STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	04/29/2025

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 Complaint IN00457746. Complaint IN00457746 - State deficiencies related to the allegations are cited at R0090 and R0091. Survey date: April 29, 2025 Facility number: 005729 Residential Census: 27 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on April 30, 2025.	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 0090	Administration and Management - Deficiency 410 IAC 16.2-5-1.3(g)(1-6) (g) The administrator is responsible for the overall management of the facility. The responsibilities of the	R 0090	The administrator will be reeducated and in serviced on what should be reported to the IDOH and how these issues are	05/23/2025

	administrator shall include, but are not limited to, the following: (1) Informing the division within twenty-four (24) hours of becoming aware of an unusual occurrence that directly threatens the welfare, safety, or health of a resident. Notice of unusual occurrence may be made by telephone, followed by a written report, or by a written report only that is faxed or sent by electronic mail to the division within the twenty-four (24) hour time period. Unusual occurrences include, but are not limited to: (A) epidemic outbreaks; (B)poisonings; (C) fires; or (D) major accidents. If the division cannot be reached, a call shall be made to the emergency telephone number published by the division. (2) Promptly arranging for or assisting with the provision of medical, dental, podiatry, or nursing care or other health care services as requested by the resident or resident's legal representative. (3) Obtaining director approval prior to the admission of an individual under eighteen (18) years of age to an adult facility. (4) Ensuring the facility maintains, on the premises, an accurate record of actual time worked that indicates the:		reported. The facility will review all incident reports in a timely manner according to ISDH and company policy. The facility will implement a communication log to be completed when an incident occurs until the resident returns to the facility. The Director of Operations will review with the Executive Director once monthly for six months. This will be corrected by 5/23/2025	

(A) employee's full name; and

(B) dates and hours worked during the past twelve (12) months.

(5) Posting the results of the most recent annual survey of the facility conducted by state surveyors, any plan of correction in effect with respect to the facility, and any subsequent surveys. The results must be available for examination in the facility in a place readily accessible to residents and a notice posted of their availability.

(6) Maintaining reports of surveys conducted by the division in each facility for a period of two (2) years and making the reports available for inspection to any member of the public upon request

Based on interview and record review, the facility failed to ensure a fall that resulted in a fracture was reported to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for accidents. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 4/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, hypertension, constipation, schizophrenia, depression, anxiety, dementia, and osteoarthritis.

A service plan for Resident C, dated 2/20/25, indicated

	Resident C was alert, oriented with some difficulty in new situations only. A progress note, entered 3/24/25 at 11:11 a.m., indicated the following, "...03/21/25. When clinical staff were rounding to check on the resident, she was on the floor and stated that she fell when she was trying to get in her wheelchair. When staff attempted to pick her up she stated that her hip was hurting. Np [Nurse Practitioner] notified...." A progress note, entered 3/24/25 at 11:14 a.m., indicated the following, "...03/23/35. Hospital called to give the clinical staff an update. Stated that the resident was going to be having surgery tomorrow." There was no reportable incident reported to the IDOH regarding the fall for Resident C that resulted in a fracture. An interview conducted with the Director of Nursing (DON), on 4/29/25 at 1:00 p.m., indicated she was on vacation, on 3/21/25, and when she returned from vacation, on 3/24/25, she found out about the fall incident pertaining to Resident C, and she documented the fall incident on 3/24/25. The fall incident resulting in a fracture for Resident C was not reported to the IDOH.			

This Residential tag relates to Complaint IN00457746.

Based on interview and record review, the facility failed to ensure a fall that resulted in a fracture was reported to the Indiana Department of Health (IDOH) for 1 of 3 residents reviewed for accidents. (Resident C)

Findings include:

The clinical record for Resident C was reviewed on 4/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, hypertension, constipation, schizophrenia, depression, anxiety, dementia, and osteoarthritis.

A service plan for Resident C, dated 2/20/25, indicated Resident C was alert, oriented with some difficulty in new situations only.

A progress note, entered 3/24/25 at 11:11 a.m., indicated the following, "...03/21/25. When clinical staff were rounding to check on the resident, she was on the floor and stated that she fell when she was trying to get in her wheelchair. When staff attempted to pick her up she stated that her hip was hurting. Np [Nurse Practitioner] notified...."

A progress note, entered 3/24/25 at 11:14 a.m., indicated

	the following, "...03/23/35. Hospital called to give the clinical staff an update. Stated that the resident was going to be having surgery tomorrow." There was no reportable incident reported to the IDOH regarding the fall for Resident C that resulted in a fracture. An interview conducted with the Director of Nursing (DON), on 4/29/25 at 1:00 p.m., indicated she was on vacation, on 3/21/25, and when she returned from vacation, on 3/24/25, she found out about the fall incident pertaining to Resident C, and she documented the fall incident on 3/24/25. The fall incident resulting in a fracture for Resident C was not reported to the IDOH. This Residential tag relates to Complaint IN00457746.			
R 0091	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(h)(1-4) (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.	R 0091	All staff will be reeducated and in serviced on the fall policy, nursing staff will be reeducated and in serviced on documentation of falls, and notification to responsible party and medical provider in a timely manner. The facility will review all	05/23/2025

(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 ensure the fall policy was implemented regarding documentation of a fall event and notification of responsible party and/or medical provider timely for 2 of 3 residents reviewed for accidents. (Resident C and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 4/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, hypertension, constipation, schizophrenia, depression, anxiety, dementia, and osteoarthritis.

A service plan for Resident C, dated 2/20/25, indicated Resident C was alert, oriented with some difficulty in new situations only.

A progress note, entered 3/24/25 at 11:11 a.m., indicated the following, "...03/21/25. When clinical staff were rounding to check on the resident, she was on the floor and stated that she fell when she was trying to get in her wheelchair. When staff

incident reports in a timely manner according to ISDH and company policy.

Nursing staff will be educated and in serviced on the use of the communication log for incidents.

The Executive Director will review with the Director of Nursing and Nursing Staff once monthly for six months.

This will be corrected by 5/23/2025

attempted to pick her up she stated that her hip was hurting. Np [Nurse Practitioner] notified...."

A progress note, entered 3/24/25 at 11:14 a.m., indicated the following, "...03/23/35. Hospital called to give the clinical staff an update. Stated that the resident was going to be having surgery tomorrow."

2. The clinical record for Resident D was reviewed on 4/29/25 at 11:30 a.m. The diagnoses included, but were not limited to, bipolar disorder, chronic pain, hypertension, and diabetes mellitus.

A service plan for Resident D, dated 2/20/25, indicated Resident D was alert, oriented, and able to make sound independent decisions.

A progress note, entered 3/24/25 at 11:04 a.m., indicated the following, "...03/21/25. Clinical staff reported that the resident fell, face down trying to pick up his papers that fell on the ground. Resident reported the statement to the ED [Executive Director] as well. Resident was sent out to the hospital and received stitches. No new orders at this time. Np [Nurse Practitioner] notified of the situation...."

An incident report, dated 3/21/25 at 12:50 p.m., indicated

staff were called to another resident room where Resident D was observed face down in a pool of blood in from of the chair. Resident D was reaching for something and fell face first. Resident D was noted with a "very bloody" nose. He was then transferred to a local hospital by emergency medical services. The incident report indicated "N/A" (not applicable) was documented pertaining to the Director of Nursing (DON) or designee being notified.

An interview conducted with the Director of Nursing (DON), on 4/29/25 at 1:00 p.m., indicated she was on vacation, on 3/21/25, and when she returned from vacation, on 3/24/25, she found out about the fall incidents pertaining to Resident C and Resident D, and she documented the fall incidents on 3/24/25. The Executive Director was on-call during the time the DON was on vacation, on 3/21/25. The expectations were for the nursing staff, whether a Qualified Medication Aide (QMA) or a nurse, would be to document the fall incident on the 24-hour report sheet and complete a fall incident report. There were no fall incident reports completed for Resident C, dated 3/21/25.

A policy entitled "FALL PREVENTION AND MANAGEMENT", dated

12/2024, was provided by the Director of Nursing (DON) on 4/29/25 at 11:45 a.m. The policy indicated the following, "...IN THE EVENT OF A FALL... If a resident incurs a fall, notify the nurse in the facility (if available) to assess the resident... If no nurse is available in the facility, adhere to the following guidelines... Call 911 for ANY of the following... any obvious broken bones are observed... Notify the nurse on call AND family/responsible party of the fall and transport to the hospital, if applicable...."

A policy entitled "MANAGEMENT NOTIFICATION", undated, was provided by the DON on 4/29/25 at 11:45 a.m. The policy indicated notifying the Director of Health Services of any fall or any injury. Notification of the Executive Director was to occur for any fall resulting in a fracture or that needed treatment with sutures or stables.

This Residential tag relates to Complaint IN00457746.

Based on interview and record review, the facility failed to ensure the fall policy was implemented regarding documentation of a fall event and notification of responsible party and/or medical provider timely for 2 of 3 residents reviewed for accidents.

(Resident C and Resident D)

Findings include:

1. The clinical record for Resident C was reviewed on 4/29/25 at 10:30 a.m. The diagnoses included, but were not limited to, hypertension, constipation, schizophrenia, depression, anxiety, dementia, and osteoarthritis.

A service plan for Resident C, dated 2/20/25, indicated Resident C was alert, oriented with some difficulty in new situations only.

A progress note, entered 3/24/25 at 11:11 a.m., indicated the following, "...03/21/25. When clinical staff were rounding to check on the resident, she was on the floor and stated that she fell when she was trying to get in her wheelchair. When staff attempted to pick her up she stated that her hip was hurting. Np [Nurse Practitioner] notified...."

A progress note, entered 3/24/25 at 11:14 a.m., indicated the following, "...03/23/35. Hospital called to give the clinical staff an update. Stated that the resident was going to be having surgery tomorrow."

2. The clinical record for Resident D was reviewed on 4/29/25 at 11:30 a.m. The diagnoses included, but were

not limited to, bipolar disorder, chronic pain, hypertension, and diabetes mellitus.

A service plan for Resident D, dated 2/20/25, indicated Resident D was alert, oriented, and able to make sound independent decisions.

A progress note, entered 3/24/25 at 11:04 a.m., indicated the following, "...03/21/25. Clinical staff reported that the resident fell, face down trying to pick up his papers that fell on the ground. Resident reported the statement to the ED [Executive Director] as well. Resident was sent out to the hospital and received stitches. No new orders at this time. Np [Nurse Practitioner] notified of the situation...."

An incident report, dated 3/21/25 at 12:50 p.m., indicated staff were called to another resident room where Resident D was observed face down in a pool of blood in from of the chair. Resident D was reaching for something and fell face first. Resident D was noted with a "very bloody" nose. He was then transferred to a local hospital by emergency medical services. The incident report indicated "N/A" (not applicable) was documented pertaining to the Director of Nursing (DON) or designee being notified.

An interview conducted with the Director of Nursing (DON), on 4/29/25 at 1:00 p.m., indicated she was on vacation, on 3/21/25, and when she returned from vacation, on 3/24/25, she found out about the fall incidents pertaining to Resident C and Resident D, and she documented the fall incidents on 3/24/25. The Executive Director was on-call during the time the DON was on vacation, on 3/21/25. The expectations were for the nursing staff, whether a Qualified Medication Aide (QMA) or a nurse, would be to document the fall incident on the 24-hour report sheet and complete a fall incident report. There were no fall incident reports completed for Resident C, dated 3/21/25.

A policy entitled "FALL PREVENTION AND MANAGEMENT", dated 12/2024, was provided by the Director of Nursing (DON) on 4/29/25 at 11:45 a.m. The policy indicated the following, "...IN THE EVENT OF A FALL... If a resident incurs a fall, notify the nurse in the facility (if available) to assess the resident... If no nurse is available in the facility, adhere to the following guidelines... Call 911 for ANY of the following... any obvious broken bones are observed... Notify the nurse on call AND family/responsible party of the fall and transport to the hospital,

	if applicable...." A policy entitled "MANAGEMENT NOTIFICATION", undated, was provided by the DON on 4/29/25 at 11:45 a.m. The policy indicated notifying the Director of Health Services of any fall or any injury. Notification of the Executive Director was to occur for any fall resulting in a fracture or that needed treatment with sutures or stables. This Residential tag relates to Complaint IN00457746.			

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 SIGNATURE	TITLE	(X6) DATE