

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  09/09/2025
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 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>(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 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</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 flushing orders and flushing of the catheter, medications administered as ordered, documentation of the insertion and discontinuation of the catheter, assessments of the catheter line with dressing changes and after discontinuing the catheter, for 3 of 3 residents reviewed for midline/PICC (peripherally inserted central catheter) care. (Residents B, C, and F) Findings include: 1. Resident B's closed record was reviewed on 9/8/25 at 9:56 a.m. The diagnoses included, but were not limited to, urinary tract infection and bladder cancer. A Care Plan, dated 6/2/25, indicated IV medication was being administered. The interventions included, the dressing for the site was to be changed daily and the observations of the site were to be recorded and the IV line was to be flushed per the Physician's Orders. A Physician's Order, dated 6/2/25, indicated the dressing on the midline was to be changed every seven days for midline maintenance per the midline maintenance protocol. The Medication Administration Record (MAR), dated 6/2025, had initials as completed on June 2, 10, 26, and 24, 2025. There was no assessment of site and length of the IV line documented. A Physician's Order, dated 6/2/25, indicated piperacillin-tazobactam (antibiotic) 3-0.375 grams was to be administered per the IV in 100 milliliters (ml) of normal saline every eight hours. The Medication Administration Record (MAR), dated 6/2025, indicated the last dose of the antibiotic had been administered on 6/10/25 at 2:00 p.m. A Physician's Order, dated 6/2/25 and discontinued on 6/30/25, indicated a normal saline flush solution, 10 mls was to be used to flush the midline before and after the medication was infused. The MAR, dated 6/2025, indicated the flush was scheduled as needed and had not been administered from 6/2/25 to 6/30/25. A Nurse Practitioner's (NP) Progress Note, dated 6/3/25 at 2:37 p.m., indicated the IV antibiotic was to be discontinued on 6/9/25. An admission Minimum Data Set (MDS) assessment, dated 6/7/25, indicated a moderately impaired cognitive status, and indwelling urinary catheter was present, had a urinary tract infection in the last 30 days, and an IV was present. There was no documentation on the MAR or the Nurses' Progress Notes that indicated the IV line had been flushed before and after the medication and after the IV antibiotics had been discontinued. A Nurse's Progress Note, dated 6/25/25 at 7:07 p.m., indicated the midline in the right upper arm had been removed per the NP orders. There was no bleeding or signs of infection. The resident had tolerated the procedure well. There was documentation in the Nurse's Progress Note that indicated the length of the IV line and the condition of the tip of the catheter. During an interview on 9/8/25 at 12:05 p.m., the Director of Nursing (DON), indicated the midlines/PICC lines were usually discontinued when it was determined there would be no further treatment. When the line was no longer in use, it was to be flushed with 10 ml normal saline twice a day. During an interview on 9/8/25 at 1:25 p.m., the DON indicated she was trying to find the flush orders for before and after the antibiotic was administered and assumed it had been done per the as needed order when the medication had been administered. She acknowledged there was no assessment of the length of the line and the tip condition with dressing changes and when the line had been discontinued. 2. During an observation on 9/8/25 at 8:25 a.m., Resident C was lying in bed and had an IV line in her upper left arm. The dressing that covered the insertion site had a date of 9/5/25. Resident C's record was reviewed on 9/8/25 at 1:37 p.m. The diagnoses included, but were not limited to urinary tract infection. A Physician's Order, dated 9/4/25, indicated meropenem (antibiotic) one gram was to be administered per the IV every 12 hours for seven days due to a urinary tract infection. A Physician's order, dated 9/5/25, indicated a midline IV was to be inserted for the antibiotic treatment. The MAR, dated 9/2025, indicated the meropenem had not been administered as ordered on 9/5/25 at 9:00 a.m., 9/6/25 at 9:00 p.m. and 9/7/25 at 9:00 p.m. There were no Physician's Orders for the weekly dressing change, assessment of the site, or the normal saline flushes before and after the antibiotic until 9/8/25 at 8:53 a.m. An NP Progress Note, dated 9/4/25 at 3:25 p.m., indicated, a urinary tract infection was present secondary to the urinary catheter. Cipro (antibiotic) had been initiated for seven days, pending the final sensitivity report. A MAR Note, dated 9/5/25 at 9:00 a.m., indicated the meropenem had not arrived from the pharmacy and had not been administered. An NP Progress Note, dated 9/5/25 at 4:21 p.m. and written on 9/6/25 at 12:22 p.m., indicated meropenem per IV had been ordered due to the sensitivity indicating the organism was resistant to the Cipro. A heparin lock (IV insertion) had been placed in the antecubital for IV access and a midline catheter had been ordered. A MAR Note, dated 9/6/25 at 8:57 p.m. indicated the meropenem had not been administered. No reason was documented. A</p>		