Robert Petty

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

05/19/2025

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155835	(X2) MULTIPLE C A. BUILDING B. WING	construction 00	(X3) DATE SURVEY COMPLETED 05/01/2025	
		100000	_	LANDRIGG CHILL CHI TO THE COL	30/01/2020	
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD S MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		VN POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	``	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG F 0000	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE	
0000						
Bldg. 00						
	This visit was for the Investigation of Complaints IN00457153 and IN00458560.		F 0000	The facility respectfully request desk review	sts a	
	-	7153 - Federal/State deficiencies ations are cited at F580, F677,				
	Complaint IN0045 the allegations are	8560 - No deficiencies related to cited.				
	Unrelated deficience	cies are cited.				
	Survey dates: Apri	il 30 and May 1, 2025				
	Facility number: 0 Provider number: 1					
	Census Bed Type: SNF: 63					
	Residential: 28 Total: 91					
	Census Payor Type Medicare: 59 Other: 4 Total: 63	::				
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.				
	Quality review con	npleted on 5/8/25.				
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(Notify of Changes	iv)(15) s (Injury/Decline/Room, etc.)				
		view and interview, the facility sident's physician and	F 0580	Ignite Crown Point Compliant survey: 5/1/2025	05/18/2025	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S S	IGNATURE	TITLE	(X6) DATE	

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

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Administrator

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILI		00	COMPLE	
		155835	B. WING	·		05/01/2	2025
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROWI	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION	1	ΓAG	DEFICIENCY)		DATE
	1 1	at a medication was					
		9 residents reviewed for			Please accept the following as	the	
		le party notification.			facility's credible allegation of		
(Resident D)				compliance. This plan of			
	Finding includes:				correction does not constitute		
	Finding includes:				admission of guilt or liability by		
	Resident Dis record	was reviewed on 5/1/25 at			facility and is submitted only in	'	
		gnoses included, but were not			response to the regulatory		
	_	elitis left ankle/foot and			requirement. F580 Notify of changes		
	dementia.	onds for anxio/100t and			What corrective action(s) wil	, 1	
	acinomia.				be accomplished for those	.	
	A Social Service as	sessment, dated 4/30/25,			residents found to have beer	,	
		ognitive impairment			affected by the deficient	.	
		6			practice.		
	A family member w	vas designated as the legal			Resident D's POA and		
	Power of Attorney (Physician were notified of		
					missing antibiotic		
	A Physician's Order	r, dated 4/29/25 at 6:00 p.m.,			Resident D antibiotic was		
	indicated IV (intrav	enous) ampicillin-sulbactam			delivered by pharmacy and		
	(antibiotic) 3 grams	(gm) was to be administered			administered as ordered.		
	every six hours due	to a wound infection.			Resident D sustained no har	m	
					from alleged missing antibio	tic.	
		ministration Record (MAR),					
		eated the antibiotic had not			How the facility will identify		
		was not given on 4/30/25 at			other residents having the		
	12:00 p.m. and 6:00) p.m.			potential to be affected by th	e	
	TO 3445 1 . 15	2025 1 1 4 1 4 2 2 2 2 2			same deficient practice and		
	· ·	2025, indicated the antibiotic			what corrective action will be	e	
		ble and was not given on			taken.		
	5/1/25 at 12:00 a.m	. and 0:00 a.m.			All residents have the potentia		
	Cross reference F75	55			be affected by the same allege	ea	
	Cross reference F/3	٥٠.			deficient practice.	tod	
	There was no door	nentation to indicate the			MAR to cart audit was comple to ensure medications that have		
		and POA had been notified of			been ordered, are available to	ı	
	the missed antibioti				administer.	' l	
	are missed antiblott	c doses.			What measures will be put in	10	
	During an interview	on 5/1/25 at 10:56 a.m., the			place or what systemic		
		indicated the POA and the			changes will be made to		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	r í	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155835	B. W		00	05/01/	
NAME OF F	PROVIDER OR SUPPLIEI	3			ADDRESS, CITY, STATE, ZIP COD MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROWN POINT, IN 46307			
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
		ave been notified of the missed			ensure that the deficient		
	doses of the antibio	tic			practice does not recur.		
					Nurses were re-educated on		
		r physician notification, dated			notifying and documenting		
		ed from the Director of Nursing d the physician or nurse			physician and responsible par any changes, new orders, and	-	
		be notified if it was deemed			missing or delay in medication		
		priate in the best interest of the			from pharmacy.	•	
		nunication with the responsible			How the corrective action(s)		
		physician was to be			will be monitored to ensure	the	
	documented in the	medical record.			deficient practice will not		
	This sidedis a meledes	- 4- C1-:4 DI00457152			recur, i.e., what quality	4	
	I his citation relates	s to Complaint IN00457153.			assurance programs will be into place.	put	
	3.1-5(a)(3)				CNO/designee will randomly	audit	
					5 residents new/existing orde		
					weekly to ensure mediations		
					delivered and being administe	ered	
					as ordered		
					CNO/designee will present a		
					summary of the audits to the		
					Quality Assurance committee monthly for 6 months. Therea		
					if determined by the Quality	aitoi,	
					Assurance committee, auditin	g	
					and monitoring will be done	J	
					quarterly and present quarter	y at	
					the QA meeting. Monitoring v	vill	
					be on going.		
					Date by which systemic		
					corrections will be complete 5/18/2025	d:	
F 0677	483.24(a)(2)	16 5 1 15 11 1					
SS=D Bldg. 00	ADL Care Provide	ed for Dependent Residents					
Diug. 00	Based on observation	on, record review, and	F 0	677	Ignite Crown Point		05/18/2025
		ity failed to provide incontinent	1 0	0//	Compliant Survey: 5/1/2025		03/16/2023
		nner and failed to ensure					

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLETED
		155835	B. W	ING		05/01/2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIEF	8			MAIN STREET	
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROW	N POINT, IN 46307	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG		LISC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	DATE
		hed after a large amount of			Please accept the following as	s the
		e for 2 of 3 residents reviewed			facility's credible allegation of	
for activities of daily living (ADL's). (Residents D				compliance. This plan of		
	and E)				correction does not constitute	
	Findings 1 1 1				admission of guilt or liability by	
	Findings include:				facility and is submitted only in	۱
	1 Danin1	viction on 4/20/25 from 0.07			response to the regulatory	
		vation on 4/29/25 from 9:07 a.m.			requirement.	
	_	Resident D was lying in bed			F677 ADL Care Provided for	
	yellow tinged color	bed elevated. There was a			Dependent Residents	
	1 -	at was under the resident.			What corrective action(s) will	·
		entered the room. CNA 2			be accomplished for those	
		in to work at 6 a.m. and she			residents found to have been	1
		e resident for urinary			affected by the deficient	
		she started work that morning.			practice.	
		e gown was wet with urine and			Resident D's bedding was	ivad
		e gown was wet with time and ontinence pads under the			changed, and resident D rece a shower.	iveu
		aturated with urine. The sheet			Resident Es bedding was	
		nce pads was soaked with			changed, and resident E recei	ivod
		ere was a drying ring of urine			a shower.	iveu
		of the bed. The top sheet and			How the facility will identify	
		et. CNA 2 indicated the gown			other residents having the	
		rief were saturated with urine.			potential to be affected by the	10
		was removed and the bed			same deficient practice and	
	_	d. The resident's peri area and			what corrective action will be	e
	_	leansed with wipes. The other			taken.	
		ne, the abdomen, back, arms			All incontinent residents have	the
	I -	vashed. A clean brief was			potential to be affected by the	
	_	dent was dressed without the			same alleged deficient practic	
	other areas of the bo				House sweep of residents	
					requiring assistance with activ	rities
	Resident D's record	was reviewed on 5/1/25 at			of daily living, especially perso	II.
		gnoses included, but were not			hygiene, was completed to en	
		elitis left ankle/foot and			staff are providing care as nee	II.
	dementia.				including but not limited to	
					showers/baths as scheduled a	and
	An Admission Nurs	sing Assessment, dated			as needed, and proper cleans	ing
		., indicated an open wound on			of residents and bedding, if	
	_	and bowel incontinence.			required is completed after ea	ach

	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CON				Ϋ́		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155835	B. Wl	ING		05/01/2025	
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
					MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	re COM	PLETION
TAG		LSC IDENTIFYING INFORMATION	_	TAG	DEFICIENCY)	П	ATE
	_	ired for ADL's, and a PICC			incontinent episode.		
		ed central catheter) line was			What measures will be put in	to	
	present.				place or what systemic		
	AC DI 1.1	4/20/25 : 1: 4 1 : 4			changes will be made to		
		4/29/25, indicated assistance			ensure that the deficient		
	_	DL's. The intervention			practice does not recur.		
		assistance would be required			Nurses and nurse aides were		
	incontinent and wor	eting. The resident was			re-educated on checking	,	
	incontinent and wor				incontinent residents every 2-		
	meonumency every	2-3 HOUIS.			hours and providing peri care needed including cleansing of		
	A Social Service of	sessment, dated 4/30/25,			after each incontinent episode		
		ognitive impairment.			as needed.	anu	
	illulcated a severe c	ogintive impairment.					
					How the corrective action(s) will be monitored to ensure to	ho	
	2 During an obser	vation on 4/30/25 at 8:30 a.m.,			deficient practice will not	ile	
	1	f urine outside Resident E's			recur, i.e., what quality		
		room. Resident E was lying in			assurance programs will be	out	
		losed. CNA 5 entered the room			into place.		
	1	kfast tray. CNA 5 donned			CNO/designee will randomly		
		e bed covers were damp and			observe 5 incontinent resident	٠	
	_	ng was wet. There was a large			weekly to ensure residents are		
		incontinence pad under the			being checked and changed p		
	_	g urine on the edges. The			plan of care and showers/bath		
		vas saturated with urine. CNA			and/or cleansing of surroundir		
		not checked the resident for			skin from incontinent episodes	-	
		she started work at 6:00 a.m.			being provided as needed.		
		while" since the resident had			CNO/designee will present a		
		continence. She then			summary of the audits to the		
	completed inconting	ence care with the wet wipes at			Quality Assurance committee		
	1 -	ced a new incontinence brief			monthly for 6 months. Therea	fter,	
	_	clothing was changed after			if determined by the Quality	·	
	the skin was washed				Assurance committee, auditin	₃	
					and monitoring will be done		
	Resident E's record	was reviewed on 5/1/25 at			quarterly and present quarterl	/ at	
	11:12 a.m. The diag	gnoses included, but were not			the QA meeting. Monitoring v		
	limited to dementia				be on going.		
	A C Pi	4/04/05 11 11 11					
		4/24/25, indicated assistance			Date by which systemic	.	
I	i was required with A	ADL's. The interventions	1		corrections will be complete	n. I	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	f /		ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPL	
		155835	B. WI	_		05/01/	2025
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC			MAIN STREET N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	Τ	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E	DATE
		assistance would be provided			5/18/2025		
	~	thing. The resident would be					
	checked for inconti	nence every 2-3 hours.					
	During an interview	v on 4/30/25 at 10:17 a.m., the					
	-	indicated the residents should					
		for incontinence and changed					
	•	tion and they should have					
	of urine incontinent	athed due to the large amount					
	of urme meditinent						
	During an interview	v on 5/1/25 at 8:39 a.m., LPN 4					
	indicated the night	shift CNA's start their last					
	rounds at 4:00-4:30	a.m.					
	and received from t	nce care policy, dated 11/2024 he Director of Nursing as acontinent residents were					
	changed every two needed.	hours and more frequently if					
	This citation relates	to Complaint IN00457153.					
	3.1-38(a)(3)						
F 0694	483.25(h)						
SS=D	Parenteral/IV Fluid	ds					
Bldg. 00	interview, the facili catheter (inserted in	on, record review and ty failed to care for a midline ato a vein in the upper arm for eatments) in accordance with	F 06	594	Ignite Crown Point Compliant: 5/1/2025 Please accept the following as	s the	05/18/2025
		rds of practice related to a			facility's credible allegation of		
		change and a lack of dressing assessments of the site, and			compliance. This plan of	0.0	
		ter for 2 random PICC line			correction does not constitute admission of guilt or liability by		
	observations. (Residual				facility and is submitted only in		
	Findings include:	•			response to the regulatory requirement.		

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Event ID:

L71E11

Facility ID: 013452

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/01/2025 155835 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1555 S MAIN STREET IGNITE MEDICAL RESORT CROWN POINT LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 1. During an observation on 4/29/25 at 9:46 a.m., What corrective action(s) will Resident D was lying in bed with the head of the be accomplished for those bed elevated. There was a PICC line in the left residents found to have been upper extremity. LPN 3 indicated there was blood affected by the deficient on the PICC line dressing and the dressing practice. needed to be changed. A sterile dressing kit was Resident D was assessed by due placed on the resident's bed and opened up. LPN to non-sterile technique being 3 applied sterile gloves after using the alcohol used for PIC line dressing change based hand rub. She then lifted the resident's left with no signs of infection, or harm arm up with the sterile gloves on and placed a due to alleged deficient practice. sterile pad under the arm. She then put a face LPN3 was educated on sterile mask on herself and touched the top of her ears technique for dressing changes and hair with the sterile gloves. The soiled PICC with return demonstration. line dressing was removed and the insertion area Resident J was assessed due to was cleansed with the alcohol cleaning utensil in lack of monitoring orders, flush the kit. She then removed the gloves and applied a orders, dressing change orders to second pair of sterile gloves without cleansing her PIC line, with no signs of infection, hands. While the sterile gloves were applied, she or harm due to alleged deficient touched the fingers of the right hand glove with practice. Orders were her ungloved fingers of the left hand. She then immediately placed for care, applied the left sterile glove. She touched the monitoring, flushes, and dressing underside of the kit wrap and moved the kit in the changes of PIC line. bed, then touched the resident's arm for How the facility will identify positioning and placed a new dressing on the other residents having the PICC line insertion site. potential to be affected by the same deficient practice and Resident D's record was reviewed on 5/1/25 at what corrective action will be 10:00 a.m. The diagnoses included, but were not taken: limited to, osteomyelitis left ankle/foot and All residents with intravascular dementia. accesses have the potential to be affected by the same alleged An Admission Nursing Assessment, dated deficient practice. 4/29/25 at 1:30 p.m., indicated an open wound on Residents with intravascular the right heel, urine and bowel incontinence, access sites records were assistance was required for ADL's, and a PICC reviewed to ensure orders were (peripherally inserted central catheter) line was placed for care of, required present. flushes, sterile dressing changes if required, and monitoring of sites. A Care Plan, dated 4/29/25, indicated an IV was Assessments of current sites present. The interventions indicated the dressing were completed to ensure the

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CTATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(3/2) 3.4	IIII TIDI E CO	ONETDUCTION	(V2) DATE (CLIDVEN
	NT OF DEFICIENCIES	, '	l í		ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPL	
		155835	B. W	TNG		05/01/	2025
NAME OF F	PROVIDER OR SUPPLIER	R			ADDRESS, CITY, STATE, ZIP COD		
	IDDR OR BOTT DID				MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROW	N POINT, IN 46307		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	would be changed of	every week.			areas are clean, with no signs	of	
					infection, and dressing chang	es	
	During an interview	v on 4/30/25 at 10:17 a.m., the			have been completed as orde	red.	
	Director of Nursing	g indicated PICC line dressing			What measures will be put in	nto	
	changes were to be	completed using a sterile			place or what systemic		
	dressing change pro	ocess.			changes will be made to		
					ensure that the deficient		
					practice does not recur.		
	2. During an obser	vation on 5/1/25 at 1:45 p.m.,			Licensed staff educated on		
	_	ng in a wheelchair in his room.			intravascular access site		
		line inserted into the right upper			requirements including but no	ıt İ	
		26/25 written on the dressing			limited to;	-	
	site.	8			Obtaining orders for		
					monitoring, flushing, dressing		
	Resident I's record	was reviewed on 5/1/25 at 1:10			changes, sterile dressing cha		
		s included, but were not limited			when required	inges	
		s. The admission date was			How to complete a "ster	"مان	
	4/2/25.	s. The admission date was			dressing change and what sit		
	7/2/23.				require sterile technique	cs	
	Δ Physician's Order	r, dated 4/16/25, indicated a			How to assess access s	·ito	
	1	was to be placed for IV			and what to look for when	one-	
	antibiotic administr	-			assessing to ensure there is r		
	antibiotic administr	ation.			infection	10	
	A Nurse's Progress	Note, dated 4/16/25 at 4:58			Intection		
		urse from the IV insertion			How the corrective action(s)		
	*	e facility and a midline catheter			How the corrective action(s) will be monitored to ensure		
	was placed in the ri					uie	
	was placed ill tile fi	gni ailli.			deficient practice will not		
	A Drofessional Nove	rsing Service Note, dated			recur, i.e., what quality	n .	
					assurance programs will be	put	
		a midline IV had been inserted.			into place.		
	_	dicated to flush the line with			CNO/desimper will make 5		
	•	meters) of normal saline before			CNO/designee will monitor 5		
		all infusions per facility			sterile dressing changes a we		
	1 ^	sing was to be changed within			to ensure proper technique is		
		on, then weekly and as needed			being used, as applicable.		
	for soiling and loos	seness.			CNO/designee will review 5		
		44-0-14			residents' orders weekly to er	nsure	
		4/17/25, indicated the resident			orders to monitor, required		
	_	ntibiotic through an IV. The			flushes, dressing changes are		
	interventions include	ded the dressing over the IV			place and being completed, a	s	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLETE	
		155835	B. W	ING		05/01/202	25
NAME OF B	DOLUDED OD GLIDDLIED		•	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIER	t .		1555 S	MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE CO	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION every shift, the dressing	+	TAG			DATE
		weekly and flushed per the			applicable.		
		The IV insertion site was to be			CNO/designee will review nev	′	
		tion and other concerns.			orders 5 days a week during clinical meeting for IV fluid/IV		
	monitored for finee	tion and other concerns.			medication orders to ensure the	1999	
	The Physician's anti	ibiotic orders included the			residents have corresponding	1000	
	following:				orders for required care,		
	_	vancomycin, 1 gm (gram) daily			monitoring, and flushing of		
	for knee infection.				intravascular lines, as applical	ole.	
	4/18/25 to 4/21/25 -	- meropenem - 1 gm every 12			Director of Nursing/designee		
	hours				present a summary of the aud		
	4/22/25 - ampicillin	2 gm to be given every 8 hours			to the Quality Assurance		
	for a left knee infec	tion.			committee monthly for 6 mont	hs.	
					Thereafter, if determined by th	ie	
		rs to flush and monitor the			Quality Assurance committee,		
		e dressing changes written as a			auditing and monitoring will be	•	
	-	There was no documentation			done quarterly and present		
		ressing had been changed 24			quarterly at the QA meeting.		
		rtion or the midline had been			Monitoring will be on going.		
		after the medication. There					
		ion the midline had been			Date by which systemic		
	_	ent and signs and symptoms			corrections will be complete	d:	
	of infection.				5/18/2025		
	During an interview	on 5/1/25 at 2:03 p.m., the					
	~	indicated there was an order					
	-	there were no orders for the					
		age, or the care of the midline.					
	_						
		e policy, dated 11/2024 and					
		Director of Nursing as current,					
		ents and dressing required a					
		the dressing was to be					
		fter insertion and then at least					
		the dressing became moist,					
	· ·	The PICC line must remain					
	sterile.						
	2 1 47(-)(2)						
	3.1-47(a)(2)						
			ı		I		

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

Event ID: L71E11

Facility ID: 013452

If continuation sheet Page 9 of 16

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155835	B. W	ING		05/01/	2025
		<u> </u>		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	₹			MAIN STREET		
IGNITE N	MEDICAL RESORT	CROWN POINT LLC		CROW	N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΙΤΕ	COMPLETION
TAG	ĺ	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0755	483.45(a)(b)(1)-(3	3)					
SS=D	Pharmacy	(D) : ((D))					
Bldg. 00		/Pharmacist/Records	Б.0/	7.5.5			05/10/2025
		view and interview, the facility	F 0'	/33	Ignite Crown Point		05/18/2025
		esident was provided with an attibiotic in a timely manner by			Complaint Survey: 5/1/2025		
	, ,	macy, related to the antibiotic			Diagon accept the following of	a tha	
	_	to be administered as ordered			Please accept the following as facility's credible allegation of		
	_	r 1 of 3 residents reviewed for			compliance. This plan of		
	antibiotic medication				correction does not constitute	an	
	antibiotic incarcation	ons. (Resident D)			admission of guilt or liability by		
	Finding includes:				facility and is submitted only in	-	
	i mang meraacs.				response to the regulatory		
	Resident D's record	l was reviewed on 5/1/25 at			requirement.		
		gnoses included, but were not			F755 Pharmacy Services		
		relitis left ankle/foot and			What corrective action(s) wil	11	
	dementia.				be accomplished for those		
					residents found to have been	n	
	A Care Plan, dated	4/29/25, indicated an IV			affected by the deficient		
	antibiotic was order	red by the physician for a			practice.		
	wound infection. T	The goal indicated there would			Resident D medications were		
	be no complications	s related to the IV therapy.			ordered and have been receiv	⁄ed	
					from pharmacy and being		
		r, dated 4/29/25 at 6:00 p.m.,			administered as ordered. Res	ident	
		ampicillin-sulbactam (antibiotic)			D sustained no harm from the		
		o be administered every six			alleged missing antibiotic.		
	hours due to a wour	nd infection.			How the facility will identify		
					other residents having the		
		Iministration Record (MAR),			potential to be affected by th	ı e	
		ated the IV antibiotic was given			same deficient practice and		
	_	p.m., 4/30/25 at 12:00 a.m. and			what corrective action will be	е	
		R indicated the medication had			taken.		
		and was not given on 4/30/25			All facility residents that requir	e	
	at 12:00 p.m. and 6	:00 p.m.			pharmacy services have the		
	The MAD date 15/	2025 indicated the antibiation			potential to be affected by the		
		2025, indicated the antibiotic			same alleged deficient practic		
	5/1/25 at 12:00 a.m	ble and was not given on			MAR to cart audit was comple to ensure ordered medications		
	3/1/23 at 12.00 a.III	and 0.00 a.m.					
	Δ Medication Adm	inistration Progress Note,			available and being administe as ordered.	ieu	
	1 1 Iviculcation Auni	ministration i rogicos rvote,	1		as olucicu.		I

		X2) MULTIPLE CONSTRUCTION (X3) DATE SU					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETE	
		155835	B. WI	NG		05/01/20	25
IGNITE N	PROVIDER OR SUPPLIEF	CROWN POINT LLC		1555 S CROWI	ADDRESS, CITY, STATE, ZIP COD MAIN STREET N POINT, IN 46307		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		37 a.m., indicated the antibiotic			What measures will be put in	to	
		the Emergency Drug Kit			place or what systemic		
(EDK). The pharmacy was notified and they expected the antibiotic to be delivered by 1 p.m.				changes will be made to			
	on 4/30/25.	oue to be derivered by 1 p.m.			ensure that the deficient		
	011 4/30/23.				practice does not recur. Nurses were re-educated on		
	A Medication Adm	inistration Progress Note,					
		95 p.m., indicated the antibiotic			ordering medications through Pharmacy portal		
		nd the pharmacy was notified			Nurses were re-educated on		
		red to bring the antibiotic as			notifying physicians and family	of	
	soon as possible.	ted to oring the unitorous us			any delay of medications from		
	I				pharmacy and document any		
	A Medication Adm	inistration Progress Note,			orders received.		
		a.m., indicated the antibiotic			How the corrective action(s)		
		ed and was on order.			will be monitored to ensure t	he	
					deficient practice will not		
	During an interview	on 5/1/25 at 10:56 a.m., the			recur, i.e., what quality		
	Director of Nursing	indicated the first three doses			assurance programs will be	out	
	of the antibiotic we	re taken from the IV EDK			into place.		
	(emergency drug ki	t). The pharmacy had been			CNO/designee will randomly a	udit	
	notified and would	be delivering the antibiotic.			5 residents medications week	y to	
					ensure mediations were delive	ered	
		delivery policy, dated 1/2023			from pharmacy and being		
		he Director of Nursing as			administered as ordered		
		ne pharmacy will have a daily			The Director of Nursing/design	nee	
	delivery of medicat	ions and supplies.			will present a summary of the		
					audits to the Quality Assurance		
	This citation relates	to Complaint IN00457153.			committee monthly for 6 mont		
	2.1.25()				Thereafter, if determined by th		
	3.1-25(a)				Quality Assurance committee,		
					auditing and monitoring will be	·	
					done quarterly and present		
					quarterly at the QA meeting.		
					Monitoring will be on going.		
					Date by which systemic		
					corrections will be complete	_{d:}	
					5/18/2025		

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Event ID: L71E11 Facility ID: 013452

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	IT OF DEFICIENCIES OF CORRECTION				(X3) DATE SURVEY COMPLETED 05/01/2025	
	PROVIDER OR SUPPLIER	CROWN POINT LLC	1555	ET ADDRESS, CITY, STATE, ZIP COD 5 S MAIN STREET DWN 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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E COMPLETION	
F 0772 SS=D Bldg. 00	483.50(a)(1)(iv) Lab Services Not	Provided On-Site				
	failed to ensure a re services as ordered residents reviewed t (Resident B) Finding includes:	riew and interview, the facility sident received laboratory by the physician for 1 of 3 for laboratory services.	F 0772	Ignite Crown Point Complaint Survey: 5/1/2025 Please accept the following the facility's credible allega of compliance. This plan of correction does not constitute an admission of guilt or liaby the facility and is submi	g as ation of tute bility	
	A Wound Physician indicated a Stage IV extensive destruction on the coccyx. An o	a Progress Note, dated 4/18/25, V (full thickness skin loss with n) pressure ulcer was present order for a pre-albumin and a nt (CBC) was received.		only in response to the regulatory requirement. F772 Lab Services What corrective action(s) when the services residents found to have be affected by the deficient practice. No harm came to resident B	en	
	were not in the med documentation the l completed.	d complete blood count results ical record and there was no aboratory testing had been on 4/30/25 at 4:42 p.m.,		related to this alleged deficient practice. The laboratory supervisor was notified of lab not being obtained the facility.	as ained.	
	Wound Nurse 1 ind had been ordered an pre-albumin and the the lab. It was scheed 4/20/25. The lab was the testing had not be unable to provide a not been done.	icated the laboratory testing and sent to the lab. The CBC were not completed by duled to be completed on as notified and they indicated been completed and were reason why the testing had		How the facility will identify other residents having the potential to be affected by same deficient practice and what corrective action will taken. All residents requiring a physician's order for laborate services have the potential to	the d be ory o be	
	3.1-49(e)	to Complaint IN00457153.		affected by the same alleged deficient practice. Current lab orders were revito ensure the lab was drawn	ewed	

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Event ID:

L71E11

Facility ID: 013452

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICADE & MEDICAD SERVICES

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155835		(X2) MULTIPLE C A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 05/01/2025	
	PROVIDER OR SUPPLIE	R CROWN POINT LLC	1555 S	ADDRESS, CITY, STATE, ZIP COD S MAIN STREET IN POINT, IN 46307	•
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
				results are available. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur. Nurses were in-serviced on; ensuring all ordered lab drawn/collected as ordered notify physician, respon party, laboratory, and clinical manager if a lab is missed to obtain new orders How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place. CNO/designee will audit 'lab or reports 5 times per week to ensure ordered labs are drawn/collected as ordered. CNO/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. There if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarter the QA meeting. Monitoring will be on going. Date by which corrections will completed: 5/18/2025	s are sible the put due' after, ng ly at will
F 0880	483.80(a)(1)(2)(4	.)(e)(f)			

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Infection Prevention & Control

SS=D

Event ID:

L71E11

Facility ID: 013452

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTI		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		00	COMPLETED		
		155835	B. WING			05/01/2025		
		ı	STREET /	ADDRESS, CITY, STATE, ZIP COD	<u> </u>			
NAME OF PROVIDER OR SUPPLIER					MAIN STREET			
IGNITE MEDICAL RESORT CROWN POINT LLC				CROWN POINT, IN 46307				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION	
TAG			TAG		DEFICIENCY)		DATE	
Bldg. 00								
	Based on observation, interview, and record review, the facility failed to ensure correct		F 08	380	Crown Point		05/18/2025	
					Complaint Survey: 5/1/2025	- I		
	Personal Protective Equipment (PPE) was used by				Please accept the following as the			
	a staff members (LPN 3, CNA 2, CNA 6, and CNA				facility's credible allegation of			
	7) when providing care to a residents (Residents				compliance. This plan of			
	D and J) who were in Enhanced Barrier				correction does not constitute	an		
	Precautions (EBP) for two random observations				admission of guilt or liability b	guilt or liability by the		
	for infection control.				facility and is submitted only i			
	Findings include:				response to the regulatory			
					requirement.			
					F880 Infection Prevention ar	nd		
	1. During an observation on 4/29/25 from 9:07 a.m.				Control			
	through 9:32 a.m., Resident D was lying in bed				What corrective action(s) will			
	with the head of the	e bed elevated. There was a			be accomplished for those			
	peripherally inserte	d central catheter (PICC)			residents found to have been	n		
	inserted in the left t	apper arm and a wound			affected by the deficient			
	dressing on the right heel. The resident had been				practice.			
	incontinent of urine	and LPN 3 and CNA 2 had			Resident D is on enhanced ba	arrier		
	gloves on and were	starting to complete			precautions staff immediately			
	incontinence care a	nd were stopped. LPN 3			donned proper PPE, no harm	was		
	indicated she was u	nsure if the resident required			sustained from the alleged			
	EBP and indicated	there was no sign on the door			deficient practice, enhanced			
	that indicated he re-	quired EBP and EBP was not			barrier precautions sign was			
	needed. LPN 3 ther	n indicated the resident had a			immediately placed on the roo	om		
	wound and EBP wo	ould be needed. CNA 2 and			door			
	LPN 3 then donned a gown and changed gloves and began incontinence care.				Resident J is on enhanced ba			
					precautions staff immediately			
					donned proper PPE. no harm	ı was		
	Resident D's record	was reviewed on 5/1/25 at			sustained from the alleged			
	10:00 a.m. The diag	gnoses included, but were not			deficient practice.			
	limited to, osteomy	elitis left ankle/foot and			No residents were affected by	the		
	dementia.				alleged deficient practice.			
					LPN 3, C.N.A's' 2, 6, and 7 we	ere		
	An Admission Nursing Assessment, dated				educated on EBP signage and	d		
	4/29/25 at 1:30 p.m	., indicated an open wound on			PPE requirements.			
	the right heel, urine	and bowel incontinence,			How the facility will identify			
	assistance was required for ADL's, and a PICC				other residents having the			
line was present.				potential to be affected by th	ne			

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 05/01/2025 155835 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 1555 S MAIN STREET IGNITE MEDICAL RESORT CROWN POINT LLC CROWN POINT, IN 46307 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE same deficient practice and A Care Plan, dated 4/29/25, indicated EBP was what corrective action will be required due to the PICC line and gowns and gloves were to be worn during high contact care All residents have requiring activities. isolation have the potential to be affected by the same alleged deficient practice. 2. During an observation on 4/30/25 at 10:50 a.m., Facility sweep of current residents there was a sign on the outside door frame that on isolation including EBP was indicated the resident required EBP. Resident J completed to ensure signage was was lying in bed. There was a PICC line observed properly placed on residents' in the right upper arm. CNA 6 and CNA 7 were in doors, PPE was available, and the room and indicated they were giving a bed staff were donning appropriate bath and getting ready to wash the resident's PPE prior to entering rooms. back. There was a wash basin with soapy water Infection preventionist is updating and washcloths sitting on the night stand. CNA 6 isolation precaution list daily to and CNA 7 had gloves on. CNA 6 indicated EBP ensure staff are aware of changes was not required and only gloves were required and signage is accurate for each with care. CNA 7 then read the sign on the door resident. frame and both CNA's then place gowns on over What measures will be put into their uniforms. place or what systemic changes will be made to Resident J's record was reviewed on 5/1/25 at 1:10 ensure that the deficient p.m. The diagnoses included, but were not limited practice does not recur. to, diabetes mellitus. The admission date was Facility Infection Preventionist has 4/2/25. re-educated staff on isolation precautions including but not A Care Plan, dated 4/2/25, indicated EBP was limited to enhanced barrier required. The interventions included gowns and precautions PPE gloves would be used when providing high Members of the leadership team contact resident care. were educated on completing Infection control surveillance A Physician's Order, dated 4/16/25, indicated a rounds to ensure compliance. midline IV catheter was to be placed for IV Facility medical director is also an antibiotic administration. infectious disease specialist and has provided the facility guidance A facility EBP policy, dated 3/2024 and identified on PPE and infection control. as current by the Vice President of Operations, How the corrective action(s) indicated staff were to don a gown and gloves will be monitored to ensure the during high-contact resident care. EBP PPE was deficient practice will not

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

PRINTED: 05/29/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155835	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	COMP	(X3) DATE SURVEY COMPLETED 05/01/2025		
	PROVIDER OR SUPPLIER 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 CROSS TAG	PROVIDER'S PLAN OF CORRECTION TH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
	to be used for residents with wounds. 3.1-18(b)	recur, assura into p GM/de facility compl week i and or compl DON/I 5 staff compl dressi contact times shifts The A preser to the comm There Quality auditir done of quarte Monito Date b	esignee will randomly audit a staff members for iance with PPE 5 times per including week-end shifts, in alternating shifts to ensure iance. Designee will randomly audit if members for PPE iance during bathing, ing changes, and other high contract care activities 5 per week on alternating to ensure compliance. In a summary of the audits in a			

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