STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	10/11/2024

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

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: October 10 and 11, 2024 Facility number: 012129 Residential Census: 43 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed October 18, 2024.	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 0149 Bldg. 00	410 IAC 16.2-5-1.5(f) Sanitation and Safety Standards - Deficiency Based on interview and record review, the facility failed to develop and implement a pest control program to reduce the number of resident rooms with bed bug infestations or sightings, prevent the recurrence of bed bugs in the same area, and prevent the spread of bed bags to new locations. This deficient practice had the potential to impact 43 of 43 residents in the facility. Findings include:	R 0149	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 policy, education and in service training on Updated policy and preventative Maintenance for Bedbugs.	11/01/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Cook	Administrator	11/15/2024

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	Confidential interviews were completed during the survey and indicated the following: 1. The facility had bed bugs for a long time. They were bad on the second floor. 2. The resident had bed bugs in their room in the past. They did not know where they came from and were afraid to have guests come inside to visit for fear they would go home with bed bugs. They had visited with guests outside. 3. The bed bugs had been very bad and they [the facility] didn't seem to get rid of them. Everyone was afraid they would get them. 4. Multiple rooms had bed bugs and were still there. Everyone had been afraid they would get them. 5. The facility had bed bugs in many places, including resident rooms. Resident had not gone in the sunroom because they thought they were there. They were afraid they would get them. 6. There were bed bugs in the building and the facility had not gotten rid of them yet. They were in common areas and residents rooms. "Blank Preventative Maintenance Checklist" documents for May 8, 2024 to October 8, 2024 contained the following legible information regarding bed bug inspections and sightings as follows: May 2024- 8 resident rooms were checked and 5 had live bed bugs, June 2024- 5 resident rooms were checked and 4		Education provided to staff in the form of in-service. During said in service the staff was educated with on Updated policy and Preventative maintenance for Bedbugs treatments. We will be monitoring and follow-up with our New Log tracker. Added additional tracking log for Monitoring on weekly ,Bi-Weekly, and Monthly. Each check will be recorded. The Administrator or designee will check and log on checks on logs	

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	had live bed bugs, July 2024- 4 resident rooms were checked and 4 had live bed bugs, August 2024- 5 resident rooms were checked and 5 had live bed bugs, September 2024- 4 resident rooms were checked and 4 had live bed bugs, October 2024 only 1 date entered, 10/8/24- 1 resident room checked with live bed bugs found, and May 24, 2024 was the last date listed when a profession pest treatment company came into the facility and treated for bed bugs. The information on the 5/8/24 to 10/8/24 "Blank Preventative Maintenance Checklist" included, but was not limited to, the following resident rooms with repeat bed big sightings: Rom 2--, Second floor 5/8/24- found and sprayed, due date for next check- as need No documented checks until 7/31/24 7/31/24- found, sprayed and powdered, due date for next check- week No documented checks until 8/30/24 8/30/24- found, sprayed and powdered, due date for next check-week No documented checks until 9/18/24 9/18/24- found, spray and heat, due date for next check- 9/20/24 Room 2-- Second floor 5/15/24-found , powder, due date for next check- as needed			

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	No documented checks until 6/24/24 6/24/24- found, spray and heat, due date for next check- as needed 8/14/24- found, sprayed and powdered, due date of next check- week No documented checks until 9/4/24 9/4/24- found, spray and powdered, due date of next check- 9/11/24 9/11/24- nothing found, spray, due date of next check- week 9/19/24- found, spray and powdered, due date of next check-week 9/23/24- found, spray, powder, and heat, due date of next check-week 9/29/24-found, spray, powder, and heat, due date of next check-week Room 2--Second floor 6/17/24-found, sprayed, due date for next check-as needed No checks found unit 7/15/24 7/15/24-found, spray, powdered and heated, due date of next check-week 7/22/24- found, sprayed-due date of next check-week 7/29/24-none found 8/9/24-found-powdered- due date of next check-week No documented checks since 8/9/24. Room 2--, Second floor 7/8/24- found, sprayed and powdered, due date of next check-week 7/15/24- none found 7/22/25- found, spray and powdered, due date of next check-week 7/24/24- none found 8/9/24- found, sprayed and heat, due date of next check-week No documented checks until 8/30/24			

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	8/30/24- follow up spray No documented checks until 9/30/24 9/30/24-found, sprayed, due date of next check-week No documented checks after 9/30/24 First floor - New room location 9/3/24-found, sprayed, powdered, and heated, due date of next check-9/5/24 9/5/24- found, sprayed and powdered, due date of next check-9/19/24 No other checks were documented after 9/5/24. Review of the facility floor plan, provided by the Administrator on 10/10/24 following entrance conference, indicated 10 rooms were found to have active bed bugs from may 2024 to October 2024 were located on the Second floor. Six rooms were in the North East hall. Four rooms were located in the Atrium that adjoined the Second floor North east hall. The location reflected a geographic pattern in that no rooms on the second floor South West halls were impacted. During an interview, on 10/11/24 at 9:51 a.m., the Maintenance Director indicated he was not a pest control specialist. He had been trained by the facility. There was not an evaluation to determine which treatment or treatments would be used for bed bug sightings or infestations. The facility did not have an approach for more aggressive treatment for "hot spots" or re-infestations of the same geographic area. He regularly followed the instructions of the Administrator, who regularly lead or assisted with bed bug treatment. He did not always maintain a log for follow-up checks following treatments for bed bugs. A current, undated, facility policy titled, "Bed Bug Protocol/Procedures Crownpointe of Anderson,"			

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	provided by the Administrator on 10/11/24 at 11:20 a.m., indicated the following: "...Maintenance staff will inspect the unit to see what type of treatment is necessary (Spray, powder, heat, or all of them)... If spray and powder are needed (generally that is our first treatment), the resident will be asked to leave their apartment for 2 hours... If heat treatment is necessary, the resident will be moved to a room specifically set aside for over night use..." The policy did not establish a criteria to identify which treatment or treatments were indicated.			
R 0270 Bldg. 00	410 IAC 16.2-5-5.1(c)(1-3) Food and Nutritional Services - Deficiency Based on interview and record review, the facility failed to honor residents' dietary preferences for variety and lack of repetition in the menu. This deficient practice had the potential to impact 43 of 43 residents. Findings include: Confidential interviews were conducted during the survey and indicated the following: 1. There had been no variety in the menu. Residents got the same items over and over. They served Turkey Manhattan twice in the same week. They had made concerns known to the Administrator and he said he would look into it. No change had occurred. The facility said they were on a new menu but the same problems continued. There had been zero change. 2. They repeated food frequently. Residents had complained and nothing changed. They had pizza and pizza sandwiches just days apart. They told	R 0270	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 policy, education and in service training for dietary manager on using Created updated menus. Education provided to staff in the form of in-service. During said in service the staff was educated on gathering any new menu requests and logged them for future items to be placed on menus. Administrator and Dietary manager met with residents and gathered changes . New menus has been updated and reflects new Winter Southern Menu for 2024 We will be monitoring and follow-up on future feedback . The Administrator or designee will	11/01/2024

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	the Administrator and nothing changed. 3. They served the same things repeatedly. They had complained but nothing happened. The facility said it was a new menu but nothing was corrected. They had turkey Manhattans twice in one week. 4. The menus have been repetitive. They say the state makes them serve it. They had the same food served days in a row. Residents told the Administrator they were unhappy but nothing changed. 5. The food had not been good. They repeated meals over and over. They cut the smoked sausage into little coin rings and gave them a few. Residents said they were tired of the repeating. 6. The resident was very unhappy with the food. It had not tasted good. The facility repeated the menu. It appeared they did not care at all. 7. The food always repeated. They had turkey Manhattan twice in the same week. No one cared. No one in leadership or dietary noticed. Residents told the facility they were unhappy with repeated menus. A current ,12/5/23, facility document titled, "Winter Southern 2023," provided by the Administrator following the entrance conference on 10/10/24 indicated the following issues regarding repetition and lack of variety: Week 1 ,Tuesday lunch menu had an entree of roasted pork tenderloin. Sunday lunch of week 5 menu had an entree of honey mustard pork tenderloin. This menu resulted in pork tenderloin being served twice in a three day period.		check and follow-up as needed . Updated with a new log tracker for Menus and new reviews. The menus and preference will be reviewed on weekly, bi-weekly and monthly for up to 6months with the new Kitchen Audit Tool.	

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	Week 1 Wednesday dinner (evening meal) had soft shelled beef tacos and Spanish rice as the entree. Week 1 Friday dinner menu had Chicken enchiladas and Spanish rice as the entree. This resulted in a Mexican food with Spanish rice being served twice in a three day period. Week 1 Tuesday dinner had Polish Sausage and potatoes as the entree. Week 2 Tuesday dinner had Polish Sausage and au grautin potatoes as the entree. Week 4 Friday dinner had Polish sausage and au gratin potatoes as an entree. This resulted in 2 of 4 weeks having the same sausage for a meal. Week 1 Friday dinner had a BLT as the entree. Week 2 Wednesday dinner had a BLT as the entree. This resulted in 2 weeks in a row having BLTs for dinner. No other week had BLTs and spacing between meals was not used when developing the menu. Week 2 Thursday dinner had pizza burger and tossed salad as an entree. Week 2 Saturday dinner had cheese pizza and tossed salad as the entree. This resulted in 2 pizza based meals being served in a three day period. Week 4 Sunday lunch and Week 4 Thursday lunch both had grilled chicken breast fillet as the entree. This resulted in chicken being prepared in the same manner being served twice in a five day period. Week 5 Sunday lunch and Saturday dinner had Turkey Manhattan as the entree. This resulted in the same entree being served 2 times in one week. During an interview on 10/11/24 at 12:03 p.m., the			

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	Administrator indicated the facility changed menus September 1, 2024. He was unaware if the menus had been reviewed for repeating meals and lack of variety. He indicated the registered dietitian had spoken to resident on their last visit on October 7, 2024. Changes to the menu had not yet been made.			
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, interview, and record review, the facility failed to ensure over easy eggs (with soft runny yolks) were prepared using pasteurized eggs to reduce the risk of food born illness. Findings include: During a kitchen tour on 10/10/24 at 11:02 a.m., a box of unpasteurized eggs in their shell were observed in the refrigerator. During an interview on 10/10/24 at 11:10 a.m., Cook 5 indicated the facility served over easy eggs with a runny yolk to those residents who requested over easy eggs. The eggs were prepared using the eggs in the refrigerator. Pasteurized eggs were not used. On average, six residents each day would request over easy eggs. She had never been informed she needed to use pasteurized eggs. Her only instructions were to not prepare any sunny side up eggs. During an interview on 10/10/24 at 11:30 a.m., the Administrator indicated the facility did not purchase pasteurized eggs due to cost. He believed the residents could have over easy eggs if they requested them.	R 0273	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 policy, education and in service training for dietary manager on ordering Pasteurized Eggs Education provided to staff in the form of in-service. The Eggs have been updated on Administrator and Dietary manager met with residents and gathered changes . New menus has been updated and reflects new Winter Southern Menu for 2024 We will be monitoring and follow-up on future feedback .The Administrator or designee will check and follow-up as needed. Have created a new Kitchen audit tool for Pasteurized eggs. Will track invoices and review stock on a weekly, bi-weekly and Monthly basis for 6 months . The dietary manager that orders all products has been educated on regulations on the preparing of eggs.	11/01/2024

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	A current, undated, facility policy titled, "Consumer Advisory for Meat/Eggs Preparation," provided by the Administrator on 10/10/24 at 1:42 p.m., indicated "... soft-cooked eggs...I significantly increase my risk of contracting foodborne illness...I recognize 'hard' cooked eggs, etc., are considered to be safe for the consumption."		regulations and audit tool and inservice has been added .	
R 0328 Bldg. 00	410 IAC 16.2-5-7.1(c)(1-3) Activities Programs - Noncompliance Based in interview and record review the facility failed to employ a qualified activity director. This deficient practice had the potential to impact 43 of 43 residents. Findings include: Employee records were reviewed on 10/10/24. The Activity Director's record was lacking a certification or educational record to qualify her as an Activity Director (AD). The employee record form indicated the AD was hired on 12/6/21. During an interview on 10/11/24 at 9:29 a.m., the Business Office Manager indicated the AD did not have a degree or certificate to qualify her as an Activity Director. During an interview on 10/11/24 at 10:18 a.m., the Administrator indicated the AD had begun her employment as an AD on 12/06/21. She had taken a class but had not passed her test. She would need to repeat the process.	R 0328	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 policy, education and in service training on completing Activity License. License is complete and Certificate is attached Education provided to staff in the form of in-service. During said in service the staff(activity Director) was educated on License requirements. All education and testing has been complete and is current . The Administrator or designee has review for completion.	11/01/2024