility shall receive medications as ordered by their physician to treat specific medical conditions...If resident is incapable to self-administer medications with		error reports for four (4) weeks. Thereafter, monthly audits will be conducted for two (2) additional months. The audits will verify: • Medications are administered as ordered. • Controlled substance records reconcile with MAR documentation. • Medication administration is documented accurately and timely. • Medication errors are reported, investigated, and documented according to facility policy. Audit findings will be reviewed through by the Director of Nursing. Any identified concerns will result in immediate corrective action, including additional education and competency validation as needed. • Date of Compliance: 6/28/2026 Responsible Party:	

	or without reminders, a licensed nurse or qualified medication aide shall be expected to administer medications as ordered by the physician..." This citation is related to Intake 469884.		Director of Nursing	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATUREAndrea Wilson	TITLERCA	(X6) DATE06/24/2026