STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING B. WING	11/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROWNPOINTE OF LEBANON	610 CROWNPOINTE DRIVE, LEBANON, , 46052

(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 Complaints IN00367009 and IN00362381. Complaint IN00367009 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00362381 - Substantiated. No deficiencies related to the allegation are cited. Survey dates: November 29 and 30, 2021 Facility number: 013582 Residential Census: 55 Crownpointe of Lebanaon was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaints IN00367009 and IN00362381. Quality review was completed on December 6, 2021.	R 0000	R0000 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 0052	Residents' Rights - Offense 410 IAC 16.2-5-1.2(v)(1-6) (v) Residents have the right to be free from: (1) sexual abuse; (2) physical abuse; (3) mental abuse; (4) corporal punishment; (5) neglect; and (6) involuntary seclusion. Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when she wandered across a busy parking lot, from the facility grounds, without the facility staff's knowledge for 1 of 3 residents being reviewed for neglect. (Resident B) Resident B, on November 11, 2021, required staff to pick her up from an office at the local hospital 0.2 miles from the facility. Finding includes: During a walk-through of the facility, on November 29, 2021 beginning at 9:55 a.m., with Maintenance Staff 1 the following observations were made: the main dining area had a door which opened out to a patio area with access to a	R 0052	R0052 1.) Resident B was relocated to a more appropriate facility on November 18, 2021. Resident B was admitted to facility on November 30, 2020, since her admission resident B has never exhibited wandering behaviors outside of facility grounds, then on November 10, 2021, One-year post-admission. 2.) All residents have the potential to be affected. All residents will be re-assessed for elopement risk, and facility policy will be followed as deemed necessary. Facility elopement assessment form has been updated to ensure continued resident safety. Prior to resident B walking to Witham Hospital for an appointment all of her Elopement Risk Assessments had no history of wandering. Resident B was not wandering when she went to Witham Hospital, she thought she had an appointment scheduled. Resident B does have baseline	12/29/2021

	pond. The door was not locked and there was a camera pointed at the door. In the first floor east hall, there was a door which opened to an unfenced area which had access to the pond. The door was not locked and did not have an alarm. At the end of the hall, there was an unlocked door which led to a small entry with another unlocked door which led outside with access to the pond. There was a camera pointed at the door. On the first floor west side, there was an unlocked door with an alarm at the top. At that time, Maintenance Staff 1 indicated the facility did not use the alarm. The door opened to a small entry with another unlocked door which led to State Road 39. There was a camera pointed at the door. On the second floor, there was one door, on the east side of the building which led to a stairway and an exit door. The door accessed the parking lot and was unlocked with no camera present. The record for Resident B was reviewed on November 29, 2021 at 1:41 p.m. Diagnoses included, but were not limited to, pain in right lower leg, major depressive disorder and renal insufficiency.		confusion, but was not exhibiting exit-seeking prior to November 10, 2021. Resident has never exhibited exit-seeking behaviors nor did resident B previously exit the facility and leave facility grounds. Resident B would often sit outside in the sun, walk around facility, never left facility grounds. 3.) Any cognitive changes noted a re-assessment will be completed and facility policy shall be followed to ensure resident safety. All staff shall be re-educated on Resident Rights and how/when to report those changes, and nurses on proper completion of elopement risk assessments. 4.) All resident’s elopement assessment reviewed and updated. Elopement assessment are completed every 3 months, unless cognitive changes are noted prior, and upon re-admissions and new admissions. Health and Service Director will report any concerns to the Quality Assurance Committee and will follow recommendations to ensure compliance. Our Corporate	

	A progress note, dated November 16, 2020, indicated the resident had Alzheimer's disease with baseline confusion. A multi-use facility document, titled "ELOPEMENT RISK ASSESSMENT," dated November 30, 2020, indicated "...Does the resident have a diagnosis of Alzheimer's, Organic Brain Syndrome, Dementia, Mental Retardation or Mental Illness...if yes, list...." the form indicated yes, but which diagnosis was appropriate was not listed. A second entry, dated January 26, 2021, also indicated yes to the question, but the diagnosis was not listed. The form indicated "...Resident is considered a risk of elopement if mobile and any question above is answered "YES"...." On November 30, 2020, the form indicated Resident B was not at risk. On January 26, 2021, the form indicated Resident B was at risk. Subsequent assessments, on October 7, 2021 and November 16, 2021, did not indicate the resident had any of the diagnoses and she was not an elopement risk. A facility document, titled "ACCIDENT/INCIDENT REPORT," provided by the Executive Director on November 29, 2021 at 2:10 p.m., indicated on November 11, 2021 at 1:00 p.m., the facility received a call		Nurse/Infection Preventionist will audit monthly (X 6months) all elopement assessments to ensure accuracy and on-going compliance. 5.) 12/29/2021	

from the wound center located in the local hospital informing them Resident B was there for an appointment. Resident B had left the facility with her walker. She did not have an appointment scheduled. There were no apparent injuries. An attached document, titled "Resident Transfer Form," indicated the resident was "...Confused...."

A nursing note, dated November 11, 2021 at 1:00 p.m., indicated a call was received from the local hospital. Resident B was in the wound center office requesting to be seen by the physician. She did not have an appointment at the office. The resident had left the facility without notifying the staff.

During an interview, on November 29, 2021 at 11:55 a.m., the Director of Nursing indicated the last observation of Resident B was on November 11, 2021 at the lunch service, between 12:00 p.m. and 12:30 p.m. The time Resident B left the facility was unknown but indicated the resident was unaccounted for approximately 35-45 minutes. The Director of Nursing received a call from the wound center at the local hospital and she left with another staff member to retrieve the resident. She did not know what exit the resident used to leave the property. She

indicated she believed she was Resident B's nurse on that day.

During an interview, on November 29. 2021 at 3:10 p.m., the Director of Nursing indicated the facility should know where the residents were at all times, there was no policy but she would check. She further indicated a resident with dementia was not expected to remember to sign out when they left the facility.

An attempt to contact the CNA who was on duty November 11, 2021 was made on November 29, 2021 at 2:22 p.m. A message was left with contact information. As of November 30, 2021, there was no return contact.

During an interview, on November 30, 2021 at 8:45 a.m., a staff member from the wound center indicated the resident walked in and indicated she had an appointment. The resident was not a wound care patient and did not have an appointment. The employee called the facility and informed them Resident B was there. Staff from the facility showed up about a minute later and picked up the resident. She indicated the resident was there for about 10 minutes. She was unable to recall if the resident was using a walker or wearing a coat.

	During an interview, on November 30, 2021 at 9:40 a.m., the Director of Nursing indicated the reason dementia was not included on the most recent elopement assessments was because the physician who assessed the resident on November 10, 2021, did not include a dementia diagnosis so it was not used on the assessment dated November 16, 2021. A current facility policy, titled "ABUSE POLICY," provided by the Executive Director on November 30, 2021 at 9:20 a.m., indicated "...Neglect...Any...action or lack of action that you have a duty to perform and your failure to act could result negatively affect the resident's health, safety or welfare...." This State finding relates to Complaint IN00367009.			

Based on observation, interview and record review, the facility failed to ensure a resident was free from neglect when she wandered across a busy parking lot, from the facility grounds, without the facility staff's knowledge for 1 of 3 residents being reviewed for neglect. (Resident B) Resident B, on November 11, 2021, required staff to pick her up from an office at the local hospital 0.2 miles from the facility.

Finding includes:

During a walk-through of the facility, on November 29, 2021 beginning at 9:55 a.m., with Maintenance Staff 1 the following observations were made: the main dining area had a door which opened out to a patio area with access to a pond. The door was not locked and there was a camera pointed at the door. In the first floor east hall, there was a door which opened to an unfenced area which had access to the pond. The door was not locked and did not have an alarm. At the end of the hall, there was an unlocked door which led to a small entry with another unlocked door which led outside with access to the pond. There was a camera pointed at the door. On the first floor west side, there was an unlocked door with an alarm at the top. At that time, Maintenance Staff 1 indicated

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	could result negatively affect the resident's health, safety or welfare...." This State finding relates to Complaint IN00367009.			

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