STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. BUILDING 00 B. WING	02/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT CROWN POINT LLC	1555 S MAIN STREET CROWN POINT, IN 46307

(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
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00421580, IN00425544, IN00426084, and IN00428145. This visit included the Investigation of Residential Complaint IN00424886. Complaint IN00421580 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00425544 - No deficiencies related to the allegations are cited. Complaint IN00426084 - Federal/state deficiencies related to the allegations are cited at F677 and F842. Complaint IN00428145 - Federal/state deficiencies related to the allegations are cited at F842. Complaint IN00424886 - No deficiencies related to the allegations are cited. Survey dates: February 13 & 14, 2024 Facility number: 013452 Provider number: 155835 Census Bed Type: SNF: 68 Residential: 28 Total: 96 Census Payor Type: Medicare: 45 Other: 23 Total: 68	F 0000	The facility respectfully is requesting a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Petty	Administrator	02/23/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/16/24.			
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; Based on record review and interview, the facility failed to ensure residents who required assistance for activities of daily living (ADL's), received bathing/showers at least twice a week, for 4 of 5 residents who require extensive to dependent assistance for ADL's. (Residents D, E, F, and H) Findings include 1) Resident D's closed record was reviewed on 2/14/24 at 9:06 a.m. The diagnoses included, but were not limited to, Chronic lymphocytic leukemia and cognitive communication deficit. An Admission/5-Day Minimum Data Set (MDS) assessment, dated 1/26/24, indicated a severely impaired cognitive status, no behaviors, and was dependent on staff for bathing and hygiene. A Care Plan, dated 1/22/24, indicated assistance would be provided for ADL's. The bathing schedule, indicated the resident's bathing was to be completed on Wednesdays and Saturdays on the first shift. The shower forms and tasks area of the record indicated bathing/showers were not completed on	F 0677	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. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm came to residents D, E, F, or H. All identified residents who remain in house are following their assigned shower schedules and showers/baths have been completed and documented accordingly. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	02/23/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	January 24, 2024 and February 10, 2024. 2) During an interview on 2/13/24 at 2:26 p.m., Resident E indicated bathing was not completed as it should be. She indicated her last bed bath was a week ago, and showers were not offered because she was unable to stand. Her bathing was scheduled for Mondays and Thursdays. Resident E's record was reviewed on 2/13/24 at 3:06 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly MDS assessment, dated 12/19/23, indicated an intact cognitive status, no behaviors, and required moderate assistance with showers. A Care Plan, dated 9/12/23, indicated assistance was required for ADL's. The bathing schedule indicated bathing was to occur on Mondays and Thursdays during the first shift. The tasks form in the record indicated bathing (type of bathing was not documented) on February 1 and 12, 2024. The shower forms, indicated no shower or bed bath had been completed on February 1, 5, 8, and 12, 2024. 3) Resident F's record was reviewed on 2/13/24 at 3:55 p.m. The diagnoses included, but were not limited to, pulmonary fibrosis and diabetes mellitus. An Admission/5-Day MDS assessment, dated 1/22/24, indicated a severely impaired cognitive status, no behaviors, and was dependent for		**taken;** All residents have the potential to be affected by the same alleged deficient practice. Full house audit of all current residents has been completed including shower sheet reviews and interviews with alert and oriented residents. Current residents' showers/baths have been provided and documented. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nursing staff was in-serviced on; The standard shower/bath schedule being two times a week for all residents, with proper documentation on shower sheets. Following each resident's shower/bath schedules assigned 2 x weekly or more depending on preferences with proper documentation completion on shower sheets including documentation of refusals. Providing the type of bathing preference to be given and number of times per week to be given based off resident requests/preference, with proper documentation on shower sheets. **How the corrective action(s)**	

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	showers. A Care Plan, dated 1/16/24, indicated assistance was needed for all ADL's. The resident was scheduled for bathing on Mondays and Thursdays during the first shift. The bathing forms indicated bathing had not occurred on January 29, 2024 and February 8, 2024. 4) During an interview on 2/13/24 at 2:03 p.m., Resident H indicated she had not received any showers at the facility due to a pressure ulcer on her buttocks. She seldom received bed baths, and has had one bed bath in the past three weeks. Resident H record was reviewed on 2/14/24 at 11:36 a.m., The diagnoses included, but were not limited to, stage 4 (deep pressure wound/ulcer) of the sacral region. An Admission/5-Day MDS assessment, dated 12/25/23, indicated an intact cognitive status, no behaviors, and was dependent for showers. A Care Plan, dated 12/18/23, indicated assistance was required for all ADL's. The bathing schedule for January, 2024, indicated bathing was to be completed on Mondays and Thursdays on day shift. Bathing was not completed on January 11 and 15, 2024. The bathing schedule for February, 2024, indicated bathing was to be completed on Wednesdays and Saturdays on the first shift. Bathing had not been completed on February 7 and 10, 2024.		**will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will review 20 resident shower sheets weekly to ensure residents are receiving showers/baths and they are being documented. DON/designee will interview 10 alert and oriented residents on both units weekly to ensure resident's shower schedules are being followed and they are receiving showers/baths based on their preferences. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of completion: 2/23/2024**	

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	During an interview on 2/14/24 at 1:45 p.m., the Director of Nursing indicated showers/bathing was to be completed at least twice a week, unless it was refused by the resident. This citation relates to Complaints IN00421580 and IN00426084. 3.1-38(a)(3) 3.1-38(b)(2)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable			

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	law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic			

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	services reports as required under §483.50. Based on record review and interview, the facility failed to ensure a resident's record was complete and accurate, related to documentation of dietary intakes, for 3 of 3 residents reviewed for dietary intakes. (Residents D, F, and G) Findings include: 1) Resident D's closed record was reviewed on 2/14/24 at 9:06 a.m. The diagnoses included, but were not limited to, chronic lymphocytic leukemia and cognitive communication deficit. An Admission/5-Day Minimum Data Set (MDS) assessment, dated 1/26/24, indicated a severely impaired cognitive status, no behaviors, and moderate assistance was required for dietary intake. A Care Plan, dated 1/22/24 and revised on 1/29/24, indicated she was a risk for malnutrition. The interventions included she would be assisted with eating her meals. The food consumption task documentation, dated 1/21/24 through 2/12/24, indicated there were no meal consumption's documented for the following days and meals: 1/21/24 supper 1/22/24 lunch and supper 1/23/24 lunch and supper 1/24/24 lunch and supper 1/25/24 lunch and supper 1/26/24 breakfast, lunch, and supper 1/27/24 breakfast, lunch, and supper 1/28/24 lunch and supper 1/29/24 breakfast, lunch, and supper 1/30/24 breakfast, lunch, and supper 1/31/24 breakfast, lunch, and supper	F 0842	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. **F842 Resident Records-Identifiable information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm or weight loss was identified for Resident D, F, or G. All identified residents still current, have had meal intakes documented and will be on-going for all residents **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. Full house audit was completed to help identify trends with staff documentation. All consumption records for current residents are now completed at 100%. **What measures will be put into place or what systemic changes will be made to**	02/23/2024

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	2/1 - 2/11/24 breakfast, lunch, and supper 2/12/24 supper 2. Resident F's record was reviewed on 2/13/24 at 3:55 p.m. The diagnoses included, but were not limited to, pulmonary fibrosis and diabetes mellitus. An Admission/5-Day MDS assessment, dated 1/22/24, indicated a severely impaired cognitive status, no behaviors, and required maximum assistance with dietary intake. A Care Plan, dated 1/16/24, indicated assistance was needed for all ADL's (activities of daily living). The food consumption task documentation, dated 1/16/24 through 2/12/24, indicated there were no meal consumption's documented for the following days and meals: 1/16/24 supper 1/17/24 breakfast, lunch, and supper 1/18/24 breakfast and supper 1/19/24 breakfast, lunch, and supper 1/20/24 breakfast, lunch, and supper 1/21/24 supper 1/22/24 breakfast, lunch, and supper 1/23/24 supper 1/24/24 lunch and supper 1/25/24 lunch and supper 1/26/24 through 1/29/24 breakfast, lunch, and supper 1/30/24 supper 1/31/24 lunch and supper 2/8/24 and 2/9/24 breakfast, lunch, and supper 2/10/24 supper 2/11/24 breakfast, lunch, and supper 2/12/24 supper 3. The record for Resident G was reviewed on		**ensure that the deficient practice does not recur;** Nursing staff was educated on dietary intake/ food consumption and documentation and the importance of documenting every shift and as needed to help identify trends in resident's nutritional status. Nursing staff was educated on all point of care documentation for ADLs and the importance of documenting every shift and as needed to help identify trends in resident's status. Any identified concerns with staff documentation will be immediately addressed with staff member. Any identified concerns with resident declines or weight loss will be immediately addressed with resident's responsible party and physician. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** 5 days a week during clinical meeting the Director of nursing or designee will review 10 resident records for Point Of Care food consumption logs to ensure documentation of meal intake / food consumption is completed. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance	

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	2/14/24 at 8:44 a.m. Diagnoses included, but were not limited to dementia, hypertension, and chronic kidney disease. The Admission Minimum Data Set (MDS) assessment, dated 1/28/24, indicated the resident was cognitively impaired and required partial to moderate assistance with eating. A current care plan indicated the resident had an ADL self-care deficit and was dependent on staff for assistance with eating. The food consumption task documentation, dated 1/21/24 through 2/14/24, indicated there were no meal consumption's documented for the following days and meals: 1/22/24 breakfast, lunch, and dinner 1/23/24 breakfast, and dinner 1/24/24 breakfast, lunch, and dinner 1/25/24 dinner 1/26/24 breakfast, lunch, and dinner 1/27/24 lunch and dinner 1/28/24 lunch 1/29/24 breakfast and lunch 1/30/24 breakfast and dinner 1/31/24 breakfast and dinner 2/1/24 lunch 2/2/24 breakfast and dinner 2/3/24 breakfast and dinner 2/4/24 breakfast and dinner 2/5/24 dinner 2/6/24 dinner 2/7/24 breakfast, lunch, and dinner 2/8/24 dinner 2/9/24 dinner 2/10/24 breakfast and dinner 2/11/24 dinner 2/12/24 breakfast, lunch, and dinner 2/13/24 breakfast and dinner		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 of completion: 2/23/2024**	

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	During an interview with the Director of Nursing (DON), on 2/14/24 at 1:45 p.m., she indicated the facility had just switched to twelve hours shifts on February 1st, and the meal consumption charting was something they needed to work out. This citation relates to Complaints IN00426084 and IN00428145. 3.1-50(a)(1) 3.1-50(a)(2)			
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00424886. This visit included the Investigation of Nursing Home Complaints IN00421580, IN00425544, IN00426084, and IN00428145. Complaint IN00424886 - No deficiencies related to the allegations are cited. Complaint IN00421580 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00425544 - No deficiencies related to the allegations are cited. Complaint IN00426084 - Federal/state deficiencies related to the allegations are cited at F677 and F842. Complaint IN00428145 - Federal/state deficiencies related to the allegations are cited at F842. Survey dates: February 13 & 14, 2024	R 0000	The facility respectfully is requesting a desk review.	

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	Facility number: 013452 Residential Census: 28 Ignite Medical Resort Crown Point, LLC was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00424886. Quality review completed on 2/16/24.			