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	07/16/2024

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 the Investigation of Complaints IN00433869, IN00436496 and IN00437883. Complaint IN00433869 - No deficiencies related to the allegations are cited. Complaint IN00436496 - Federal/State deficiencies related to the allegations are cited at F609 and F732. Complaint IN00437883 - Federal/State deficiencies related to the allegations are cited at F609. Unrelated deficiency is cited. Survey dates: July 15 & 16, 2024 Facility number: 013452 Provider number: 155835 Census Bed Type: SNF: 66 Residential: 23 Total: 89 Census Payor Type: Medicare: 62 Other: 4 Total: 66 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/17/24.	F 0000	The facility respectfully requests a desk review	
F 0609 SS=D	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations			

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

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Bldg. 00	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the Administrator and the Indiana Department of Health (IDOH) immediately or within the 2 hour time period for 1 of 3 residents reviewed for abuse. (Resident E) Finding includes:	F 0609	**Ignite Medical Resorts** **Crown Point Indiana** **Compliant survey 7/16/2024** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the	07/25/2024

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	During an interview on 7/15/24 at 4:35 a.m., LPN 1 indicated a "few weeks" ago, Resident E had made the allegation the staff were rough with her during care. She was unable to give the names of the staff. LPN 1 immediately reported the allegation to the Director of Nursing (DON) and the DON indicated she would follow up on the allegation. During an interview on 7/15/24, the Administrator indicated he was not notified of the allegation of the staff being rough during care by Resident E. There was no reported incident to the IDOH about the allegation. During an interview on 7/16/24 at 9:45 a.m., the Administrator indicated he had spoken to the DON, who was on vacation, and the DON indicated LPN 1 had reported the allegation to her. The DON had interviewed the resident she had not voiced an allegation about rough care during the interview. The Administrator indicated as soon as he had been aware of the allegation on 7/15/24, he immediately reported it to the IDOH. Resident E's record was reviewed on 7/16/24 at 11:03 a.m. The diagnoses included, but were not limited to malignant cancer of the breast and uterus. An Admission Minimum Data Set assessment, dated 6/25/24, indicated a moderately impaired cognitive status and required supervision for bed mobility and upper body dressing, moderate assistance with lower body dressing, hygiene, and transfers, and maximum assistance for toileting and bathing. There was no documentation in the Nurses' Progress notes from 6/18/24 through 7/14/24 that indicated an allegation of rough care was voiced		facility and is submitted only in response to the regulatory requirement. **F609 Reporting of alleged violations** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E no longer resides in the facility No harm came to Resident E related to alleged deficient practice. Reportable was sent to Indiana State Department of Health via Gateway reporting system. **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 have potential to be affected by the same alleged deficient practice. Administrator reviewed all current grievance/concern forms and verbal concerns from residents, staff, and family members to ensure any alleged abuse was reported immediately and investigated thoroughly. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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	by the resident. A facility abuse policy, dated 3/2024 and received as current from the Administrator, indicated an allegation of abuse was to be immediately reported to the Administrator. If the Administrator was not present, the allegation was to be reported to their immediate supervisor and/or the facility DON. The Administrator or designee were to report the allegation to the IDOH immediately, within two hours if actual harm was suspected and 24 hours for all other alleged allegations. This citation relates to Complaints IN00436496 and IN00437883. 3.1-28(c)		**practice does not recur;** Director of nursing has been re-educated on abuse and state regulatory reporting guidelines including but not limited to reporting all allegations of abuse immediately (within 2 hours) using the ISDH gateway. All departments have been educated on abuse and state regulatory reporting guidelines including but not limited to reporting all allegations of abuse immediately to administrator. In circumstances where administrator may not be available, the staff were educated to report suspected or allegations to DON and/or supervisor immediately. **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;** 5 days a week, the administrator will review; all grievances through the facility written grievance process, any new grievances/concerns/complaints daily that ambassadors collect during rounds daily and turn in (document: Ambassador checklist), verbal allegations or grievances reviewed during stand up and stand down meetings Monday through Friday, that meet	

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			the reporting requirements criteria (document: morning meeting questionnaire). To ensure any/all concerns/complaints/potential abuse allegations, are immediately reported when meeting the reporting criteria. Administrator will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. **Date by which corrections will be completed: 7/25/24**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral			

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	eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure standard practice of care was followed during an observation of a gastrostomy (g-tube) (feeding tube) medication administration, related to the placement of the g-tube not being confirmed prior to the administration of the medications, for 1 of 1 resident observed and reviewed for g-tube care. (Resident F) Finding includes: During a medication administration observation on 7/15/24 at 8:28 a.m., LPN 2 entered Resident F's room with 11 medication cups containing one crushed medication in each cup, a glass with apple juice which contained a medication that required apple juice for administration, and 30 ml (milliliters) of a protein supplement. The medications were placed on the over bed table. LPN 2 mixed the medications with 5 mls of water in each cup, flushed the g-tube with 60 ml of water, then administered the protein supplement and the medications separately through the resident's g-tube. LPN 2 did not confirm the placement of the g-tube prior to the administration of the medications. During an interview on 7/15/24 at 8:28 a.m., LPN 2 indicated she was unsure how to confirm placement of the g-tube at the facility. She indicated she worked in other facilities and was not sure of this facility's policy for how to check	F 0693	**Ignite Medical Resorts** **Crown Point Indiana** **Compliant survey 7/16/2024** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F693 tube feeding management/ restore eating skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm came to Resident F related to the alleged deficient practice. LPN #2 was educated with appropriate return demonstration on checking for placement of gastrostomy tube prior to administering any medications, fluids, and/or nutrition. **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;**	07/25/2024

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	for placement. A facility medication administration via a g-tube policy, dated 3/2023 and received as current from the Assistant Director of Nursing, indicated medications were to be given separately through the g-tube. The placement of the tube was to be confirmed prior to the administration of the medications by gently drawing back on the piston of the syringe for gastric content, which would indicate the g-tube was patent and in the stomach. 3.1-44(a)(2)		All residents with a feeding tube (gastrostomy/NG/peg tube) have potential to be affected by the same alleged deficient practice. An audit of current residents with feeding tubes was completed to ensure the nurses caring for them properly checked for placement prior to administration of medications, fluids, and/or nutrition. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses have been educated on properly checking for tube placement prior to administration of medications, fluids, and/or nutrition through gastrostomy tube. **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;** DON/designee will complete observations on 5 residents with gastrostomy tubes on alternating shifts weekly for six months to ensure that the nurse providing care properly checks tube placement prior to administration of any medications, fluids, and/or nutrition. Director of Nursing/designee will present a summary of the audits	

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			to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. **Date by which corrections will be completed: 7/25/24**	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse			

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	staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information included only the staff who were providing direct resident care, related to Nursing Administration hours included on the postings. This had the potential to affect all residents who resided in the facility during May, June, and July, 2024. Finding includes: During an observation on 7/15/24 at 4:30 a.m., there were two nurses, one QMA, and three CNAs working the evening/night shift. LPN 1 indicated the staff work 12 hours shifts. During an observation on 7/15/24 at 8 a.m., there were four nurses and six CNAs working the day/evening shift. Nursing schedules and posted nursing hours, dated 5/19/24 through 6/9/24 and 7/1/24 through 7/14/24 were reviewed on 7/16/24 at 12:00 p.m. The scheduled hours for the nurses did not match the posted hours when compared for each day. The nurses' hours were higher on the Nurse Staffing Information than the observations of the nurses in the facility who provided direct resident care. During an interview on 7/16/24 at 1:04 p.m., the	F 0732	**Ignite Medical Resorts** **Crown Point Indiana** **Compliant survey 7/16/2024** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F732 posted Nurse Staffing Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm to any resident resulted related to the alleged deficient practice. The posted nurse staffing information was corrected immediately and reposted at front desk. **How the facility will identify other residents having the potential to be affected by the same deficient practice and**	07/25/2024

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	Assistant Director of Nursing (ADON) indicated the Nurse Staffing Information included all the Administrative Nursing staff, which included, but was not limited to, the Director of Nursing, the ADON, and the Minimum Data Set (MDS) assessment Nurse. She indicated the Administrative Nursing staff did not provide continual direct resident care. The Corporate Regional Vice President indicated the nursing hours reported for the CMS Staffing Data Report were only nurses who provided direct resident care and the Administrative Nursing staff hours were not reported for the Data Report. This citation is related to Complaint IN00436496.		**what corrective action will be taken;** All residents have potential to be affected by the same alleged deficient practice. The last two weeks of posted nurse staffing information was reviewed to track any trends and educate based on root cause. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurse managers and staffing coordinator/scheduler have been educated on posting requirement per ISDH guidelines. **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;** Administrator or designee will review daily postings 5 days a week for the next six months to ensure all reported staffing hours are in compliance with ISDH regulations. Administrator will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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