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	04/02/2026

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

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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. Based on observation, record review, and interview, the facility failed to ensure food was stored and served under sanitary conditions related to dirty food equipment, boxes stored on the floor, dirty dishes stored on food equipment, and lack of sanitation of the food thermometer for 1 of 1 kitchen. (The Main Kitchen) This had the potential to affect the 68 residents who received food from the kitchen. Findings include:1. During the Kitchen Sanitation Initial Tour on 3/29/26 at 9:55 a.m. with [NAME] 1, the following was observed:a. The grill had an accumulation of crumbs and debris on it.b. There was a stack of dirty pans and dishes on top of the flat-top grill.c. There were multiple boxes of food stored on the floor of the walk-in freezer. Some of the boxes were open and tipped over.d. There were multiple boxes of food and non-food items stored on the floor in the dry storage area. Some of the boxes were open and tipped over.e. There were multiple boxes of cups and straws stored on the floor in the hallway outside the kitchen.During an interview at that time, [NAME] 1 indicated all of the above was in need of cleaning. The items should not have been on the floor. They had been there for a few days and no one had put them away like they were supposed to. A facility policy, titled, Dietary Cleaning Policy, indicated, .Staff will use a ?clean as you go' technique to keep the facility and neighborhood kitchen areas clean, functional and attractive.The Retail Food Establishment Sanitation Requirements, dated 11/13/04, indicated .Food storage.Sec. 189. (a). food must be protected from contamination by storing the food as follows: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches (fifteen centimeters) above the floor. Storage of equipment, utensils, linens, and single-service and single-use articles.cleaned equipment and utensils, laundered linens, and single-service and single-use articles must be stored: (1) In a clean, dry location. (2) Where it is not exposed to splash, dust, or other contamination. (3) At least six (6) inches (fifteen centimeters) above the floor. 2. On 4/1/26 at 11:51 a.m., the Sous Chef was observed checking the lunch food temperatures. He had two thermometers in a basin of ice water. He took one thermometer out of the water, wiped it off on a blue towel sitting on steam table, and checked the food temperature of the hamburgers. He took the second thermometer out of the water, wiped it off on the same blue towel, and checked the food temperature of the stuffing. He had not sanitized either thermometer prior to using them to check the food temperatures. He then wiped both thermometers off on the same blue towel and continued to check food temperatures. He wiped the thermometer off in between each food using a paper towel, but had not sanitized the thermometers in between checking each food temperature.During an interview at that time, the Sous Chef indicated he should have been using probe wipes to clean the thermometer between each food temperature, but they did not have any right now. He was unable to ask his manager what he should do because his manager had not shown up to work the past few days and probably no longer worked at the facility. During an interview on 4/1/26 at 2:42 p.m., the Administrator was made aware of the kitchen sanitation concerns. He indicated he had been trying to contact his Dietary Manager for the past few days but had been unable to reach him.A facility policy, titled, Food, indicated, .Food temperatures will be taken using a clean, rinsed and sanitized air-dried metal stem type thermometer, numerically scaled and accurate to plus or minus 2F. Test the temperature of a hot food before (continued on next page)

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	serving, insert the thermometer at 45-degree angle to the middle of the food item. Take care not to touch the container or bone, if a meat item. Read the temperature and remove thermometer from food item and immediately wipe and sanitize with alcohol wipe, and air dry .410 IAC (Indiana Administrative Code) 16.2-3.1-21(i)(3)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to dirty floors and shelved for 1 of 1 kitchen. (The Main Kitchen) Finding includes:Findings include:During the Kitchen Sanitation Initial Tour on 3/29/26 at 9:55 a.m. with [NAME] 1, the following was observed:a. An accumulation of dirt and debris was observed on the floor in front of the oven.b. An accumulation of dirt and debris was observed on the floor in between the oven, grill, and fryer.c. An accumulation of dried food spillage, dirt, and debris was observed on the shelf underneath the grill.d. An accumulation of dried white and pink substance was on the bottom shelf of the prep table.During an interview at that time, [NAME] 1 indicated all of the above was in need of cleaning. A facility policy, titled, Dietary Cleaning Policy, indicated, .Keep floor of kitchen free of debris. Staff will use a ?clean as you go' technique to keep the facility and neighborhood kitchen areas clean, functional and attractive.the following areas and equipment will be cleaned daily.kitchen walls and floors.410 IAC (Indiana Administrative Code) 16.2-3.1-19(f)

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F 0680 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the activities program is directed by a qualified professional. Based on record review and interview, the facility failed to ensure the Activities Program was directed by a qualified professional who met required training and certification standards prior to assuming the role of Activities Director. This failure had the potential to affect 69 of 69 residents who relied on the activities program to meet their psychosocial, emotional, and social needs. Finding includes: The employee records were reviewed on 4/1/26. The Activity Director was hired on 10/20/25. There was a certificate, dated 12/31/25, for Hospitality Management Studies. There was no indication she had completed the Activities Director course. During an interview on 4/1/26 at 11:25 a.m., the Activities Director indicated she had a certificate in hotel hospitality and she had not completed the Activity Director course. She indicated she was not aware it was necessary. She did not have 2 years prior experience and was not a therapeutic recreations specialist or an activities professional. The policy and or qualifications was requested from the Director of Nursing (DON). During an interview on 4/2/26 at 8:50 a.m., the DON indicated she did not have a policy related to the Activity Director or qualifications. 410 IAC (Indiana Administrative Code) 16.2-3.1-33(e)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to honor a resident's food preferences for 1 of 2 residents reviewed for food choices. (Resident 104) Finding includes:On 3/29/26 at 1:51 p.m., Resident 104 was observed sitting in his room with his daughter. The resident indicated he wanted soup for lunch and he was told they did not have any. The resident's daughter indicated she had to go upstairs to his Assisted Living apartment to get a can of soup for him to eat for lunch. They both indicated he did not always receive what he ordered from the menu.Record review for Resident 104 was completed on 4/1/26 at 9:02 a.m. The resident was admitted to the facility on [DATE].During an interview on 4/1/26 at 9:08 a.m., the A Unit Manager indicated the resident's daughter filled out his meal tickets for the week and the kitchen had his meal tickets.The Lunch Meal Ticket, dated 4/1/26, indicated the resident chose:-soup of the day-small salad with French dressing-chilled peachesOn 4/1/26 at 1:42 p.m., Resident 104 was observed sitting in his room eating lunch. The resident had a salad and the chilled peaches. The resident did not have any soup. The resident indicated he also wanted soup for lunch but did not receive any. During an interview on 4/1/26 at 1:42 p.m., the Sous Chef indicated he did not make any soup that day and one of the cooks was supposed to make it.During an interview on 4/1/26 at 1:52 p.m., [NAME] 1 indicated [NAME] 2 was supposed to make the soup for the day and she was unsure why she didn't. During an interview on 4/1/26 at 2:39 p.m., the Administrator indicated [NAME] 2 had already left for the day. He called her and she indicated she thought [NAME] 1 was supposed to make the soup and there was confusion on who was supposed to make it, so no one made the soup. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(u)(3)

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure non-pharmacological interventions were attempted prior to administering as needed (PRN) antipsychotic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident G)Finding includes:Resident G's record was reviewed on 3/31/26 at 8:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia, mood disorder and metabolic encephalopathy.The admission Minimum Data Set assessment, dated 2/24/26, indicated the resident had severe cognitive impairment and received antipsychotic medications.A Physician's Order, dated 2/18/26, indicated to give quetiapine fumarate, (an antipsychotic) 12.5 milligrams (mg) every eight hours as needed for agitation. The order was discontinued on 2/20/26.A Physician's Order, dated 2/20/26, indicated to give quetiapine fumarate, 12.5 mg every eight hours as needed for psychotic behaviors for 14 days. The order was discontinued on 2/24/26.A Physician's Order, dated 2/26/26, indicated to give quetiapine fumarate, 12.5 mg every eight hours as needed for psychosis related to dementia with psychotic disturbance for 14 days. The February and March 2026 Medication Administration Record (MAR) indicated the resident received the quetiapine fumarate nine times between 2/26/26 and 3/1/26. There was no documentation in the MAR, nurse's notes, or behavior narrative notes that any non-pharmacological interventions had been attempted prior to giving the medication on 2/19, 2/24, 2/26, 3/1 or 3/7/26. The policy, Psychotropic Medications, reviewed 5/2025, indicated, .Use of alternative non-pharmacologic interventions for psychiatric disorders and problem behaviors related to dementia will be attempted prior to and during administration of antipsychotic medications .During an interview on 4/1/26 at 9:42 a.m., the Director of Nursing indicated non-pharmacologic interventions should have been attempted prior to giving the medication. 410 IAC (Indiana Administrative Code) 16.2-3.1-3(w)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure the Minimum Data Set (MDS) comprehensive assessment was accurately completed related to oxygen use for 1 of 22 MDS assessments reviewed. (Resident M)Finding includes:On 3/29/26 at 11:10 a.m., Resident M was observed lying in bed. The resident had oxygen on via a nasal cannula and attached to a concentrator. The flow rate was set at 4 liters. The resident indicated she had been on 3 liters of oxygen since she was admitted to the facility and was unsure why it was set at 4 liters.Record review for Resident M was completed on 3/30/26 at 2:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, and respiratory failure. The resident was admitted to the facility on [DATE].A Physician's Order, dated 2/2/26, indicated the resident was to receive oxygen at 3 liters every shift.The admission MDS assessment, dated 2/9/26, indicated the resident was cognitively intact. The assessment did not have checked that the resident received oxygen on admission or as a resident. During an interview on 3/31/26 at 10:35 a.m., MDS Coordinator 1 indicated the resident had been on oxygen since admission and it was not coded on the assessment.410 IAC (Indiana Administrative Code) 16.2-3.1-31(i)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review, and interview, the facility failed to ensure a care plan was implemented for pressure ulcers for 1 of 2 residents reviewed for pressure ulcers. (Resident F)Finding includes:During an interview on 3/29/26 at 12:59 p.m., Resident F indicated she was receiving treatment for multiple pressure ulcers that were causing a lot of pain and she received antibiotics for an infection in the wounds.On 4/2/26 at 10:23 p.m., Resident F's wound care was observed for the left and right buttocks wounds and the left lateral posterior thigh with the Wound Nurse. The Wound Nurse indicated the wounds had been infected and the resident had been receiving antibiotics for wound infections. The resident was noncompliant with offloading and wound care.Resident F's record was reviewed on 3/30/26 at 1:33 p.m. Diagnoses included, but were not limited to, local infection of skin and subcutaneous tissue.The admission Minimum Data Set (MDS) assessment, dated 2/25/26, indicated the resident was cognitively intact and had two stage IV pressure ulcers, two unstageable pressure ulcers, and two venous/arterial ulcers. The resident was also receiving antibiotic treatment.The Wound Rounds, dated 3/24/26, indicated the resident had a stage IV pressure ulcer to the right buttocks measuring 9.0 cm long by 17.0 cm wide by 2.0 cm deep. She had an unstageable pressure ulcer on the left lateral posterior thigh measuring 9.5 cm long by 5.0 cm wide. She had a stage IV pressure ulcer to the left buttocks measuring 6.5 cm long by 18.0 cm wide by 2.0 cm deep. The pressure ulcers were present on admission.The comprehensive care plan lacked a care plan related to the pressure ulcers that identified needs, including measurable goals, resident involvement and choice, and interventions to heal/prevent pressure ulcers.During an interview on 4/2/26 at 1:12 p.m., the Director of Nursing indicated there was a skin impairment care plan implemented, but there was no care plan implemented related to the pressure ulcers.A facility policy titled, Wound Policy & Procedure, indicated, .Documentation and Care Planning.The wound management program documentation requirements include: Identification of the location and frequency of wound documentation, Required comprehensive description of pressure ulcer weekly at a minimum, Delineation of in-house documentation required and by whom, Goals of the wound care plan collaboratively determined with the resident, family, and interdisciplinary team, Assigned responsibility/accountability for the initial care plan and for subsequent updating, Determined facility time frames for care plan updating; Resident risk factors and interventions are documented including: Impaired mobility, Need for pressure relief such as support surfaces, repositioning, pressure relieving devices, Nutritional status, Incontinence, Skin condition, Complications such as infection and pain, General treatment regimen.410 IAC (Indiana Administrative Code) 16.2-3.1-35(b)(1)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure dependent residents received showers or baths as scheduled for 2 of 2 residents reviewed for activities of daily living (ADL) care. (Residents H and J)Findings include: 1. On 3/29/26 at 11:37 a.m., Resident H was observed in his bed. His hair was uncombed and he was unshaven. The resident was unable to communicate if he had a shower recently or preferred to be clean shaven.Resident H's record was reviewed on 4/1/26 at 3:44 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, metabolic encephalopathy and chronic obstructive pulmonary disease.The admission Minimum Data Set assessment, dated 3/1/26, indicated the resident was rarely or never understood, and was dependent for toileting, bed mobility, and transfers.The ADL Care Plan, dated 2/26/26, indicated the resident had self-care deficits, performance deficit, and limitations in physical mobility. Interventions included, but were not limited to, provide partial to moderate assistance with tub and/or shower transfers.The shower book indicated the resident was scheduled for showers or bed baths on Tuesday and Friday during the day shift. There were no showers or baths documented on 2/27, 3/13, 3/20, or 3/24/26.During an interview on 4/2/26 at 9:43 a.m., the A-Unit Manager indicated there was no additional documentation that the scheduled showers had been completed. 2. On 3/29/26 at 12:51 p.m., Resident J was observed lying in her bed. She indicated she had not had a shower since she had been in the facility.Resident J's record was reviewed on 3/30/26 at 11:57 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, low back pain and atrial fibrillation.The admission Minimum Data Set assessment, dated 3/29/26, indicated the resident was cognitively intact and required partial to moderate assistance for showering and toileting.The shower book did not have a page for the resident. The resident who previously resided in Resident J's room was still in the shower book.During an interview on 3/31/26 at 1:46 p.m., the A-Unit Manager indicated there were no shower sheets for the resident. She would ensure the resident was showered that day.This citation relates to Intake 2729246.410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure activities were provided to a dependent resident as care-planned for 1 of 1 resident reviewed for activities. (Resident 51)Finding includes: On 3/29/26 at 2:20 p.m., Resident 51 was observed in her bed. She indicated she liked to go to activities, but nobody would take her to them. Resident 51's record was reviewed on 3/30/26 at 2:12 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure and morbid obesity. The Leisure Preferences Care Plan, dated 2/12/26, indicated the resident would participate in leisure activities as desired through the review period. Interventions included, but were not limited to, creative arts, music, puzzles and trivia, and music.The admission Minimum Data Set assessment, dated 2/18/26, indicated the resident had moderate cognitive impairment and needed substantial maximum assistance for transfers. During an interview on 3/31/26 at 10:11 a.m., the Activity Director indicated it was difficult to get the resident to activities. The resident liked to come to Friday dinner and a movie with her family. Her family was unable to push her in her wheelchair, but their staff could push her. All activities were documented in the electronic record. The activities log in the resident's electronic record was reviewed for the past 30 days. There was no documentation of any one on one or group activities. During an interview on 4/1/26 at 10:57 a.m., the resident's family member indicated she would like to go to activities, but no one would take her and she was unable to push the wheelchair. During another interview on 4/1/26 at 11:25 a.m., the Activity Director was made aware there were no activities documented in the resident's record for the past 30 days. The Activity Director indicated staff could take her to the activities. 410 IAC (Indiana Administrative Code) 16.2-3.1-33(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure weekly weights were obtained as ordered for 1 of 5 residents reviewed for nutrition. (Resident G) The facility also failed to ensure physician's orders were in place for a bandage and an abrasion and a bruise were assessed and monitored for 2 of 3 residents reviewed for non-pressure skin conditions. (Residents K and L)Findings include:1. Resident G's record was reviewed on 3/31/26 at 8:45 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, dementia, diabetes mellitus and dysphagia (difficulty swallowing). A Nutritional Care Plan, dated 2/17/26, indicated the resident had potential for alteration in nutrition and hydration. Interventions included, but were not limited to, obtain and document weights per physician order and facility protocol. A Physician's Order, dated 2/17/26, indicated to obtain a weekly weight every Sunday. A Physician's Order, dated 3/16/26, indicated to weigh the resident in the morning, this was ordered weekly no weight in 30 days documented. There was a weight documented on 2/17/26 and 3/19/26. The admission Minimum Data Set assessment, dated 2/24/26, indicated the resident had severe cognitive impairment and needed supervision or touch assistance for eating. During an interview on 4/1/26 at 9:42 a.m., the Director of Nursing was made aware of the missing weights and indicated she would look into it. No additional information was provided. 2. On 3/29/26 at 10:19 a.m., Resident K was observed lying in bed with her eyes closed. There was an undated white bandage observed to her left inner elbow and a thick black scabbed area to her left forearm. On 4/2/26 at 11:01 a.m., Resident K was observed lying in bed. There was an undated white bandage observed to her left inner elbow and a thick black scabbed area to her left forearm. The resident indicated she was unsure why she had the bandage or how she received the scabbed area. The resident then proceeded to remove the bandage. The skin underneath the bandage was observed with a green discoloration. Record review for Resident K was completed on 3/31/26 at 1:49 p.m. Diagnoses included, but were not limited to, atrial fibrillation, diabetes mellitus, and end stage renal disease. The admission Minimum Data Set (MDS) assessment, dated 2/25/26, indicated the resident was cognitively intact. The resident had an impairment on one side of her upper extremities for a functional limitation in range of motion. The resident required a substantial maximal assistance for upper body dressing. The resident received anticoagulant medication. A Care Plan, dated 2/23/26, indicated the resident received anticoagulant therapy. An intervention included to monitor, document, and report bruising. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Daily Skilled Nursing Evaluation, dated 3/29/26, indicated the skin/wound section was blank. There was a lack of documentation to indicate there was a physician's order for the bandage to the resident's inner elbow or why the bandage was there. There was also a lack of documentation to indicate the resident's scabbed area on her skin was assessed and or monitored. During an interview on 4/2/26 at 11:02 a.m., RN 1 indicated she was unaware of the scabbed area to the resident's arm. She further indicated the resident had probably had blood work completed and that was why there was a bandage. The bandage should not have been on her arm for that many days. 3. Record review for Resident L was completed on 3/31/26 at 1:38 p.m. Diagnoses included, but were not limited, Guillain-Barre syndrome (immune system attacks peripheral nerves), atrial fibrillation, and diabetes mellitus. The resident was admitted to the facility on [DATE]. A Nursing Evaluation, dated 3/18/26 at 3:30 p.m., indicated the resident was admitted from the hospital. The skin color to all extremities were normal and warm. The admission Minimum Data Set (MDS) assessment, dated 3/23/26, indicated the resident was cognitively intact. The resident had an impairment to both sides of his upper and lower extremities for a functional limitation in range of motion. The resident was dependent on staff for toileting, hygiene and transfers. The resident received anticoagulant medication. A Care Plan, dated 3/18/26 and revised 3/25/26, indicated the resident had an ADL (activities of daily living) self-care deficit and limitations in physical mobility related to tetraquadraplegia and ascending paralysis. An intervention included for staff to assist with all ADLs and may use Hoyer lift (mechanical lift) for transfers. A Care Plan, dated 3/24/25, indicated the resident received anticoagulant therapy. An intervention included to monitor, document, and report any adverse reactions of anticoagulant therapy which included bruising. During a random observation on 4/1/26 at 12:01 p.m., Resident L was observed lying in bed. The resident had on a shirt and an incontinence brief. There was large dark purple discoloration observed to his right upper inner thigh from his groin area extended to the middle part of his upper leg. The resident indicated he was unsure how he received it. There was a lack of documentation to indicate the resident's discoloration on his skin was assessed and or monitored. During an interview on 4/1/26 at 12:07 p.m., LPN 2 indicated she was unaware of the discoloration to the resident's leg. During an interview on 4/1/26 at 12:10 p.m., CNA 1 indicated she believed the discoloration to his leg was there since he was admitted but she was unsure. During an interview on 4/1/26 at 2:35 p.m., the A Unit Manager and the Director of Nursing (DON) indicated the resident's discoloration was not there on admission. They believe it may have come from using the Hoyer lift. The staff should have observed the discoloration and assessed it. (continued on next page)

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	155835	A. Building B. Wing	04/02/2026

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Wound Policy & Procedure and received as current from the facility on 4/2/26, indicated, .Procedure: Accountability The Wound Management Program identifies staff participation and accountability to include .Expectation of all caregivers to observe resident skin integrity during the daily provision of the resident's personal care . This citation is related to Intakes 2729246 and 2786645. 410 IAC (Indiana Administrative Code) 16.2 3.1-37(a)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure pressure ulcer care was provided as ordered for 1 of 2 residents reviewed for pressure ulcers. (Resident F)Finding includes:During an interview on 3/29/26 at 12:59 p.m., Resident F indicated she was receiving treatment for multiple pressure ulcers that were causing a lot of pain and she received antibiotics for an infection in the wounds.Resident F's record was reviewed on 3/30/26 at 1:33 p.m. Diagnoses included, but were not limited to, local infection of skin and subcutaneous tissue.The admission Minimum Data Set (MDS) assessment, dated 2/25/26, indicated the resident was cognitively intact and had two stage IV pressure ulcers, two unstageable pressure ulcers, and two venous/arterial ulcers. The resident was also receiving antibiotic treatment.The Wound Round Notes, dated 3/24/26, indicated the resident had a stage IV pressure ulcer to the right buttocks measuring 9.0 cm long by 17.0 cm wide by 2.0 cm deep. She had an unstageable pressure ulcer on the left lateral posterior thigh measuring 9.5 cm long by 5.0 cm wide. She had a stage IV pressure ulcer to the left buttocks measuring 6.5 cm long by 18.0 cm wide by 2.0 cm deep. The pressure ulcers were present on admission.A Physician's Order, dated 2/24/26 and discontinued on 3/25/26, indicated wound care to left buttocks/ischium, irrigate with Vashe (wound cleanser) and normal saline, pack saline moistened roll gauze and cover with bordered gauze, change daily and as needed every day shift.The March 2026 Medication and Treatment Administration Records (MAR/TAR) indicated the wound care for the left buttocks/ischium was not marked as completed on 3/1/26, 3/7/26, 3/8/26, 3/14/26, 3/15/26, 3/21/26, and 3/22/26.A Physician's Order, dated 2/24/26 and discontinued on 3/25/26, indicated wound care to right buttocks/ischium, irrigate with Vashe and normal saline, pack saline moistened roll gauze and cover with bordered gauze, change daily and as needed every day shift.The March 2026 MAR/TAR indicated the wound care for the right buttocks/ischium was not marked as completed on 3/1/26, 3/7/26, 3/8/26, 3/14/26, 3/15/26, 3/21/26, and 3/22/26.A Physician's Order, dated 2/25/26 and discontinued on 3/25/26, indicated wound care to the left lateral posterior thigh, cleanse with Vashe wash, apply Vashe moistened gauze and cover with bordered gauze, change daily and as needed every day shift.The March 2026 MAR/TAR indicated the wound care for the left lateral posterior thigh was not marked as completed on 3/1/26, 3/7/26, 3/8/26, 3/14/26, 3/15/26, 3/16/26, 3/21/26, and 3/22/26.A Physician's Order, dated 3/25/26, indicated wound care to the left buttocks/ishium, irrigate with Vashe or Dakin's 1/4 strength (wound cleanser), pack with MediHoney (antibacterial honey product) and calcium alginate (highly absorbent dressing), cover with bordered gauze, change daily and as needed every day shift.The March 2026 MAR/TAR indicated the wound care for the left buttocks/ischium was not marked as completed on 3/28/26 and 3/29/26.A Physician's Order, dated 3/25/26, indicated wound care to the left lateral posterior thigh, cleanse with Vashe wash, pack with Medihoney and calcium alginate, cover with bordered gauze and change daily and as needed every day shift.The March 2026 MAR/TAR indicated the wound care for the left lateral posterior thigh was not marked as completed on 3/28/26 and 3/29/26.A Physician's Order, dated 3/25/26, indicated wound care to the right buttocks/ischium, cleanse with Vashe wash, pack with Medihoney and calcium alginate, cover with bordered gauze and change daily and as needed every day shift.The March 2026 MAR/TAR indicated the wound care for the right buttocks/ischium was not marked as completed on 3/28/26 and 3/29/26.There were no refusals documented in the medical record.On 4/2/26 at 10:23 p.m., Resident F's wound care was observed for the left and right buttocks wounds and the left lateral posterior thigh with the Wound Nurse. The Wound Nurse indicated the wounds had been infected and the resident had been receiving antibiotics for wound infections. The resident was noncompliant with offloading and wound care.During a follow-up interview on 4/2/26 at 11:12 a.m., the Wound Nurse indicated the nurses who were scheduled during the weekend were supposed to provide the wound care, as she only worked Monday through Friday. The resident was very noncompliant, and it took her a while to convince the resident to allow anyone to do the wound care.This citation relates to Intake 2729246.410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure safety was maintained related to fall interventions not in place for 1 of 4 residents reviewed for accidents (Resident 79)Finding includes:On 3/29/26 at 1:30 p.m., Resident 79 was observed lying in bed watching television. There were no floor mats in place on either side of the bed.On 3/30/26 at 9:17 a.m., Resident 79 was observed lying in bed. There were no floor mats in place on either side of the bed.On 3/31/26 at 11:40 a.m., Resident 79 was observed lying in bed. There were no floor mats in place on either side of the bed.Resident 79's record was reviewed on 3/31/26 at 9:34 a.m. Diagnoses included, but were not limited to, hypertension and type 2 diabetes mellitus. The resident was admitted to the facility on [DATE]. She was discharged to the hospital on 3/16/26 and returned to the facility on 3/28/26. The admission Minimum Data Set (MDS) assessment was still in progress.A Baseline Care Plan, initiated on 3/8/26, indicated the resident was at risk for falls. A Fall Note, dated 3/16/26 at 5:15 a.m., indicated the resident was found on the floor next to her bed. She had an abrasion to her left forehead and was guarding her right arm. The resident was sent to the emergency room for evaluation.An Interdisciplinary Team (IDT) Meeting Note, dated 3/16/26 at 9:22 a.m., indicated the resident was found on the floor with an abrasion to her forehead. She was sent to the hospital for evaluation. A mat on the floor would be implemented upon her return.A falls Care Plan was updated on 3/16/26 to include the intervention of floor mat next to the bed.During an interview on 3/31/26 at 2:41 p.m., the Director of Nursing was made aware the fall mat was not in place.During an interview on 4/1/26 at 9:39 a.m., the C Unit Manager indicated the resident had been sent out to the hospital and the floor mat was not put in place upon her return. The resident was no longer attempting to self-transfer, so she didn't think the floor mat was an appropriate intervention.A facility policy, titled, Post Fall Policy, indicated, .Fall is documented on the care plan with interventions to prevent further falls based on the determined causal factors at the time of the initial fall follow up .410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)

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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. Based on observation, record review, and interview, the facility failed to ensure an indwelling urinary catheter bag and tubing was placed below the level of the bladder and not on the floor for 2 of 3 residents reviewed for catheters. (Residents 115 and F)Findings include: 1. On 3/29/26 at 12:04 p.m., Resident 115 was observed seated in her wheelchair in the Main Dining Room. Her catheter bag was hanging from the back rest of her wheelchair, not below the level of the bladder. On 3/29/26 at 1:25 p.m., Resident 115 was observed seated in her wheelchair with family pushing her down the hallway towards her room. Her catheter bag was hanging from the back rest of her wheelchair, not below the level of the bladder. On 3/31/26 at 12:52 p.m., Resident 115 was observed seated in her wheelchair in the Main Dining Room. Her catheter bag was hanging from the bottom of her wheelchair with the bag touching the floor. The record for Resident 115 was reviewed on 3/30/26 at 2:46 p.m. Diagnoses included, but were not limited to, acute kidney failure. A Care Plan, updated 3/25/26, indicated the resident had a urinary catheter. The interventions included check placement of tubing each shift. During an interview on 3/31/26 at 2:41 p.m., the Director of Nursing was made aware the catheter had not been below bladder level and was touching the floor. The facility policy was requested. 2. On 3/31/26 at 11:13 a.m., Resident F was observed lying in bed. Her catheter bag was secured onto the footboard of the bed, above the level of the bladder. On 4/1/26 at 1:42 p.m., Resident F was observed sitting up in a wheelchair eating lunch. The catheter bag was sitting on the floor underneath the wheelchair and the tubing was touching the floor. Resident F's record was reviewed on 3/30/26 at 1:33 p.m. A Care Plan, dated 2/21/26, indicated the resident had a urinary catheter. Interventions included, but were not limited to, check placement of tubing each shift. A Physician's Order, dated 3/20/26, indicated to check placement and patency of the Foley catheter, 16 FR/10 cc balloon (sizing of catheter). During an interview on 4/1/26 at 4:10 p.m., the Director of Nursing indicated she had no further information to provide. A facility policy titled, Urinary Indwelling Catheter Management, indicated, .Additional Care Practices.Securing the catheter to facilitate flow of urine, preventing kinking of the tubing and position below the level of the bladder. 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, record review, and interview, the facility failed to ensure to follow-up and implement recommendations from the Registered Dietician for a resident with documented weight loss and lack of documentation of meal intakes for 2 of 4 residents reviewed for nutrition. (Residents F and C)Findings include:1. Resident F's record was reviewed on 3/30/26 at 1:33 p.m.On 3/15/26, the resident weighed 186 pounds (lbs). On 3/20/26, the resident weighed 156 lbs. On 3/29/26, the resident weighed 159 lbs, which was a -14.52% weight loss from 3/15/26 to 3/29/26.A Care Plan, dated 2/23/26, indicated the resident had the potential for alterations in nutrition and hydration. Interventions included, but were not limited to, evaluate any weight changes, determine percentage changed and follow facility protocol for weight change, monitor/record/report to the physician any signs/symptoms of malnutrition, significant weight loss (3 lbs in 1 week, greater than 5% in a month, and greater than 10% in six months); Registered Dietician (RD) to evaluate and make diet change recommendations as needed.A Dietician Evaluation, dated 2/27/26 at 11:18 a.m., indicated the resident was on a regular texture low concentrated sweets/no added salt diet. She was a new admission from the hospital for diabetic ketoacidosis and severe clostridium difficile colitis (gastrointestinal infection), and infected gluteal ulcer. She was receiving intravenous antibiotics. She would benefit from liquid protein 30 milliliters twice daily and double portion protein foods for wound healing. Recommendations included to add liquid protein 30 milliliters twice daily and add double portion protein foods at all meals.There were no physician's orders for the liquid protein or double portion protein foods initiated after the recommendations were made by the RD. During an observation on 3/31/26 at 1:13 p.m., Resident F was observed sitting in bed. A lunch tray was sitting on the bedside table that had two chicken strips, two pieces of bread, a serving of potato wedges, and a dessert. There was not a double serving of protein or a health shake observed on the tray.During an observation on 4/1/26 at 1:42 p.m., Resident F was observed sitting in her wheelchair. A lunch tray was observed on the bedside table that had a single turkey patty, cooked zucchini, and a starch side dish. There was not a double serving of protein or a health shake observed on the tray.The Amount Eaten Point of Care documentation was reviewed for the last 30 days. There were no documented meal entries on 3/4/26, 3/6/26, 3/8/26, and 3/12/26. There was one meal entry on 2/22/26, 2/23/26, 3/3/26, 3/7/26, 3/19/26, 3/21/26, 3/23/26, 3/25/26, and 3/27/26. There were two meal entries on 2/24/26, 2/26/26, 2/27/26, 3/1/26, 3/9/26, 3/10/26, 3/13/26, 3/16/26, and 3/29/26.During an interview on 4/1/26 at 9:42 a.m., the C Wing Unit Manager indicated she reviews all the RD's recommendations once the RD sends them over via email. Resident F was never listed as a resident who was reviewed by the RD on her visit before or after 2/27/26 when her note was entered in the resident's record. The recommendations were missed and not entered as new orders in the Physician's Order Summary.During an interview on 4/2/26 at 1:12 p.m., the Director of Nursing indicated the scales had recently been recalibrated as they were finding errors with residents' weights. The resident weighed 62 kilograms (136.7 pounds) on 2/18/26 per the hospital paperwork. A Work History Report provided at the time indicated that preventative maintenance was completed on the resident scales, and the calibration was checked on the scales on 3/18/26. The RD's recommendations were due to wound healing and not for weight loss as the resident had not actually had a large weight loss. 2. Resident C's record was reviewed on 3/31/26 at 12:51 p.m.On 2/13/26, the resident weighed 250 pounds (lbs). On 3/29/2026, the resident weighed 218 lbs which was a -12.8% weight loss.A Dietician Evaluation, dated 3/13/26 at 2:18 p.m., indicated the resident required hemodialysis and had history of osteomyelitis (bone infection) and left great toe amputation with complications. Diet was adequate to meet needs, but additional protein was indicated for wound healing. Eating 50-100% of meals. Per the chart, obesity was documented. The resident was receiving two Nepro (supplement) a day. Recommendations were given to decrease to one Nepro daily with 30 milliliters of liquid protein.The Amount Eaten Point of Care documentation was reviewed for the last (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	30 days. There were no documented meal entries on 3/9/26, 3/11/26, 3/20/26, 3/22/26, 3/23/26. There was one meal entry on 3/8/26, 3/12/26, 3/14/26, 3/16/26, 3/19/26, 3/25/26, and 3/27/26. There were two meal entries on 3/6/26, 3/7/26, 3/10/26, 3/13/26, and 3/29/26.During an interview on 4/1/26 at 4:10 p.m., the Director of Nursing indicated each meal should have been documented.During a follow-up interview on 4/2/26 at 1:12 p.m., the Director of Nursing indicated the scales had recently been recalibrated as they were finding errors with residents' weights.A facility policy was requested and not received.410 IAC (Indiana Administrative Code) 16.2-3.1-46(a)

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure residents received the necessary respiratory care and treatment related to incorrect oxygen flow rate and not monitoring oxygen saturation levels every shift as ordered for 2 of 5 residents reviewed for respiratory care (Resident 51 and C) and 1 of 5 residents reviewed for unnecessary medications. (Resident M) The facility also failed to ensure pre and post nebulizer assessments were completed and the licensed nurse remained with the resident during the nebulizer treatment for one resident observed during medication pass (Resident 51) and 1 of 5 residents reviewed for unnecessary medications. (Resident M)Findings include:1. On 3/29/26 at 2:20 p.m., and 3/30/26 at 9:00 a.m., Resident 51 was observed in her bed with her oxygen on via nasal cannula. The oxygen concentrator was flowing at 1 liter per minute (lpm). The resident's record was reviewed on 3/30/26 at 2:12 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, acute respiratory failure with hypoxia (low oxygen saturation), pleural effusion (fluid build up between the lungs and chest wall) and pneumonia. The admission Minimum Data Set assessment, dated 2/18/26, indicated the resident had moderate cognitive deficits and used oxygen. An Oxygen Care Plan, dated 2/12/26, indicated the resident required oxygen. Interventions included, but were not limited to, administer oxygen per physician's order and monitor vital signs as ordered (skin color, pulse oximetry, airway functioning and degree of restlessness which may indicated hypoxia). A Physician's Order, dated 2/17/26, indicated oxygen at 2 lpm every shift. A Physician's Order, dated 2/17/26, indicated to monitor Resident 51's oxygen saturation every shift. The oxygen saturation log in the vital signs section of the electronic record was reviewed for the previous two weeks. The log was missing entries on 3/18, 3/20, 3/23, 3/25, 3/26, and 3/28. On 3/31/26 at 9:46 a.m., the A Unit Manager observed the oxygen concentrator and indicated it was flowing at 1 lpm. She indicated it should be on 2 lpm. She asked a family member present who had turned the oxygen down. The family member said someone had turned it down about a week ago. The A Unit Manager checked the resident's record and indicated there were no new orders or documentation the oxygen had been changed. During an interview at that time., the A Unit Manager was made aware there were missing oxygen saturation in the vital signs. No additional information was provided. 2. On 3/29/26 at 11:10 a.m., and again on 3/30/26 at 2:03 p.m., Resident M was observed lying in bed. The resident had oxygen on via a nasal cannula and attached to a concentrator. The flow rate was set at 4 liters. The resident indicated she had been on 3 liters of oxygen since she was admitted to the facility and was unsure why it was set at 4 liters. Record review for Resident M was completed on 3/30/26 at 2:00 p.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, asthma, and respiratory failure. The resident was admitted to the facility on [DATE]. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission MDS assessment, dated 2/9/26, indicated the resident was cognitively intact. The assessment did not have checked that the resident received oxygen on admission or as a resident. A Care Plan, dated 2/2/26, indicated the resident required oxygen therapy. An intervention included to administer oxygen and nebulizers per the physician's orders. The March 2026 Physician's Order Summary (POS) indicated orders for the following:-ipratropium-albuterol inhalation solution, inhale 3 ml (milliliters) every 4 hours for wheezing-oxygen at 3 liters every shift. The February and March 2026 Medication Administration Records (MARs) indicated the resident received the inhalation medication every day. There was not a respiratory assessment section included on the MARs with each time the medication was administered. There was a lack of documentation to indicate respiratory assessments were completed prior to or after the inhalation medication was administered. During an interview on 3/30/26 at 2:04 p.m., LPN 1 indicated the resident was supposed to be on 3 liters of oxygen. During an interview on 3/31/26 at 10:11 a.m., the Director of Nursing (DON) indicated the resident should have been on 3 liters of oxygen. The nurses should be completing and documenting respiratory assessments prior to and after the inhalation medication treatments. She would fix the section on the MAR to include the respiratory assessments. 3. During a medication administration pass on 3/31/26 at 9:51 a.m., LPN 2 was observed preparing Resident 51's medications, which included a Duoneb solution (inhalation breathing treatment medication solution). The nurse poured the solution into the mask's chamber, applied the mask to the resident, and then left the room. The nurse then proceeded to move down the hallway with her medication cart. The nurse did not complete a respiratory assessment prior to administering the inhalation medication. During an interview at the time of the observation, LPN 2 indicated she does not complete respiratory assessments prior to administering the inhalation medication. She always left the residents' rooms during the breathing treatments and did not stay with them. She would go back to the resident's room in 15 minutes to check to see if the breathing treatment was completed. During an interview on 3/31/26 at 9:58 a.m., the DON indicated the nurses should be doing respiratory assessment prior to administering the breathing treatments and they should be staying in the resident's room during the breathing treatments. A facility policy titled, Nebulizer Use and received as current from the DON on 3/31/26, indicated, .Infection Prevention and Control .4. Respiratory pre and post assessment to be completed .Documentation Staff must document in the medical record: .Pre and post assessment Time spent in guest room . 4. On 3/29/26 at 1:10 p.m., Resident C was observed sitting in bed. He had oxygen infusing via a nasal cannula. The oxygen concentrator was set to 2 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/1/26 at 9:01 a.m., Resident C was observed lying in bed. He had oxygen infusing via a nasal cannula. The oxygen concentrator was set to 2 liters per minute. Resident C's record was reviewed on 3/31/26 at 12:51 p.m. A Physician's Order, dated 3/4/26, indicated continuous oxygen via nasal cannula at 4 liters per minute every shift. A Care Plan, dated 2/12/26, indicated the resident required oxygen therapy. Interventions included, but were not limited to, administer oxygen per physician's orders. During an interview on 4/1/26 at 4:10 p.m., the Director of Nursing had no further information to provide. A facility policy titled, Oxygen, indicated, General: Ensure residents are receiving oxygen per physician orders. Provide Guidance to Staff and Family of any precautions or oxygen use upon entering patients rooms.Guideline: 1. Residents who are admitted on oxygen or have new orders for oxygen should be assessed to ensure it is required. 2. Order for oxygen should be obtained by a qualified provider.4. Oxygen orders should include rate of administration and how they are receiving it. 5. Order should be written in the EMR and signed out by the nursing staff each shift to ensure resident is tolerating oxygen therapy. 410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(6)

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	04/02/2026

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

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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 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to timely address a pharmacy recommendation as requested for 1 of 5 residents reviewed for unnecessary medications (Resident L). Finding includes:Record review for Resident L was completed on 3/31/26 at 1:38 p.m. Diagnoses included, but were not limited, heart failure, Guillain-Barre syndrome (immune system attacks peripheral nerves), and atrial fibrillation. The resident was admitted to the facility on [DATE].A Consultant Pharmacist Recommendations to Nursing form, dated 3/20/26, indicated the resident's current order for sacubitril-valsartan (heart medication) 24/26 mg (milligrams) was for once a day. Per the hospital discharge summary, the resident was to receive the medication twice a day. Please clarify with the prescriber and update accordingly.There was a lack of documentation to indicate the recommendation was clarified with the prescriber and updated until 3/31/26.During an interview on 3/31/26 at 2:46 p.m., the Director of Nursing (DON) indicated the pharmacy recommendation had not been completed until 3/31/26. The medication should have been clarified with the physician when the resident was admitted from the hospital.A facility policy titled, Pharmacy Recommendations and received as current from the DON on 4/1/26, indicated, .The facility requires that all pharmacy recommendations be: .Reviewed, acted upon, or acknowledged by the prescriber in a timely manner .410 IAC (Indiana Administrative Code) 16.2-3.1-25(i)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to a Qualified Medication Aide documenting administration of injectable medications for 2 of 2 residents reviewed for anticoagulant administration. (Residents B and D)Findings include:1. Resident B's closed record was reviewed on 3/31/26 at 2:16 p.m.The Discharge Minimum Data Set (MDS) assessment, dated 3/13/26, indicated the resident was cognitively intact and received anticoagulant and antiplatelet medications while a resident.A Care Plan, dated 1/29/26, indicated the resident received anticoagulant medications. Interventions included, but were not limited to, administer anticoagulant medications as ordered by the physician.A Physician's Order, dated 1/15/26, indicated Lovenox (anticoagulant) injection solution prefilled syringe 40 milligrams/0.4 milliliters, inject 0.4 milligrams (mg) once a day for blood clot prevention.The January and February 2026 Medication Administration Record (MAR) indicated QMA 1 marked the Lovenox injection as administered on 1/24/26, 1/25/26, 1/26/26, 2/2/26, 2/18/26, and 2/20/26 at 6:00 a.m. During a telephone interview on 4/2/26 at 1:03 p.m., QMA 1 indicated when she was administering medications and someone required an injectable medication that she was not qualified to administer, she would go get the nurse to administer that medication. She did not give any injections or intravenous medications. On her computer, she would have two separate MARs open, one logged in under her own username and another that was logged in with the nurse's username. When the nurse administered the medication, she would open her own MAR (on QMA 1's computer) and then mark the medications as administered, however sometimes the nurses would open the wrong window and falsely documented the administration under QMA 1's username.During an interview on 4/2/26 at 1:23 p.m., the Director of Nursing indicated she had no further information to provide. 2. Resident D's closed record was reviewed on 3/31/26 at 3:58 p.m.The Discharge Minimum Data Set assessment, dated 2/24/26, indicated the resident was cognitively intact and received anticoagulant medications while a resident.A Care Plan, dated 1/15/26, indicated the resident received anticoagulant medications. Interventions included, but were not limited to, administer anticoagulant medications as ordered by the physician.A Physician's Order, dated 1/14/26, indicated Lovenox (anticoagulant) injection solution prefilled syringe 40 milligrams/0.4 milliliters, inject 0.4 milligrams (mg) once daily.The January and February 2026 Medication Administration Record (MAR) indicated QMA 1 marked the Lovenox injection as administered on 1/16/26, 1/17/26, 1/24/26, 1/25/26, 1/26/26, 1/31/26, and 2/21/26 at 6:00 a.m. During a telephone interview on 4/2/26 at 1:03 p.m., QMA 1 indicated when she was administering medications and someone required an injectable medication that she was not qualified to administer, she would go get the nurse to administer that medication. She did not give any injections or intravenous medications. On her computer, she would have two separate MARs open, one logged in under her own username and another that was logged in with the nurse's username. When the nurse administered the medication, she would open her own MAR (on QMA 1's computer) and then mark the medications as administered, however sometimes the nurses would open the wrong window and falsely documented the administration under QMA 1's username.During an interview on 4/2/26 at 1:23 p.m., the Director of Nursing indicated she did not believe the QMA was administering the injectables, but there was incorrect documentation.This citation relates to Intake 2785715.410 IAC (Indiana Administrative Code) 16.2-3.1-50(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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure infection control practices were in place and implemented related to guidelines for residents in EBP (Enhanced Barrier Precautions), and staff not wearing a gown during a PICC (peripherally inserted central catheter) medication administration during random infection control observations. (Residents L, 104, and E) Findings include:1. On 3/29/26 at 11:47 a.m., Resident L was observed lying in bed. There were no signs on the doorway or in the room that indicated the resident was on any infection control precautions.Record review for Resident L was completed on 3/31/26 at 1:38 p.m. Diagnoses included, but were not limited, Guillain-Barre syndrome (immune system attacks peripheral nerves), and urinary tract infection in the past 30 days. The resident was admitted to the facility on [DATE].The admission MDS assessment, dated 3/23/26, indicated the resident was cognitively intact. The resident had an impairment to both sides of his upper and lower extremities for a functional limitation in range of motion. The resident was dependent on staff for toileting hygiene and transfers. The resident received antibiotic medication.A Physician Progress Note, dated 3/20/26 at 3:23 p.m., indicated the resident had a urinary tract infection with MDRO (multidrug-resistant organisms) with ESBL (extended spectrum beta-lactamase) production. The resident's antibiotic was to be continued through 3/20/26.There was a lack of documentation to indicate the resident had been put under any infection control precautions for the ESBL infection.During an interview on 4/1/26 at 8:40 a.m., the Director of Nursing (DON) indicated the resident should have had EBP in place due to the history of ESBL in his urine. 2. On 3/29/26 at 1:51 p.m., Resident 104 was sitting in a wheelchair in his room. There were no signs on the doorway or in the room that indicated the resident was on any infection control precautions.On 3/30/26 at 9:40 a.m., Resident 104's door was closed and he had a sign on the door for droplet precautions.Record review for Resident 104 was completed on 4/1/26 at 9:02 a.m. The resident was admitted to the facility on [DATE].A Health Status Note, dated 4/1/26 at 11:33 a.m., indicated the resident was asymptomatic related to previous RSV (respiratory syncytial virus) diagnoses. The resident was asymptomatic and would be removed from strict isolation and entered into EBP isolation related to a history of ESBL in urine.There was a lack of documentation to indicate the resident had been placed under precautions prior to 3/30/26.During an interview on 4/1/26 at 8:40 a.m., the DON indicated the resident did not require droplet precautions anymore related to having RSV, but the resident should have been placed on EBP after admission due to the history of ESBL in his urine. 3. During a medication administration on 4/1/26 at 10:24 a.m., LPN 3 was observed preparing Resident E's medications, which included an antibiotic medication to be administered through the resident's PICC line. The resident's doorway had a sign that indicated EBP was to be used. The nurse went into the resident's room, washed her hands, applied gloves, but did not put on a gown. She then proceeded to administer the medication through the PICC line. Interview at the time of the observation with the nurse indicated she was unsure if she should wear a gown when administering a medication through a PICC line.During an interview on 4/1/26 at 11:21 a.m., the DON indicated the nurse should have worn a gown when she administered the resident's medication through the PICC line.The EBP policy for MDROs was not provided. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)