

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING -- B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
E 0000  Bldg. --	<p>An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73.</p> <p>Survey Date: 05/03/2024</p> <p>Facility Number: 013452 Provider Number: 155835 AIM Number: 201299290</p> <p>At this Emergency Preparedness survey, Ignite Medical Resort Crown Point, was found not in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73</p> <p>The facility has 68 certified beds. 65 beds are certified for Medicare only. 3 beds are dually certified for Medicare and Medicaid. At the time of the survey, the census was 67.</p> <p>Quality Review completed on 05/13/24</p>			E 0000	The facility respectfully requests a desk review		
E 0041 SS=F Bldg. --	<p>482.15(e), 483.73(e), 485.625(e) Hospital CAH and LTC Emergency Power §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1) (i) and (ii) of this section.</p> <p>§483.73(e), §485.625(e) (e) Emergency and standby power systems.</p>						

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

TITLE

(X6) DATE

Robert Petty

Administrator

05/28/2024

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards 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 disclosable 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>The [LTC facility and the CAH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section.</p> <p>§482.15(e)(1), §483.73(e)(1), §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated.</p> <p>482.15(e)(2), §483.73(e)(2), §485.625(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code.</p> <p>482.15(e)(3), §483.73(e)(3), §485.625(e)(3) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates.</p> <p>*[For hospitals at §482.15(h), LTC at §483.73(g), and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to:  <a href="http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html">http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html</a>.            If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes.</p> <p>(1) National Fire Protection Association, 1 Batterymarch Park,            Quincy, MA 02169, <a href="http://www.nfpa.org">www.nfpa.org</a>,            1.617.770.3000.</p> <p>(i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011.</p> <p>(ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011.</p> <p>(iii) TIA 12-3 to NFPA 99, issued August 9, 2012.</p> <p>(iv) TIA 12-4 to NFPA 99, issued March 7, 2013.</p> <p>(v) TIA 12-5 to NFPA 99, issued August 1, 2013.</p> <p>(vi) TIA 12-6 to NFPA 99, issued March 3, 2014.</p> <p>(vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011.</p> <p>(viii) TIA 12-1 to NFPA 101, issued August 11, 2011.</p> <p>(ix) TIA 12-2 to NFPA 101, issued October 30, 2012.</p> <p>(x) TIA 12-3 to NFPA 101, issued October 22, 2013.</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(xi) TIA 12-4 to NFPA 101, issued October 22, 2013.</p> <p>(xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..</p> <p>Based on records review and interview, the facility failed to implement the emergency power system requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code in accordance with 42 CFR 483.73(e)(2). This deficient practice could affect approximately all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services on 05/03/24 between 09:24 a.m. and 11:35 a.m., the generator lacked weekly visual inspections required by LSC and NFPA 110. Based on interview at the time of record review, the Director of Environmental Services acknowledged the missing weekly inspections.</p> <p>The findings were reviewed with the Executive Director and Director of Plant Operations at the exit conference.</p>			E 0041	<p><b>Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p> <p>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.</p> <p><b>E041 Emergency generator inspection and testing. The LTC facility must implement the emergency power system inspection, testing, and maintenance requirements found in the healthcare facilities code NFPA 110 and life safety code</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No harm came to any residents related to this alleged deficient practice.</p> <p><b>How the facility will identify other residents having the potential to be affected by the</b></p>		05/28/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024

FORM APPROVED

OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835	X2) MULTIPLE CONSTRUCTION A. BUILDING      -- B. WING            _____		X3) DATE SURVEY COMPLETED 05/03/2024
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<b>same deficient practice and what corrective action will be taken;</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Maintenance staff were re-educated on weekly visual inspections on emergency generator and maintaining weekly inspection logs. <b>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;</b> Administrator or designee will randomly audit generator testing logs for 6 months to ensure compliance with life safety code requirements.  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. <b>Date by which corrections will be completed: 05/28/2024</b>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING: -- B. WING: --		X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0000  Bldg. 01	<p>A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).</p> <p>Survey Date: 05/03/2024</p> <p>Facility Number: 013452 Provider Number: 155835 AIM Number: 201299290</p> <p>At this Life Safety Code survey, the health care portion of Ignite Medical Resort Crown Point, the first floor, was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety From Fire and the 2012 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies.</p> <p>This two story facility was determined to be of Type V (111) construction and fully sprinklered. A 2 hour fire wall is provided to divide the facility into two separate buildings. Each separate building is subdivided into two smoke compartments. Separation between the first floor healthcare occupancy and the second floor residential occupancy is provided by a 2 hour horizontal floor/ceiling assembly and fire barriers. The rated floor/ceiling system is supported by 2 hour rated construction. The second floor contains a theater room that skilled residents and staff do occupy on certain days and times. The facility has a fire alarm system with smoke detection in the corridor and in all areas open to the corridor. The facility has smoke detectors hard</p>			K 0000	The facility respectfully requests a desk review		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0222 SS=E Bldg. 01	<p>wired to the fire alarm system installed in all resident sleeping rooms. The building is fully protected by a 300 kW diesel powered emergency generator.</p> <p>The facility has 68 certified beds. 65 beds are certified only for Medicare, 3 beds are dually certified for Medicare and Medicaid . At the time of the survey, the census was 67.</p> <p>All areas where the residents have customary access were sprinklered. All areas providing facility services were sprinklered</p> <p>Quality Review completed on 05/13/24</p> <p>NFPA 101 Egress Doors Egress Doors Doors in a required means of egress shall not be equipped with a latch or a lock that requires the use of a tool or key from the egress side unless using one of the following special locking arrangements: CLINICAL NEEDS OR SECURITY THREAT LOCKING Where special locking arrangements for the clinical security needs of the patient are used, only one locking device shall be permitted on each door and provisions shall be made for the rapid removal of occupants by: remote control of locks; keying of all locks or keys carried by staff at all times; or other such reliable means available to the staff at all times. 18.2.2.2.5.1, 18.2.2.2.6, 19.2.2.2.5.1, 19.2.2.2.6 SPECIAL NEEDS LOCKING ARRANGEMENTS Where special locking arrangements for the</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>safety needs of the patient are used, all of the Clinical or Security Locking requirements are being met. In addition, the locks must be electrical locks that fail safely so as to release upon loss of power to the device; the building is protected by a supervised automatic sprinkler system and the locked space is protected by a complete smoke detection system (or is constantly monitored at an attended location within the locked space); and both the sprinkler and detection systems are arranged to unlock the doors upon activation.</p> <p>18.2.2.2.5.2, 19.2.2.2.5.2, TIA 12-4 DELAYED-EGRESS LOCKING ARRANGEMENTS Approved, listed delayed-egress locking systems installed in accordance with 7.2.1.6.1 shall be permitted on door assemblies serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system or an approved, supervised automatic sprinkler system.</p> <p>18.2.2.2.4, 19.2.2.2.4 ACCESS-CONTROLLED EGRESS LOCKING ARRANGEMENTS Access-Controlled Egress Door assemblies installed in accordance with 7.2.1.6.2 shall be permitted.</p> <p>18.2.2.2.4, 19.2.2.2.4 ELEVATOR LOBBY EXIT ACCESS LOCKING ARRANGEMENTS Elevator lobby exit access door locking in accordance with 7.2.1.6.3 shall be permitted on door assemblies in buildings protected throughout by an approved, supervised automatic fire detection system and an approved, supervised automatic sprinkler system.</p>						



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
	<p>18.2.2.2.4, 19.2.2.2.4</p> <p>Based on observation and Interview, the facility failed to ensure 1 of 8 delayed egress locking arrangements were installed in accordance with LSC 7.2.1.6.1(3) which states an irreversible process shall release the lock in the direction of egress within 15 seconds, or 30 seconds where approved by the authority having jurisdiction, upon application of a force to the release device required in 7.2.1.5.10 under all of the following conditions:</p> <p>(a) The force shall not be required to exceed 15 lbf (67 N).</p> <p>(b) The force shall not be required to be continuously applied for more than 3 seconds.</p> <p>(c) The initiation of the release process shall activate an audible signal in the vicinity of the door opening.</p> <p>(d) Once the lock has been released by the application of force to the releasing device, relocking shall be by manual means only. This deficient practice could affect approximately 15 residents and staff who use or be near the main dining area.</p> <p>Findings include:</p> <p>Based on observation during a tour of the facility with the Director of Environmental Services on 05/03/24 between 11:00 a.m. and 11:30 a.m., the emergency exit doors leading out to the courtyard from the main dining area were installed with a 15 second egress function. When tested, the 15-second egress function did not initiate after multiple attempts. The alarm speaker for the door magnet was covered with painters tape. Based on interview at the time of observation, the Director of Environmental Services confirmed that the door had a delay-egress function for the door and did not initiate when tested. He further stated that the</p>		K 0222	<p><b>Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p> <p>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.</p> <p><b>K222 an irreversible process shall release the lock in the direction of egress within 15 seconds or 30 seconds were 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 force shall not be required to exceed 15 lbs, the force shall not be required to be continuously applied for more than 3 seconds, the initiation of the release process shall activate an audible signal in the vicinity of the door opening, once the lock has been released by the application of force to the releasing device relocking shall be by manual means only.</b></p> <p><b>What corrective action(s) will be accomplished for those</b></p>		05/28/2024	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>doors do have this issue sometimes and it has to be reset for it to initiate like it should.</p> <p>The findings were reviewed with the Director of Environmental Services and Executive Director during the exit conference.</p> <p>3.1-19(b)</p>		<p><b>residents found to have been affected by the deficient practice;</b> No harm came to any residents related to this alleged deficient practice. <b>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;</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Door was inspected and found to be fully functional prior to surveyor exiting the facility. Maintenance staff will check all Egress doors weekly to ensure proper egress operation and document proper egress operation. <b>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;</b> Administrator or designee will randomly audit Egress door operation logs for 6 months to ensure compliance with life safety code requirements.</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0345 SS=C Bldg. 01	<p>NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.4.5 states unless otherwise permitted by other sections of this Code, testing shall be performed in accordance with the schedules in Table 14.4.5, or more often if required by the authority having 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</p>			K 0345	<p>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. <b>Date by which corrections will be completed: 05/28/2024</b></p> <p><b>Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p> <p>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.</p>		05/28/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>smoke detector sensitivity shall be checked every alternate year thereafter unless otherwise permitted by compliance with Section 14.4.5.3.3. This deficient practice could affect approximately all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services on 05/03/24 between 09:24 a.m. and 11:35 a.m., the last documented smoke detector sensitivity testing was dated 04/28/22. The smoke detector sensitivity testing should have been conducted by 04/28/24. An email was produced during record review between the facility and the contracted alarm company indicating that a fire alarm inspection is going to be completed at a later date. Based on interview at the time of record review, the Director of Environmental Services confirmed that the smoke detector sensitivity inspection is past due. This finding was reviewed with the Director of Environmental Services and Executive Director at the exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on record review, observation and interview; the facility failed to ensure all fire alarm system initiating devices were tested in accordance with the schedules for testing frequency in NFPA 72. LSC Section 33.2.3.4.1 states a manual fire alarm system shall be provided in accordance with Section 9.6, unless the provisions of 33.2.3.4.1.1 or 33.2.3.4.1.2 are met. LSC Section 9.6.1.3 states a fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electric Code and NFPA 72, National Fire Alarm and Signaling Code. NFPA 72, 2010 Edition, Section 14.4.5 states testing shall be performed in accordance</p>				<p><b>K345 Fire alarm system-Testing and maintenance. A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National electric code, and NFPA , National Fire alarm and signaling code. Records of system acceptance, and maintenance and testing are readily available.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No harm came to any residents related to this alleged deficient practice.</p> <p><b>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;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Facility has a contracted service provider to perform all scheduled maintenance to fire alarm systems including annul testing and inspections. Alarm system</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0353 SS=F Bldg. 01	<p>with the schedules in Table 14.4.5. Table 14.4.5 requires alarm notification appliances, batteries, and initiating devices to be tested at least annually. This deficient practice could affect approximately all clients, staff, and visitors.</p> <p>Findings include:</p> <p>Based on record review from 09:24 a.m. to 11:35 a.m. on 05/03/24 with the Director of Environmental Services, the latest annual functional testing was dated 04/19/23. No other documentation could be located during the survey to indicate if the fire alarm system has had functional testing within the past year. During the survey, documentation of an email was located between the facility and the alarm company indicated that the system was to be inspected this year at a later date. Based on interview at the time of record review, the Director of Environmental Services agreed that the annual functional testing is overdue.</p> <p>Findings were discussed with the Director of Environmental Services and Executive Director at exit conference.</p> <p>3.1-19(b)</p> <p>NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance,</p>				<p>service contractor is currently on-site preforming both annual alarm and annual sensitivity testing ensuring the facility is compliance with life safety code. <b>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;</b> Administrator or designee will review annual alarm system and smoke detector sensitivity tests upon completion to ensure compliance with life safety code requirements.</p> <p>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. <b>Date by which corrections will be completed: 05/28/2024</b></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked</p> <p>b) Who provided system test</p> <p>c) Water system supply source</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 2 of 2 sprinkler system in accordance with LSC 9.7.5. LSC 9.7.5 requires all automatic sprinkler systems shall be inspected and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 edition, Table 5.1.1.2 indicates the required frequency of inspection and testing. NFPA 25, 5.2.4.1 states gauges on wet pipe sprinkler systems shall be inspected monthly and gauges on dry systems (5.2.4.2) shall be inspected weekly to ensure normal water or air pressure is being maintained. NFPA 25 13.3.2.1 states valves should be inspected weekly or valves secured locks or supervised (13.3.2.1.1) shall be permitted to be inspected monthly. This deficient practice could affect approximately all occupants.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services on 05/03/24 between 10:03 a.m., there was no monthly inspection of the wet and dry pipe sprinkler system's gauges and valves for the past 12 months. During an interview at the time of record review, the Director of</p>	K 0353	<p><b>Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p> <p>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. <b>K353 sprinkler system-maintenance and testing automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, standard for the inspection, testing, and maintaining a water-based Fire Protection systems. Records of system design, maintenance, inspection and testing are maintained in a secure</b></p>		05/28/2024		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Environmental Services agreed that the documentation was unable to be found during the survey and stated he fills out weekly forms, however he was unsure where they were at. Later during the survey he was able to provide a template form of what is filled out for weekly/monthly sprinkler systems, but was not filled out.</p> <p>Findings were reviewed with the Director of Environmental Services and Executive Director at exit conference.</p> <p>3.1-19(b)</p>				<p><b>location and readily available.</b> <b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> No harm came to any residents related to this alleged deficient practice. <b>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;</b> All residents have the potential to be affected by the same alleged deficient practice. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Maintenance director has been re-educated and will ensure valves and wet sprinkler system is inspected monthly, and Dry system is inspected weekly and documented in accordance with NFPA 25 and life safety code. <b>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;</b> Administrator or designee will randomly audit sprinkler gauge logs weekly for 6 months to ensure compliance with life safety</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0712 SS=C Bldg. 01	<p>NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 Based on record review and interview, the facility failed to conduct quarterly fire drills at unexpected times under varying conditions on third shift for 3 of 4 quarters. This deficient practice could affect approximately all residents, staff and visitors in the facility.</p> <p>Findings include:  Based on record review with the Director of</p>			K 0712	<p>code requirements.</p> <p>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. <b>Date by which corrections will be completed: 05/28/2024</b></p> <p><b>Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p> <p>Please accept the following as the facility's credible allegation of compliance. This plan of</p>		05/28/2024



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Environmental Services on 05/03/24 between 09:24 a.m. and 11:35 a.m., all second quarter fire drills were conducted on June 1st and all third quarter drills were conducted on September 13th. Furthermore, the first shift fire drill was also conducted on October 13th. Based on interview at the time of record review, the Director of Environmental Services agreed that the fire drills were conducted on predictable dates.</p> <p>This finding was reviewed with the Director of Environmental Services and Executive Director during the exit conference.</p> <p>3.1-19(b) 3.1-51(c)</p>				<p>correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>K712 Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with the procedures and is aware that drills are part of an established routine. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> No harm came to any residents related to this alleged deficient practice.</p> <p><b>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;</b> All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into</b></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 0918 SS=F Bldg. 01	NFPA 101 Electrical Systems - Essential Electric Syste Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power		<p><b>place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> Maintenance director has reviewed the current year's fire drills to ensure that all drills were conducted in the proper time frame. The maintenance director has scheduled the remaining drills for this year to ensure compliance.</p> <p><b>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;</b> Administrator or designee will audit fire drills for 6 months to ensure compliance with life safety code requirements.</p> <p>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.</p> <p><b>Date by which corrections will be completed: 05/28/2024</b></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110.</p> <p>Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations.</p> <p>6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70)</p> <p>1. Based on record review and interview, the facility failed to ensure a written record of weekly inspections for the generator was maintained for 4 of 52 weeks. NFPA 99, 6.4.4.1.3 requires onsite generators shall be maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 8.4.1 requires an</p>			K 0918	<p><b>Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p>		05/28/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Emergency Power Supply System (EPSS) including all appurtenant components, shall be inspected weekly and exercised monthly. NFPA 99, 6.4.4.2 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice could affect approximately all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on record review with the Director of Environmental Services on 05/03/24 between 09:24 a.m. and 11:35 a.m., no documentation was available for review to show if the diesel generator set in service was inspected weekly between 12/20/23 and 01/27/24. Based on an interview at the time of record review, the Director of Environmental Operations acknowledged the lack of documentation during the survey and stated he was unsure where the documentation could be.</p> <p>Findings were discussed with the Director of Environmental Services and Executive Director at exit conference.</p> <p>3.1-19(b)</p> <p>2. Based on record review and interview, the facility failed to exercise the generator for 12 of 12 months to meet the requirements of NFPA 110, 2010 Edition, the Standard for Emergency and Standby Powers Systems, Chapter 8.4.2. Section 8.4.2 states diesel generator sets in service shall be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods:</p> <p>(1) Loading that maintains the minimum exhaust gas temperatures as recommended by the</p>				<p>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.</p> <p><b>K918 Generator sets are inspected weekly exercised under load 30 minutes 12 times a year in 20 - 40 day intervals, and exercise once every 36 months for 4 continuous hours. Scheduled test under load conditions including complete simulated cold start and automatic or manual transfer of all ESS loads and are conducted by competent personnel. Maintenance and testing of stored energy power sources are in accordance with NFPA 111 main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No harm came to any residents</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>manufacturer</p> <p>(2) Under operating temperature conditions and at not less than 30 percent of the EPS (Emergency Power Supply) nameplate kW rating. Section 8.4.2.3 states diesel-powered EPS installations that do not meet the requirements of 8.4.2 shall be exercised monthly with the available EPSS (Emergency Power Supply System) load and shall be exercised annually with supplemental loads at not less than 50 percent of the EPS nameplate kW rating for 30 continuous minutes and at not less than 75 percent of the EPS nameplate kW rating for 1 continuous hour for a total test duration of not less than 1.5 continuous hours. This deficient practice could affect approximately all occupants.</p> <p>Findings include:</p> <p>Based on review of generator load testing documentation with the Director of Environmental Services from 09:24 a.m. to 11:35 a.m. on 05/03/24, the load information to show the actual load percentage for the diesel powered generator was not documented. Based on interview at the time of record review, the Director of Plant Operations acknowledged that the monthly load testing was missing and further stated he was unsure what the load percentage of the generator usually is.</p> <p>This finding was reviewed with the Director of Environmental Services and Executive Director at the exit conference.</p> <p>3.1-19(b)</p>				<p>related to this alleged deficient practice.</p> <p><b>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;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance staff were re-educated on weekly and monthly inspections and testing of emergency generator, and maintaining weekly and monthly inspection logs documenting, performance, exercising period and percentage of load.</p> <p><b>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;</b></p> <p>Administrator or designee will randomly audit generator testing logs for 6 months to ensure compliance with life safety code requirements.</p> <p>Administrator/designee will present a summary of the audits to the Quality Assurance</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
K 0927 SS=E Bldg. 01	<p>NFPA 101 Gas Equipment - Transfilling Cylinders Gas Equipment - Transfilling Cylinders Transfilling of oxygen from one cylinder to another is in accordance with CGA P-2.5, Transfilling of High Pressure Gaseous Oxygen Used for Respiration. Transfilling of any gas from one cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or to portable containers over 50 psi comply with conditions under 11.5.2.3.1 (NFPA 99). Transfilling to liquid oxygen containers or to portable containers under 50 psi comply with conditions under 11.5.2.3.2 (NFPA 99). 11.5.2.2 (NFPA 99)</p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 oxygen storage/transfer location had proper separation in accordance with NFPA 99. NFPA 99, Health Care Facilities Code, 2012 Edition, Section 11.5.2.3.1(1) states, (transfilling shall occur in) A designated area separated from any portion of a facility wherein patients are housed, examined, or treated by a fire barrier of 1 hour fire-resistive construction. This deficient practice could affect approximately 30 residents and staff.</p> <p>Findings include:</p>			K 0927	<p>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. <b>Date by which corrections will be completed: 05/28/2024</b></p> <p><b>Ignite Medical Resorts Crown Point Indiana Life Safety Survey: 05/03/2024 The facility respectfully requests a desk review</b></p> <p>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.</p>		05/28/2024

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT CROWN POINT LLC				STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S MAIN STREET CROWN POINT, IN 46307			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCY (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Based on observation with the Director of Environmental Services during a tour of the facility between 12:20 p.m. and 1:49 p.m. on 05/03/24 the oxygen storage/transfer room across from the C wing nurses station was used by employee #1. The employee entered the oxygen transfilling room and let the door close. While transfilling was occurring, employee #2 entered the same transfilling room and propped the door open while talking with employee #1 while transfilling was occurring. Based on interview at the time of observation, the Director of Environmental Services agreed that the door had been propped while transfilling was in progress and did discuss the issue with employee #2 when done.</p> <p>Findings were discussed with the Director of Environmental Services and Executive Director at exit conference.</p> <p>3.1-19(b)</p>				<p><b>K927 Gas equipment-transfilling cylinders, transfilling of oxygen from one cylinder to another in accordance with CGAE-P 2.5, transfilling of high-pressure gaseous oxygen used for respiration. transfilling of any gas from 1 cylinder to another is prohibited in patient care rooms. Transfilling to liquid oxygen containers or portable containers over 50 PSI comply with conditions under 11.5.2.3.1 NFPA 99. Transfilling to liquid oxygen containers or to portable containers under 50 PSI comply with conditions under 11.5.2.3.2 NFPA 99</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>No harm came to any residents related to this alleged deficient practice.</p> <p><b>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;</b></p> <p>All residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient</b></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/03/2024  
FORM APPROVED  
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  155835		X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING		X3) DATE SURVEY COMPLETED 05/03/2024	
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	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					<p><b>practice does not recur;</b> Nursing staff have been re-educated on proper transfilling procedures Including not propping door open while transfilling is in progress in accordance with life safety code.</p> <p><b>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;</b> Administrator or designee will randomly observe oxygen transfilling process for 6 months to ensure compliance of life safety code requirements.</p> <p>Administrator/designee will present a summary of the observations 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.</p> <p><b>Date by which corrections will be completed: 05/28/2024</b></p>		