STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. Building B. Wing	04/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Crown Point LLC	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 32582 Based on observation, record review, and interview, the facility failed to ensure residents received the necessary care and treatment related to lack of assessment and treatment order for a skin tear, for 1 of 1 residents reviewed for non-pressure skin conditions. (Resident 31) Finding includes: On 4/1/24 at 2:23 p.m., Resident 31 was observed seated in his room. He had a dressing on his right elbow that was coming loose and was soiled with blood. He indicated he had bumped his elbow that morning and got a skin tear. Resident 31's record was reviewed on 4/2/24 at 9:28 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus and a foot ulcer. The Admission Minimum Data Set assessment, dated 2/22/24, indicated the resident required extensive staff assistance for transfers and toileting. He was cognitively intact. The record lacked documentation or assessment of the skin tear on his right elbow. The record lacked a Physician's Order for treatment of the skin tear. During an interview on 4/2/24 at 9:35 a.m., LPN 4 indicated she was unaware of what had happened to the resident's elbow. During an interview on 4/2/24 at 10:44 a.m., the Unit Manager indicated she had spoken to the nurse who was taking care of the resident the previous day. The nurse indicated she had forgotten to document the wound, but had notified the Wound Nurse, and there was not a treatment order in place. 3.1-37(a)

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

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32788 Based on observation, record review, and interview, the facility failed to ensure a Physician's Order was obtained for a urinary catheter, catheter care was completed, and urinary output was recorded for 1 of 3 residents reviewed for urinary catheters. (Resident 105) Finding includes: On 4/1/24 at 10:44 a.m., Resident 105 was observed in his room with a urinary catheter bag in place. On 4/3/24 at 1:30 p.m., Resident 105 was observed seated in his wheelchair in his room. He had a catheter bag in place. The record for Resident 105 was reviewed on 4/4/24 at 9:51 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, anemia, and dementia. The resident was admitted to the facility on [DATE]. A Care Plan, dated 3/28/24, indicated the resident had a urinary catheter. The Admission Nursing Evaluation, dated 3/28/24, indicated the resident had a 16f (french, catheter size) indwelling catheter. The Admission Progress Note from the Nurse Practitioner, dated 3/29/24 6:04 p.m., indicated the resident had a chronic foley catheter, last changed on 3/20/24. He had a follow up appointment with urology on 4/11/24 for a catheter exchange. The Physician's Order Summary, dated 4/2024, lacked any orders for the urinary catheter, catheter care, or to record urine output. An order, dated 4/2/24, indicated to give ceftriaxone (an antibiotic) 1 gram every 24 hours intravenously for 5 days for a urinary tract infection (UTI). The Medication Administration Records (MAR) and Treatment Administration Records (TAR), dated 3/2024 and 4/2024, lacked any documentation of catheter care or urine output. The resident was currently receiving an antibiotic treatment for a UTI. The Bladder Continence Task documentation, dated 3/2024 and 4/2024, indicated the urine output had only been documented one time since the resident's admission to the facility: 3/31/24 at 5:59 a.m. - 1800 cc (cubic centimeters) During an interview with the Director of Nursing (DON) on 4/4/24 at 11:34 a.m., she indicated the resident had a catheter since admission. There were no orders in the computer for the urinary catheter, catheter care, or for recording the urine output. 3.1-41(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32582 Based on observation, record review, and interview, the facility failed to ensure residents received the correct and necessary respiratory treatment, related to no Physician's Order for oxygen and incorrect oxygen flow rate, for 2 of 4 residents reviewed for respiratory care. (Residents 258 and 3) Findings include: 1. On 4/1/24 at 11:05 a.m., Resident 258 was observed lying in bed. He had a nasal cannula in place with oxygen flowing at 2.5 liters per minute. Resident 258's record was reviewed on 4/3/24 at 9:05 a.m. Diagnoses included, but were not limited to, acute kidney failure, Diabetes Mellitus and congestive heart failure. There was no Physician's Order for the oxygen. An Admission Nursing Evaluation, dated 3/21/24, indicated the resident's oxygen saturation was 94% on oxygen via nasal cannula. During an interview on 4/3/24 at 2:45 p.m., the Unit Manager indicated there was no Physician's Order for the oxygen. 32664 2. On 4/2/24 at 9:22 a.m., Resident 3 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate at 2.5 liters. On 4/2/24 at 12:52 p.m., Resident 3 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate at 2.5 liters. On 4/3/24 at 10:00 a.m., Resident 3 was lying in bed. The resident was wearing oxygen via a nasal cannula with a flow rate at 2.5 liters. Record review for Resident 3 was completed on 4/2/24 at 1:12 p.m. Diagnoses included, but were not limited to, depression, chronic obstructive pulmonary disease (COPD) and asthma. The Annual Minimum Data Set (MDS) assessment, dated 3/15/24, indicated the resident was cognitively intact. The resident required assistance with ADLs (activities of daily living). The resident did not have oxygen therapy. A Care Plan, dated 4/1/23 and revised 3/31/24, indicated the resident had oxygen therapy at 3 liters via nasal cannula PRN (when necessary) related to COPD. An intervention included to administer oxygen per physicians orders. The April 2024 Physician's Order Summary indicated and order for Oxygen at 3 liters per nasal cannula every shift PRN. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 4/3/24 at 10:55 a.m., the Director of Nursing indicated the resident's oxygen was a PRN order. The staff should have set the flow rate at 3 liters when the resident required the oxygen. 3.1-47(a)(6)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 32582 Based on observation and interview, the facility failed to ensure there was a sanitary kitchen, related to undated and/ or unlabeled food, a build up on ice in the freezer, and a spilled substance and food on the floors in a refrigerator and dry storage room. This had the potential to affect all 68 residents who received meals prepared in the kitchen. Findings include: On 4/1/24 at 8:45 a.m., during the initial kitchen tour with Cook 1, the following was observed: a. In the walk in refrigerator, there were boxes of soda and pies sitting directly on the floor. b. In the walk in refrigerator, there was a package of raw meat, gravy in a plastic container, and mashed potatoes that were unlabeled and undated. c. There was a raw potato and a pink substance spilled on the refrigerator floor. d. In the freezer, there was a heavy build up of ice on the ceiling and on two boxes of food. e. In the dry storage room, there was a large amount of dry oatmeal spilled on the shelves and floor. During an interview with Cook 1 at the time of observation, she indicated the items should be labeled and dated. She indicated the spills just happened recently and the staff was busy preparing breakfast. 3.1-21(i)(3)