STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPL				
		155835	B. W	ING		04/05/	2024
NA 77 07 -	DOLUBED OF STREET			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER				MAIN STREET		
	MEDICAL RESORT	CROWN POINT LLC	•	CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION	
TAG F 0000	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEI RELEXCTY		DATE
1 0000							
Bldg. 00							
	This visit was for a	Recertification and State	F 00	000	The facility respectfully asks fo	or a	
	_	nd Investigation of Complaints		desk review.			
		100429874. This visit included a					
	State Residential Li	censure Survey.					
	Complaint IN00420	437 - No deficiencies related to					
	the allegations are c						
	ane unegations are c	11041					
	Complaint IN00429	9874 - No deficiencies related to					
	the allegations are c						
	Survey dates: April	1, 2, 3, 4, and 5, 2024					
	Facility number: 01	3452					
	Provider number: 15						
	AIM number: 20129						
	Census Bed Type:						
	SNF: 68						
	Residential: 28						
	Total: 96						
	Census Payor Type:	•					
	Medicare: 47	•					
	Medicaid: 0						
	Other: 21						
	Total: 68						
		Mark River State					
		reflect State Findings cited in					
	accordance with 410	U IAC 10.2-3.1.					
	Quality review com	pleted on 4/15/24.					
F 0623	483.15(c)(3)-(6)(8)	)					
SS=A	Notice Requireme						
Bldg. 00	Transfer/Discharge						
	§483.15(c)(3) Noti	ce before transfer.					
			1		<u> </u>		Ī

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Robert Petty Administrator 05/09/2024

Any defiency statement 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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	MENT OF DEFICIENCIES  AN OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	 JILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/05/	ETED
	OF PROVIDER OR SUPPLIEI	CROWN POINT LLC	1555 S	DDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
	resident, the facilii (i) Notify the resident representative(s) and the reasons of a language and market facility must send representative of Long-Term Care (ii) Record the readischarge in the maccordance with presentation; and (iii) Include in the in paragraph (c) (5) §483.15(c) (4) Tim (i) Except as speciand (c) (8) of this stransfer or dischasection must be not adopted to the section of the section would be endanged (ii) Notice must be practicable before (A) The safety of would be endanged (i) (C) of this section (B) The health of would be endanged (i) (D) of this section; (C) The resident's to allow a more in discharge, under section; (D) An immediate required by the reneeds, under parasection; or	ent and the resident's of the transfer or discharge or the move in writing and in nanner they understand. The a copy of the notice to a the Office of the State Ombudsman. asons for the transfer or esident's medical record in paragraph (c)(2) of this notice the items described of of this section.  Sing of the notice. Sified in paragraphs (c)(4)(ii) section, the notice of arge required under this hade by the facility at least the resident is transferred or the made as soon as transfer or discharge when- andividuals in the facility thered under paragraph (c)(1) on; individuals in the facility thered, under paragraph (c)(1)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155835	B. W	ING		04/05/	/2024
	F PROVIDER OR SUPPLIEF	CROWN POINT LLC	•	1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWDENG BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	for 30 days.						
	§483.15(c)(5) Corwritten notice spethis section must in (i) The reason for (ii) The effective of (iii) The location to transferred or disc (iv) A statement or rights, including the and email), and the entity which receive information on how and assistance in submitting the app (v) The name, add and telephone number of the disabilities address and telephone numbers and telephone numbers of individuals with established under Developmental Die Bill of Rights Act of codified at 42 U.S (vii) For nursing farmental disorder or mailing and email number of the age protection and admental disorder exprotection and Addindividuals Act.	If the resident's appeal the name, address (mailing the plephone number of the twes such requests; and twe to obtain an appeal form the completing the form and the please (mailing and email) the care Ombudsman; the cility residents with the evelopmental disabilities or the mailing and email the number of the agency the protection and advocacy the developmental disabilities					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	l í	JILDING	onstruction 00	(X3) DATE COMPL 04/05	ETED
			B. WI		ADDRESS, CITY, STATE, ZIP COD	04/05/	ZUZ <del>4</del>
	PROVIDER OR SUPPLIEF MEDICAL RESORT	CROWN POINT LLC		1555 S	MAIN STREET N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	, and the second	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	facility must updar notice as soon as updated information of the classification of the resident of the plan for the transcription of the resident of the completed for a resident of the resid	Insfer or discharge, the te the recipients of the practicable once the on becomes available.  In advance of facility  It y closure, the individual strator of the facility must diffication prior to the extra the State Survey experience of the State Long-Term in, residents of the facility, expresentatives, as well as ansfer and adequate esidents, as required at §  In a well interview, the facility insfer/ discharge papers were ident sent to the hospital, for 1 wed for hospitalization.  In a well interview on 4/2/24 at the ses included, but were not experience in the well and Parkinson's experience in the well and parkinson's experience in the well and parkinson floor in the bathroom floor in the pain. He was not provided the pain. He was not provided the point of the hospital for an elevated by the provided cardiac marker).	F 06		All deficiencies have been corrected and will be reviewed monthly QAPI meetings to en continued compliance for the six months.	sure	04/20/2024

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 04/05/2024
	ROVIDER OR SUPPLIER	CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0641 SS=A Bldg. 00	discharge paperwork provided to the resident time of transfer.  During an interview Manager indicated a transfer paperwork a medications and oth form could be comp was some difficulty page. She was made documentation any completed at the time 3.1-12(a)(6)(A)  483.20(g)  Accuracy of Assess §483.20(g) Accuracy of Assess §483.20(g) Accuracy interview, the facility Minimum Data Set accurately complete an indwelling cather assessments review Findings include:  1. On 4/1/24 at 11:00 observed lying in be place with oxygen for (lpm).  The resident's record 9:05 a.m. Diagnose		F 0641	All deficiencies have been corrected and will be reviewed monthly QAPI meetings to encontinued compliance for the six months.	sure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155835	A. BUILDING B. WING	00	COMPLETED 04/05/2024
		100000			U <del>4</del> /UJ/ZUZ4
NAME OF I	PROVIDER OR SUPPLIEF	₹		FADDRESS, CITY, STATE, ZIP COD S MAIN STREET	
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		VN POINT, IN 46307	
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE CONTINUE
TAG	congestive heart fai	R LSC IDENTIFYING INFORMATION	TAG	BEIGHACI	DATE
		ital V.			
	The Admission MD	OS, dated 3/28/24, indicated the			
	resident did not use	oxygen.			
	An Admission Num	sing Evaluation, detail 2/21/24			
	An Admission Nursing Evaluation, dated 3/21/24, indicated the resident's oxygen saturation was				
	94% on oxygen via nasal cannula.				
		v on 4/3/34 at 2:52 p.m., the			
		ed she used the Physician e if the resident was on oxygen.			
		ician's Order for oxygen, so the			
	MDS had been coded incorrectly. 2. On 4/1/24 at				
	10:44 a.m., Resider	nt 105 was observed in his room			
	with a urinary cathe	eter bag in place.			
	On 4/3/24 at 1:30 p	.m., Resident 105 was observed			
	_	chair in his room. He had a			
	urinary catheter bag	g in place.			
		1 . 105			
		dent 105 was reviewed on Diagnoses included, but were			
		2 diabetes mellitus, anemia,			
	and dementia.	2 diabetes memus, anema,			
		OS assessment, dated 4/2/24,			
	urinary catheter.	nt did not have an indwelling			
	armary cameter.				
	A Care Plan, dated	3/28/24, indicated the resident			
	had a urinary cather	ter.			
	The Admission Nov	rsing Evaluation, dated 3/28/24,			
		nt had a 16f (french, catheter			
	size) indwelling uri	· ·			
		gress Note from the Nurse			
		3/29/24 6:04 p.m., indicated the			

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE ( A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 04/05/2024
	PROVIDER OR SUPPLIER	CROWN POINT LLC	1555	r address, city, state, zip cod S MAIN STREET VN POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0684 SS=D Bldg. 00	(DON) on 4/4/24 at resident had a cather were no orders in the catheter, catheter care output. The MDS at 3.1-31(i)  483.25 Quality of Care § 483.25 Quality of Care is a applies to all treath facility residents. Ecomprehensive as facility must ensur treatment and care professional stand comprehensive peand the residents' Based on observation interview, the facility received the necessate to lack of assessments win tear, for 1 of 1 non-pressure skin care. Finding includes:  On 4/1/24 at 2:23 peaced in his room, elbow that was comblood. He indicated morning and got a service were careful to the control of the contro	a fundamental principle that ment and care provided to Based on the seessment of a resident, the e that residents receive e in accordance with lards of practice, the erson-centered care plan, choices.  In record review, and ty failed to ensure residents ary care and treatment related and treatment order for a residents reviewed for conditions. (Resident 31)	F 0684	Ignite Medical Resorts Crown Point Indiana Annual Survey: 04/05/2024  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement.  F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	an / the n

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  04/05/2024	
	ROVIDER OR SUPPLIER	CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD S MAIN STREET VN POINT, IN 46307	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	to, Diabetes Mellitu The Admission Mindated 2/22/24, indicextensive staff assistoileting. He was confident to the record lacked of the skin tear on head treatment of the skin During an interview indicated she was used to the resident's elbert Unit Manager indicenturse who was takin previous day. The metallic forms to docume to the proportion of the skin tear on head treatment of the skin tear of the skin t	s and a foot ulcer.  simum Data Set assessment, rated the resident required tance for transfers and regnitively intact.  socumentation or assessment ris right elbow.  Physician's Order for a tear.  on 4/2/24 at 9:35 a.m., LPN 4 maware of what had happened row.  on 4/2/24 at 10:44 a.m., the rated she had spoken to the regizer of the resident the rurse indicated she had ent the wound, but had Nurse, and there was not a		practice. Investigation completed for Resident #31's skin tear. Physician and family were may aware. Documentation was completed. Residents #31 was discharged from facility same R#31 no longer resides in the facility. No harm came to R#3 related to late documentation. 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 the potential be affected by the same alleged deficient practice. Full house skin sweep complewith no further undocumented areas.  What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur.  Nurses were educated on; addressing and assessichanges in skin condition, documenting changes in skin condition, immediately obtaining a implementing orders for treatment and initiating intervention per physician orders.  Direct care staff were educated on; Immediately notifying the immediately notify	ade as day. a1 . ne e al to ed eted d skin nto  ng n nd ment, ns ed
				nurse of any observed change	e in

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		ILDING	00	COMPLETED	
		155835	B. WI	NG _		04/05/2024	
	PROVIDER OR SUPPLIE	R CROWN POINT LLC		1555 S	ADDRESS, CITY, STATE, ZIP COD S MAIN STREET IN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIC	ON
TAG	-	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA	DATE	
	REGULATORY	A LOCATION TINO INTO MATION			skin condition weather or not a staff member thinks it has bee addressed, assessed, and documented.  How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance programs will be into place.  DON/ designee will asses to random residents 3 times per week to identify any skin conditions, including but not limited to skin tears, to ensure assessments are completed a documented, orders are obtain and carried out, and intervention are put into place and documented.  Director of Nursing/designee will asses to the Quality Assurance committee monthly for 6 monto a summary of the audit to the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.  Date by which corrections we be completed: 4/20/2024	he  put  sss er  nd ned ons  vill its hs. he	
F 0690 SS=D Bldg. 00	§483.25(e) Incom §483.25(e)(1) The resident who is co bowel on admissi	continence, Catheter, UTI tinence. e facility must ensure that ontinent of bladder and on receives services and ntain continence unless his					

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/05/2024	
	PROVIDER OR SUPPLIER	CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD B MAIN STREET /N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
		dition is or becomes such not possible to maintain.			
	incontinence, basic comprehensive as ensure that- (i) A resident who an indwelling cath unless the resider demonstrates that necessary; (ii) A resident who indwelling cathete one is assessed for as soon as possibic clinical condition of catheterization is (iii) A resident who receives appropriate to prevent urinary restore continence §483.25(e)(3) For incontinence, basic comprehensive as ensure that a reside bowel receives appropriate to prevent urinary restore continence.	necessary; and o is incontinent of bladder ate treatment and services tract infections and to e to the extent possible.  a resident with fecal ed on the resident's esessment, the facility must dent who is incontinent of propriate treatment and e as much normal bowel			
	Based on observation interview, the facility Order was obtained	on, record review, and ty failed to ensure a Physician's for a urinary catheter, catheter , and urinary output was	F 0690	Ignite Medical Resorts Crown Point Indiana Annual Survey: 4/05/2024	04/20/2024
		residents reviewed for urinary		Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute a	
	-	a.m., Resident 105 was		admission of guilt or liability by facility and is submitted only in	the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155835	B. Wl	ING		04/05/	/2024
		<u> </u>		STREET 4	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	t .			MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			N POINT, IN 46307		
	Γ		1		1		1
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		m with a urinary catheter bag			response to the regulatory		
	in place.				requirement.		
	0 4/0/04 1 00	D 11 105 1 1			F690 Bowel/Bladder		
	On 4/3/24 at 1:30 p.m., Resident 105 was observed				Incontinence, Catheter, UTI	_	
	seated in his wheelchair in his room. He had a				What corrective action(s) wil	I	
	catheter bag in place.				be accomplished for those		
	Th 10 P	1			residents found to have been	1	
		dent 105 was reviewed on			affected by the deficient		
		Diagnoses included, but were			practice;	14	
	not limited to, type 2 diabetes mellitus, anemia,				No harm was caused to Resid		
	and dementia. The resident was admitted to the facility on 3/28/24.				#105 related to lack of indwell	ıng	
	facility on 3/26/24.				catheter documentation.		
	A Comp Plan dated 2/28/24 in directed the maridant				Orders for indwelling urinary		
	A Care Plan, dated 3/28/24, indicated the resident				catheter, indwelling urinary	.1	
	had a urinary cathet	er.			catheter care, and urine output		
	The Admission New	sing Evaluation, dated 2/20/24			were obtained and implement		
		rsing Evaluation, dated 3/28/24, nt had a 16f (french, catheter			Resident #105 no longer resid	ies in	
	size) indwelling cat	•			this facility.		
	size) ilidwelling cat	neter.			How the facility will identify		
	The Admission Pro	gress Note from the Nurse			other residents having the		
		3/29/24 6:04 p.m., indicated the			potential to be affected by the	e	
		nic foley catheter, last changed			same deficient practice and what corrective action will be	_	
		a follow up appointment with				<del>2</del>	
		for a catheter exchange.			taken; All residents have the potentia	ul to	
	a1010gy 011 7/11/24	for a cameter exchange.			be affected by the same allege		
	The Physician's Ord	der Summary, dated 4/2024,			deficient practice.	-u	
		or the urinary catheter, catheter			House sweep was completed	to	
	I	rine output. An order, dated			ensure no further residents wi		
		give ceftriaxone (an antibiotic)			indwelling catheters were with		
		urs intravenously for 5 days for			appropriate orders.	Cut	
	a urinary tract infec				What measures will be put in	nto	
	and miles	()-			place or what systemic		
	The Medication Ad	ministration Records (MAR)			changes will be made to		
		ninistration Records (TAR),			ensure that the deficient		
	dated 3/2024 and 4/				practice does not recur;		
		atheter care or urine output.			Nursing staff was in-serviced	on:	
		rrently receiving an antibiotic			Documenting indwelling	,	
	treatment for a UTI				urinary catheters upon admiss	sion	
					when indicated and when nev		

05/15/2024 PRINTED: FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/05/2024 155835 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1555 S MAIN STREET IGNITE MEDICAL RESORT CROWN POINT LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The Bladder Continence Task documentation, orders for catheters are obtained. dated 3/2024 and 4/2024, indicated the urine Timely transcription of output had only been documented one time since physician's orders including orders the resident's admission to the facility: for indwelling urinary catheter, 3/31/24 at 5:59 a.m. - 1800 cc (cubic centimeters) catheter care, and urine output. How the corrective action(s) During an interview with the Director of Nursing will be monitored to ensure the (DON) on 4/4/24 at 11:34 a.m., she indicated the deficient practice will not resident had a catheter since admission. There recur, i.e., what quality were no orders in the computer for the urinary assurance programs will be put catheter, catheter care, or for recording the urine into place; output. DON/designee will observe 5 random residents 3 times a week 3.1-41(a)(2)to ensure that if an indwelling urinary catheter is in place, all required orders are in place including but not limited to; orders for indwelling urinary catheter, indwelling urinary catheter care, and urinary output is documented. DON/designee will audit 5 residents with indwelling urinary catheters weekly to ensure indwelling urinary catheter orders are in place, indwelling urinary catheter care orders are in place, and urinary output documentation is in place. The Director of Nursing/designee 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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Monitoring will be on going. Date by which corrections will be completed: 4/20/2024

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETED	
		155835	B. W	ING		04/05/	2024
	ROVIDER OR SUPPLIER	CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Trache Suctioning § 483.25(i) Respiratory tracheostomy care The facility must eneeds respiratory tracheostomy care is provided such corresponding to professional stand comprehensive pethe residents' goal 483.65 of this sub Based on observation interview, the facility received the correct treatment, related to oxygen and incorrect residents reviewed facility and the subserved lying in between the place with oxygen for Resident 258's reconspicts a.m. Diagnose to, acute kidney fail congestive heart fair. There was no Physical An Admission Nursindicated the residence of the place with oxygen via the place with oxygen in the place with oxygen for the place with oxygen fair. There was no Physical An Admission Nursindicated the residence place with oxygen via the place wit	eostomy Care and atory care, including and tracheal suctioning. Insure that a resident who care, including and tracheal suctioning, are, consistent with lards of practice, the erson-centered care plan, and part. Is and preferences, and part. Is and preferences, and part. Is on, record review, and ty failed to ensure residents and necessary respiratory on Physician's Order for et oxygen flow rate, for 2 of 4 for respiratory care. (Residents  10.5 a.m., Resident 258 was ed. He had a nasal cannula in 11.6 lowing at 2.5 liters per minute. 12.7 ard was reviewed on 4/3/24 at 12.8 included, but were not limited lure, Diabetes Mellitus and lure. 13.6 cian's Order for the oxygen. 14.7 cian's oxygen saturation was 15.8 nasal cannula. 15.8 oxygen saturation was 16.8 nasal cannula. 16.9 on 4/3/24 at 2:45 p.m., the Unit	F 0	695	Ignite Medical Resorts Crown Point Indiana Annual Survey: 4/05/2024  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement.  F695 Respiratory What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No harm came to resident #25 related to not having oxygen orders. Resident #258 no longer resident is facility. No harm came to resident #3 related to inaccurate oxygen frate.	an y the n I 58	04/20/2024
	ivialiagei illulcated t	there was no Physician's Order			The oxygen flow rate was		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CON		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPLETED		
		155835	B. W	ING			05/2024	
				STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF F	PROVIDER OR SUPPLIE	R	1555 S MAIN STREET					
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			N POINT, IN 46307			
(X4) ID	SHMMADV	STATEMENT OF DEFICIENCIE	1	ID	<u> </u>	1	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	` `	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		DATE	
1110		On 4/2/24 at 9:22 a.m., Resident		1110	immediately corrected for		DALL	
		The resident was wearing			Resident #3 and orders were			
	, , ,	cannula with a flow rate at 2.5			clarified for oxygen.			
	liters.				How the facility will identify	,		
					other residents having the			
	On 4/2/24 at 12:52	p.m., Resident 3 was lying in			potential to be affected by t	he		
		was wearing oxygen via a nasal			same deficient practice and			
	cannula with a flow				what corrective action will be			
					taken;			
	On 4/3/24 at 10:00	a.m., Resident 3 was lying in			All residents receiving oxyge	n		
	bed. The resident	was wearing oxygen via a nasal			have the potential to be affect			
	cannula with a flow rate at 2.5 liters.				by the same alleged deficien			
					practice.			
	Record review for	Resident 3 was completed on			Full house audit was complete	ted to		
	4/2/24 at 1:12 p.m.	Diagnoses included, but were			ensure residents who are on			
	not limited to, depr	ression, chronic obstructive			oxygen have orders to receiv	re		
	pulmonary disease	(COPD) and asthma.			oxygen.			
					House audit of all residents			
		num Data Set (MDS)			receiving oxygen was comple			
	1	3/15/24, indicated the resident			to ensure orders were in place			
		act. The resident required			oxygen was running at correc	ct		
		Ls (activities of daily living).			rate.			
	The resident did no	ot have oxygen therapy.			What measures will be put i	into		
	A C D1 1 1 1	4/1/22 1			place or what systemic			
		4/1/23 and revised 3/31/24,			changes will be made to			
		ent had oxygen therapy at 3 nula PRN (when necessary)			ensure that the deficient			
		An intervention included to			practice does not recur;	<u></u>		
		per physicians orders.			Nursing has been educated of	ווע		
	administer oxygen	per physicians orders.			ensuring; Physician orders are in			
	The April 2024 Ph	ysician's Order Summary			place for oxygen.			
		for Oxygen at 3 liters per nasal			Oxygens are running at	t the		
	cannula every shift				rate/s the physician has orde			
					All staff was educated on;			
	During an interview	w on 4/3/24 at 10:55 a.m., the			Ensuring oxygen is run	ning		
	_	g indicated the resident's			at correct rate.	J		
	1	order. The staff should have			How the corrective action(s	)		
		3 liters when the resident			will be monitored to ensure			
	required the oxyger	n.			deficient practice will not			
					recur, i.e., what quality			

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STATEMENT OF DEFICIENCIES					NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPL	
		155835	B. W	NG		04/05/	2024
	PROVIDER OR SUPPLIER	CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0812	3.1-47(a)(6) 483.60(i)(1)(2)				assurance programs will be into place; DON/designee will audit 10 residents 3 times per week to ensure oxygen is set at the correct flow rate. DON/designee with audit 10 residents 3 times per week to ensure residents on oxygen, horders to receive oxygen. Director of Nursing/designee was present a summary of the audit to the Quality Assurance committee monthly for 6 mont. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.  Date by which corrections we be completed: 04/20/2024	nave vill its hs.	
SS=F Bldg. 00	§483.60(i) Food so The facility must - §483.60(i)(1) - Pro approved or consi federal, state or lo	ocure food from sources dered satisfactory by					
	directly from local applicable State a regulations. (ii) This provision	producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility					

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CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES	OMB NO. 0938-0					
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPI	LETED	
		155835	B. W	ING		04/05	/05/2024	
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		-
NAME OF PROVIDER OR SUPPLIER					MAIN STREET			
IGNITE MEDICAL RESORT CROWN POINT LLC			CROWN POINT, IN 46307					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE			PROVIDER'S PLAN OF CORRECTION	RRECTION		-
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI		(EACH CORRECTIVE ACTION SHOULD BE	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	applicable safe gr practices. (iii) This provision from consuming for facility.  §483.60(i)(2) - Sto serve food in according standards for food Based on observation failed to ensure the related to undated a up on ice in the free and food on the floor storage room. This 68 residents who related his provision include:  On 4/1/24 at 8:45 a tour with Cook 1, the soda and pies sitting b. In the walk in refused and potatoes the undated.  c. There was a raw spilled on the refrigulation.	cowing and food-handling  does not preclude residents cods not procured by the  ore, prepare, distribute and ordance with professional diservice safety.  on and interview, the facility re was a sanitary kitchen, and/or unlabeled food, a build ezer, and a spilled substance ors in a refrigerator and dry had the potential to affect all exceived meals prepared in the  a.m., during the initial kitchen the following was observed:  frigerator, there were boxes of g directly on the floor.  frigerator, there was a package in a plastic container, and at were unlabeled and  potato and a pink substance gerator floor.  ere was a heavy build up of ice	F 08	TAG	Ignite Medical Resorts Crown Point Indiana Annual Survey: 04/05/2024  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.  F812 food Procurement, Store/prepare/Serve-Sanitary What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No harm came to any resident related to this alleged deficient practice.  Sanitation in the kitchen has be corrected: All food has been dated/ labeled, dry storage are and refrigerator floors have be	s the an y the n ts t been		
	on the ceiling and o	on two boxes of food.			cleaned and freezer has been			
					defrosted of ice build-up.			
	e. In the dry storage	e room, there was a large			How the facility will identify			
	amount of dry oatmeal spilled on the shelves and				other residents having the			

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floor.

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other residents having the

potential to be affected by the

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY  COMPLETED  04/05/2024
	PROVIDER OR SUPPLIE	R CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD S MAIN STREET 'N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON (X5) BE COMPLETION DATE
	observation, she in labeled and dated.	w with Cook 1 at the time of dicated the items should be She indicated the spills just and the staff was busy t.		same deficient practice are what corrective action will taken;  All residents have the potential be affected by the same all deficient practice.  All dry storage rooms/refrigerators/freezer inspected to ensure all food dated, floors are clean, foo storage areas are clean, are ice build up was identified.  What measures will be purplace or what systemic changes will be made to ensure that the deficient practice does not recur;  Staff were educated on daic cleaning, proper food pack, and dating, ensuring nothing stored on the floors and flook kept clean, food storage areas are kept clean, preversice build-up, removing ice than the procedure of notify maintenance services of an necessary repairs.  How the corrective action will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will into place;  Dietary supervisor/ designed audit all food storage rooms/refrigerators/freezer times a week to ensure all packaged and dated appronothing is stored on the floors are clean food storage.	ntial to deged swere dis dis did not no at into ly aging aging agis ors are and prepenting build-up, aing any (s) re the be put see will so 3 food is priately, ors and

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155835		A. BUILDING 00  B. WING		COMPLETED 04/05/2024			
	PROVIDER OR SUPPLIER	CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
R 0000 Bldg. 00	This visit was for a Survey. This visit in State Licensure Survey. Complaints IN00429 the allegations are c Complaint IN00429 the allegations are c Survey dates: April Facility number: 013 Residential Census:	State Residential Licensure acluded a Recertification and vey and Investigation of 9437 and IN00429874.  437 - No deficiencies related to ited.  874 - No deficiencies related to ited.  1, 2, 3, 4, and 5, 2024  3452  28  tial Findings are cited in 0 IAC 16.2-5.	R 0000	prep areas are clean, and no ibuild-up in freezers was identified.  Administrator/designee will present a summary of the audit to the Quality Assurance committee monthly for 6 mont. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.  Date by which corrections will be completed: 04/20/2024  The facility respectfully asks for desk review.	ce fied. its hs. ne		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835			X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING  COMPLETED  04/05/2024			ETED	
	PROVIDER OR SUPPLIER	CROWN POINT LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
R 0273 Bldg. 00	(f) All food prepara (excluding areas in maintained in accollocal sanitation and standards, including Based on observation failed to ensure their related to undated a up on ice in the free and food on the flood storage room. This is 68 residents who residents who residents who residents with Cook 1, the a. In the walk in refusoda and pies sitting b. In the walk in refusoda and pies sitting b. In the walk in refusoda and pies sitting the interest of raw meat, gravy mashed potatoes the undated.  c. There was a raw possible on the refrigulation of the refrigulation of the dry storage amount of dry oatmat floor.	anal Services - Deficiency ation and serving areas in residents ' units) are ordance with state and d safe food handling and 410 IAC 7-24.  In and interview, the facility re was a sanitary kitchen, and/or unlabeled food, a build exer, and a spilled substance for in a refrigerator and dry shad the potential to affect all deceived meals prepared in the me following was observed:  In a refrigerator, there were boxes of a directly on the floor.  In a plastic container, and a plastic container, and at were unlabeled and	R 0.	273	Ignite Medical Resorts Crown Point Indiana Annual Survey: 04/05/2024  Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only ir response to the regulatory requirement.  R273 Food and Nutritional Service- Deficiency What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; No harm came to any resident related to this alleged deficient practice.  Sanitation in the kitchen has been dated/ labeled, dry storage are and refrigerator floors have be cleaned and freezer has been defrosted of ice build-up. How the facility will identify other residents having the potential to be affected by the same deficient practice and	an y the n  II n ts tt peen ea	04/20/2024

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE C A. BUILDING B. WING	OO	(X3) DATE SURVEY COMPLETED 04/05/2024			
	PROVIDER OR SUPPLIER	CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	(X5) E COMPLETION DATE			
	labeled and dated.	dicated the items should be she indicated the spills just and the staff was busy .		taken; All residents have the potent be affected by the same alled deficient practice. All dry storage rooms/refrigerators/freezers inspected to ensure all food dated, floors are clean, food storage areas are clean, and ice build up was identified. What measures will be put place or what systemic changes will be made to ensure that the deficient practice does not recur; Staff were educated on daily cleaning, proper food packa and dating, ensuring nothing stored on the floors and flookept clean, food storage and areas are kept clean, preverice build-up, removing ice build-up, removing ice build and the procedure of notifying maintenance services of any necessary repairs. How the corrective action(will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; Dietary supervisor/ designed audit all food storage rooms/refrigerators/freezers times a week to ensure all for packaged and dated appropnothing is stored on the floofloors are clean, food storage prep areas are clean, and no build-up in freezers was identifications.	were is dono into // ging ging gis rs are doprep nting wild-up, ng // ss) ethe e put e will a good is rriately, rs and e and o ice			

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULT A. BUILI B. WING	DING	nstruction <u>00</u>	(X3) DATE : COMPL 04/05/	ETED	
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PR	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
					Administrator/designee will present a summary of the audit to the Quality Assurance committee monthly for 6 month Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which corrections will be completed: 04/20/2024	ns. e		

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