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	11/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CROWNPOINTE OF INDIANAPOLIS	7365 E 16TH ST INDIANAPOLIS, IN 46219

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00446446. Complaint IN00446446 - State deficiencies related to the allegations are cited at R0029. Survey date: November 25, 2024 Facility number: 005729 Residential Census: 29 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on December 2, 2024.	R 0000	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 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 0029 Bldg. 00	410 IAC 16.2-5-1.2(d) Residents' Rights - Deficiency Based on interview and record review, the facility failed to ensure a dignified environment pertaining to two staff members having a verbal and physical altercation in a common area of the facility that was witnessed by a resident. (Resident C) Findings include: An incident reported to the Indiana Department of Health survey report system, dated 10/25/24, indicated a verbal and physical altercation occurred between two staff members and a family member of one of the staff members. The altercation took place around the entrance to the	R 0029	R_0029 1. 1. All residents including resident “C” have been re-educated and in-serviced on the policy of workplace violence and Resident Rights. Residents have been educated on their right to file a grievance to the administrator or their designee of any unacceptable or threatening behavior by employees. 2. 2. Employees have been informed on how engaging in unacceptable behavior affects the dignity of all residents and their	12/14/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Andrea Wilson	RCA	12/10/2024

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	facility. Resident C was listed as a resident involved and witnessed the incident. A telephone interview was conducted with the former Executive Director (ED) on 11/25/24 at 1:51 p.m. She indicated Qualified Medication Aide (QMA) 2 and Certified Nurse Aide (CNA) 4 were "getting into it" in the foyer/entrance of the facility. QMA 2 experienced stress and felt upset towards CNA 4. The former ED encouraged QMA 2 to wait until their shift was over, but QMA 2 kept "carrying on" about how CNA 4 was not conducting their job. The former ED then heard commotion about QMA 2 stating "they are going to mess with my car". The front doors were locked at that time and QMA 2 yelled out "they got their hands on me" and the phone appeared to have gone to the floor. The former ED instructed QMA 2 to call the police. The former ED was able to bring up the camera system on the phone to review. It appeared QMA 2 raised the window in the foyer, took the screen out, and yelled at CNA 4 and the family member, who were at the front door. QMA 2 kept opening and closing the front door and let CNA 4 and their family member inside. Resident C was present and had seen the whole fight take place. Resident C was the one that called 9-1-1. Both QMA 2 and CNA 4 were terminated after the incident. The investigative file was reviewed during the survey. A statement signed by Resident C, dated 10/28/24, indicated the following, "...Prior to the event, while in my room with my door shut and tv on I could hear [name of QMA 2] yelling and screaming at [name of CNA 4]. Then about 30 mins [minutes] away and I heard a voice say get the f**k away from my vehicle [sic]...then they all three just started at each other. I would soy [sic] maybe 30-45 seconds of fighting then the girls ran		living environment. Employees were informed that any allegation of unacceptable, threatening and/or violent behavior will result in immediate termination in addition to a complaint against any professional license. 3. 3.Employees have been re-educated and in-serviced on workplace violence and Resident Rights. Employees also completed a pre and posttest on Resident Rights. 4. 4.Employees will receive continuous education semi annually for one year, annually, and upon hire on the policies of Work Place violence and Resident Rights by the administrator and monitored for compliance by the Director of Operations. 5. 5. 12/14/2024	

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	and jumped into the truck and tore out of here...." A document titled "RESIDENTS RIGHTS", undated, was provided by the Executive Director on 11/25/24 at 4:10 p.m. The document indicated the facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. This citation relates to Complaint IN00446446.			