CENTERS FO	R MEDICARE & MEDIC	AID SERVICES				OM	IB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	ľ	JILDING	ONSTRUCTION	(X3) DATE COMPI 05/03	LETED
	PROVIDER OR SUPPLIER	CROWN POINT LLC		1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
	1		1		T		
(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
E 0000							
Bldg		paredness Survey was idiana Department of Health in CFR 483.73.	E 00	000	The facility respectfully reque desk review	sts a	
	Survey Date: 05/03	3/2024					
	Medical Resort Cro compliance with Er Requirements for M	155835					
	certified for Medica certified for Medica of the survey, the co	certified beds. 65 beds are are only. 3 beds are dually are and Medicaid. At the time ensus was 67.					
E 0041 SS=F Bldg	§482.15(e) Condit (e) Emergency an The hospital must standby power sy- emergency plan s this section and in procedures plan s (i) and (ii) of this s §483.73(e), §485.	LTC Emergency Power tion for Participation: ad standby power systems. implement emergency and stems based on the et forth in paragraph (a) of the policies and et forth in paragraphs (b)(1) section.					

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

TITLE (X6) DATE

Robert Petty Administrator 05/28/2024

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 disclodays 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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	OF CORRECTION	IDENTIFICATION NUMBER 155835	A. BUILE B. WING			COMPL 05/03/	ETED
	PROVIDER OR SUPPLIER	CROWN POINT LLC	1	555 S N	DDRESS, CITY, STATE, ZIP COD MAIN STREET I POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PRI	D EFIX AG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
TAG	The [LTC facility a implement emerge systems based or forth in paragraph §482.15(e)(1), §48 Emergency generator must be the location requir Care Facilities Co Interim Amendme 12-4, TIA 12-5, ar Code (NFPA 101 Amendments TIA and TIA 12-4), and structure is built o structure or buildin 482.15(e)(2), §483 Emergency gener The [hospital, CAI implement the eminspection, testing requirements four Facilities Code, N Code. 482.15(e)(3), §483 Emergency gener and LTC facilities] source to power enave a plan for hotelline for the system of	and the CAH] must ency and standby power the emergency plan set (a) of this section. 33.73(e)(1), §485.625(e)(1) ator location. The elocated in accordance with ements found in the Health de (NFPA 99 and Tentative ints TIA 12-2, TIA 12-3, TIA and TIA 12-6), Life Safety and Tentative Interim 12-1, TIA 12-2, TIA 12-3, d NFPA 110, when a new in when an existing ing is renovated. 3.73(e)(2), §485.625(e)(2) ator inspection and testing. H and LTC facility] must ergency power system in, and [maintenance] and in the Health Care FPA 110, and Life Safety 3.73(e)(3), §485.625(e)(3) ator fuel. [Hospitals, CAHs it that maintain an onsite fuel imergency generators must is wit will keep emergency iderational during the	T	AG			DATE
	§483.73(g), and C The standards inc this section are ap	§482.15(h), LTC at CAHs §485.625(g):] corporated by reference in proved for incorporation by					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING		COMPLETED	
		155835	B. W	ING		05/03/2	2024
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			MAIN STREET N POINT, IN 46307		
	1		-		T On T , II TOOU	1	OUE.
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
		in accordance with 5 U.S.C.					
		R part 51. You may obtain					
	the material from the sources listed below.						
	You may inspect a	a copy at the CMS					
	Information Resor	urce Center, 7500 Security					
	Boulevard, Baltim	ore, MD or at the National					
	Archives and Rec	ords Administration					
	(NARA). For infor	mation on the availability of					
	this material at NA	ARA, call 202-741-6030, or					
	go to:						
		es.gov/federal_register/code					
		ations/ibr_locations.html.					
		this edition of the Code are					
		eference, CMS will publish a					
		ederal Register to					
	announce the cha	-					
		Protection Association, 1					
	Batterymarch Par						
	Quincy, MA 02169	9, www.nfpa.org,					
	1.617.770.3000.						
	1 ' '	th Care Facilities Code,					
		ed August 11, 2011.					
		rim amendment (TIA) 12-2 to					
	NFPA 99, issued	~					
	` '	FPA 99, issued August 9,					
	2012.	5DA 00 issued 14					
	(IV) HA 12-4 to NI 2013.	FPA 99, issued March 7,					
		FPA 99, issued August 1,					
	2013.	i A 00, issued August 1,					
		FPA 99, issued March 3,					
	2014.	,					
	(vii) NFPA 101, Li	fe Safety Code, 2012					
	edition, issued Au	-					
		IFPA 101, issued August					
	11, 2011.	J					
	(ix) TIA 12-2 to NI	FPA 101, issued October					
	30, 2012.						
	` '	FPA 101, issued October					
	22 2013						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING		COMPLETED
		155835	B. W	ING		05/03/2024
NAME OF I	PROVIDER OR SUPPLIEF	\			ADDRESS, CITY, STATE, ZIP COD	
ICNITE N	MEDICAL DESCRI	CROWN POINT LLC			MAIN STREET N POINT, IN 46307	
IGNITE	HEDICAL RESORT	CROWN POINT LLC		CROW	IN POINT, IIN 40307	
(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 APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION FPA 101, issued October		TAG	DEFECTIVE 17	DATE
	22, 2013.	-FA 101, Issued October				
		tandard for Emergency and				
	, ,	ystems, 2010 edition,				
	including TIAs to	chapter 7, issued August 6,				
	2009 Based on records re	eview and interview, the facility	E 0	041		05/28/2024
		the emergency power system		V 11	Crown Point Indiana	03/20/2024
	•	in the Health Care Facilities			Life Safety Survey: 05/03/20	24
	_	and Life Safety Code in			The facility respectfully	
		CFR 483.73(e)(2). This			requests a desk review	
		ould affect approximately all				
	occupants.				Please accept the following as	I
					facility's credible allegation of	
	Findings include:				compliance. This plan of correction does not constitute	an
	Rased on record rev	view with the Director of			admission of guilt or liability b	
		vices on 05/03/24 between 09:24			facility and is submitted only in	-
		, the generator lacked weekly			response to the regulatory	
		equired by LSC and NFPA			requirement.	
	110. Based on inter	rview at the time of record			E041 Emergency generator	
	review, the Director	r of Environmental Services			inspection and testing. The	LTC
	acknowledged the r	missing weekly inspections.			facility must implement the	
	TEL (* 1'	1 14 4 E 2			emergency power system	
		reviewed with the Executive			inspection, testing, and	
	exit conference.	or of Plant Operations at the			maintenance requirements found in the healthcare	
	CAR COMMERCIAL.				facilities code NFPA 110 and	<u>,</u>
					life safety code	
					What corrective action(s) will	ıı
					be accomplished for those	
					residents found to have bee	n
					affected by the deficient	
					practice;	
					No harm came to any residen	
					related to this alleged deficien)T
					practice.	
					How the facility will identify other residents having the	
					potential to be affected by the	ne

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		l í	ILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/03/2024	
	PROVIDER OR SUPPLIER	CROWN POINT LLC	<u> </u>	1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	same deficient practice and what corrective action will be taken; All residents have the potential be affected by the same alleged deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; Maintenance staff were re-educated on weekly visual inspections on emergency generator and maintaining we inspection logs. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be into place; Administrator or designee will randomly audit generator testif logs for 6 months to ensure compliance with life safety coorrequirements. Administrator/designee will present a summary of the audit to 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: 05/28/2024	e al to ed ato ekly the put ing de lits hs. he

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/03/2024	
	PROVIDER OR SUPPLIEF	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 CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
K 0000					
Bldg. 01	Licensure Survey w	Recertification and State vas conducted by the Indiana th in accordance with 42 CFR	K 0000	The facility respectfully required desk review	uests a
	Survey Date: 05/03 Facility Number: 0 Provider Number: AIM Number: 201	13452 155835			
	portion of Ignite Me first floor, was four Requirements for P Medicare/Medicaid Life Safety From F National Fire Protes	, 42 CFR Subpart 483.90(a), ire and the 2012 Edition of the ction Association (NFPA) 101, SC), Chapter 19, Existing			
	Type V (111) const A 2 hour fire wall is into two separate be building is subdivice compartments. Sep healthcare occupan- residential occupan- horizontal floor/ceil hour rated floor/ceil hour rated construct contains a theater re- staff do occupy on facility has a fire all detection in the con-	ity was determined to be of ruction and fully sprinklered. It is provided to divide the facility wildings. Each separate led into two smoke learnation between the first floor recy and the second floor recy is provided by a 2 hour ling assembly and fire barriers. It is gystem is supported by 2 tion. The second floor room that skilled residents and certain days and times. The farm system with smoke ridor and in all areas open to ceility has smoke detectors hard			

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		IDENTIFICATION NUMBER 155835	î ´	JILDING	01	COMPL 05/03/	ETED
	ROVIDER OR SUPPLIER	CROWN POINT LLC		1555 S	NDDRESS, 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)	ΓE	(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	wired to the fire alar resident sleeping rooprotected by a 300 kgenerator. The facility has 68 certified only for Medical of the survey, the certified for Medical facility services were sprinkle faci	rm system installed in all oms. The building is fully as well diesel powered emergency bertified beds. 65 beds are edicare, 3 beds are dually re and Medicaid. At the time ensus was 67. residents have customary ered. All areas providing re sprinklered appleted on 05/13/24 d means of egress shall not a latch or a lock that fa tool or key from the susing one of the following		TAG	DEFICIENCY)		DATE
	19.2.2.2.6 SPECIAL NEEDS ARRANGEMENTS Where special lock						

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	ENT OF DEFICIENCIES N OF CORRECTION	IDENTIFICATION NUMBER 155835	UILDING	01	COMPL 05/03/	ETED
	F PROVIDER OR SUPPLIEF	CROWN POINT LLC	1555 S	NDDRESS, 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 R 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
TAG	safety needs of the the Clinical or Secare being met. In electrical locks that release upon loss building is protected automatic sprinkled space is protected detection system at an attended lock space); and both systems are arrandupon activation. 18.2.2.2.5.2, 19.2 DELAYED-EGRE ARRANGEMENT Approved, listed of systems installed 7.2.1.6.1 shall be assemblies serving contents in building an approved, superfection system automatic sprinkled 18.2.2.2.4, 19.2.2 ACCESS-CONTR LOCKING ARRANDA Access-Controlled installed in accordable permitted. 18.2.2.2.4, 19.2.2 ELEVATOR LOBE LOCKING ARRANDE LOCKING ARRAN	SS LOCKING S lelayed-egress locking in accordance with permitted on door g low and ordinary hazard ags protected throughout by ervised automatic fire or an approved, supervised er system. 2.4 COLLED EGRESS NGEMENTS d Egress Door assemblies lance with 7.2.1.6.2 shall 2.4 BY EXIT ACCESS	TAG	DEFICIENCY)		DATE

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MUI A. BUII B. WIN	LDING	nstruction 01	(X3) DATE COMPL 05/03/	LETED
	PROVIDER OR SUPPLIER	CROWN POINT LLC		1555 S	DDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE PRIATE	(X5) COMPLETION DATE
	failed to ensure 1 o arrangements were LSC 7.2.1.6.1(3) w process shall releas egress within 15 sea approved by the aurupon application of required in 7.2.1.5. conditions: (a) The force shall continuously applied (c) The initiation of activate an audible door opening. (d) Once the lock happlication of force relocking shall be deficient practice or residents and staff vidining area. Findings include: Based on observation with the Director of 05/03/24 between 1 emergency exit doof from the main dining second egress function 15-second egress function 15-second egress function for the main dining area was covered interview at the time of Environmental Shad a delay-egress and the second egress functions and a delay-egress and the second egress function of Environmental Shad a delay-egress and the second egress function of Environmental Shad a delay-egress and the second egress functions are second egress functions and the second egres functions are second egres functions and the second egres functions are se	on and Interview, the facility of 8 delayed egress locking installed in accordance with hich states an irreversible the lock in the direction of conds, or 30 seconds where thority having jurisdiction, a force to the release device 10 under all of the following the required to exceed 15 lbf and be required to be d for more than 3 seconds. The release process shall signal in the vicinity of the as been released by the to the releasing device, y manual means only. This build affect approximately 15 who use or be near the main on during a tour of the facility Tenvironmental Services on 1:00 a.m. and 11:30 a.m., the res leading out to the courtyard ag area were installed with a 15 ion. When tested, the anction did not initiate after The alarm speaker for the door d with painters tape. Based on the of observation, the Director function for the door and did sted. He further stated that the	K 022	22	Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03 The facility respectfully requests a desk review Please accept the following facility's credible allegation compliance. This plan of correction does not constit admission of guilt or liabilit facility and is submitted on response to the regulatory requirement. K222 an irreversible proc shall release the lock in the direction of egress within seconds or 30 seconds we approved by the authority having jurisdiction, upon application of a force to release device required in 7.2.1.5.10 under all of the following conditions. The shall not be required to ex 15 lbs, the force shall not required to be continuous applied for more than 3 seconds, the initiation of release process shall action an audible signal in the vi of the door opening, once lock has been released by application of force to the releasing device relocking shall be by manual mean only. What corrective action(s) be accomplished for thos	g as the n of ute an y by the ly in ess he n 15 vere y n force exceed t be sly the ivate icinity e the y the e g us will	05/28/2024

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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 05/03/2024		
	PROVIDER OR SUPPLIE	R CROWN POINT LLC		1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	<u> </u>	
	SUMMARY (EACH DEFICIENT REGULATORY OF doors do have this be reset for it to initial to the findings were seen as the seen as t	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION issue sometimes and it has to tiate like it should. reviewed with the Director of vices and Executive Director		1555 S	MAIN STREET	n ts ts t t ee e e e e e e e e e e e e e	(X5) COMPLETION DATE
					assurance programs will be into place; Administrator or designee will randomly audit Egress door operation logs for 6 months to ensure compliance with life sa code requirements.		

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	T OF HEALTH AND HU R MEDICARE & MEDIC				FORM APPROVED OMB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 2 01	X3) DATE SURVEY COMPLETED 05/03/2024
	PROVIDER OR SUPPLIEI	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
				Administrator/designee will present a summary of the audit 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: 05/28/2024	S.
K 0345 SS=C Bldg. 01	in accordance wit complying with th National Electric (National Fire Alar Records of syster and testing are re 9.6.1.3, 9.6.1.5, N	m - Testing and m is tested and maintained th an approved program e requirements of NFPA 70, Code, and NFPA 72, rm and Signaling Code. m acceptance, maintenance radily available. IFPA 70, NFPA 72			
	failed to ensure 1 of maintained in accordance with maintained in accordance of 9.6.1.3 requires a fit tested, and maintain 70, National Electronational Fire Alarr 14.4.5 states unless sections of this Coolin accordance with	view and interview, the facility of 1 fire alarm systems was rdance with LSC 9.6.1.3. LSC ire alarm system to be installed, ned in accordance with NFPA ical Code and NFPA 72, n Code. NFPA 72, Section so therwise permitted by other de, testing shall be performed the schedules in Table 14.4.5, quired by the authority having	K 0345	Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review Please accept the following as a facility's credible allegation of compliance. This plan of correction does not constitute a admission of guilt or liability by	the n

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jurisdiction. NFPA 72, Section 14.4.5.3.1 states

smoke detector sensitivity shall be checked within

1 year after installation. NFPA 72, 14.4.5.3.2 states

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requirement.

facility and is submitted only in

response to the regulatory

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 01 B. WING 05/03/2024 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 smoke detector sensitivity shall be checked every K345 Fire alarm system-Testing alternate year thereafter unless otherwise and maintenance. A fire alarm permitted by compliance with Section 14.4.5.3.3. system is tested and This deficient practice could affect approximately maintained in accordance with all occupants. an approved program complying with the Findings include: requirements of NFPA 70, National electric code, and Based on record review with the Director of NFPA, National Fire alarm and Environmental Services on 05/03/24 between 09:24 signaling code. Records of a.m. and 11:35 a.m., the last documented smoke system acceptance, and detector sensitivity testing was dated 04/28/22. maintenance and testing are The smoke detector sensitivity testing should readily available. have been conducted by 04/28/24. An email was What corrective action(s) will produced during record review between the be accomplished for those facility and the contracted alarm company residents found to have been indicating that a fire alarm inspection is going to affected by the deficient be completed at a later date. Based on interview at practice; the time of record review, the Director of No harm came to any residents Environmental Services confirmed that the smoke related to this alleged deficient detector sensitivity inspection is past due. practice. This finding was reviewed with the Director of How the facility will identify Environmental Services and Executive Director at other residents having the the exit conference. potential to be affected by the 3.1-19(b) same deficient practice and 2. Based on record review, observation and what corrective action will be interview; the facility failed to ensure all fire alarm system initiating devices were tested in All residents have the potential to accordance with the schedules for testing be affected by the same alleged frequency in NFPA 72. LSC Section 33.2.3.4.1 deficient practice. states a manual fire alarm system shall be What measures will be put into provided in accordance with Section 9.6, unless place or what systemic the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are changes will be made to met. LSC Section 9.6.1.3 states a fire alarm system ensure that the deficient required for life safety shall be installed, tested, practice does not recur; and maintained in accordance with the applicable Facility has a contracted service requirements of NFPA 70, National Electric Code provider to perform all scheduled and NFPA 72, National Fire Alarm and Signaling maintenance to fire alarm systems Code. NFPA 72, 2010 Edition, Section 14.4.5 including annul testing and states testing shall be performed in accordance inspections. Alarm system

ENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OM	IB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155835	B. WING		05/03	/2024
			<u> </u>	-	00,00	
NAME OF I	PROVIDER OR SUPPLIEF	3		ADDRESS, CITY, STATE, ZIP COD		
TOTAL OF T	NO VIDER OR SCITELLI		1555 8	S MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC	CROV	VN POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	1		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTION (EACH CORRECTION SHOULD B) CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
IAU		in Table 14.4.5. Table 14.4.5	IAG	acrica contractor is surrently	.,	DATE
				service contractor is currentle	•	
	_	fication appliances, batteries, es to be tested at least		on-site preforming both annual	ıaı	
	_			alarm and annual sensitivity	_	
	-	cient practice could affect		testing ensuring the facility is		
	approximately all c	lients, staff, and visitors.		compliance with life safety c		
	Pindinas instala			How the corrective action(s	-	
	Findings include:			will be monitored to ensure	tne	
	D 1 1			deficient practice will not		
		view from 09:24 a.m. to 11:35		recur, i.e. what quality		
	a.m. on 05/03/24 w			assurance programs will be	e put	
		vices, the latest annual		into place;	•••	
	_	vas dated 04/19/23. No other		Administrator or designee w		
		ld be located during the		review annual alarm system		
		f the fire alarm system has had		smoke detector sensitivity te	sts	
		vithin the past year. During the		upon completion to ensure		
	-	tion of an email was located		compliance with life safety c	ode	
	-	and the alarm company		requirements.		
	-	ystem was to be inspected this				
		Based on interview at the time		Administrator/designee will		
		ne Director of Environmental		present a summary of the au	ıdits	
	_	t the annual functional testing		to the Quality Assurance		
	is overdue.			committee monthly for 6 mon		
				Thereafter, if determined by		
		assed with the Director of		Quality Assurance committe		
		vices and Executive Director at		auditing and monitoring will	be	
	exit conference.			done quarterly and present		
				quarterly at the QA meeting.		
	3.1-19(b)			Monitoring will be on going.		
				Date by which corrections	will	
				be completed: 05/28/2024		
K 0353	NFPA 101					
SS=F		- Maintenance and Testing				
Bldg. 01		- Maintenance and Testing				
	-	er and standpipe systems				
		ted, and maintained in				
		NFPA 25, Standard for the				
	Inspection, Testin	g, and Maintaining of				
	Water-based Fire	Protection Systems.				
	Records of system	n design, maintenance,				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE S A. BUILDING (01) COMPLE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER			01	COMPL	
		155835	B. WI	NG		05/03/	/2024
	PROVIDER OR SUPPLIER	CROWN POINT LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307			
	T				I		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LISC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
TAG	inspection and tessecure location ar a) Date sprinkler b) Who provided c) Water system Provide in REMAR	sting are maintained in a and readily available. system last checked system test supply source		IAG	Barchaett		DATE
	coverage for any rautomatic sprinkle	=					
	Based on record rev failed to maintain 2 accordance with LS automatic sprinkler and maintained in a Standard for the Ins Maintenance of Wa Systems. NFPA 25 indicates the require testing. NFPA 25, 5 pipe sprinkler syste and gauges on dry s inspected weekly to pressure is being m states valves should valves secured lock shall be permitted to deficient practice of occupants. Findings include: Based on record rev Environmental Serva, there was no resulted to the service of the ser	view and interview, the facility of 2 sprinkler system in C 9.7.5. LSC 9.7.5 requires all systems shall be inspected ecordance with NFPA 25, pection, Testing, and ter-Based Fire Protection, 2011 edition, Table 5.1.1.2 ed frequency of inspection and 6.2.4.1 states gauges on wet ms shall be inspected monthly systems (5.2.4.2) shall be ensure normal water or air aintained. NFPA 25 13.3.2.1 dbe inspected weekly or so or supervised (13.3.2.1.1) to be inspected monthly. This build affect approximately all	K 03	353	Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/20 The facility respectfully requests a desk review 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. K353 sprinkler system- maintenance and testing automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance wi NFPA 25, standard for the inspection, testing, and maintaining a water-based F Protection systems. Records	an y the n	05/28/2024
		ler system's gauges and valves ths. During an interview at the			system design, maintenance inspection and testing are) ,	
	time of record revie	_			maintained in a secure		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			· /		ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER			ILDING	<u>01</u>	COMPLETED
		155835	B. WI	NG		05/03/2024
	PROVIDER OR SUPPLIE	R CROWN POINT LLC		1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	BROWINERIC BY AN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	Environmental Ser	vices agreed that the			location and readily available	e.
		s unable to be found during the			What corrective action(s) wil	ı
	1	ne fills out weekly forms,			be accomplished for those	
		sure where they were at. Later			residents found to have been	n
		ne was able to provide a			affected by the deficient	
	_	hat is filled out for			practice;	
		orinkler systems, but was not			No harm came to any residen	
	filled out.				related to this alleged deficien	t
	F: 1:				practice.	
	_	ewed with the Director of vices and Executive Director at			How the facility will identify	
	exit conference.	vices and Executive Director at			other residents having the potential to be affected by the	
	exit conference.				same deficient practice and	.e
	3.1-19(b)				what corrective action will be	•
	3.1 17(0)				taken;	
					All residents have the potentia	al to
					be affected by the same allege	
					deficient practice.	
					What measures will be put in	nto
					place or what systemic	
					changes will be made to	
					ensure that the deficient	
					practice does not recur;	
					Maintenance director has bee	
					re-educated and will ensure va	alves
					and wet sprinkler system is	
					inspected monthly, and Dry	
					system is inspected weekly ar	
					documented in accordance wi	
					NFPA 25 and life safety code.	
					How the corrective action(s) will be monitored to ensure to	
					deficient practice will not	.iie
					recur, i.e. what quality	
					assurance programs will be	nut
					into place;	Put
					Administrator or designee will	
					randomly audit sprinkler gaug	
					logs weekly for 6 months to	=
					ensure compliance with life sa	ıfety

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/03/2024
	ROVIDER OR SUPPLIER	CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD S MAIN STREET IN 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
K 0712 SS=C Bldg. 01	NFPA 101 Fire Drills Fire Drills Fire drills include to alarm signal and some conditions. Fire drills and unexpected to conditions, at leass The staff is familia aware that drills aroutine. Where dried 9:00 PM and 6:00 announcement manualible alarms. 19.7.1.4 through 1 Based on record reversalled to conduct quitable.	he transmission of a fire imulation of emergency fire ills are held at expected mes under varying t quarterly on each shift. It with procedures and is re part of established ills are conducted between AM, a coded ay be used instead of	K 0712	code requirements. Administrator/designee will present a summary of the aud 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 which corrections where completed: 05/28/2024 Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/20	o5/28/2024
		leficient practice could affect esidents, staff and visitors in		The facility respectfully requests a desk review Please accept the following as	s the
	Based on record rev	riew with the Director of		facility's credible allegation of compliance. This plan of	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	01	COMPLE	
		155835	B. W	'ING		05/03/2	2024
NAME OF B	DOLUDED OD GLIDDLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER		1555 S MAIN STREET				
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROWI	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		vices on 05/03/24 between 09:24			correction does not constitute		
		, all second quarter fire drills			admission of guilt or liability by		
		June 1st and all third quarter			facility and is submitted only in	۱	
		ed on September 13th.			response to the regulatory		
		est shift fire drill was also			requirement.		
		per 13th. Based on interview at eview, the Director of			K712 Fire drills include the transmission of a fire alarm		
		vices agreed that the fire drills					
	were conducted on	9			signal and simulation of emergency fire conditions. F	iro	
	were conducted on	predictore dates.			drills are held at expected ar		
					unexpected times under	··	
	This finding was re	viewed with the Director of			varying conditions, at least		
	_	vices and Executive Director			quarterly on each shift. The		
	during the exit conf				staff is familiar with the		
					procedures and is aware tha	t l	
	3.1-19(b)				drills are part of an establish		
	3.1-51(c)				routine. Where drills are		
					conducted between 9:00 PM		
					and 6:00 AM a coded		
					announcement may be used		
					instead of audible alarms		
					What corrective action(s) wil	ı	
					be accomplished for those		
					residents found to have been	n	
					affected by the deficient		
					practice;		
					No harm came to any residen		
					related to this alleged deficien	t	
					practice.		
					How the facility will identify		
					other residents having the		
					potential to be affected by the	ie	
					same deficient practice and		
					what corrective action will be	e	
					taken;		
					All residents have the potentia		
					be affected by the same allege	ed	
					deficient practice.		
					What measures will be put ir	πο	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SU		SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	01	COMPL	ETED
		155835	B. W	ING		05/03/	/2024
				_	_		
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
				1555 S MAIN STREET			
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROW	N 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
					place or what systemic		
					changes will be made to		
					ensure that the deficient		
					practice does not recur;		
					Maintenance director has revi	ewed	
					the current year's fire drills to		
					ensure that all drills were		
					conducted in the proper time		
					frame. The maintenance direc	tor	
					has scheduled the remaining	drills	
					for this year to ensure complia	ance.	
					How the corrective action(s)		
					will be monitored to ensure t	the	
					deficient practice will not		
					recur, i.e. what quality		
					assurance programs will be	put	
					into place;		
					Administrator or designee will		
					audit fire drills for 6 months to		
					ensure compliance with life sa	ıfety	
					code requirements.		
					Administrator/designee will		
					present a summary of the aud	lite	
					to the Quality Assurance	iilo	
					committee monthly for 6 mont	he	
					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 w	ill	
					be completed: 05/28/2024		
					20 00mpiotod: 00/20/2027		
K 0918	NFPA 101						
SS=F	Electrical Systems	s - Essential Electric Syste					
Bldg. 01		s - Essential Electric					
=	System Maintenar						
	1 -	other alternate power					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 05/03/2024
	PROVIDER OR SUPPLIER	CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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
	of supplying service 10-second criterion monthly test, a programmal critical and testing of the switches are performed in 10-second critical and testing of the switches are performed in 10-second critical and testing of the switches are performed in 20-40 day once every 36 moscheduled test under a complete simular automatic or manuloads, and are compersonnel. Mainte energy power sour accordance with noticicular components is estimated in 10-second components in 10-second components in 10-second critical in 10-second critia	ual transfer of all EES inducted by competent nance and testing of stored rces (Type 3 EES) are in NFPA 111. Main and feeder is inspected annually, and a dically exercising the tablished according to uirements. Written records and testing are maintained ble. EES electrical panels arked, readily identifiable, a normal power circuits. ssibility of damage of the source is a design new installations. (NFPA 99), NFPA 110, 0 (NFPA 70)	V 0010	Jamita Madigal Pagarta	05/29/2024
	facility failed to ensinspections for the gof 52 weeks. NFPA generators shall be NFPA 110, Standar	review and interview, the sure a written record of weekly generator was maintained for 4 A 99, 6.4.4.1.3 requires onsite maintained in accordance with d for Emergency and Standby FPA 110, 8.4.1 requires an	K 0918	Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/20 The facility respectfully requests a desk review	24

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155835	B. W	ING _		05/03/	/2024
		1		STREET 4	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			N POINT, IN 46307		
IOINITE I	WEDIOAL NEOUNT	OROVIVI OINT LLO		CINOVI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Supply System (EPSS)			Please accept the following as		
	0 11	enant components, shall be			facility's credible allegation of		
		nd exercised monthly. NFPA			compliance. This plan of		
	_	a written record of inspection,			correction does not constitute		
	_	ising period, and repairs for the			admission of guilt or liability by	-	
		ılarly maintained and available			facility and is submitted only in	า	
	for inspection by th				response to the regulatory		
		eficient practice could affect			requirement.		
	approximately all re	esidents, staff and visitors.			K918 Generator sets are		
					inspected weekly exercised		
	Findings include:				under load 30 minutes 12 tin		
					a year in 20 - 40 day intervals	s,	
		view with the Director of			and exercise once every 36		
		vices on 05/03/24 between 09:24			months for 4 continuous hou	urs.	
		., no documentation was			Scheduled test under load		
		v to show if the diesel generator			conditions including comple	te	
		nspected weekly between			simulated cold start and		
		/24. Based on an interview at			automatic or manual transfe	r of	
		eview, the Director of			all ESS loads and are		
	_	erations acknowledged the lack			conducted by competent		
		uring the survey and stated he			personnel. Maintenance and		
	was unsure where t	he documentation could be.			testing of stored energy pow	/er	
					sources are in accordance w	/ith	
	_	ussed with the Director of			NFPA 111 main and feeder		
		vices and Executive Director at			circuit breakers are inspecte	d	
	exit conference.				annually, and a program for		
					periodically exercising the		
	3.1-19(b)				components is established		
					according to manufacturer		
		review and interview, the			requirements. Written record		
		ercise the generator for 12 of 12			of maintenance and testing a	are	
		requirements of NFPA 110,			maintained and readily		
	•	tandard for Emergency and			available.		
		stems, Chapter 8.4.2. Section					
	_	enerator sets in service shall			What corrective action(s) wil	II	
		t once monthly, for a minimum			be accomplished for those		
		g one of the following			residents found to have been	n	
	methods:				affected by the deficient		
	(1) Loading that ma	aintains the minimum exhaust			practice;		
	gas temperatures as	recommended by the			No harm came to any residen	ts	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	01	COMPLETED
		155835	B. W	'ING		05/03/2024
				STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF P	PROVIDER OR SUPPLIER	8			MAIN STREET	
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			N POINT, IN 46307	
			1		, I	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION
TAG	manufacturer	R LSC IDENTIFYING INFORMATION	+	TAG		DATE 4
		temperature conditions and at			related to this alleged deficien	ι
		-			practice.	
	Power Supply) nam	cent of the EPS (Emergency			How the facility will identify	
		es diesel-powered EPS			other residents having the	
		not meet the requirements of			potential to be affected by th	e
		ised monthly with the available			same deficient practice and what corrective action will be	,
		Power Supply System) load and			taken;	=
		nnually with supplemental			All residents have the potentia	al to
		n 50 percent of the EPS			be affected by the same allege	
		g for 30 continuous minutes			deficient practice.	ou
	•	75 percent of the EPS			What measures will be put ir	nto
		g for 1 continuous hour for a			place or what systemic	
	-	f not less than 1.5 continuous			changes will be made to	
		at practice could affect			ensure that the deficient	
	approximately all o	-			practice does not recur;	
	approximately all o	ecapanis.			Maintenance staff were	
	Findings include:				re-educated on weekly and	
	8				monthly inspections and testir	ng of
	Based on review of	generator load testing			emergency generator, and	.9 0.
		the Director of Environmental			maintaining weekly and month	nlv
	Services from 09:24	4 a.m. to 11:35 a.m. on 05/03/24,			inspection logs documenting,	,
	the load information	n to show the actual load			performance, exercising perio	d
	percentage for the d	liesel powered generator was			and percentage of load.	
	not documented. Ba	ased on interview at the time of				
	record review, the I	Director of Plant Operations			How the corrective action(s)	
	acknowledged that	the monthly load testing was			will be monitored to ensure t	he
	missing and further	stated he was unsure what the			deficient practice will not	
	load percentage of t	the generator usually is.			recur, i.e. what quality	
					assurance programs will be	put
	-	viewed with the Director of			into place;	
		vices and Executive Director at			Administrator or designee will	
	the exit conference.				randomly audit generator testi	ng
					logs for 6 months to ensure	
	3.1-19(b)				compliance with life safety cod	de
					requirements.	
					Administrator/designee will	
					present a summary of the aud	its
					to the Quality Assurance	

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	OF CORRECTION	IDENTIFICATION NUMBER 155835	A. BUILDING B. WING	01	COMPLETED 05/03/2024
	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
				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: 05/28/2024	e ·
K 0927 SS=E Bldg. 01	Gas Equipment - Transfilling of oxyganother is in according Transfilling of High Oxygen Used for Fany gas from one prohibited in patient to liquid oxygen containers over 50 under 11.5.2.3.1 (I liquid oxygen containers under 50 containers under 50 containers under 51	1.5.2.3.2 (NFPA 99).			
	Based on observation failed to ensure 1 of location had proper NFPA 99. NFPA 99 2012 Edition, Section (transfilling shall occur separated from any patients are housed, barrier of 1 hour fire	n and interview, the facility 2 oxygen storage/transfer separation in accordance with 4, Health Care Facilities Code, 5 on 11.5.2.3.1(1) states, 6 cur in) A designated area portion of a facility wherein examined, or treated by a fire ex-resistive construction. This and affect approximately 30	K 0927	Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/202 The facility respectfully requests a desk review 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.	the an the

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GN9K21

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	<u>01</u>	COMPLETED
		155835	B. W	ING		05/03/2024
	PROVIDER OR SUPPLIER	CROWN POINT LLC		1555 S	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	T	(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
		on with the Director of			K927 Gas	
		vices during a tour of the			equipment-transfilling	
		20 p.m. and 1:49 p.m. on			cylinders, transfilling of oxyg	ien
	05/03/24 the oxygen	n storage/transfer room across			from one cylinder to another	
	from the C wing nu	rses station was used by			accordance with CGAE-P 2.5	,
		employee entered the oxygen			transfilling of high-pressure	
	~	d let the door close. While			gaseous oxygen used for	
	_	urring, employee #2 entered			respiration. transfilling of an	
		g room and propped the door			gas from 1 cylinder to anothe	er
		with employee #1 while			is prohibited in patient care	
	_	curring. Based on interview at			rooms. Transfilling to liquid	
	the time of observat				oxygen containers or portab	
		vices agreed that the door had			containers over 50 PSI comp	·
		transfilling was in progress			with conditions under 11.5 2.	
		issue with employee #2 when			NFPA 99. Transfilling to liqui	a
	done.				oxygen containers or to	,
	Findings were discu	ussed with the Director of			portable containers under 50 PSI comply with conditions	
	_	vices and Executive Director at			under 11.5.2.3.2 NFPA 99	
	exit conference.	rices and Executive Director at			What corrective action(s) will	ı
	can conference.				be accomplished for those	•
	3.1-19(b)				residents found to have beer	1
	211 17(0)				affected by the deficient	•
					practice;	
					No harm came to any resident	s
					related to this alleged deficien	
					practice.	
					How the facility will identify	
					other residents having the	
					potential to be affected by th	e
					same deficient practice and	
					what corrective action will be)
					taken;	
					All residents have the potentia	
					be affected by the same allege	ed
					deficient practice.	
					What measures will be put in	to
					place or what systemic	
					changes will be made to	
					ensure that the deficient	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	01	COMPL	ETED
		155835	B. WI	NG		05/03/	2024
	PROVIDER 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 LISC 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
	REGULTION ON				practice does not recur; Nursing staff have been re-educated on proper transfill procedures Including not prop door open while transfilling is i progress in accordance with lift safety code. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance programs will be i into place; Administrator or designee will randomly observe oxygen transfilling process for 6 month ensure compliance of life safe code requirements. Administrator/designee will present a summary of the observations to the Quality Assurance committee monthly 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going. Date by which corrections will be completed: 05/28/2024	ping in fe	

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