PRINTED: 02/28/2024
FORM APPROVED

CENTERS FOI	R MEDICARE & MEDIC	CAID SERVICES			OM	B NO. 0938-039	
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155835	B. WING		02/14/2024		
		133033	D. WING		02/14/	12024	
	PROVIDER OR SUPPLIEI	CROWN POINT LLC	STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DO AND DO AND		(X5)	
PREFIX		NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
	•			CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENC!		DATE	
F 0000							
F 0000 Bldg. 00	Home Complaints IN00426084, and Inthe Investigation of IN00424886. Complaint IN0042 related to the allegations are of Complaint IN00420 related to the Allegations are of Com	6084 - Federal/state deficiencies ations are cited at F677 and 8145 - Federal/state deficiencies ations are cited at F842. 4886 - No deficiencies related to cited. uary 13 & 14, 2024 13452 55835	F 0000	The facility respectfully is requesting a desk review.			

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

(X6) DATE

TITLE

Robert Petty Administrator 02/23/2024

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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		î ´	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
OF CORRECTION					1		
	155835	B. WING 02/14/2024					
			STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET CROWN POINT, IN 46307				
SUMMARY	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CODDECTION	(X5)		
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	P	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
			TAG	DEFICIENCY)		DATE	
	Č						
Quality review com	pleted on 2/16/24.						
§483.24(a)(2) A recarry out activities necessary service	esident who is unable to of daily living receives the s to maintain good						
Based on record reversal for activities of dail bathing/showers at residents who requires assistance for ADL' Findings include 1) Resident D's clocate 2/14/24 at 9:06 a.m. were not limited to, and cognitive common assessment, dated 1 impaired cognitive dependent on staff of the A Care Plan, dated would be provided to the bathing was to be constant of the shower forms at the shower forms at the shower forms at the statistical statistics.	dents who required assistance y living (ADL's), received least twice a week, for 4 of 5 re extensive to dependent s. (Residents D, E, F, and H) sed record was reviewed on . The diagnoses included, but Chronic lymphocytic leukemia nunication deficit. ay Minimum Data Set (MDS) /26/24, indicated a severely status, no behaviors, and was for bathing and hygiene. 1/22/24, indicated assistance for ADL's. le, indicated the resident's completed on Wednesdays and st shift.	F 067	77	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. 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. F, or H. All identified residents who ret in house are following their assigned shower schedules a showers/baths have been completed and documented accordingly. How the facility will identify other residents having the potential to be affected by th same deficient practice and	an y the n II n , E, main nd	02/23/2024	
	PROVIDER OR SUPPLIER MEDICAL RESORT SUMMARY: (EACH DEFICIEN REGULATORY OR These deficiencies is accordance with 41. Quality review community of the second	DENTIFICATION NUMBER 155835 PROVIDER OR SUPPLIER MEDICAL RESORT CROWN POINT LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/16/24. 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)	DENTIFICATION NUMBER 155835 ROVIDER OR SUPPLIER MEDICAL RESORT CROWN POINT LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/16/24. 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	ABUILDING BROVIDER OF CORRECTION IDENTIFICATION NUMBER 155835 RROVIDER OR SUPPLIER ### MEDICAL RESORT CROWN POINT LLC SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. 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I9QZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING 00 COMP.		COMPL	LETED
		155835	B. W	ING		02/14/	/2024
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R			MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			N POINT, IN 46307		
	1		1		1		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	,	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
	January 24, 2024 a	nd February 10, 2024.			taken;		
	2) During an inter	view on 2/12/24 at 2:26 n m			All residents have the potent		
	2) During an interview on 2/13/24 at 2:26 p.m., Resident E indicated bathing was not completed				be affected by the same alle	ged	
		e indicated her last bed bath			deficient practice. Full house audit of all curren	4	
		nd showers were not offered			residents has been complete		
	_	nable to stand. Her bathing			including shower sheet revie		
		Mondays and Thursdays.			and interviews with alert and		
	was selleduled for	wiondays and Thursdays.			oriented residents. Current		
	Resident E's record	l was reviewed on 2/13/24 at			residents' showers/baths have	VA	
	3:06 p.m. The diagnoses included, but were not				been provided and documen		
	limited to, diabetes mellitus.				What measures will be put		
	minute to, diagonal monitor				place or what systemic		
	A Quarterly MDS assessment, dated 12/19/23,				changes will be made to		
	indicated an intact cognitive status, no behaviors,				ensure that the deficient		
		rate assistance with showers.			practice does not recur;		
	1				Nursing staff was in-serviced	d on:	
	A Care Plan, dated	9/12/23, indicated assistance			The standard shower/ba		
	was required for A				schedule being two times a	week	
					for all residents, with proper		
	The bathing schedu	ale indicated bathing was to			documentation on shower sh	neets.	
	occur on Mondays	and Thursdays during the first					
	shift.				Following each resident	ťs	
					shower/bath schedules assig	gned 2	
		he record indicated bathing			x weekly or more depending	on	
		as not documented) on			preferences with proper		
	February 1 and 12,	2024.			documentation completion o	n	
					shower sheets including		
		indicated no shower or bed			documentation of refusals.		
		pleted on February 1, 5, 8, and			Providing the type of ba	-	
	12, 2024.				preference to be given and n		
	1 a b				of times per week to be give	n	
		cord was reviewed on 2/13/24 at			based off resident		
		noses included, but were not			requests/preference, with pro	-	
	limited to, pulmons mellitus.	ary fibrosis and diabetes			documentation on shower sh	ieets.	
	An Admission/5-D	ay MDS assessment, dated					
	1/22/24, indicated	a severely impaired cognitive					
	status, no behavior	s, and was dependent for			How the corrective action(s	5)	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155835	B. W	ING		02/14/	/2024
		<u> </u>	<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEI	R			MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			N POINT, IN 46307		
IONITE		CKOWINT OINT LEG		CITOVI			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΛΤΕ.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
	showers.				will be monitored to ensure t	the	
					deficient practice will not		
		1/16/24, indicated assistance			recur, i.e., what quality		
	was needed for all ADL's.				assurance programs will be	put	
					into place;		
		cheduled for bathing on			DON/designee will review 20		
		sdays during the first shift.			resident shower sheets weekl	-	
	_	indicated bathing had not			ensure residents are receiving	•	
	l .	y 29, 2024 and February 8,			showers/baths and they are b	eing	
	2024.				documented.	-	
	0/10/04 + 0.00				DON/designee will interview 1		
	4) During an interview on 2/13/24 at 2:03 p.m.,				alert and oriented residents or	1	
		ed she had not received any			both units weekly to ensure		
		lity due to a pressure ulcer on			resident's shower schedules a	are	
		eldom received bed baths, and			being followed and they are	d	
	nas nad one bed ba	th in the past three weeks.			receiving showers/baths base	a on	
	Dagidant II magand	was reviewed on 2/14/24 at			their preferences.		
		agnoses included, but were not			The Director of Nursing/design	nee	
		deep pressure wound/ulcer) of			will present a summary of the		
	the sacral region.	deep pressure would/ulcer) or			audits to the Quality Assurance		
	the sacrar region.				committee monthly for 6 mont Thereafter, if determined by the		
	An Admission/5-D	ay MDS assessment, dated			Quality Assurance committee,		
		an intact cognitive status, no			auditing and monitoring will be		
		dependent for showers.			done quarterly and present	•	
	Conaviors, and was	dependent for showers.			quarterly at the QA meeting.		
	A Care Plan, dated	12/18/23, indicated assistance			Monitoring will be on going.		
	was required for all				Date of completion: 2/23/202	4	
	1					-	
	The bathing schedu	ale for January, 2024, indicated					
	_	completed on Mondays and					
	1	shift. Bathing was not					
		ary 11 and 15, 2024.					
	•	-					
	The bathing schedu	ıle for February, 2024,					
	1	vas to be completed on					
	Wednesdays and Saturdays on the first shift.						
		en completed on February 7					
	and 10, 2024.	-					
	I		1		I		I

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ULTIPLE CO JILDING	onstruction 00		TE SURVEY IPLETED
		155835	B. W.	ING		02/	14/2024
	PROVIDER OR SUPPLIEI	CROWN POINT LLC	•	1555 S	ADDRESS, CITY, STATE, ZIP MAIN STREET N POINT, IN 46307	COD	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Director of Nursing was to be complete it was refused by th						
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) Res (i) A facility may n is resident-identifi (ii) The facility ma resident-identifiab accordance with a agent agrees not	is - Identifiable Information ident-identifiable information. ot release information that able to the public. y release information that is le to an agent only in a contract under which the to use or disclose the t to the extent the facility					
	professional stand	ccordance with accepted dards and practices, the sain medical records on a are- eumented; sible; and					
	resident's records regardless of the the records, exce (i) To the individual	ormation contained in the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
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		155835	B. W	ING		02/14	/2024	
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NAME OF F	PROVIDER OR SUPPLIE	R			MAIN STREET			
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TAG	_	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	law;							
	(ii) Required by Law;							
	1 ' '	, payment, or health care						
	operations, as per	•						
	compliance with 4							
	1 ' '	alth activities, reporting of						
	1	r domestic violence, health						
		s, judicial and administrative 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.							
	Compilario Will	10 01 10 1.012.						
	§483.70(i)(3) The	facility must safeguard						
	- ',''	formation against loss,						
	destruction, or un							
	·							
	§483.70(i)(4) Med	lical records must be						
	retained for-							
	(i) The period of ti	ime required by State law; or						
	(ii) Five years fror	n the date of discharge						
	when there is no i	requirement in State law; or						
	1 ' '	years after a resident						
	reaches legal age	under State law.						
	0.400 = 0.00 (=) =							
	\	medical record must						
	contain-							
	l ''	mation to identify the						
	resident;	regidentle geografia						
	1 ' '	e resident's assessments;						
	' '	ensive plan of care and						
	services provided; (iv) The results of any preadmission screening and resident review evaluations and							
	_	onducted by the State;						
		urse's, and other licensed						
	professional's pro							
	1 '	igress notes, and idiology and other diagnostic						
I	(vi) Laboratory, ra	wiology and outer diagnostic	ı		I		1	

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NAME OF I	PROVIDER OR SUPPLIE	R			MAIN STREET		
ICNITE I	MEDICAL DESCRI	CROWN POINT LLC			N POINT, IN 46307		
IGNITE	VIEDICAL RESORT	CROWN POINT LLC		CKOW	N FOINT, IN 40307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
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TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	services reports a	as required under §483.50.					
	Based on record re	view and interview, the facility	F 08	342	Please accept the following as	s the 02/23/2024	
	failed to ensure a re	esident's record was complete			facility's credible allegation of		
	and accurate, relate	ed to documentation of dietary			compliance. This plan of		
	intakes, for 3 of 3 r	residents reviewed for dietary			correction does not constitute	an	
	intakes. (Residents	D, F, and G)			admission of guilt or liability by	y the	
					facility and is submitted only in	า	
	Findings include:				response to the regulatory		
					requirement.		
	1) Resident D's clo	osed record was reviewed on			F842 Resident Records-		
2/14/24 at 9:06 a.m. The diagnoses included, but					Identifiable information		
were not limited to, chronic lymphocytic leukemia				What corrective action(s) wil	ıl		
and cognitive communication deficit.				be accomplished for those			
				residents found to have been	n		
	An Admission/5-D	ay Minimum Data Set (MDS)			affected by the deficient		
	assessment, dated	1/26/24, indicated a severely			practice;		
	impaired cognitive	status, no behaviors, and			No harm or weight loss was		
	moderate assistanc	e was required for dietary			identified for Resident D, F, or	· G.	
	intake.				All identified residents still cur	rent,	
					have had meal intakes		
	· ·	1/22/24 and revised on 1/29/24,			documented and will be on-go	oing	
		a risk for malnutrition. The			for all residents		
	interventions inclu-	ded she would be assisted with			How the facility will identify		
	eating her meals.				other residents having the		
					potential to be affected by the	e	
	_	tion task documentation, dated			same deficient practice and		
		12/24, indicated there were no			what corrective action will be	9	
	_	s documented for the following			taken;		
	days and meals:				All residents have the potentia		
	1/21/24 supper				be affected by the same alleg	ed	
	1/22/24 lunch and				deficient practice.		
	1/23/24 lunch and				Full house audit was complete	ed to	
	1/24/24 lunch and				help identify trends with staff		
	1/25/24 lunch and	• •			documentation.		
	1/26/24 breakfast,				All consumption records for		
	1/27/24 breakfast,				current residents are now		
	1/28/24 lunch and	* *			completed at 100%.		
	1/29/24 breakfast,				What measures will be put in	ito	
	1/30/24 breakfast,				place or what systemic		
1/31/24 breakfast, lunch, and supper				changes will be made to			

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A. BLLIDNO COMPLETED COMPLETED COMPLETED COMPLETED CP/14/2024	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
Invalid	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ΓED	
IGNITE MEDICAL RESORT CROWN POINT LLC IGNITE MEDICAL RESORT CROWN POINT LLC SUMMARY STATEMENT OF DEFICIENCIE GEACH DEFICIENCY MUST BE PRECEDED BY PULL TAG 21 - 2711/24 breakfast, lunch, and supper 21/22/4 supper 22 - 28-sident Ps record was reviewed on 2/13/24 at 3.55 p.m. The diagnoses included, but were not limited to, pulmonary fibroxis 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 was needed for all ADL's (activities of daily living). The food consumption task documentation, dated 1/16/24 through 2/12/24, indicated desistance 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 breakfast, lunch, and supper 1/17/24 breakfast, lunch, and supper 1/18/24 breakfast and supper 1/18/24 breakfast, lunch, and supper 1/20/24 breakfast, lunch, and supper 1/26/24 through 1/29/24 breakfast, l			155835	B. W	ING		02/14/2	024
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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 1/31/24 supper 2/10/24 supper 2/12/24 supper 1/12/24 supper 2/12/24 supper 1/28/24 and supper 2/12/24 supper 1/31/24 breakfast, lunch, and supper 2/11/24 breakfast, lunch, and supper 2/12/24 supper 1/31/24 breakfast, lunch, and supper 2/12/24 supper 1/31/24 breakfast, lunch, and supper 2/12/24 supper 1/31/24 breakfast, lunch, and supper 2/11/24 breakfast, lunch, and supper 2/11/24 supper 1/31/24 breakfast, lunch, and supper 2/11/24 supper 1/31/24 breakfast, lunch, and supper 2/11/24 breakfast, lunch, and supper 2/11/24 supper			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 2/11/24 breakfast, lunch, and supper 2/12/24 supper The Director of Nursing/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						_	g or	
supper 1/30/24 supper 1/31/24 lunch and supper 2/8/24 and 2/9/24 breakfast, lunch, and supper 2/11/24 breakfast, lunch, and supper 2/12/24 supper 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			**			_	~	
1/30/24 supper 1/31/24 lunch and supper 2/8/24 and 2/9/24 breakfast, lunch, and supper 2/11/24 breakfast, lunch, and supper 2/12/24 supper consumption logs to ensure documentation of meal intake / food consumption is completed. The Director of Nursing/designee will present a summary of the		_	-,, -****			_		
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 The Director of Nursing/designee will present a summary of the							.	
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 The Director of Nursing/designee will present a summary of the			supper			_	,	
2/10/24 supper 2/11/24 breakfast, lunch, and supper 2/12/24 supper The Director of Nursing/designee will present a summary of the							-	
2/11/24 breakfast, lunch, and supper 2/12/24 supper The Director of Nursing/designee will present a summary of the			, -,					
2/12/24 supper will present a summary of the			unch, and supper			The Director of Nursing/design	nee	
		· ·	, 11					
			Resident G was reviewed on			· · ·	e l	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155835	B. WING		02/14/2024	
NAME OF D	PROVIDER OR SUPPLIER	· ?	STREE	T ADDRESS, CITY, STATE, ZIP COD	•	
				S MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC	CRO	WN POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	ATE COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION	TAG		DATE	
		. Diagnoses included, but were		committee monthly for 6 mon		
		entia, hypertension, and chronic		Thereafter, if determined by t		
	kidney disease.			Quality Assurance committee		
	The Admission Mis	nimum Data Set (MDS)		auditing and monitoring will b	e	
		/28/24, indicated the resident		done quarterly and present quarterly at the QA meeting.		
		paired and required partial to		Monitoring will be on going.		
	moderate assistance			Date of completion: 2/23/202) ₄	
	moderate assistance	Caring.		Date of completion. 2/23/202	-	
		indicated the resident had an				
	ADL self-care deficit and was dependent on staff					
	for assistance with	eating.				
	The food consumpt	ion task documentation, dated				
		4/24, indicated there were no				
	_	s documented for the following				
	days and meals:	_				
	1/22/24 breakfast, l	unch, and dinner				
	1/23/24 breakfast, a	and dinner				
	1/24/24 breakfast, l	unch, and dinner				
	1/25/24 dinner					
	1/26/24 breakfast, l	unch, and dinner				
	1/27/24 lunch and d	linner				
	1/28/24 lunch					
	1/29/24 breakfast a					
	1/30/24 breakfast a					
	1/31/24 breakfast a	nd dinner				
	2/1/24 lunch					
	2/2/24 breakfast and					
	2/3/24 breakfast and					
	2/4/24 breakfast and	d dinner				
	2/5/24 dinner					
	2/6/24 dinner	1 11				
	2/7/24 breakfast, lu	nch, and dinner				
	2/8/24 dinner					
	2/9/24 dinner	1.1:				
	2/10/24 breakfast a	nd dinner				
	2/11/24 dinner	1 1 2				
	2/12/24 breakfast, l					
	2/13/24 breakfast a	na ainner	1	Ī	l l	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

19QZ11

Facility ID: 013452

If continuation sheet Page 9 of 11

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

PRINTED: 02/28/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		A. BU	A. BUILDING 00 B. WING		COMPLETED 02/14/2024		
	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)	ΓE	(X5) COMPLETION DATE
	(DON), on 2/14/24 a facility had just swit on February 1st, and charting was someth	with the Director of Nursing at 1:45 p.m., she indicated the tehed to twelve hours shifts of the meal consumption ning they needed to work out. to Complaints IN00426084					
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.		R 0000		The facility respectfully is requesting a desk review.		
	Complaint IN00424 the allegations are c	886 - No deficiencies related to ited.					
	•	580 - Federal/state deficiencies tions are cited at F677.					
	Complaint IN00425 the allegations are c	544 - No deficiencies related to ited.					
	_	084 - Federal/state deficiencies tions are cited at F677 and					
	Complaint IN00428 related to the allegat F842.	1145 - Federal/state deficiencies tions are cited at					
	Survey dates: Febru	ary 13 & 14, 2024					

State Form Event ID: 19QZ11 Facility ID: 013452 If continuation sheet Page 10 of 11

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

PRINTED: 02/28/2024 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835 NAME OF PROVIDER OR SUPPLIER		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1555 S MAIN STREET				ETED	
IGNITE MEDICAL RESORT CROWN POINT LLC			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
TAG	Facility number: 01 Residential Census: Ignite Medical Reso	28 ort Crown Point, LLC was bliance with 410 IAC 16.2-5 in igation of Residential 1886.		TAG	DEFICIENCE		DATE

State Form Event ID: 19QZ11 Facility ID: 013452 If continuation sheet Page 11 of 11