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	04/05/2024

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 a Recertification and State Licensure Survey and Investigation of Complaints IN00429437 and IN00429874. This visit included a State Residential Licensure Survey. Complaint IN00429437 - No deficiencies related to the allegations are cited. Complaint IN00429874 - No deficiencies related to the allegations are cited. Survey dates: April 1, 2, 3, 4, and 5, 2024 Facility number: 013452 Provider number: 155835 AIM number: 201299290 Census Bed Type: SNF: 68 Residential: 28 Total: 96 Census Payor Type: Medicare: 47 Medicaid: 0 Other: 21 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/15/24.	F 0000	The facility respectfully asks for a desk review.	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Petty	Administrator	05/09/2024

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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	Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility			

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	for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior			

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	to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure transfer/ discharge papers were completed for a resident sent to the hospital, for 1 of 3 residents reviewed for hospitalization. (Resident 36) Finding includes: Resident 36's record was reviewed on 4/2/24 at 12:53 p.m. Diagnoses included, but were not limited to, Diabetes Mellitus and Parkinson's disease. The Admission Minimum Data Set assessment, dated 2/5/24, indicated the resident had severe cognitive impairment. A Nurse's Note, dated 3/13/24, indicated the resident had been found on the bathroom floor and was complaining of right hip pain. He was sent to the Emergency Room for evaluation. He was later admitted to the hospital for an elevated troponin level (an abnormal cardiac marker).	F 0623	All deficiencies have been corrected and will be reviewed at monthly QAPI meetings to ensure continued compliance for the next six months.	04/20/2024

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	The record lacked documentation that transfer/ discharge paperwork had been completed and provided to the resident or his representative at the time of transfer. During an interview on 4/2/24 at 2:40 p.m., the Unit Manager indicated residents were sent out with transfer paperwork that included diagnoses, medications and other information, or an e-interact form could be completed and printed out. There was some difficulty getting staff on the same page. She was made aware there was no documentation any transfer forms had been completed at the time of transfer. 3.1-12(a)(6)(A)			
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) assessments were accurately completed, related to oxygen use and an indwelling catheter, for 2 of 19 MDS assessments reviewed. (Residents 258 and 105) Findings include: 1. On 4/1/24 at 11:05 a.m., Resident 258 was observed lying in bed. He had a nasal cannula in place with oxygen flowing at 2.5 liters per minute (lpm). The resident's record was reviewed on 4/3/24 at 9:05 a.m. Diagnoses included, but were not limited to, acute kidney failure, Diabetes Mellitus and	F 0641	All deficiencies have been corrected and will be reviewed at monthly QAPI meetings to ensure continued compliance for the next six months.	04/20/2024

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	congestive heart failure. The Admission MDS, dated 3/28/24, indicated the resident did not use oxygen. An Admission Nursing Evaluation, dated 3/21/24, indicated the resident's oxygen saturation was 94% on oxygen via nasal cannula. During an interview on 4/3/34 at 2:52 p.m., the MDS nurse indicated she used the Physician Orders to determine if the resident was on oxygen. There was no Physician's Order for oxygen, so the MDS had been coded incorrectly. 2. On 4/1/24 at 10:44 a.m., Resident 105 was observed in his room with a urinary catheter bag in place. On 4/3/24 at 1:30 p.m., Resident 105 was observed seated in his wheelchair in his room. He had a urinary catheter bag in place. The record for Resident 105 was reviewed on 4/4/24 at 9:51 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, anemia, and dementia. The Admission MDS assessment, dated 4/2/24, indicated the resident did not have an indwelling urinary catheter. A Care Plan, dated 3/28/24, indicated the resident had a urinary catheter. The Admission Nursing Evaluation, dated 3/28/24, indicated the resident had a 16f (french, catheter size) indwelling urinary catheter. The Admission Progress Note from the Nurse Practitioner, dated 3/29/24 6:04 p.m., indicated the resident had a chronic foley catheter, last changed			

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	on 3/20/24. During an interview with the Director of Nursing (DON) on 4/4/24 at 11:34 a.m., she indicated the resident had a catheter since admission. There were no orders in the computer for the urinary catheter, catheter care, or for recording the urine output. The MDS assessment was incorrect. 3.1-31(i)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care and treatment related to lack of assessment and treatment order for a skin tear, for 1 of 1 residents reviewed for non-pressure skin conditions. (Resident 31) Finding includes: On 4/1/24 at 2:23 p.m., Resident 31 was observed seated in his room. He had a dressing on his right elbow that was coming loose and was soiled with blood. He indicated he had bumped his elbow that morning and got a skin tear. Resident 31's record was reviewed on 4/2/24 at 9:28 a.m. Diagnoses included, but were not limited	F 0684	**Ignite Medical Resorts** **Crown Point Indiana** **Annual Survey: 04/05/2024** 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. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	04/20/2024

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	to, Diabetes Mellitus and a foot ulcer. The Admission Minimum Data Set assessment, dated 2/22/24, indicated the resident required extensive staff assistance for transfers and toileting. He was cognitively intact. The record lacked documentation or assessment of the skin tear on his right elbow. The record lacked a Physician's Order for treatment of the skin tear. During an interview on 4/2/24 at 9:35 a.m., LPN 4 indicated she was unaware of what had happened to the resident's elbow. During an interview on 4/2/24 at 10:44 a.m., the Unit Manager indicated she had spoken to the nurse who was taking care of the resident the previous day. The nurse indicated she had forgotten to document the wound, but had notified the Wound Nurse, and there was not a treatment order in place. 3.1-37(a)		**practice.** Investigation completed for Resident #31's skin tear. Physician and family were made aware. Documentation was completed. Residents #31 was discharged from facility same day. R#31 no longer resides in the facility. No harm came to R#31 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 to be affected by the same alleged deficient practice. Full house skin sweep completed with no further undocumented skin areas. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nurses were educated on; addressing and assessing changes in skin condition, documenting changes in skin condition, immediately obtaining and implementing orders for treatment, and initiating interventions per physician orders. Direct care staff were educated on; Immediately notifying the nurse of any observed change in	

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			skin condition weather or not a staff member thinks it has been addressed, assessed, and documented. **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 assess 5 random residents 3 times per week to identify any skin conditions, including but not limited to skin tears**,** to ensure assessments are completed and documented, orders are obtained and carried out, and interventions are put into place and documented. 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. **Date by which corrections will be completed: 4/20/2024**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his			

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	or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was obtained for a urinary catheter, catheter care was completed, and urinary output was recorded for 1 of 3 residents reviewed for urinary catheters. (Resident 105) Finding includes: On 4/1/24 at 10:44 a.m., Resident 105 was	F 0690	**Ignite Medical Resorts** **Crown Point Indiana** **Annual Survey: 4/05/2024** 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	04/20/2024

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	observed in his room with a urinary catheter bag in place. On 4/3/24 at 1:30 p.m., Resident 105 was observed seated in his wheelchair in his room. He had a catheter bag in place. The record for Resident 105 was reviewed on 4/4/24 at 9:51 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, anemia, and dementia. The resident was admitted to the facility on 3/28/24. A Care Plan, dated 3/28/24, indicated the resident had a urinary catheter. The Admission Nursing Evaluation, dated 3/28/24, indicated the resident had a 16f (french, catheter size) indwelling catheter. The Admission Progress Note from the Nurse Practitioner, dated 3/29/24 6:04 p.m., indicated the resident had a chronic foley catheter, last changed on 3/20/24. He had a follow up appointment with urology on 4/11/24 for a catheter exchange. The Physician's Order Summary, dated 4/2024, lacked any orders for the urinary catheter, catheter care, or to record urine output. An order, dated 4/2/24, indicated to give ceftriaxone (an antibiotic) 1 gram every 24 hours intravenously for 5 days for a urinary tract infection (UTI). The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 3/2024 and 4/2024, lacked any documentation of catheter care or urine output. The resident was currently receiving an antibiotic treatment for a UTI.		response to the regulatory requirement. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm was caused to Resident #105 related to lack of indwelling catheter documentation. Orders for indwelling urinary catheter, indwelling urinary catheter care, and urine output were obtained and implemented. Resident #105 no longer resides in this facility. **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 to be affected by the same alleged deficient practice. House sweep was completed to ensure no further residents with indwelling catheters were without appropriate orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff was in-serviced on; Documenting indwelling urinary catheters upon admission when indicated, and when new	

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	The Bladder Continence Task documentation, dated 3/2024 and 4/2024, indicated the urine output had only been documented one time since the resident's admission to the facility: 3/31/24 at 5:59 a.m. - 1800 cc (cubic centimeters) During an interview with the Director of Nursing (DON) on 4/4/24 at 11:34 a.m., she indicated the resident had a catheter since admission. There were no orders in the computer for the urinary catheter, catheter care, or for recording the urine output. 3.1-41(a)(2)		orders for catheters are obtained. Timely transcription of physician's orders including orders for indwelling urinary catheter, catheter care, and urine output. **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 observe 5 random residents 3 times a week 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. Monitoring will be on going. **Date by which corrections will be completed: 4/20/2024**	

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F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review, and interview, the facility failed to ensure residents received the correct and necessary respiratory treatment, related to no Physician's Order for oxygen and incorrect oxygen flow rate, for 2 of 4 residents reviewed for respiratory care. (Residents 258 and 3) Findings include: 1. On 4/1/24 at 11:05 a.m., Resident 258 was observed lying in bed. He had a nasal cannula in place with oxygen flowing at 2.5 liters per minute. Resident 258's record was reviewed on 4/3/24 at 9:05 a.m. Diagnoses included, but were not limited to, acute kidney failure, Diabetes Mellitus and congestive heart failure. There was no Physician's Order for the oxygen. An Admission Nursing Evaluation, dated 3/21/24, indicated the resident's oxygen saturation was 94% on oxygen via nasal cannula. During an interview on 4/3/24 at 2:45 p.m., the Unit Manager indicated there was no Physician's Order	F 0695	**Ignite Medical Resorts** **Crown Point Indiana** **Annual Survey: 4/05/2024** 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. **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 #258 related to not having oxygen orders. Resident #258 no longer resides in this facility. No harm came to resident #3 related to inaccurate oxygen flow rate. The oxygen flow rate was	04/20/2024

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	155835	A. BUILDING 00 B. WING	04/05/2024

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	for the oxygen. 2. On 4/2/24 at 9:22 a.m., Resident 3 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate at 2.5 liters. On 4/2/24 at 12:52 p.m., Resident 3 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate at 2.5 liters. On 4/3/24 at 10:00 a.m., Resident 3 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate at 2.5 liters. Record review for Resident 3 was completed on 4/2/24 at 1:12 p.m. Diagnoses included, but were not limited to, depression, chronic obstructive pulmonary disease (COPD) and asthma. The Annual Minimum Data Set (MDS) assessment, dated 3/15/24, indicated the resident was cognitively intact. The resident required assistance with ADLs (activities of daily living). The resident did not have oxygen therapy. A Care Plan, dated 4/1/23 and revised 3/31/24, indicated the resident had oxygen therapy at 3 liters via nasal cannula PRN (when necessary) related to COPD. An intervention included to administer oxygen per physicians orders. The April 2024 Physician's Order Summary indicated and order for Oxygen at 3 liters per nasal cannula every shift PRN. During an interview on 4/3/24 at 10:55 a.m., the Director of Nursing indicated the resident's oxygen was a PRN order. The staff should have set the flow rate at 3 liters when the resident required the oxygen.		immediately corrected for Resident #3 and orders were clarified for oxygen. **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 receiving oxygen have the potential to be affected by the same alleged deficient practice. Full house audit was completed to ensure residents who are on oxygen have orders to receive oxygen. House audit of all residents receiving oxygen was completed to ensure orders were in place and oxygen was running at correct rate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing has been educated on ensuring; Physician orders are in place for oxygen. Oxygens are running at the rate/s the physician has ordered. All staff was educated on; Ensuring oxygen is running at correct rate. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	3.1-47(a)(6)		**assurance programs will be put 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, have orders to receive oxygen. 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. Monitoring will be on going. **Date by which corrections will be completed: 04/20/2024**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with			

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	applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility failed to ensure there was a sanitary kitchen, related to undated and/ or unlabeled food, a build up on ice in the freezer, and a spilled substance and food on the floors in a refrigerator and dry storage room. This had the potential to affect all 68 residents who received meals prepared in the kitchen. Findings include: On 4/1/24 at 8:45 a.m., during the initial kitchen tour with Cook 1, the following was observed: a. In the walk in refrigerator, there were boxes of soda and pies sitting directly on the floor. b. In the walk in refrigerator, there was a package of raw meat, gravy in a plastic container, and mashed potatoes that were unlabeled and undated. c. There was a raw potato and a pink substance spilled on the refrigerator floor. d. In the freezer, there was a heavy build up of ice on the ceiling and on two boxes of food. e. In the dry storage room, there was a large amount of dry oatmeal spilled on the shelves and floor.	F 0812	**Ignite Medical Resorts** **Crown Point Indiana** **Annual Survey: 04/05/2024** 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. **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 residents related to this alleged deficient practice. Sanitation in the kitchen has been corrected: All food has been dated/ labeled, dry storage area and refrigerator floors have been 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**	04/20/2024

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	During an interview with Cook 1 at the time of observation, she indicated the items should be labeled and dated. She indicated the spills just happened recently and the staff was busy preparing breakfast. 3.1-21(i)(3)		**same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. All dry storage rooms/refrigerators/freezers were inspected to ensure all food is dated, floors are clean, food storage areas are clean, and no ice build up was identified. **What measures will be put into 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 packaging and dating, ensuring nothing is stored on the floors and floors are kept clean, food storage and prep areas are kept clean, preventing ice build-up, removing ice build-up, and the procedure of notifying maintenance services of any necessary repairs. **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;** Dietary supervisor/ designee will audit all food storage rooms/refrigerators/freezers 3 times a week to ensure all food is packaged and dated appropriately, nothing is stored on the floors and floors are clean, food storage and	

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			prep areas are clean, and no ice build-up in freezers was identified. Administrator/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. Monitoring will be on going. **Date by which corrections will be completed: 04/20/2024**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and Investigation of Complaints IN00429437 and IN00429874. Complaint IN00429437 - No deficiencies related to the allegations are cited. Complaint IN00429874 - No deficiencies related to the allegations are cited. Survey dates: April 1, 2, 3, 4, and 5, 2024 Facility number: 013452 Residential Census: 28 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/15/24.	R 0000	The facility respectfully asks for a desk review.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to ensure there was a sanitary kitchen, related to undated and/ or unlabeled food, a build up on ice in the freezer, and a spilled substance and food on the floors in a refrigerator and dry storage room. This had the potential to affect all 68 residents who received meals prepared in the kitchen. Findings include: On 4/1/24 at 8:45 a.m., during the initial kitchen tour with Cook 1, the following was observed: a. In the walk in refrigerator, there were boxes of soda and pies sitting directly on the floor. b. In the walk in refrigerator, there was a package of raw meat, gravy in a plastic container, and mashed potatoes that were unlabeled and undated. c. There was a raw potato and a pink substance spilled on the refrigerator floor. d. In the freezer, there was a heavy build up of ice on the ceiling and on two boxes of food. e. In the dry storage room, there was a large amount of dry oatmeal spilled on the shelves and floor. During an interview with Cook 1 at the time of	R 0273	**Ignite Medical Resorts** **Crown Point Indiana** **Annual Survey: 04/05/2024** 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. **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 residents related to this alleged deficient practice. Sanitation in the kitchen has been corrected: All food has been dated/ labeled, dry storage area and refrigerator floors have been 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 what corrective action will be**	04/20/2024

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	observation, she indicated the items should be labeled and dated. She indicated the spills just happened recently and the staff was busy preparing breakfast.		**taken;** All residents have the potential to be affected by the same alleged deficient practice. All dry storage rooms/refrigerators/freezers were inspected to ensure all food is dated, floors are clean, food storage areas are clean, and no ice build up was identified. **What measures will be put into 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 packaging and dating, ensuring nothing is stored on the floors and floors are kept clean, food storage and prep areas are kept clean, preventing ice build-up, removing ice build-up, and the procedure of notifying maintenance services of any necessary repairs. **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;** Dietary supervisor/ designee will audit all food storage rooms/refrigerators/freezers 3 times a week to ensure all food is packaged and dated appropriately, nothing is stored on the floors and floors are clean, food storage and prep areas are clean, and no ice build-up in freezers was identified.	

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			Administrator/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. Monitoring will be on going. **Date by which corrections will be completed: 04/20/2024**	