

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155835	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Crown Point LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 1555 S Main Street Crown Point, IN 46307	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>20580</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was reported to the Administrator and the Indiana Department of Health (IDOH) immediately or within the 2 hour time period for 1 of 3 residents reviewed for abuse. (Resident E)</p> <p>Finding includes:</p> <p>During an interview on 7/15/24 at 4:35 a.m., LPN 1 indicated a few weeks ago, Resident E had made the allegation the staff were rough with her during care. She was unable to give the names of the staff. LPN 1 immediately reported the allegation to the Director of Nursing (DON) and the DON indicated she would follow up on the allegation.</p> <p>During an interview on 7/15/24, the Administrator indicated he was not notified of the allegation of the staff being rough during care by Resident E. There was no reported incident to the IDOH about the allegation.</p> <p>During an interview on 7/16/24 at 9:45 a.m., the Administrator indicated he had spoken to the DON, who was on vacation, and the DON indicated LPN 1 had reported the allegation to her. The DON had interviewed the resident she had not voiced an allegation about rough care during the interview. The Administrator indicated as soon as he had been aware of the allegation on 7/15/24, he immediately reported it to the IDOH.</p> <p>Resident E's record was reviewed on 7/16/24 at 11:03 a.m. The diagnoses included, but were not limited to malignant cancer of the breast and uterus.</p> <p>An Admission Minimum Data Set assessment, dated 6/25/24, indicated a moderately impaired cognitive status and required supervision for bed mobility and upper body dressing, moderate assistance with lower body dressing, hygiene, and transfers, and maximum assistance for toileting and bathing.</p> <p>There was no documentation in the Nurses' Progress notes from 6/18/24 through 7/14/24 that indicated an allegation of rough care was voiced by the resident.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility abuse policy, dated 3/2024 and received as current from the Administrator, indicated an allegation of abuse was to be immediately reported to the Administrator. If the Administrator was not present, the allegation was to be reported to their immediate supervisor and/or the facility DON. The Administrator or designee were to report the allegation to the IDOH immediately, within two hours if actual harm was suspected and 24 hours for all other alleged allegations.</p> <p>This citation relates to Complaints IN00436496 and IN00437883.</p> <p>3.1-28(c)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure standard practice of care was followed during an observation of a gastrostomy (g-tube) (feeding tube) medication administration, related to the placement of the g-tube not being confirmed prior to the administration of the medications, for 1 of 1 resident observed and reviewed for g-tube care. (Resident F)</p> <p>Finding includes:</p> <p>During a medication administration observation on 7/15/24 at 8:28 a.m., LPN 2 entered Resident F's room with 11 medication cups containing one crushed medication in each cup, a glass with apple juice which contained a medication that required apple juice for administration, and 30 ml (milliliters) of a protein supplement. The medications were placed on the over bed table.</p> <p>LPN 2 mixed the medications with 5 mls of water in each cup, flushed the g-tube with 60 ml of water, then administered the protein supplement and the medications separately through the resident's g-tube.</p> <p>LPN 2 did not confirm the placement of the g-tube prior to the administration of the medications.</p> <p>During an interview on 7/15/24 at 8:28 a.m., LPN 2 indicated she was unsure how to confirm placement of the g-tube at the facility. She indicated she worked in other facilities and was not sure of this facility's policy for how to check for placement.</p> <p>A facility medication administration via a g-tube policy, dated 3/2023 and received as current from the Assistant Director of Nursing, indicated medications were to be given separately through the g-tube. The placement of the tube was to be confirmed prior to the administration of the medications by gently drawing back on the piston of the syringe for gastric content, which would indicate the g-tube was patent and in the stomach.</p> <p>3.1-44(a)(2)</p>

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information included only the staff who were providing direct resident care, related to Nursing Administration hours included on the postings. This had the potential to affect all residents who resided in the facility during May, June, and July, 2024.</p> <p>Finding includes:</p> <p>During an observation on 7/15/24 at 4:30 a.m., there were two nurses, one QMA, and three CNAs working the evening/night shift. LPN 1 indicated the staff work 12 hours shifts.</p> <p>During an observation on 7/15/24 at 8 a.m., there were four nurses and six CNAs working the day/evening shift.</p> <p>Nursing schedules and posted nursing hours, dated 5/19/24 through 6/9/24 and 7/1/24 through 7/14/24 were reviewed on 7/16/24 at 12:00 p.m. The scheduled hours for the nurses did not match the posted hours when compared for each day. The nurses' hours were higher on the Nurse Staffing Information than the observations of the nurses in the facility who provided direct resident care.</p> <p>During an interview on 7/16/24 at 1:04 p.m., the Assistant Director of Nursing (ADON) indicated the Nurse Staffing Information included all the Administrative Nursing staff, which included, but was not limited to, the Director of Nursing, the ADON, and the Minimum Data Set (MDS) assessment Nurse. She indicated the Administrative Nursing staff did not provide continual direct resident care. The Corporate Regional [NAME] President indicated the nursing hours reported for the CMS Staffing Data Report were only nurses who provided direct resident care and the Administrative Nursing staff hours were not reported for the Data Report.</p> <p>This citation is related to Complaint IN00436496.</p>		