STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT CROWN POINT LLC	1555 S MAIN STREET CROWN POINT, IN 46307

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00393079, IN00395998, IN00397323, IN00404534 and IN00404619. This visit included a State Residential Licensure Survey. Complaint IN00393079 - Federal/ state deficiencies related to the allegations are cited at F697. Complaint IN00395998 - No deficiencies related to the allegations are cited. Complaint IN00397323 - No deficiencies related to the allegations are cited. Complaint IN00404534 - No deficiencies related to the allegations are cited. Complaint IN00404619 - No deficiencies related to the allegations are cited. Survey dates: March 20, 21, 22, 23, 24 and 27, 2023. Facility number: 013452 Provider number: 155835 AIM number: 201299290 Census Bed Type: SNF/NF: 60 NF: 3 Residential: 24 Total: 87 Census Payor Type: Medicare: 29	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Medicaid: 3 Other: 31 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/3/23.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 residents reviewed for self-administration of medication. (Resident 160) Finding includes: During a random observation on 3/20/23 at 9:45 a.m., a basin was noted in the bathroom that held a bottle of throat spray and a bottle of Dakins solution. During a random observation on 3/21/23 at 9:29 a.m., a basin was noted in the bathroom that held a bottle of throat spray and a bottle of Dakins solution. Resident 160's record was reviewed on 3/22/23 at 1:51 p.m. Diagnoses included, but were not limited to, high blood pressure and hypothyroidism. A Physician's Order, dated 3/17/23, indicated Dakins External Solution 0.25 % (sodium hypochlorite), apply to mid abdomen topically every day shift for wound care. Cleanse with wound cleanser, pack lightly with Dakins soaked	F 0554	R160 no longer resides in the facility. Dakin's solution and throat spray were removed from R160s room immediately. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice.Full house audit was completed with no further medications left in resident rooms without assessments, orders, and careplans updated to reflect self administration. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff were educated on ensuring medications are not left at bedside unless there is a self-administration assessment, a physician order, and an updated	05/05/2023

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	gauze, cover with abd pad and dry dressing. There were no orders for a throat spray. There were no orders for self-administration of any medications. A self-administration of medication assessment was not completed. Interview with the Director of Nursing on 3/23/23 at 2:55 p.m., indicated the resident said those were her personal belongings that came from the hospital that she wanted to keep but she had not used them since she arrived to the facility. 3.1-11(a)		careplan for the medications and for self-administration of medication. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will monitor 10 residents weekly on alternating shifts to ensure no medications are left at resident's bedside unless there is a self-administration assessment, a physician order, and updated careplan for the medications and for self-administration of medication. The DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to hypnotic and opioid medication use for 2 of 21 MDS assessments reviewed. (Residents 5 and 112) Findings include: 1. The record for Resident 5 was reviewed on	F 0641	What Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 5's record has been updated to show there was no use of hypnotic medication. Resident 112 assessment has been updated to reflect the use of an antiemetic rather than an	05/05/2023

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	3/22/23 at 11:32 a.m. Diagnoses included, but were not limited to, hypertension, chronic kidney disease, and atrial fibrillation. The Admission MDS assessment, dated 2/5/23, indicated the resident had received a hypnotic medication in the past seven days. The March 2023 Physician's Order Summary lacked any orders for a hypnotic medication. The February 2023 Medication Administration Record (MAR) lacked any administration of a hypnotic medication. Interview with the MDS Nurse on 3/24/23 at 9:05 a.m., indicated the MDS was incorrect, there was no hypnotic medication received. She would make a correction. 2. Resident 112's record was reviewed on 3/21/23 at 2:40 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, atrial fibrillation, and hypertension. The Admission MDS assessment, dated 3/15/23, indicated the resident had received an opioid medication in the past seven days. The March 2023 Physician's Order Summary lacked any orders for an opioid medication. The March 2023 Medication Administration Record (MAR) lacked any administration of an opioid medication. Interview with the MDS Nurse on 3/24/23 at 9:05 a.m., indicated the MDS was incorrect, there was no opioid medication received. She had mistakenly marked opioid for the Marinol		opioid. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken. A review of resident assessments has been completed. No like concerns were identified. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. MDS coordinator has been educated to ensure medications are coded correctly on the MDS and care planned accordingly. How will the corrective actions be monitored to ensure the deficient practice does not recur? What QA will be put into place? A random accuracy review of 5 MDS assessments will be completed on a monthly basis by the DON/Designee and concerns will be brought to the QAPI committee for no less than 6 mos.	

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	medication because it was a controlled substance, however it was classified as an antiemetic. She would make a correction. 3.1-31(i)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen was properly placed for 1 of 2 residents reviewed for respiratory services. (Resident 162) Finding includes: On 3/20/23 at 11:27 a.m., Resident 162 was observed in bed. His nasal cannula and oxygen tubing were noted to be hanging on the bedside rail and not in use. On 3/21/23 at 9:26 a.m., Resident 162 was observed in bed. The oxygen was not in use. Resident 162's record was reviewed on 3/22/23 at 11:47 a.m. Diagnoses included, but were not limited to heart failure, chronic obstructive pulmonary disease, high blood pressure, and diabetes mellitus. A Physician's Order, dated 3/15/23, indicated oxygen at 2 liters per minute continuously. A Care Plan, dated 3/16/23, indicated the resident had oxygen therapy. Interventions included, but were not limited to, administer oxygen per physicians orders. Interview with the Director of Nursing on 3/24/23 at 8:59 a.m., indicated the respiratory therapist had	F 0695	What Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Resident 162 orders for oxygen were discontinued on 3/21/23. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken. All residents with orders for oxygen have the potential to be affected by the alleged deficient practice. A full house audit of all guests on oxygen therapy was completed to ensure oxygen was in use per physician's orders. No like concerns were identified. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. DON/Designee will monitor 10 residents receiving oxygen per week on all shifts to ensure oxygen is in place per physician's orders. The results of these audits will brought to the QAPI Committee	05/05/2023

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	instructed the resident to start weaning off of the oxygen, but there was no documentation. 3.1-47(a)(6)		monthly for no less than 6 mos.	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on observation, record review, and interview, the facility failed to ensure a pain medication was provided for a resident experiencing pain for 1 of 1 residents reviewed for pain. (Resident B) Finding includes: On 3/21/23 at 9:57 a.m., Resident B was observed seated on the edge of her bed. She was rubbing her knees and grimacing, she indicated her knees and hips were hurting. On 3/23/23 at 2:26 p.m., the resident was seated in her wheelchair in her room. She indicated it hurt every time she moved in her knees and hips. The resident's record was reviewed on 3/22/23 at 2:47 p.m. The resident was admitted on 3/23/23. Diagnoses included, but were not limited to, dementia, heart disease and gout. A Pain Screen, dated 3/21/23, indicated the resident was having occasional pain in the past five days. A Physical Therapy Treatment Encounter Note, dated 3/18/23, indicated the patient was having increased pain in both knees requiring her to sit back in the wheelchair. A Note, dated 3/22/23, indicated she was having difficulty standing due	F 0697	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident Bs pain medication was scheduled to me administered 500mg 1 tab every 6 hours. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this alleged deficient practice.Full house audit was completed to ensure residents received appropriate PRN pain medication when in pain. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff educated on ensuring that residents with complaints of pain and non-verbal symptoms of pain receive the proper PRN pain medication based on the resident's pain level **How will the corrective actions(s) be monitored to**	05/05/2023

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	to complaints of pain in both knees. Physician's Orders, dated 3/20/23, indicated to apply Voltaren gel (topical pain medication) 4 grams to the left knee every 6 hours as needed for pain and give Tylenol 500 milligrams every 6 hours as needed for pain. The March 2023 Medication Administration Record (MAR) indicated Voltaren gel had never been administered and Tylenol had been given one time on 3/23/23. A pain assessment was completed three times a day and marked as having no pain every time. Interview with LPN 1 on 3/23/23 at 2:45 p.m., indicated she had done the pain assessment that shift and didn't think the resident was having any pain. She indicated when the resident was moved she would complain of pain or tell them not to touch her bad leg. She indicated she had never given the resident anything for pain. This Federal tag relates to Complaint IN00393079. 3.1-37(a)		**ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will monitor 15 PRN pain medication administrations a week to ensure appropriate medication administered based on resident's pain level. DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0726 SS=D Bldg. 00	483.35(a)(3)(4)(c) Competent Nursing Staff Based on observation, record review, and interview, the facility failed to ensure there was competent nursing staff provided for proper medication administration of an IV (intravenous) medication related to heparin (blood thinner) flushes for a random medication administration observation. (LPN 2 and Resident 29) Finding includes:	F 0726	What Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? No harm came to resident 29. Resident 29 no longer resides in the facility. How will you identify other residents having the potential to be affected by the same practice	05/05/2023

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	On 3/23/23 at 10:44 a.m., LPN 2 was observed passing medications to Resident 29. She prepared the ceftriaxone sodium (an antibiotic medication) 2 grams after performing hand hygiene and donning gloves. She primed new intravenous (IV) tubing, cleaned the midline access site with an alcohol swab, flushed the IV with 10 milliliters (ml) of normal saline and then attached the IV tubing containing the ceftriaxone. At 11:26 a.m., LPN 2 was observed disconnecting the IV tubing after the medication had completed infusing. She clamped the tubing, cleaned the access site with an alcohol swab, flushed the IV with 10 ml of normal saline, flushed the IV with 5 ml of heparin (an anticoagulant), cleaned the site again and applied a new cap to the access site. Resident 29's record was reviewed on 3/24/23 at 9:33 a.m. Diagnoses included, but were not limited to, pneumonia, anemia, and atrial fibrillation (irregular heart beat). A Physician's Order, dated 3/19/23, indicated IV non-valved midline, flush with 10 ml normal saline before and after medications, then flush with 3 ml heparin (10 units/ml). Interview with the Director of Nursing on 3/23/23 at 2:55 p.m., indicated the LPN should have given the ordered dose of heparin flush. 3.1-17(a)		and what corrective action will be taken. All residents with IV medications have the potential to be affected. Orders related to IV flush have been adjusted to reflect the policy/flush protocols which read 5 ml of heparin. Nurses have been educated on the policy/procedure for IV medication administration. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. Orders related to IV flush have been adjusted to reflect the policy/flush protocols which read 5 ml of heparin. The DON/Designee will monitor 5 random IV medication administrations per week to ensure physician's orders/ policy is followed. The results of these audits will be brought to the QAPI Committee monthly for no less than 6 mos.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure medications were given as	F 0757	What¿Corrective actions will be accomplished for those residents	05/05/2023

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	ordered for 1 of 5 residents reviewed for unnecessary medications. (Resident 1) Finding includes: Resident 1's record was reviewed on 3/21/23 at 2:57 p.m. Diagnoses included, but were not limited to cellulitis, high blood pressure, and coronary artery disease. The Admission Minimum Data Set (MDS) assessment, dated 3/14/23, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 3/8/23, indicated midodrine 5 milligram (mg) tablet, 1 tablet by mouth every 12 hours for hypotension. The February 2023 Medication Administration Record (MAR) indicated the midodrine medication was not administered as ordered on the following dates and times: - 2/18/23 at 9:00 p.m. with a blood pressure of 161/70 - 2/20/23 at 9:00 a.m. with a blood pressure of 146/83 - 2/21/23 at 9:00 a.m. with a blood pressure of 140/62 - 2/21/23 at 9:00 p.m. with a blood pressure of 124/55 - 2/24/23 at 9:00 a.m. with a blood pressure of 167/75 - 2/25/23 at 9:00 a.m. with a blood pressure of 132/60		found to have been affected by the alleged deficient practice? The facility is unable to retrospectively address the cited concern. No harm came to Resident 1.¿ Resident 1 no longer resides in the facility. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken. A review of all residents with orders requiring parameters such as midodrine was completed.¿ Parameter orders were placed per physician orders when appropriate. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. Nursing staff educated on obtaining parameter orders for Midodrine when ordered. Nursing staff educated on medications that may be accompanied by parameters for use. Nursing staff on ensuring that medications are administered appropriately as it relates to order parameters. How will the corrective actions be monitored to ensure the deficient practice does not recur?¿ What QA will be put into place? The DON/Designee will monitor 10 random medications with parameters including Midodrine administrations per week to ensure physician's orders are followed, notifications and that these actions are documented in the EMR. The results of these	

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	- 2/26/23 at 9:00 a.m. with a blood pressure of 132/63 - 2/26/23 at 9:00 p.m. with a blood pressure of 138/69 Interview with the Director of Nursing on 3/24/23 at 8:59 a.m., indicated there were no orders received for holding the midodrine medication on those days. 3.1-48(a)(1)		audits will be brought to the QAPI Committee monthly for no less than 6 mos.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented related to not cleaning a glucometer observed during medication pass. (LPN 3) Finding includes: On 3/23/23 at 10:59 a.m., LPN 3 was observed preparing to check a resident's blood sugar. She removed a glucometer, lancet, alcohol swabs, and the test strips from the medication cart. She performed hand hygiene and donned gloves and proceeded to walk into the residents room and check her blood sugar. Once the procedure was completed, she put the lancet in the sharps container, removed her gloves, performed hand hygiene and placed the glucometer back into the medication cart. She did not clean the glucometer before or after use. Interview with LPN 3 on 3/23/23 at 11:05 a.m., indicated she washed the glucometer with an	F 0880	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No residents were affected by the alleged deficient practice. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents with orders for blood sugar checks have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff have been educated on the procedure for cleaning a glucometer. Staff have been educated on how and when to don and doff PPE with return	05/05/2023

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	alcohol swab after every use. Interview with the Director of Nursing on 3/24/23 at 8:59 a.m., indicated the LPN should have used a sanitation wipe that was approved to clean the glucometer before and after use. A Policy titled, "Blood Glucose Monitoring Machine Cleaning," and noted as current, indicated "...Policy:...4. Cleanse and disinfect meter between each use." 3.1-18(b)		demonstrations. Staff involved have been educated in infection control practices regarding wound care, including but not limited to dressing changes. Staff have been educated on infection control practices during med administration to prevent possible contamination of medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Infection Control Preventionist/ DON / Designee will observe random blood sugar checks daily for to ensure proper cleaning procedures occur. In addition, IP/DON/Designee will ensure all nursing staff receive training specific to infection control including glucometer cleaning prior to floor orientation. Infection Control Preventionist /DON/ Designee will complete daily visual rounds throughout the facility to ensure staff are practicing appropriate infection control practices and complying with policies related to infection control. Daily visual audits will take place for 6 weeks. Training as described will be verified during the orientation process by Administration. Weekly visual audits will commence for 5 months. The results of these audits will be submitted to the QAPI Commitee for no less than 6	

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			months to ensure compliance.	
R 0000 Bldg. 00		R 0000		

This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00393079, IN00395998, IN00397323, IN00404534 and IN00404619.

Complaint IN00393079 - Federal/ state deficiencies related to the allegations are cited at F697.

Complaint IN00395998 - No deficiencies related to the allegations are cited.

Complaint IN00397323 - No deficiencies related to the allegations are cited.

Complaint IN00404534 - No deficiencies related to the allegations are cited.

Complaint IN00404619 - No deficiencies related to the allegations are cited.

Survey dates: March 20. 21, 22, 23, 24 and 27, 2023.

Facility number: 013452

Residential Census: 24

These State Residential Findings are cited in accordance with 410 IAC 16.2-5.

Quality review completed on 4/3/23.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. BUILDING 00 B. WING	03/27/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT CROWN POINT LLC	1555 S MAIN STREET CROWN POINT, IN 46307

(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 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to provide service plans to residents on admission for 4 of 7 resident records reviewed. (Residents 1, 4, 5 and 7) Findings include: 1. Resident 1's record was reviewed on 3/24/23 at 10:19 a.m. The resident was admitted on 2/2/23. There was no signed service plan in the resident's record. 2. Resident 7's closed record was reviewed on 3/27/23 at 10:46 a.m. The resident was admitted on 12/29/22. There was no signed service plans in the resident's record. 3. The record for Resident 5 was reviewed on 3/27/23 at 10:29 a.m. Diagnoses included, but were not limited to, anxiety disorder, osteoporosis, and chronic obstructive pulmonary disease (COPD). The resident was admitted to the facility on 11/5/22. A Service Plan was completed on 11/5/22. There was no signature noted of the resident and/or responsible party to indicate the service plan had been reviewed with the resident.4. The record for Resident 4 was reviewed on 3/27/23 at 9:52 a.m. The resident was admitted on 1/3/23. There was no signed service plan in the resident's record. Interview with the Assisted Living Director on 3/27/23 at 11:33 a.m., indicated she was unaware she needed to have the residents sign a service plan upon admission.	R 0217	What Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Service plans were completed and signed for Residents 1,7,5 and 4. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken. A review of all AL residents' records was completed. No like concerns were identified. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. Director has been educated to ensure that service plans are discussed and signed upon admission for all AL residents. How will the corrective actions be monitored to ensure the deficient practice does not recur? What QA will be put into place? AI Director or Designee will review all AL admissions monthly to ensure that the service plans are completed and signed on admission. The results of these audits will be brought to the QAPI Committee monthly for no less than 6 months.	05/05/2023

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R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the resident emergency binder had complete information for all residents for 3 of 5 current residents reviewed. (Residents 1, 4 and 5) Findings include: The resident emergency binder was reviewed on 3/24/23 at 10:45 a.m. The binder was missing the following resident information: 1. Resident 1 had no photograph or hospital preference. 2. Resident 4 had no photograph or hospital preference. 3. Resident 5 had no photograph. Interview with the Assisted Living Director, on 3/24/23 at 12:50 p.m., indicated she was not aware the binder was missing resident information.	R 0356	What Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? The emergency binder has been updated to include photograph and hospital preference for Resident 1 and 4 and photograph for resident 5. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken. A review of all AL residents' records was completed. No like concerns were identified. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. Director has been to ensure that the emergency binder includes a photograph and hospital preference for all AL Residents. How will the corrective actions be monitored to ensure the deficient practice does not recur? What QA will be put into place? Al Director or Designee will review the emergency binder monthly to ensure photographs and hospital preferences are present for all Residents. The results of these audits will be brought to the QAPI Committee monthly for no less than 6 mos.	05/05/2023

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R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to lack of tracking infections and lack of increased monitoring for a resident diagnosed with COVID-19 for 1 of 2 residents reviewed for COVID-19. (Assisted Living Unit and Resident 5) Findings include: 1. The infection control program was reviewed on 3/24/23. There was no documentation related to the tracking of infections on Assisted Living. Interview with the Assisted Living Director, on 3/24/23 at 12:50 p.m., indicated she did not track infections and was not aware she needed to do so. 2. The record for Resident 5 was reviewed on 3/27/23 at 10:29 a.m. Diagnoses included, but were not limited to, anxiety disorder, osteoporosis, and chronic obstructive pulmonary disease (COPD). A Progress Note, dated 2/9/23 at 2:00 p.m., indicated the resident had complained of a sore throat, headache, congestion, and fatigue. A rapid COVID test was completed and was positive. A COVID-19 Monitoring Evaluation was completed on 2/10/23 and 2/13/23. There was a lack of documentation of any other COVID-19 monitoring or assessment of vital signs for the resident while positive for COVID-19.	R 0407	What Corrective actions will be accomplished for those residents found to have been affected by the alleged deficient practice? Infection control tracking was completed for AL for the the last 3 mos. Resident 5 no longer has COVID symptoms. How will you identify other residents having the potential to be affected by the same practice and what corrective action will be taken. A all residents was completed, and any infections were logged per policy. There are currently no COVID positive residents in AL. What measures will be put in place or what systematic changes will be made to ensure the deficient practice does not recur. Director has been educated to ensure that infection control tracking is maintained for all residents in AL. AL Director has been educated to ensure that Residents with COVID have symptoms and vitals are monitored per policy. How will the corrective actions be monitored to ensure the deficient practice does not recur? What QA will be put into place? AL director or will complete a monthly review of all infections in AL to ensure they are logged and tracked, and symptoms are documented appropriately. The results of these	05/05/2023

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	Interview with the Assisted Living Director on 3/27/23 at 11:54 a.m., indicated the resident was checked on frequently but she was unable to provide further documentation of vital signs or COVID assessments. She indicated they were to document by exception. A facility policy, titled "Documentation By Exception", received as current, indicated "...2. Documentation should include any unusual event or change of condition of the resident..." A facility policy, titled "COVID-19 Clinical Guidance-Indiana", received as current, indicated "...Assessment of Residents. Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry...Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximetry, and respiratory exam, to at least three times daily to identify and quickly manage serious infection..."		audits will be brought to the QAPI Committee monthly for no less than 6 mos.	