

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 05/01/2025
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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to notify a resident's physician and responsible party that a medication was unavailable for 1 of 9 residents reviewed for physician/responsible party notification. (Resident D)</p> <p>Finding includes:</p> <p>Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia.</p> <p>A Social Service assessment, dated 4/30/25, indicated a severe cognitive impairment</p> <p>A family member was designated as the legal Power of Attorney (POA).</p> <p>A Physician's Order, dated 4/29/25 at 6:00 p.m., indicated IV (intravenous) ampicillin-sulbactam (antibiotic) 3 grams (gm) was to be administered every six hours due to a wound infection.</p> <p>The Medication Administration Record (MAR), dated 4/2025, indicated the antibiotic had not been available and was not given on 4/30/25 at 12:00 p.m. and 6:00 p.m.</p> <p>The MAR, dated 5/2025, indicated the antibiotic had not been available and was not given on 5/1/25 at 12:00 a.m. and 6:00 a.m.</p> <p>Cross reference F755.</p> <p>There was no documentation to indicate the resident's physician and POA had been notified of the missed antibiotic doses.</p> <p>During an interview on 5/1/25 at 10:56 a.m., the Director of Nursing indicated the POA and the Physician should have been notified of the missed doses of the antibiotic</p> <p>A facility policy for physician notification, dated 10/2024 and received from the Director of Nursing as current, indicated the physician or nurse practitioner would be notified if it was deemed necessary or appropriate in the best interest of the resident. The communication with the responsible party as well as the physician was to be documented in the medical record.</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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This citation relates to Complaint IN00457153.</p> <p>3.1-5(a)(3)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to provide incontinent care in a timely manner and failed to ensure Resident D was bathed after a large amount of urinary incontinence for 2 of 3 residents reviewed for activities of daily living (ADL's). (Residents D and E)</p> <p>Findings include:</p> <p>1. During an observation on 4/29/25 from 9:07 a.m. through 9:32 a.m., Resident D was lying in bed with the head of the bed elevated. There was a yellow tinged color on the edge of the incontinence pad that was under the resident. LPN 3 and CNA 2 entered the room. CNA 2 indicated she came in to work at 6 a.m. and she had not checked the resident for urinary incontinence since she started work that morning. CNA 2 indicated the gown was wet with urine and there were two incontinence pads under the resident that were saturated with urine. The sheet under the incontinence pads was soaked with urine as well and there was a drying ring of urine on the bottom sheet of the bed. The top sheet and covers were also wet. CNA 2 indicated the gown and incontinence brief were saturated with urine. The resident's gown was removed and the bed linens were changed. The resident's peri area and buttocks area was cleansed with wipes. The other areas soaked by urine, the abdomen, back, arms and legs, were not washed. A clean brief was applied and the resident was dressed without the other areas of the body being cleansed.</p> <p>Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia.</p> <p>An Admission Nursing Assessment, dated 4/29/25 at 1:30 p.m., indicated an open wound on the right heel, urine and bowel incontinence, assistance was required for ADL's, and a PICC (peripherally inserted central catheter) line was present.</p> <p>A Care Plan, dated 4/29/25, indicated assistance was required for ADL's. The intervention included maximum assistance would be required for bathing and toileting. The resident was incontinent and would be checked for incontinency every 2-3 hours.</p> <p>A Social Service assessment, dated 4/30/25, indicated a severe cognitive impairment.</p> <p>2. During an observation on 4/30/25 at 8:30 a.m., there was an odor of urine outside Resident E's room and inside the room. Resident E was lying in bed with her eyes closed. CNA 5 entered the room with a covered breakfast tray. CNA 5 donned gloves and stated the bed covers were damp and the resident's clothing was wet. There was a large ring of urine on the incontinence pad under the resident with drying urine on the edges. The incontinence brief was saturated with urine. CNA 5 indicated she had not checked the resident for incontinence since she started work at 6:00 a.m. and it had been a while since the resident had been checked for incontinence. She then completed incontinence care with the wet wipes at the bedside and placed a new incontinence brief on the resident. The clothing was changed after the skin was washed with the wipes.</p> <p>Resident E's record was reviewed on 5/1/25 at 11:12 a.m. The diagnoses included, but were not limited to dementia.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Care Plan, dated 4/24/25, indicated assistance was required with ADL's. The interventions included moderate assistance would be provided for toileting and bathing. The resident would be checked for incontinence every 2-3 hours.</p> <p>During an interview on 4/30/25 at 10:17 a.m., the Director of Nursing indicated the residents should have been checked for incontinence and changed prior to the observation and they should have been showered or bathed due to the large amount of urine incontinence.</p> <p>During an interview 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.</p> <p>A facility incontinence care policy, dated 11/2024 and received from the Director of Nursing as current, indicated incontinent residents were changed every two hours and more frequently if needed.</p> <p>This citation relates to Complaint IN00457153.</p> <p>3.1-38(a)(3)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p>20580</p> <p>Based on observation, record review and interview, the facility failed to care for a midline catheter (inserted into a vein in the upper arm for intravenous [IV] treatments) in accordance with professional standards of practice related to a non-sterile dressing change and a lack of dressing changes to the site, assessments of the site, and flushes of the catheter for 2 random PICC line observations. (Residents D and J)</p> <p>Findings include:</p> <p>1. During an observation on 4/29/25 at 9:46 a.m., Resident D was lying in bed with the head of the bed elevated. There was a PICC line in the left upper extremity. LPN 3 indicated there was blood on the PICC line dressing and the dressing needed to be changed. A sterile dressing kit was placed on the resident's bed and opened up. LPN 3 applied sterile gloves after using the alcohol based hand rub. She then lifted the resident's left arm up with the sterile gloves on and placed a sterile pad under the arm. She then put a face mask on herself and touched the top of her ears and hair with the sterile gloves. The soiled PICC line dressing was removed and the insertion area was cleansed with the alcohol cleaning utensil in the kit. She then removed the gloves and applied a second pair of sterile gloves without cleansing her hands. While the sterile gloves were applied, she touched the fingers of the right hand glove with her ungloved fingers of the left hand. She then applied the left sterile glove. She touched the underside of the kit wrap and moved the kit in the bed, then touched the resident's arm for positioning and placed a new dressing on the PICC line insertion site.</p> <p>Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia.</p> <p>An Admission Nursing Assessment, dated 4/29/25 at 1:30 p.m., indicated an open wound on the right heel, urine and bowel incontinence, assistance was required for ADL's, and a PICC (peripherally inserted central catheter) line was present.</p> <p>A Care Plan, dated 4/29/25, indicated an IV was present. The interventions indicated the dressing would be changed every week.</p> <p>During an interview on 4/30/25 at 10:17 a.m., the Director of Nursing indicated PICC line dressing changes were to be completed using a sterile dressing change process.</p> <p>2. During an observation on 5/1/25 at 1:45 p.m., Resident J was sitting in a wheelchair in his room. There was a PICC line inserted into the right upper arm with date of 4/26/25 written on the dressing site.</p> <p>Resident J's record was reviewed on 5/1/25 at 1:10 p.m. The diagnoses included, but were not limited to, diabetes mellitus. The admitted was 4/2/25.</p> <p>A Physician's Order, dated 4/16/25, indicated a midline IV catheter was to be placed for IV antibiotic administration.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurse's Progress Note, dated 4/16/25 at 4:58 p.m., indicated a nurse from the IV insertion company was at the facility and a midline catheter was placed in the right arm.</p> <p>A Professional Nursing Service Note, dated 4/16/25, indicated a midline IV had been inserted. The nursing care indicated to flush the line with 10 cc's (cubic centimeters) of normal saline before and and right after all infusions per facility protocols. The dressing was to be changed within 24 hours of insertion, then weekly and as needed for soiling and looseness.</p> <p>A Care Plan, dated 4/17/25, indicated the resident was receiving an antibiotic through an IV. The interventions included the dressing over the IV would be observed every shift, the dressing would be changed weekly and flushed per the physician's orders. The IV insertion site was to be monitored for infection and other concerns.</p> <p>The Physician's antibiotic orders included the following:</p> <p>4/16/25 to 4/21/25 - vancomycin, 1 gm (gram) daily for knee infection.</p> <p>4/18/25 to 4/21/25 - meropenem - 1 gm every 12 hours</p> <p>4/22/25 - ampicillin 2 gm to be given every 8 hours for a left knee infection.</p> <p>There were no orders to flush and monitor the midline IV or for the dressing changes written as a Physician's Order. There was no documentation that indicated the dressing had been changed 24 hours after the insertion or the midline had been flushed before and after the medication. There was no documentation the midline had been assessed for placement and signs and symptoms of infection.</p> <p>During an interview on 5/1/25 at 2:03 p.m., the Director of Nursing indicated there was an order for the midline, but there were no orders for the flush, dressing change, or the care of the midline.</p> <p>A PICC line/midline policy, dated 11/2024 and received from the Director of Nursing as current, indicated the treatments and dressing required a physician's order. The dressing was to be changes 24 hours after insertion and then at least weekly or any time the dressing became moist, loosened, or soiled. The PICC line must remain sterile.</p> <p>3.1-47(a)(2)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure a resident was provided with an intravenous (IV) antibiotic in a timely manner by the contracted pharmacy, related to the antibiotic not being available to be administered as ordered by the physician for 1 of 3 residents reviewed for antibiotic medications. (Resident D)</p> <p>Finding includes:</p> <p>Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia.</p> <p>A Care Plan, dated 4/29/25, indicated an IV antibiotic was ordered by the physician for a wound infection. The goal indicated there would be no complications related to the IV therapy.</p> <p>A Physician's Order, dated 4/29/25 at 6:00 p.m., indicated an IV of ampicillin-sulbactam (antibiotic) 3 grams (gm) was to be administered every six hours due to a wound infection.</p> <p>The Medication Administration Record (MAR), dated 4/2025, indicated the IV antibiotic was given on 4/29/25 at 6:00 p.m., 4/30/25 at 12:00 a.m. and 6:00 a.m. The MAR indicated the medication had not been available and was not given on 4/30/25 at 12:00 p.m. and 6:00 p.m.</p> <p>The MAR, dated 5/2025, indicated the antibiotic had not been available and was not given on 5/1/25 at 12:00 a.m. and 6:00 a.m.</p> <p>A Medication Administration Progress Note, dated 4/30/25 at 11:37 a.m., indicated the antibiotic was not available in the Emergency Drug Kit (EDK). The pharmacy was notified and they expected the antibiotic to be delivered by 1 p.m. on 4/30/25.</p> <p>A Medication Administration Progress Note, dated 4/30/25 at 5:05 p.m., indicated the antibiotic was not available and the pharmacy was notified again and was ordered to bring the antibiotic as soon as possible.</p> <p>A Medication Administration Progress Note, dated 5/1/25 at 4:07 a.m., indicated the antibiotic was not administered and was on order.</p> <p>During an interview on 5/1/25 at 10:56 a.m., the Director of Nursing indicated the first three doses of the antibiotic were taken from the IV EDK (emergency drug kit). The pharmacy had been notified and would be delivering the antibiotic.</p> <p>A facility pharmacy delivery policy, dated 1/2023 and received from the Director of Nursing as current, indicated the pharmacy will have a daily delivery of medications and supplies.</p> <p>This citation relates to Complaint IN00457153.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3.1-25(a)</p>

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<p>F 0772</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have an agreement with an approved laboratory to obtain services, if on-site laboratory services aren't provided.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure a resident received laboratory services as ordered by the physician for 1 of 3 residents reviewed for laboratory services. (Resident B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 4/30/25 at 2:12 p.m. The diagnoses included, but were not limited to, stroke and dementia.</p> <p>A Wound Physician Progress Note, dated 4/18/25, indicated a Stage IV (full thickness skin loss with extensive destruction) pressure ulcer was present on the coccyx. An order for a pre-albumin and a complete blood count (CBC) was received.</p> <p>The pre-albumin and complete blood count results were not in the medical record and there was no documentation the laboratory testing had been completed.</p> <p>During an interview on 4/30/25 at 4:42 p.m., Wound Nurse 1 indicated the laboratory testing had been ordered and sent to the lab. The pre-albumin and the CBC were not completed by the lab. It was scheduled to be completed on 4/20/25. The lab was notified and they indicated the testing had not been completed and were unable to provide a reason why the testing had not been done.</p> <p>This citation relates to Complaint IN00457153.</p> <p>3.1-49(e)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20580</p> <p>Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff members (LPN 3, CNA 2, CNA 6, and CNA 7) when providing care to a residents (Residents D and J) who were in Enhanced Barrier Precautions (EBP) for two random observations for infection control.</p> <p>Findings include:</p> <p>1. During an observation on 4/29/25 from 9:07 a.m. through 9:32 a.m., Resident D was lying in bed with the head of the bed elevated. There was a peripherally inserted central catheter (PICC) inserted in the left upper arm and a wound dressing on the right heel. The resident had been incontinent of urine and LPN 3 and CNA 2 had gloves on and were starting to complete incontinence care and were stopped. LPN 3 indicated she was unsure if the resident required EBP and indicated there was no sign on the door that indicated he required EBP and EBP was not needed. LPN 3 then indicated the resident had a wound and EBP would be needed. CNA 2 and LPN 3 then donned a gown and changed gloves and began incontinence care.</p> <p>Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia.</p> <p>An Admission Nursing Assessment, dated 4/29/25 at 1:30 p.m., indicated an open wound on the right heel, urine and bowel incontinence, assistance was required for ADL's, and a PICC line was present.</p> <p>A Care Plan, dated 4/29/25, indicated EBP was required due to the PICC line and gowns and gloves were to be worn during high contact care activities.</p> <p>2. During an observation on 4/30/25 at 10:50 a.m., there was a sign on the outside door frame that indicated the resident required EBP. Resident J was lying in bed. There was a PICC line observed in the right upper arm. CNA 6 and CNA 7 were in the room and indicated they were giving a bed bath and getting ready to wash the resident's back. There was a wash basin with soapy water and washcloths sitting on the night stand. CNA 6 and CNA 7 had gloves on. CNA 6 indicated EBP was not required and only gloves were required with care. CNA 7 then read the sign on the door frame and both CNA's then place gowns on over their uniforms.</p> <p>Resident J's record was reviewed on 5/1/25 at 1:10 p.m. The diagnoses included, but were not limited to, diabetes mellitus. The admitted was 4/2/25.</p> <p>A Care Plan, dated 4/2/25, indicated EBP was required. The interventions included gowns and gloves would be used when providing high contact resident care.</p> <p>A Physician's Order, dated 4/16/25, indicated a midline IV catheter was to be placed for IV antibiotic administration.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A facility EBP policy, dated 3/2024 and identified as current by the [NAME] President of Operations, indicated staff were to don a gown and gloves during high-contact resident care. EBP PPE was to be used for residents with wounds.</p> <p>3.1-18(b)</p>