

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 07/23/2026	
NAME OF PROVIDER OR SUPPLIER CROWNPOINTE OF ANDERSON		STREET ADDRESS, CITY, STATE, ZIP CODE 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 the Investigation of Intakes 470984. Intake 470984 - State deficiency related to the allegations is cited at R0145. Survey date: July 23, 2026 Facility number: 012129 Residential Census: 46 This state finding is cited in accordance with 410 IAC 16.2-5. Quality review completed July 29, 2026.	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 0145	Sanitation and Safety Standards - Deficiency 410 IAC 16.2-5-1.5(b) (b) The facility shall maintain equipment and supplies in a safe and operational condition and in sufficient quantity to meet the	R 0145	For the residents found to be affected by the deficient practice and all other residents with the potential to be affected the facility. The plan of correction will include , log tracking, monitoring, education and in service training for Activity Director, activities Assistant and other transportation staff for	07/23/2026			

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needs of the residents.

Based on observation, interview and record review, the facility failed to ensure a resident recieved transportation in a safe and secure manner, and in accordance with facilty policy, for 1 of 3 residents reviewed for accidents. (Resident B)

Findings include:

During an interview, on 7/23/26 at 11:26 a.m., Resident B indicated during a facility transport to an appointment, the facility driver failed to secure the resident's electric wheelchair to the floor of the facility van. The driver also failed to secure the resident with a seatbelt. When the driver turned a corner, the wheelchair tipped over, and the resident was thrown from the wheelchair onto the floor.

Resident B's clinical record was reviewed on 7/23/26 at 1: 00 p.m. Diagnoses included spina bifida and hydrocephalus.

During an interview, on 7/23/26 at 1:09 p.m., the facility Transport Driver indicated that while transporting Resident B to an appointment, she failed to secure the resident's electric wheelchair to the van per safety guidelines. The wheelchair should have been secured at four points, and the driver only

Wheelchair Safety on Bus Policy and safety for Van .

Education provided to staff in the form of in-service .The Administrator or designee will check and follow-up as needed. Have created a new Transportation audit tool for checking Bus and van for safety services . Will track and review on a weekly, bi-weekly and Monthly basis for 6 months . The Activity Director and Activity Assistant/Transportation staff has been educated on procedures on audit tool and in-service has been added .

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used two points to secure the wheelchair. The Transport Driver did not place the resident in a seatbelt per the safety policy. During the transport, the van turned a corner, and both the resident and the wheelchair were displaced, and the resident was thrown to the floor. The Transport Driver was educated on the safety guidelines for resident transportation at the time of her hire. The Transport Driver indicated both the resident, and the wheelchair should have been secured per safety guidelines.

During an interview on 7/23/26 at 2:52 p.m., the Maintenance Supervisor indicated the facility transport vehicle's wheelchair secure/safety hardware was checked and found to be in working order.

Review of Resident B's hospital notes, dated 7/21/26, indicated the resident sustained a laceration to the head requiring five staples and a cervical (C7/ neck bone) fracture related to a fall.

Review of the Transport Driver's education records indicated she was educated on transport safety guidelines on 3/18/26.

A current undated policy, titled "Wheelchair Safety on the Bus," and provided by the DON on 7/23/26 at 2:15 p.m., indicated

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FORM APPROVED

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OMB NO. 0938-0391

the following: ".... Motorized Wheelchair...Four hooks that are attached to the floor of the bus will be attached to a nonmoving part of the wheel chair [sic]. The hooks will be tightened to ensure no leeway for the wheelchair to move. 2 hooks in the front, 2 hooks in the back...There will be a seat belt that goes around the person and wheelchair. Both ends of the seatbelt connect to the floor of the bus. The power button for the motorized wheelchair must be turned off at all times during transportation. This includes while being on the lift."

This citation relates to Intake 470984.

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
SIGNATURERobert Cook

TITLEadministrator

(X6) DATE08/04/2026