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	01/13/2025

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 a Recertification and State Licensure Survey and the Investigation of Complaint IN00449507. This visit included a State Residential Licensure Survey. Complaint IN00449507 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: January 6, 7, 8, 9, 10, and 13, 2025 Facility number: 013452 Provider number: 155835 Census Bed Type: SNF: 67 Residential: 23 Total: 90 Census Payor Type: Medicare: 65 Other: 2 Total: 67 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/21/25.	F 0000	We are respectfully requesting a desk review.	
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 1 of 1 resident reviewed for	F 0554	**Ignite Medical Resorts Crown Point**	01/27/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Robert Petty | Administrator | 01/29/2025

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	self-administration of medication. (Resident 40) Finding includes: During a random observation on 1/6/25 at 10:52 a.m., there was a medication tablet in a clear medication cup on Resident 40's bedside table. At the time, Resident 40 indicated the medication was an extra strength Tylenol and the nurse always left her medications at the bedside for her to take before she went to therapy. Resident 40's record was reviewed on 1/7/25 at 3:07 p.m. Diagnoses included, but were not limited to, acute kidney failure, pressure ulcer of the sacral region, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact for daily decision making. A Care Plan, revised on 1/6/25, indicated the resident had an order for self-administration of all medications and may keep at bedside. An intervention, dated 10/3/24, indicated to assess resident's ability to safely self-administer medications specified on admission/re-admission, quarterly, with change in medication orders, and with significant changes in condition. A Physician's Order, dated 12/30/24, indicated acetaminophen (Tylenol) oral tablet 500 milligram, give 2 tablets by mouth every 6 hours as needed for pain. There were no self-administration assessments or physician's orders for the self-administration of Tylenol. During an interview on 1/6/25 at 11:42 a.m., LPN 2		**Annual Survey: 1/13/2025** 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. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 40 no longer resides in the facility A self-administration assessment, and a physician order was obtained Resident 40. Resident 40 sustained no harm from the alleged deficient practice. **How the facility will identify other residents**	

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	indicated she had left Resident 40's medications at the bedside during the morning medication pass as the resident was allowed to self-administer all medications. During a follow up interview on 1/6/25 at 2:22 p.m., LPN 2 indicated the most recent self-administration of medications assessment did not have all of the resident's medications listed and she did not have an order to self-administer all medications. During an interview on 1/6/25 at 2:44 p.m., the Director of Nursing indicated the order for self-administration of all medications must have been dropped off when she had gone out to the hospital. A policy titled, "Self Administration of Medications and Treatments" indicated "...1. Self administration of medications and treatments is determined by physician order after determining that the resident is able to self administer...Procedure 1. If it is determined by a member of the interdisciplinary team, or if the resident requests to self administer, it is documented in the chart and the physician is called for an order to self administer medications, and keep the medications at the bedside. 2. Assessment of the ability to self-administer medications will be done by nursing using the tool Assessment for Self-Administration of Medications...7. A care plan is made for the resident who self administers medications, and documentation should be present in the nursing notes of teaching related to self administration of the medications or treatments." 3.1-11(a)		**having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with medication orders have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the**	

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			deficient practice does not recur; Staff were educated on not leaving medications at resident bedside unless there is a provider order and an assessment for self-administration in place. Full house audit was completed with no further medications left in resident rooms without assessments, orders and care plans updated to reflect self-administration. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will**	

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			be put into place; The director of nursing or designee will randomly audit 5 residents weekly to ensure no medication is stored at the bedside unless there are self-administration assessment, provider orders and care plan in place for self-administration 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 by which systemic corrections will be completed: 1/27/2025**	
F 0623 SS=D Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 1 of 4 residents reviewed for hospitalization. (Resident 40) Finding includes: Resident 40's record was reviewed on 1/7/25 at	F 0623	**Ignite Medical Resorts Crown Point** **Annual Survey: 1/13/2025**	01/27/2025

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	3:07 p.m. Diagnoses included, but were not limited to, acute kidney failure, pressure ulcer of the sacral region, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact for daily decision making. A Progress Note, dated 12/21/2024 at 7:39 a.m., indicated the resident was asleep in bed with the head of bed elevated. The resident was observed to have tremors. The resident woke up when stimulated. She was using accessory muscles while breathing, lips slightly blue, and having difficulty breathing while speaking. The resident denied shortness of breath when asked. Oxygen was applied via nasal cannula and she was sent to the hospital for a medical evaluation via 911. The resident left awake, alert and oriented, verbally responsive, and with a rebreather mask. The resident left on a stretcher accompanied via 2 attendants. The physician, emergency contact, and supervisor were made aware. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. During an interview on 1/10/25 at 10:57 a.m., the Director of Nursing indicated the resident signed/received a bed hold policy and transfer form at the time of admission. An updated form was not provided. During an interview on 1/13/25 at 12:11 p.m., the Administrator indicated all resident's received a bed hold and transfer form at the time of admission and the facility did not send it out each time of transfer from the facility.		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. **F623 Notice Requirements Before Transfer/Discharge** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents 40 no longer resides in the facility The state form 49669 and 49831 and bed policy are currently being given to all discharging and transferring residents The Ombudsman was notified of all transfers/discharges from 1/13/2025 to present. **How the facility will identify other residents**	

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	A policy titled, "Discharges" indicated "...Hospital Transfer...4. Inform the resident and resident's responsible party of the transfer. 5. Prepare transfer form with a face sheet and medication list..." 3.1-12(a)(6)(A)(ii) 3.1-12(a)(6)(A)(iii)		**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. **What measures will be put into place or what systemic changes will be made to ensure that the deficient**	

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			practice does not recur; Whole house audit of discharges dating 1/24/2025 to 1/27/2025 completed to ensure bed hold policy and state approved forms were given upon discharge. Social services has set up the on-line portal for notification to the Ombudsman for notification of transfers and discharges. Social services were re-educated on the process of notifying the Ombudsman of transfers.	

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			Social services were re-educated on using state approved forms 49669 and 49831and documenting in resident's medical record. Nursing staff and social services have been re-educated on providing bed hold policy to residents or representative upon transferring, discharging and documenting in resident's medical record. **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;** Administrator/Designee will audit monthly to ensure that the	

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			Ombudsman was notified of all transfers for the month. Administrator/Designee will randomly audit 5 residents weekly to ensure that discharged residents received facility bed hold policy and state approved forms 49831and 49669 DON/ designee will audit discharges to ensure bed hold policy and E interact were completed as required. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 1/27/2025**	
F 0625 SS=D Bldg. 00	483.15(d)(1)(2) Notice of Bed Hold Policy Before/Upon Trnsfr Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were sent the facility's bed-hold and reserve bed payment policy before and upon transfer to the hospital for 1 of 4 residents reviewed for hospitalization. (Resident 40)	F 0625	**Ignite Medical Resorts Crown Point** **Annual Survey: 1/13/2025**	01/27/2025

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	Finding includes: Resident 40's record was reviewed on 1/7/25 at 3:07 p.m. Diagnoses included, but were not limited to, acute kidney failure, pressure ulcer of the sacral region, and acute respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/31/24, indicated the resident was cognitively intact for daily decision making. A Progress Note, dated 12/21/2024 at 7:39 a.m., indicated the resident was asleep in bed with the head of bed elevated. The resident was observed to have tremors. The resident woke up when stimulated. She was using accessory muscles while breathing, lips slightly blue, and having difficulty breathing while speaking. The resident denied shortness of breath when asked. Oxygen was applied via nasal cannula and she was sent to the hospital for a medical evaluation via 911. The resident left awake, alert and oriented, verbally responsive, and with a rebreather mask. The resident left on a stretcher accompanied via 2 attendants. The physician, emergency contact, and supervisor were made aware. There was no documentation to indicate the facility's bed-hold policy was sent to the resident and/or their Responsible Party. During an interview on 1/10/25 at 10:57 a.m., the Director of Nursing indicated the resident signed/received a bed hold policy and transfer form at the time of admission. An updated form was not provided. During an interview on 1/13/25 at 12:11 p.m., the Administrator indicated all residents received a bed hold and transfer form at the time of		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. **F625 notice of bed hold** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 40 no longer resides in the facility Resident 40 sustained no harm from the alleged deficient practice **How the facility will identify other residents having the potential to be affected by the same deficient**	

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	admission and the facility did not send it out each time of transfer from the facility. 3.1-12(a)(25)(A)		**practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **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 have been re-educated on providing the resident and or their responsible party a copy of the facility bed	

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			hold policy at the time of discharge Whole house audit completed for all discharges from 1/24/2025 to 1/27/2025 to ensure bed hold policy was given upon discharge **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;** Director of nursing or designee will randomly audit 5 discharges weekly to ensure the bed hold policy was given at the time of discharge and documented in the	

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			residents medical records 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: 1/27/2025**	
F 0641 SS=A Bldg. 00	483.20(g) Accuracy of Assessments Based on observation, record review and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to intravenous (IV) access, antipsychotic medications, and anti-anxiety medications for 3 of 17 MDS assessments reviewed. (Residents 116, 22 and 262) Findings include: 1. On 1/6/25 at 1:37 p.m., Resident 116 was observed in his bed. He had a peripheral inserted central catheter (PICC) inserted in his right upper arm with a dressing dated 12/23/24. The resident's record was reviewed on 1/6/25 at 3:00 p.m. The resident was admitted to the facility on 12/24/24. Diagnoses included, but were not limited to unspecified dementia, asthma and gout. The Admission Minimum Data Set (MDS)	F 0641	**Ignite Medical Resorts Crown Point Indiana Annual survey 1/13/2025** 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. **F641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents 116 MDS was modified, and he no longer resides in the facility. Residents 22 MDS was	01/27/2025

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	assessment, dated 12/30/24, indicated the resident had moderate cognitive impairment, was dependent on staff for transfers, and did not have IV access. During an interview with the MDS Coordinator 1 on 1/8/25 at 3:00 p.m., she indicated the MDS was coded incorrectly for the IV access and she would complete a modification to correct it. 2. Resident 22's record was reviewed on 1/8/25 at 3:26 p.m. Diagnoses included, but were not limited to, psychotic disorder with hallucinations, schizophrenia, and anxiety disorder. The Admission MDS assessment, dated 12/10/24, indicated the resident had received antidepressant, anticoagulant, and diuretic medications in the past seven days. The Physician's Order Summary, dated 1/2025, indicated an order for buspirone (Buspar, an anti-anxiety medication) 5 mg (milligrams) twice a day and Nuplazid (pimavanserin, an antipsychotic medication) 34 mg daily. The Medication Administration Record (MAR), dated 12/2024, indicated the resident had received the anti-anxiety and antipsychotic medications as ordered. During an interview on 1/9/25 at 2:52 p.m., MDS Coordinator 1 and MDS Coordinator 2 indicated the medications had not been marked correctly and they would complete a modification of the assessment. 3. Resident 262's record was reviewed on 1/9/25 at 10:56 a.m. Diagnoses included, but were not limited to, encephalopathy, anxiety disorder, and major depressive disorder with psychotic symptoms.		modified, and he no longer resides in the facility Resident 262 MDS was modified, and she no longer reside in the facility Resident 116, 22, 262 sustained no harm from the alleged deficient practice **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. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** MDS staff were re-educated on ensuring the MDS is accurate and reflect the resident's current status at the time of MDS completion. MDS with ARD from 1/24/25-1/27/25 reviewed for accuracy. **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;** MDS/designee will audit 5 completed MDS's weekly including all assessment types of MDS to ensure the accuracy of the MDS. Any non-compliance will be corrected. Auditors will not	

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(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
	The Admission Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident was cognitively intact for daily decision making. She received anti-anxiety, antidepressants, and diuretic medications in the last 7 days. A Physician's Order, dated 12/24/24, indicated lurasidone (antipsychotic medication) oral tablet 60 milligrams, 1 tablet by mouth once daily. The current Care Plans indicated the resident was currently taking antidepressant, anti-anxiety, and antipsychotic medications. During an interview on 1/9/25 at 2:52 p.m., MDS Coordinator 1 indicated the MDS was not coded correctly as she had missed the antipsychotic use and would have to do a correction MDS to update for use of antipsychotics. 3.1-31(i)		audit their own work. MDS/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 by which systemic corrections will be completed: 1/27/2025**	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure a resident received medications as ordered for 1 of 1 resident reviewed for dialysis, failed to hold medications outside of ordered parameters for 1 of 1 resident reviewed for discharge, failed to assess and monitor an abdominal hernia, and lack of treatment in place for leg swelling for 1 of 3 residents reviewed for edema and skin conditions. (Residents C, B, and D) Findings include: 1. Resident C's record was reviewed on 1/7/25 at	F 0684	**Ignite Medical Resorts Crown Point** **Annual Survey: 1/13/2025** 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	01/27/2025

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	155835	A. BUILDING 00 B. WING	01/13/2025

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	2:08 p.m. The resident was admitted to the facility on 12/30/24. Diagnoses included, but were not limited to, dependence on renal dialysis, unspecified dementia, and gastrostomy. The Admission Minimum Data Set (MDS) assessment, dated 1/2/25, indicated the resident had severe cognitive impairment, received renal dialysis and tube feedings. The resident went to renal dialysis on Monday, Wednesday and Friday mornings. The resident went to dialysis on 1/2/25 and 1/3/25 due to the holiday on Wednesday,1/1/25, that week. The January 2025 Medication Administration Record (MAR) indicated the resident did not receive his morning medications on 1/2/25, 1/3/25 and 1/8/25 because he was out of the facility. The MAR was left blank on the morning of 1/6/25. The medications that were not given included, but were not limited to, doxycycline (an antibiotic), carvedilol (hypertension medication), and eopetin alfa injection (for anemia). During an interview on 1/8/25 at 2:25 p.m. with the C Unit Manager, she indicated if medications were scheduled during dialysis time, they should be rescheduled. The resident's missed medications were concerning and she would have them rescheduled. 2. Resident B's record was reviewed on 1/8/25 at 9:37 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, and chronic kidney disease. The Discharge Minimum Data Set assessment, dated 12/16/24, indicated the resident was cognitively intact for daily decision making.		facility and is submitted only in response to the regulatory requirement. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C sustained no harm from the alleged deficient practice, medications were reviewed and adjusted per provider orders to accommodate Renal Dialysis schedule and are being administered as ordered. Resident **B** no longer resides in the facility and sustained no harm from the alleged deficient practice. Resident D sustained no harm from the alleged deficient practice, Resident D has received new treatment orders related to edema care. Resident D's hernia was assessed by the physician with no new required treatment interventions. Hernia is being monitored daily for pain and/or changes requiring physician notification or new interventions. **How the facility will**	

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	The December 2024 Physician's Order Summary indicated hydralazine oral tablet 50 milligrams, 1 tablet every 8 hours, and hold for systolic blood pressure less than 130. The December 2024 Medication Administration Record indicated the resident received hydralazine on the following dates and times with a blood pressure less than 130: - 12/7/24 at 2:30 p.m. with a blood pressure of 127/74 - 12/14/24 at 10:00 p.m. with a blood pressure of 117/59 - 12/15/24 at 6:00 a.m. with a blood pressure of 120/60 - 12/16/24 at 6:00 a.m. with a blood pressure of 128/66 During an interview on 1/10/25 at 12:40 p.m., the Nurse Consultant had no further information to provide. 3. During an observation and interview on 1/7/25 at 9:35 a.m., Resident D indicated she had a large hernia that was causing discomfort and she was having a hard time eating because of it. She had a brace that she wore before in the hospital to help with the pain that she had while coughing. The resident also indicated she had edema to both of her lower legs and was supposed to have some type of wrap to them, however the facility staff were not doing that daily. The resident's legs were observed elevated on a pillow and there was a bandage on the left lower leg. There were no wraps on either leg and her legs were swollen. During an observation on 1/8/25 at 10:47 a.m., Resident D indicated her legs had no wraps on them at the time and they had never wrapped them		**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. House audit of residents who have standing appointments was completed to ensure no conflicts with medication/treatment schedules. House audit of medications with parameters was completed to ensure medications were given as directed. House audit done to identify any residents with visible hernias to ensure orders in place for assessment/monitoring. House audit completed to identify	

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	the previous day. Her legs were elevated on a pillow. Resident D's record was reviewed on 1/8/25 at 11:55 a.m. She re-admitted to the facility on 1/2/25. Diagnosis included, but were not limited to, lymphedema and heart failure. The Discharge Minimum Data Set (MDS) assessment, dated 4/15/24, indicated the resident was cognitively intact for daily decision making. The Admission Minimum Data Set (MDS) assessment, dated 1/9/25, was still in progress. The January 2025 Physician's Order Summary indicated to off load heels as tolerated every shift and give furosemide tablet (diuretic medication) 40 milligrams twice daily for fluid retention. The current Care Plan indicated the resident was at risk for alteration in skin integrity related to incontinence, head of bed elevation, and history of heart failure, lymphedema, osteoarthritis, diabetes mellitus, gastroesophageal reflux disease, and high blood pressure. Interventions included, but were not limited to, ensure the heels are elevated while in bed and monitor skin when providing cares. A Nurses' Note, dated 1/2/25 at 5:43 p.m., indicated the resident arrived to the facility and was alert and oriented and able to answer questions appropriately. She had 4+ pitting edema to the bilateral lower extremities, which were both wrapped at the time for her lymphedema. Her abdomen was soft and nontender with active bowel sounds. A Skin/Wound Note, dated 1/3/25 at 1:03 p.m.,		residents with edema/swelling to ensure provider aware and orders put in place as appropriate. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were re-educated on notifying the provider if the resident will be out of the building at medication administration times and/or treatment administration times to receive orders that allow residents to receive required medications/treatments before they depart for appointment, after they return from appointment, or if the provider wishes to hold that specific occurrence. Nurses were re-educated on	

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	indicated the resident was admitted to the facility for therapy services. She had lymphedema to bilateral lower extremities. Ammonium lactate was ordered and applied. She had a history of lymphedema and a diagphramatic hernia. A Physician Progress Note, dated 1/3/25 at 8:05 p.m., indicated the resident was observed in bed. She had bilateral lower extremities noted with chronic lymphedema and wrapped in ace wraps. She was on diuretic medication for the edema. The record lacked a care plan related to an abdominal hernia, an assessment or monitoring in place for the abdominal hernia, and orders for ace wraps to the bilateral lower extremities. During an interview on 1/9/25 at 2:05 p.m., the A Unit Manager indicated there was now an order for ace wraps for the bilateral lower extremities. The resident had a hernia that was inoperable. She was sent to the surgeon during a previous stay at the facility. The A Unit Manager was unable to locate an assessment for the hernia. During an interview on 1/9/25 at 2:15 p.m., the Director of Nursing (DON) indicated the staff would not document on the hernia unless she was having pain or telling staff she was having problems with it. The DON did not provide any further documentation regarding the hernia. During a follow up interview on 1/10/25 at 11:04 a.m., the DON provided documentation that the resident's hernia was addressed during her last stay in April and her Physician could not do any surgery for it. She was unable to provide an assessment of the hernia. She indicated the resident was currently on diuretics for edema, and wraps were now being added to the care plan.		assessing and monitoring visible hernias upon admission or with new onset of hernia, and obtaining orders for daily assessments for pain or changes that may require provider notification and/or intervention. Nurses were re-educated on assessing new onset, or increasing edema and notifying provider to obtain orders if interventions are required. Nurses were re-educated on following parameter orders, medications that have parameters, and what to do if they need to hold a medication due to parameters set. **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;** Nurse manager/ designee will audit S new residents and/or existing residents with new onset of visible hernias weekly to ensure assessment of hernia is documented and orders to monitor for pain and/or changes are in place. Nurse manager/designee will randomly audit 5 resident MAR's 3 times weekly to ensure medications were given as ordered and within the parameters Nurse manager/ designee will randomly audit S residents weekly with edema to ensure provider was	

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	This citation relates to Complaint IN00449507. 3.1-37(a)		notified and if required, treatment orders are in place. Nurse manager/designee will audit S residents receiving dialysis, or who have appointments outside the facility have orders to either hold or complete medication administration/treatments as ordered. 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: 1/27/2025**	
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, interview, and record review, the facility failed to ensure an indwelling Foley (urinary) catheter collection bag for a resident with a history of infection was kept off the floor for 1 of 1 resident reviewed for urinary catheters. (Resident 160) Finding includes: On 1/7/25 at 1:40 p.m., Resident 160 was observed sitting in a wheelchair at the nurses' station. The resident was talking on the phone and her catheter collection bag was lying on the floor underneath her wheelchair. On 1/9/24 at 9:16 a.m., Resident 160 was observed	F 0690	**Ignite Medical Resorts Crown Point Indiana AnnualSurvey:1/13/2025** 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. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will**	01/27/2025

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	sitting in a recliner in her room. The resident's catheter collection bag was touching the floor in front of the recliner. During an interview on 1/19/24 at 9:19 a.m., the A Unit Manager indicated staff should have put the resident's catheter bag into a bath basin so it would not be touching the floor. Record review for Resident 160 was completed on 1/9/24 at 9:36 a.m. Diagnoses included, but were not limited to, anxiety, cerebral palsy, chronic kidney disease, hypertension, and urinary tract infection (UTI). The resident was admitted to the facility on 1/2/25. A Care Plan, dated 1/6/25, indicated the resident had a urinary catheter. An intervention included to monitor and report signs or symptoms of a UTI. The January 2025 Physician's Order Summary indicated an order for Firvanq (antibiotic) 50 mg (milligrams)/ml (milliliters) solution. Give 2.5 ml by mouth one time a day for Sepsis (serious condition in which the body responds improperly to an infection). A facility policy titled, "Perineal Care", and received as current from the Director of Nursing on 1/9/25, indicated, "...7. Ensure Foley catheter is positioned correctly and secured..." 3.1-41(a)(2)		**be accomplished for those residents found to have been affected by the deficient practice;** Resident 160 no longer resides in the facility Resident 160 sustained no harm from the alleged deficient practice **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 with indwelling catheters have the potential to be affected by the same alleged deficient practice. House sweep was completed to ensure no further residents with indwelling catheters were noted to have the drainage bag or tubing on the floor. **Whatmeasures will be put into place orwhat systemicchanges willbe madeto ensure thatthe deficient practice does not recur;** Staff re-educated on ensuring residents with indwelling catheters keep the drainage bag and tubing off of the floor. **How the corrective action(s) will bemonitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse manager/designee will observe 5 random residents 3	

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			times a week to ensure that if an indwelling urinary catheter is in place, the bag and tubing are hung properly and not in contact with the floor 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 by which corrections will be completed: 1/27/2025**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review, observation, and interview, the facility failed to ensure timely follow up on dietary recommendations for a resident with a feeding tube was completed for 1 of 3 residents reviewed for nutrition. (Resident 46) Finding includes: Record review for Resident 46 was completed on 1/9/25 at 11:45 a.m. Diagnoses included, but were not limited to, stroke, hypertension, and intellectual disabilities. The resident was admitted to the facility on 12/12/24. The Admission Minimum Data Set (MDS) assessment, dated 12/19/24, indicated the resident was moderately cognitively impaired. The resident had a feeding tube.	F 0692	**Ignite Medical Resorts Crown Point** **Annual Survey: 1/13/2025** 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. **F692 Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	01/27/2025

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	A Care Plan, dated 12/12/24 and revised 1/6/25, indicated the resident had the potential for alteration in nutrition and hydration related to a feeding tube. An intervention included the Registered Dietician was to evaluate and make diet change recommendations when necessary. A Registered Dietician (RD) note, dated 1/7/25 at 3:52 p.m., indicated the resident's weight was slowly increasing and staff were reporting a fair intake at most meals. A recommendation was made to place the tube feedings on hold and add supplements by mouth to ensure adequate intake. Add Med Pass (nutritional supplement drink) 120 ml (milliliters) every 6 hours and give a Magic Cup (fortified nutrition dessert cup) with all meals. A Nurse Practitioner's (NP) note, dated 1/8/25 at 2:18 p.m., indicated the resident received bolus feedings every 6 hours when the resident did not eat more than 50%. The January 2025 Physician's Order Summary indicated orders for the following: - regular diet with mechanical soft texture; give feeding when the resident ate less than 50% of their meal - after meals bolus (way to send formula through a feeding tube using a syringe), feed Jevity (fortified therapeutic nutrition) 1.2. Hold the feeding if the resident ate more than 50% of each meal. There was a lack of documentation to indicate the NP was notified of the RD's recommendations of the Med Pass and Magic Cup. There were no progress notes or Physician's Orders indicating the recommendations were addressed. There were no physician's orders for the Med Pass or the Magic Cup.		**practice;** Resident 46's RD recommendations were reviewed with new recommendations, physician made aware and new orders in place and being followed Resident 46 sustained no harm from the alleged deficient practice. **How the facility will identify other residents having the potentialto be affected bythe same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **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 were re-educated on following up with RD recommendations in a timely manner and notifying physician of recommendations to obtain orders if indicated and documenting in medical record. **Howthe corrective action(s) will be monitored to ensure thedeficient practice will notrecur, i.e., what quality assurance programs will be put into place;** Director of nursing /designee will randomly audit 5 resident's dietitian recommendations weekly	

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	On 1/10/25 at 12:31 p.m., resident was sitting in a wheelchair in her room. The resident was brought her lunch tray. There was no Magic Cup observed on the tray. The resident's meal ticket did not have a Magic Cup listed. During an interview on 1/10/25 at 2:16 p.m., the A Unit Manager indicated the nursing staff was responsible to follow up with the RD's recommendations. She was unsure about the RD's recommendations for the resident and she would have to check on it. During an interview on 1/10/25 at 3:08 p.m., the A Unit Manager indicated she received the RD's recommendations on 1/8/25 and sent them to the Physician's office. The NP saw the resident on 1/8/25, but she was unsure if that was before or after she sent the recommendations to the office. She did not address the recommendations in person with the NP that day or after and the office had not responded to her about the recommendation. The A Unit Manager followed back up on the recommendation with the Physician's office on 1/10/25, and they put an order in for the Med Pass and Magic Cup. She indicated she had not followed back up on the recommendations until it was brought to her attention. A facility policy titled, "Dietary Referrals" and received as current from the Director of Nursing on 1/10/25, indicated, "...1. If there is a referral from dietician consult, the nurse is to inform the physician of the recommendation..." "...3. Documentation will be present in resident records..." 3.1-46(a)(1)		if applicable to ensure dietary recommendations are completed timely and as ordered with updated tray ticket. 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 by which systemic corrections will be completed: 1/27/2025**	

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F 0693 SS=D Bldg. 00	3.1-46(a)(2) 483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, record review, and interview, the facility failed to ensure a resident with a gastrostomy (surgical insertion of a feeding tube) received the appropriate treatment related to incorrect flow rate for the tube feeding for 1 of 1 resident reviewed for tube feedings. (Resident C) Finding includes: On 1/8/25 at 2:20 p.m., Resident C was observed lying in his bed. His tube feeding was on and flowing at 75 milliliters per hour (ml/hr). On 1/9/25 at 9:18 a.m. and 11:20 a.m., the resident was in bed and his tube feeding was on and flowing at 45 ml/hr. The resident's record was reviewed on 1/7/25 at 2:08 p.m. The resident was admitted to the facility on 12/30/24. Diagnoses included, but were not limited to, dependence on renal dialysis, unspecified dementia and gastrostomy. The Admission Minimum Data Set (MDS) assessment, dated 1/2/25, indicated the resident had severe cognitive impairment, received renal dialysis, and tube feedings. A Physician's Order, dated 1/7/25, indicated the resident was to receive Nepro with Carb Steady via tube feeding at 65 ml/hr for 24 hours daily. During an interview on 1/9/25 at 11:20 a.m., the C Unit Manager indicated the tube feeding should be 65 ml/hr and she would correct it.	F 0693	**Ignite Medical Resorts Crown Point Indiana AnnualSurvey:1/13/2025** 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. **F693 Tube Feeding Management/ restore eating skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C feeding tube rate was readjusted immediately upon notification to the correct rate No harm was caused to Resident C from the alleged deficient practice **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 with a feeding tube(gastrostomy/Peg tube) have the potential to be affected by the	01/27/2025

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(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
	3.1-44(a)(2)		same alleged deficient practice. House audit of residents with G-tube/peg tube was completed to ensure that feeding pump was set to correct rate. **What measureswill be put intoplace or what systemicchanges willbe madeto ensure that the deficient practice does not recur;** Nurses have been Re-educated on verifying the tube feeding pump is set at the correct rate per orders and prior to administration of nutritional feedings **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;** DON/designee will observe 5 residents with a (gastrostomy /Peg tubes) if applicable 3 times weekly to ensure the feeding pump rate is running as ordered. 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 by which corrections will be completed: 1/27/2025**	

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	155835	A. BUILDING 00 B. WING	01/13/2025

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F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review, and interview, the facility failed to ensure a peripheral inserted central catheter (PICC) was maintained related to the dressing not being changed as ordered for 1 of 3 residents reviewed for non-pressure skin conditions. (Resident 116) Finding includes: On 1/6/25 at 1:37 p.m., Resident 116 was observed in his bed. He had a PICC inserted in his right upper arm with a dressing dated 12/23/24. The resident's record was reviewed on 1/6/25 at 3:00 p.m. The resident was admitted to the facility on 12/24/24. Diagnoses included, but were not limited to unspecified dementia, asthma, and gout. The Admission Minimum Data Set (MDS) assessment, dated 12/30/24, indicated the resident had moderate cognitive impairment, was dependent on staff for transfers, and did not have IV access. A Physician's Order, dated 12/25/24, indicated to change the PICC dressing every seven days on Saturday. The January 2025 Medication Administration Record indicated the dressing had been changed on 1/4/25. During an interview with RN 4 on 1/6/25 at 1:51 p.m., she indicated the dressing was dated 12/23/24 and had not been changed since admission.	F 0694	**Ignite Medical Resorts** **Crown Point** **Annual Survey: 1/13/2025** 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. F694 parenteral / IV fluids **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 116 no longer resides in the facility Resident 116 sustained no harm from the alleged deficient practice. **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 with an intravascular access site have the potential to be affected by the same alleged deficient practice. House audit of residents with intravascular access was completed to ensure dressing changes were completed as	01/27/2025

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	3.1-47(a)(2)		ordered **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were re-educated on following physician orders for scheduled intravascular access dressing changes. Nurses we re-educated on checking date of dressing upon admission, placing orders for dressing changes per physician recommendations, and assessing sites and dates when providing medications/fluids through intravascular lines. **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;** Nurse manager / designee will audit 5 residents weekly with an intravascular access site to ensure dressing changes are completed as ordered 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: 1/27/2025**	

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F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control measures were in place and maintained related to improper protective personal equipment (PPE) worn in an isolation room for 1 of 1 resident reviewed for respiratory care. (Resident 125) Finding includes: On 1/7/25 at 10:35 a.m., Resident 125 was observed in her room. There were isolation signs on the resident's door that indicated she was on contact and droplet precautions. Another sign indicated the room was a Red Zone, and PPE required to enter was an N95 or approved KN95 respiratory mask, goggles or a faceshield, gown and gloves. There was a PPE bin outside the resident's room. On 1/8/25 at 9:32 a.m., LPN 1 was observed in the resident's room speaking with a family member. The nurse had her personal glasses on and was wearing a surgical mask. She was not wearing an N95 mask, goggles or a faceshield, gown or gloves. LPN 1 exited the room at 9:40 a.m. During an interview at that time, the LPN indicated the resident was on isolation because she was immunocompromised, she was not aware the resident had coronovirus. Resident 125's record was reviewed on 1/10/25 at 9:00 a.m. Diagnoses included, but were not limited to, heart failure, acute and chronic respiratory failure, and hypothyroidism. The Admission Minimum Data Set assessment, dated 1/1/25, indicated the resident was	F 0880	**Ignite Medical Resorts Crown Point Indiana** **Annual survey: 1/13/2025** 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. **F880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 125 is no longer on isolation protocol Resident 125 sustained no harm from the alleged deficient practice. No residents sustained any harm from the alleged deficient practice. **How thefacility will identify other residents having the potential to be affected by thesame deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic**	01/27/2025

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	cognitively intact, required supervision for transfers, toileting and bed mobility, and used oxygen. A Medication Administration Note, dated 1/1/25, indicated the resident had a persistent cough and chronic obstructive pulmonary disease and the on call Physician had ordered a respiratory panel (test for respiratory pathogens) to be done. A Health Status Note, dated 1/3/25, indicated the resident had tested positive for coronovirus and would be placed on strict droplet isolation. A Physician's Order, dated 1/4/25, indicated strict transmission based contact/droplet isolation precautions and all services to be provided in private room. A Physician Progress Note, dated 1/8/25, indicated the resident had tested negative for COVID-19. However the respiratory panel detected Coronovirus OC 43, "...while this is not COVID-19, COVID-19 and this virus are both coronoviruses, and are transmitted via respiratory excretion. For this reason, the patient was kept in isolation for 10 days to avoid the risk of spreading this virus to staff and patients." The document, "Infection Control Policy", reviewed 11/2024, indicated, "...Droplet Precautions will be used for residents known or suspected to be infected with microorganisms transmitted by droplets that can be generated by the resident during coughing, sneezing, talking or during cough-inducing procedures...don a mask prior to entering the room..." and, "...Contact Precautions will be used for specified resident known or suspected to be infected with microorganisms that can be transmitted by direct		**changes will be made to ensure that the deficient practice does not recur;** Whole house sweep of isolation rooms completed for correct signage to ensure proper PPE protocols in place Nurse observed without correct PPE has been re-educated on use of proper PPE Nurses were educated on proper signage to use based on type of infection and isolation guidance. Staff were educated on isolation room signage and how to identify the type of isolation and appropriate PPE to be used. **How the corrective action(s) will bemonitored to ensure thedeficient practice willnot recur,i.e., what quality assurance programs will be put into place;** Administrator/designee will randomly audit 5 staff members for compliance with PPE 3 times per week on alternating shifts to ensure compliance. DON/designee will randomly audit 5 isolation rooms for correct signage 3 times per week to ensure compliance. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present	

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	contact...or indirect contact (touching) with environmental surfaces or resident care items in the resident's environment..." Don gloves and gown when entering the room. 3.1-18(a)(2)		quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 1/27/2025**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaint IN00449507. Complaint IN00449507 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: January 6, 7, 8, 9, 10, and 13, 2025 Facility number: 013452 Residential Census: 23 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/21/25.	R 0000	We are respectfully requesting a desk review.	
R 0241 Bldg. 00	410 IAC 16.2-5-4(e)(1) Health Services - Offense Based on record review and interview, the facility failed to ensure physician's orders were followed related to laboratory (lab) tests not completed as ordered for 1 of 7 residents reviewed. (Resident 4) Finding includes:	R 0241	**Ignite Medical Resorts Crown Point Assisted**	01/27/2025

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	Resident 4's record was reviewed on 1/13/25 at 11:36 a.m. Diagnoses included, but were not limited to, hypertension, heart failure, and hypothyroidism. The Physician's Order Summary, dated 1/2025, indicated an order, dated 7/13/22, for CBC (complete blood count), CMP (comprehensive metabolic panel), and TSH (thyroid stimulating hormone) labs every 6 months. A Nurse Practitioner Note, dated 5/24/24 at 12:52 p.m., indicated there were no recent labs noted and a CBC, CMP, and TSH would be checked. A Nurse Practitioner Note, dated 11/12/24 at 12:27 p.m., indicated labs had been ordered on the last visit but results were not available. During an interview on 1/13/25 at 2:18 p.m., the Director of Assisted Living indicated she was unsure why there were routine lab orders in the computer since the resident's family took her out to her own doctor. She provided the most recent CBC, CMP, and TSH results which were completed on 2/8/23 and indicated she would update the Nurse Practitioner.		**living** **Annual Survey: 1/13/2025** 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. **R241 Health Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 4 sustained no harm from the alleged deficient practice and lab orders have been completed as ordered **How the facility will identify other residents having the potential to be**	

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			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. Current laboratory orders were reviewed to ensure collection of specimens were completed, resulted, and physician was notified. Whole house sweep completed to ensure labs have been completed as ordered. **What measures will be put into place or what systemic changes will be made to**	

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			ensure that the deficient practice does not recur; Assisted living director was re-educated that labs are to be completed as ordered. **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;** Assisted living Director/designee will randomly audit 5 charts	

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			weekly to ensure lab orders have been completed as ordered. The Assisted Living Director/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: 1/27/25**	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency Based on record review and interview, the facility failed to ensure QMAs (Qualified Medication Aides) received authorization from a licensed nurse prior to giving a PRN (as needed) medication for 1 of 7 records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 1/13/25 at 10:15 a.m. Diagnoses included, but were not limited to, prostate cancer, bladder cancer and wedge compression. A Physician's Order, dated 9/1/23, indicated the resident could have Tylenol 500 milligrams every six hours as needed for pain. The November 2024 MAR (Medication Administration Record) indicated the resident was given Tylenol on 11/27/24 by QMA 2. There was no documentation a licensed nurse had given	R 0246	**Ignite Medical Resorts Crown Point Assisted living** **Annual Survey: 1/13/2025** 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. **R246 Health services Deficiency** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 3 sustained no harm	01/27/2025

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	authorization for the medication. The December 2024 MAR indicated the resident was given Tylenol on 12/16/24 by QMA 1. There was no documentation a licensed nurse had given authorization for the medication. During an interview on 1/13/25 at 1:30 p.m., the Assisted Living Manager indicated the QMAs should get authorization from the nurse and document that in the progress notes prior to giving the medications. The current policy, "Administration of Medications", indicated, " ...PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician ...."		from the alleged deficiency and Physician was notified of PRN medication administration. **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. Audit was completed of current PRN orders to ensure QMAs who have administered a PRN medication, received authorization from a licensed nurse/provider, prior to giving the PRN medication. **Whatmeasures willbe put into place or whatsystemic changes willbe madeto ensurethat the deficient practice does not recur;** QMA's were re-educated on receiving authorization from a licensed nurse and/or licensed provider prior to administration of PRN medications. **How the corrective action(s)will be monitored to ensurethe deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Assisted Living director/designee will randomly audit 5 PRN administrations by QMAs weekly to ensure authorization from licensed nurse and/or provider was received prior to the PRN	

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			administration. The Assisted Living Director/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: 1/27/25**	
R 0247 Bldg. 00	410 IAC 16.2-5-4(e)(7) Health Services - Deficiency Based on observation, record review and interview, the facility failed to ensure medications were given as ordered for 1 of 5 residents observed for medication administration. (Resident 5) Finding includes: On 1/13/25 at 8:55 a.m., the Director of Assisted Living (AL) was observed preparing medications for Resident 5, which included a Lidocaine pain relief patch. She administered the resident's other medications and then prepared to apply the Lidocaine patch. She asked the resident if he wanted the patch on his neck or his back. The resident indicated he wanted the patch placed to his lower back. The Director of Assisted Living donned gloves and lifted the resident's shirt. There was an old Lidocaine patch in place to the resident's back. She removed the old patch and placed the new Lidocaine patch to the resident's lower back.	R 0247	**Ignite Medical Resorts Crown Point** **Assisted living Annual Survey: 1/13/2025** 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. **R247 Health services Deficiency** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 5 sustained no harm from the alleged deficient practice and lidocaine patch was applied	01/27/2025

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	Resident 5's record was reviewed on 1/13/25 at 10:26 a.m. Diagnoses included, but were not limited to, spinal stenosis and hypertension. The Physician's Order Summary, dated 1/2025, indicated an order for Lidocaine pain relief 4% patch. Apply to left neck topically one time a day for pain, remove after 12 hours. During an interview on 1/13/25 at 10:52 a.m., the Director of AL indicated the resident had been asking to have the patch applied to his back instead of his neck. She would update the Nurse Practitioner to get the order changed. She would look into documentation of the patch removal, since the old patch from the previous day had still been in place and not removed as ordered. No further information was provided.		as ordered. Resident 5 sustained no harm from the not documenting lidocaine patch removal. **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 with transdermal patches ordered have the potential to be affected by the same alleged deficient practice. An audit was completed to ensure that transdermal patches had "patch removal" documentation in the EMR and that patches were placed in specific anatomical area when order includes specific anatomical placement. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses and QMAs were re-educated on documenting removal of lidocaine patches. Nurses and QMAs were re-educated on ensuring transdermal patches are placed as ordered. **Howthe correctiveaction(s) willbe monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;**	

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			Assisted Living Director/designee will audit 5 residents EMRs who have current orders for transdermal patches, to ensure removal of patch is documented. Assisted Living Director/designee will audit 5 residents weekly to ensure transdermal patches are placed as ordered. The Assisted Living Director/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: 1/27/25**	
R 0356 Bldg. 00	410 IAC 16.2-5-8.1(i)(1-8) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure the resident Emergency Binder contained all the necessary information for 1 of 5 residents reviewed. (Resident 1) Finding includes: The resident Emergency Binder was reviewed on 1/13/25 at 12:05 p.m. Resident 1 was missing a photo, hospital preference, and phone number for the resident. During an interview on 1/13/25 at 1:30 p.m., the Assisted Living Director indicated she had been	R 0356	**Ignite Medical Resorts Crown Point Assisted living** **Annual Survey: 1/13/2025** 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. **R356 clinical records**	01/27/2025

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	01/13/2025

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

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	printing off the transfer/discharge sheet instead of the regular face sheet in case the residents had to be transferred out. Having those printed off was easier for the staff to provide the appropriate paperwork quickly. She did not know they needed to have a photo in the emergency binder, but would print off the regular face sheets that included a photo.		**non-compliance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Emergency binder was updated to include Resident I's photo, hospital preference, and phone number. Resident 1 sustained no harm from the alleged deficient practice. **How the facility will identify other residents having the potential to be affected bythe same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. House audit completed on emergency binder to ensure required resident information is current and readily available. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Assisted Living director was re-educated on emergency information required for each resident. **How thecorrective action(s) will be monitored to ensurethe deficient practice will not recur,i.e., what quality**	

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			assurance programs will be put into place; Assisted Living Director/ designee will audit emergency binder weekly for 6 months to ensure compliance. The Assisted Living Director/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: 1/27/25**	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance Based on record review and interview, the facility failed to ensure residents had an annual health statement for 2 of 7 residents reviewed. (Residents 5 and 1) Findings include: 1. Resident 5's record was reviewed on 1/13/25 at 10:26 a.m. Diagnoses included, but were not limited to, spinal stenosis and hypertension. The resident was admitted to the facility on 7/22/24. The record lacked any health statement to indicate the resident was free of communicable diseases. During an interview on 1/13/25 at 2:18 p.m., the Director of Assisted Living (AL) indicated she was unable to find any previous health statement.	R 0409	**Ignite Medical Resorts Crown Point Assisted living** **Annual Survey: 1/13/2025** 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. **R409 infection control** **What corrective action(s) will be accomplished for those**	01/27/2025

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	She provided an annual health statement dated 1/13/25. 2. Resident 1's record was reviewed on 1/10/25 at 3:03 p.m. The resident was admitted to the facility on 11/2/24. Diagnoses included, but were not limited to, dementia. The record lacked a health statement to indicate the resident was free of communicable diseases. During an interview on 1/13/25 at 11:46 a.m., the Director of Assisted Living (AL) indicated she was unable to find any previous health statement. She provided an annual health statement dated 1/13/25.		**residents found to have been affected by the deficient practice;** Resident 1 annual health statement has been updated Resident 5 annual health statement has been updated Residents 1 and 5 sustained no harm from the alleged deficient practice **How the facilitywill identifyother residentshaving thepotential 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. House audit was completed to ensure annual health statements are up to date in the EMR. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Assisted Living director was re-educated on the required annual health statement for each resident **How the correctiveaction(s) will bemonitored to ensure thedeficient practice willnot recur,i.e., what quality assurance programs will be put into place;** Assisted Living Director/ designee will audit the annual health	

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			statements monthly to ensure compliance is up to date. The Assisted Living Director/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: 1/27/25**	