STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	08/03/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF ANDERSON	2727 CROWNPOINTE CIRCLE, ANDERSON, , 46012

(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 a State Residential Licensure Survey. Survey dates: August 2 and 3, 2021 Facility number: 012129 Residential Census:53 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on August 5, 2021.	R 0000	Submission of this plan of correction shall not constitute or be construed as an admission by CrownPointe of Anderson, that the allegations contained in this survey report are accurate or reflect accurately the provision of service to residents of CrownPointe of Anderson.A corrective action is in place immediately. In-services will be held starting immediately to train all staff members on the updated policies. All staff have been educated via in-service regarding updated policies or any changes. Staff received direction and instruction on completing in-service . All identified concerns will be logs, tracked, and monitored by facility representative with tracking forms .	
R 0092	Administration and Management - Noncompliance 410 IAC 16.2-5-1.3(i)(1-2) (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows:	R 0092	For the residents found to be affected by the deficient practice and all other residents with the potential to be affectedthe facility. The plan of correction will include educating our Maintenance Director on completing all fire drills according to policy and state regulations. Will complete fire drills monthly and during each quarter	08/16/2021

	(1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to conduct fire drills on each shift every quarter. Findings include: A review of the facility's fire drill reports from 7/28/2020 to 7/28/2021, indicated there was one fire drill conducted on 8/31/2020 at 4:10 a.m., third shift. The reports lacked third shift fire drills for the remaining quarters. During an interview on 8/2/21 at		will be completing a 3rd shift drill. During said in service the maintenance director was educated on the process of handling Fire drills per policy and state regulations. Administrator track. log and monitor all drills for each month ongoing	

	1:05 p.m., the Administrator indicated he did not realize a fire drill was to be conducted on each shift every quarter. Review of the current facility policy, undated, titled "Fire Drill Policy" provided by the Administrator on 8/3/21 at 11:56 a.m., included, but was not limited to, "Policy: To ensure fire drills are conducted n each shift on a quarterly basis. Procedure: Fire exit drills shall be conducted on each shift quarterly. At least 12 drills per year shall be held. The fire alarm will not be sounded for fire drills conducted between 9 pm and 6 am a code announcement may be used instead..." Based on record review and interview, the facility failed to conduct fire drills on each shift every quarter. Findings include: A review of the facility's fire drill reports from 7/28/2020 to 7/28/2021, indicated there was one fire drill conducted on 8/31/2020 at 4:10 a.m., third shift. The reports lacked third shift fire drills for the remaining quarters. During an interview on 8/2/21 at 1:05 p.m., the Administrator			

	indicated he did not realize a fire drill was to be conducted on each shift every quarter. Review of the current facility policy, undated, titled "Fire Drill Policy" provided by the Administrator on 8/3/21 at 11:56 a.m., included, but was not limited to, "Policy: To ensure fire drills are conducted n each shift on a quarterly basis. Procedure: Fire exit drills shall be conducted on each shift quarterly. At least 12 drills per year shall be held. The fire alarm will not be sounded for fire drills conducted between 9 pm and 6 am a code announcement may be used instead..."			
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more	R 0117	For the residents found to be affected by the deficient practice and all other residents with the potential to be affectedthe facility. The plan of correction will include policy, education and in service training on completing CPR Certification. Education provided to staff in the form of in-service. During said in service the staff was educated on the process of getting CPR Certification completed on time. Administer and Director of health services took questions provided education. We will be monitoring	08/16/2021

	residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on interview and record review, the facility failed to ensure a working staff member was Cardiopulmonary Resuscitation (CPR) certified, for 15 of 21 shifts or first aid certified for 21 of 21 shifts. Findings include: During a review on the facility nursing schedule, dated 7/25/21 to 7/31/21, the following shifts did not have a staff member working with CPR certification: a. 7/26/21 second and third shift b. 7/27/21 second shift c. 7/28/21 second shift d. 7/29/21 second shift		and follow-up with our audit tool monthly . The director of health services or designee will check Monthly and ongoing there after.	

e. 7/30/31 second, and third shift

f. 7/31/21 second shift

During a review on the facility nursing schedule, dated 7/25/21 to 7/31/21, no shifts had a staff member working with first aid certification.

During an interview on 8/3/21 at 12:11 p.m., the Administrator indicted the Director of Nursing works Monday thru Friday first shift. She is CPR and first aid certified. The documentation provided by the Administrator did not indicate the Director of Nursing had worked the week 7/25/21 to 7/31/21.

During an interview on 8/3/21 at 12:11 p.m., the Administrator indicated he had just scheduled a CPR certification class to be conducted in late August. He indicated some things had slipped through the cracks.

Review of the current facility policy, dated 7/19, titled "Screening of Prospective Employee's" provided by the Administrator on 8/3/21 at 12:15 p.m., included, but was not limited to,

"Policy: This facility shall require that nursing staff have CPR and FIRST AID Certifications upon hire or within 60 days of employment. Uncertified nursing staff will not be scheduled to

work without another CPR and FIRST AID certified employee in the facility..."

Based on interview and record review, the facility failed to ensure a working staff member was Cardiopulmonary Resuscitation (CPR) certified, for 15 of 21 shifts or first aid certified for 21 of 21 shifts.

Findings include:

During a review on the facility nursing schedule, dated 7/25/21 to 7/31/21, the following shifts did not have a staff member working with CPR certification:

a. 7/26/21 second and third shift

b. 7/27/21 second shift

c. 7/28/21 second shift

d. 7/29/21 second shift

e. 7/30/31 second, and third shift

f. 7/31/21 second shift

During a review on the facility nursing schedule, dated 7/25/21 to 7/31/21, no shifts had a staff member working with first aid certification.

During an interview on 8/3/21 at 12:11 p.m., the Administrator indicted the Director of Nursing works Monday thru Friday first shift. She is CPR and first aid

	certified. The documentation provided by the Administrator did not indicate the Director of Nursing had worked the week 7/25/21 to 7/31/21. During an interview on 8/3/21 at 12:11 p.m., the Administrator indicated he had just scheduled a CPR certification class to be conducted in late August. He indicated some things had slipped through the cracks. Review of the current facility policy, dated 7/19, titled "Screening of Prospective Employee's" provided by the Administrator on 8/3/21 at 12:15 p.m., included, but was not limited to, "Policy: This facility shall require that nursing staff have CPR and FIRST AID Certifications upon hire or within 60 days of employment. Uncertified nursing staff will not be scheduled to work without another CPR and FIRST AID certified employee in the facility..."			
R 0120	Personnel - Noncompliance 410 IAC 16.2-5-1.4(e)(1-3) (e) There shall be an organized inservice education and training program planned in advance for all personnel in all departments at least annually. Training shall include, but is not limited to, residents' rights, prevention and	R 0120	For the residents found to be affected by the deficient practice and all other residents with the potential to be affectedthe facility. The plan of correction will include policy, education and in service training on completing Resident Rights and Dementia training. Education provided to staff in the	08/16/2021

	control of infection, fire prevention, safety, accident prevention, the needs of specialized populations served, medication administration, and nursing care, when appropriate, as follows: (1) The frequency and content of inservice education and training programs shall be in accordance with the skills and knowledge of the facility personnel. For nursing personnel, this shall include at least eight (8) hours of inservice per calendar year and four (4) hours of inservice per calendar year for nonnursing personnel. (2) In addition to the above required inservice hours, staff who have contact with residents shall have a minimum of six (6) hours of dementia-specific training within six (6) months and three (3) hours annually thereafter to meet the needs or preferences, or both, of cognitively impaired residents effectively and to gain understanding of the current standards of care for residents with dementia. (3) Inservice records shall be maintained and shall indicate the following: (A) The time, date, and location. (B) The name of the instructor. (C) The title of the instructor. (D) The names of the participants. (E) The program content of inservice. The employee will acknowledge		form of in-service. During said in service the staff was educated with testing and information on Resident rights and dementia training. Administer and Director of health services took questions provided education. We will be monitoring and follow-up with our audit tool monthly .The audit will include new and current employees. The Administrator or designee will check Monthly and ongoing there after.	

attendance by written signature.

Based on interview and record review, the facility failed to ensure staff completion and documentation of required in-services for 3 of 5 employee files reviewed for completion of annual dementia and resident rights training. (QMA 1, QMA 2, and Dietary 3)

Findings include:

Review of the five employees annual training, provided by the Administrator on 8/3/21 at 9:05 a.m., indicated the following:

a. QMA1's resident's rights acknowledgement, was dated 6/1/18, and dementia training, was dated 6/17/20.

b. Dietary 3's resident's rights acknowledgement, was dated 5/16/18.

c. QMA 2 had no documentation of completed training,

During an interview on 8/3/21 at 12:11 p.m., the Administrator indicated he needed to get a better schedule for annual in-service training.

On 8/3/21 at 11:56 a.m., the Administrator provided the Employee Training Program policy, dated 7/19, and indicated the policy was the current training policy being used by the

facility.

"Policy: This facility will have an organized education and training program in place for all employees as required by the State Board of Health.

Procedure: This facility will offer monthly in-services to all employees in all departments as required annually. Training shall include resident's rights and dementia...

.3. All employees are required to attend mandatory in-services..."

Based on interview and record review, the facility failed to ensure staff completion and documentation of required in-services for 3 of 5 employee files reviewed for completion of annual dementia and resident rights training. (QMA 1, QMA 2, and Dietary 3)

Findings include:

Review of the five employees annual training, provided by the Administrator on 8/3/21 at 9:05 a.m., indicated the following:

a. QMA1's resident's rights acknowledgement, was dated 6/1/18, and dementia training, was dated 6/17/20.

b. Dietary 3's resident's rights acknowledgement, was dated 5/16/18.

	c. QMA 2 had no documentation of completed training, During an interview on 8/3/21 at 12:11 p.m., the Administrator indicated he needed to get a better schedule for annual in-service training. On 8/3/21 at 11:56 a.m., the Administrator provided the Employee Training Program policy, dated 7/19, and indicated the policy was the current training policy being used by the facility. "Policy: This facility will have an organized education and training program in place for all employees as required by the State Board of Health. Procedure: This facility will offer monthly in-services to all employees in all departments as required annually. Training shall include resident's rights and dementia... .3. All employees are required to attend mandatory in-services..."			

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