STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Chesterton	2775 Village Point Chesterton, IN 46304

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident was treated with respect and dignity, related to a delay in assisting a resident out of bed upon request by the resident for 1 of 8 residents reviewed for respect and dignity. (Resident J) Finding includes: During an observation on 3/11/25 at 12:30 p.m., Resident J activated the call light. RN 1 responded to the call light and the resident indicated she wanted her meal tray removed and assistance to get out of bed. RN 1 informed the resident the staff were with another resident and when they were done, someone would assist her out of bed. During observations on 3/11/25 at 12:44 p.m., 1:21 p.m., 1:21 p.m., and 2:37 p.m., the resident remained in bed. During an interview on 3/11/25 at 2:37 p.m., the resident indicated she had been informed someone would be in to help her out of bed and no one had come to assist her. She indicated this happened often and she had things she had planned to do, but was unable to do them since she still remained in bed. During an interview on 3/11/25 at 2:39 p.m., RN 1 indicated she had informed the CNA the resident needed help to get out of bed. The resident required a mechanical lift and a second person was needed to assist with the transfer. She indicated she would assist with the transfer. Resident J's record was reviewed on 3/12/25 at 3:24 p.m. The diagnoses included, but were not limited to, congestive heart failure. A Care Plan, revised on 1/2/25, indicated assistance was required for activities of daily living. The interventions included a mechanical lift and two staff were required for transfers. A Quarterly Minimum Data Set assessment, dated 1/13/25, indicated an intact cognitive status, was dependent for transfers, and had sustained a fall. This citation relates to Complaint IN00454481. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Chesterton	2775 Village Point Chesterton, IN 46304

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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-3(t)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE: 2775 Village Point Chesterton, IN 46304	

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 20580 Based on record review and interview, the facility failed to ensure a resident's Power of Attorney (POA) was notified of falls for 1 of 3 residents reviewed for physician/responsible party notification. (Resident E) Finding includes: Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. The record indicated the resident had a POA who was the first contact person in case of changes/emergency. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status. Fall Investigations, dated 2/1/25 at 4:09 p.m., 2/9/25 at 7:40 a.m., and 2/15/25 at 5:34 p.m., indicated the resident had fallen. The person listed as number two for contact had been notified and not the POA. There was no documentation in the record that indicated the POA had been notified or why the second person was the one notified of the falls. During an interview on 3/13/25 at 10:50 a.m., the Clinical [NAME] President and Director of Nursing were unsure why the POA was not notified. A facility policy for Physician and Responsible Party Notification, dated 10/2024 and received from the [NAME] President of Operations as current, indicated the communication with the responsible party would be documented in the resident's record. The Responsible Party would be notified after the physician was notified. This citation relates to Complaint IN00455073. 3.1-5(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE 2775 Village Point Chesterton, IN 46304	

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 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** 20580 Based on observation, record review, and interview, the facility failed to ensure a resident who was dependent for care received incontinent care in a timely manner for 1 of 3 residents reviewed for incontinent care. (Resident F) Finding includes: During an observation on 3/11/25 at 10:50 a.m., Resident F's call light had been activated by a visitor in the room. RN 4 answered the call light and was informed by the visitor that the resident needed his incontinent brief changed. RN 4 and CNA 5 began the incontinence care. The resident's gown and top sheet were wet and the incontinent brief was saturated with urine. The incontinent pad under the resident was soaked with urine and under the pad were two large dried yellow/brownish rings from urine. The abdominal binder worn by the resident was also wet. RN 4 acknowledged the urine saturation and dried urine rings. The resident indicated he was last changed yesterday. During an interview on 3/11/25 at 11:16 a.m., CNA 2 indicated she was assigned to Resident F. She started work at 6 a.m. and had not yet checked on Resident F. She indicated she was still completing her morning rounds. During an interview on 3/11/25 at 11:36 a.m., the Administrator indicated the resident had his call light on at 2 a.m. on 3/11/25 and had probably been checked at that time. Resident F's record was reviewed on 3/12/25 at 2:35 p.m. The diagnoses included, but were not limited to, blood stream infection due to central venous catheter and dementia. The resident was admitted into the facility on [DATE]. A Care Plan, dated 3/7/25, indicated assistance was required for activities of daily living. The interventions indicated he was dependent for hygiene and toileting. A Care Plan, dated 3/7/25, indicated incontinence of bowel and bladder. The interventions included he would be checked every 2-3 hour and as needed for incontinence. A mental status assessment, dated 3/10/25 at 11:16 a.m., indicated his cognition was moderately impaired. This citation relates to Complaints IN00447280, IN00452124, IN00454481, and IN00455073. 3.1-38(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE: 2775 Village Point Chesterton, IN 46304	

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. 20580 Based on observation, record review, and interview, the facility failed to ensure residents received necessary care and services, related to skin assessments not completed as ordered by the Physician for residents with a brace and a immobilizer for 2 of 8 residents reviewed for quality of care. (Residents E and H) Findings include: 1. During an observation on 3/11/25 at 11:24 a.m., resident E was sitting in the wheelchair. There was a brace on the right wrist/forearm. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status and had a fall with a fracture prior to the admission into the facility. A Physician's Order, dated 1/17/25, indicated skin checks were to be completed weekly on day shift every Monday and Thursday and a Skin Evaluation must be completed when each assessment was completed. A Physician's Order, dated 1/18/25, indicated the staff were to monitor the non-removable surgical splint to the right arm every shift and all abnormal findings were to be reported to the physician. A Care Plan, dated 1/20/25, indicated a fracture of the right radius and post internal fixation for stabilization of the fracture. The goal indicated the fracture would heal without complications. The interventions indicated the physician's orders would be followed and the resident would be monitored for complications. The Treatment Administration Record (TAR), dated 1/2025 & 2/2025, indicated the weekly skin checks had not been completed on January 20, 23, 27, and 30, 2025 and February 3, 6, 17, 20, and 24, 2025. The TAR, dated 1/2025 and 2/2025, indicated the splint had not been monitored on night shift on January 21, 22, 23, 25, 28, 30, and 31, 2025 and February 4, 13, 24, 15, 21, 23, 26, and 28, 2025. The splint had not been monitored on day shift on February 19, 2025. The Clinical [NAME] President was informed of the missed assessments on 3/11/25 at 4:00 p.m. No further information was received by the facility. 48383 2. Resident H's record was reviewed on 3/12/25 at 3:45 p.m. The diagnoses included, but were not limited to, anemia (low iron), dementia, fracture of humerus, and muscle weakness. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Chesterton	2775 Village Point Chesterton, IN 46304

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	The Admission Minimum Data Set (MDS) assessment, dated 2/15/25, indicated the resident was severely impaired for daily decision making. A Care Plan, dated 2/11/25, indicated the resident was at risk for alteration in skin integrity related to decreased mobility and anticoagulant use. Interventions were to provide skin and wound treatments as ordered. A Care Plan, dated 2/11/25, indicated the resident had an alteration in musculoskeletal status related to a left humerus fracture. Interventions were to follow physician's orders for weight bearing status and see the Physician Orders and Physical Therapy Treatment Plan. A Physician's Order, dated 2/11/25, indicated for the resident to always wear the left arm immobilizer and could be removed for showers. A Physician's Order, dated 2/11/25, indicated to administer weekly skin checks every evening shift on Tuesday and Friday. Staff must open and document a Skin Evaluation for each assessment and include no new areas found. There were no Skin Evaluations completed for the following dates: 2/11, 2/14, 2/21, 2/25, 2/28, 3/4, 3/7, and 3/11/25. The Treatment Administration Record (TAR) for 2/2025 indicated skin checks were not signed out on 2/11, 2/14, and 2/21/25. During an interview on 3/13/25 at 10:54 a.m., the Director of Nursing (DON) indicated she understood the concern regarding weekly skin checks not being signed out on the TAR and weekly Skin Evaluations not being completed. This citation relates to Complaint IN00455073. 3.1-37(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE 2775 Village Point Chesterton, IN 46304	

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 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. 20580 Based on observation, record review and interview, the facility failed to ensure care plan interventions were in place to prevent falls for 1 of 3 residents reviewed for falls. (Resident E) Finding includes: During observations on 3/11/25 at 10:49 a.m., 2:44 p.m. and on 3/12/25 at 10:13 a.m., there was no stop sign in Resident E's room to remind the resident to call for assistance and no floor mat in the room. During an interview on 3/12/25 at 10:13 a.m., RN 3 indicated there was no stop sign or floor mat located in the room. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. An Admission Fall Risk Assessment, dated 1/17/25, indicated a high risk for falls. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status, required maximum assistance with transfers, was dependent for toileting and wheelchair mobility, was occasionally incontinent of bladder and frequently incontinent of bowel, and had a fall with a fracture prior to admission into the facility. A Care Plan, dated 2/9/25, indicated an actual fall and a history of falls. The interventions included on 2/1/25, a floor mat would be placed next to the bed and on 2/9/25, a stop sign wound be placed in the room as a visual reminder to stop and wait for assistance with transfers. The Nursing Progress Notes, dated 2/1/25 at 4:35 p.m., 2/9/25 at 7:00 a.m., and 2/15/25 at 6:42 p.m., indicated the resident had fallen. A fall prevention policy, dated 10/2024 and received from the [NAME] President of Operations as current, indicated the interdisciplinary team would develop interventions to reduce the resident's risk for falls. This citation relates to Complaint IN00455073. 3.1-45(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER: Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE: 2775 Village Point Chesterton, IN 46304	

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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20580 Based on observation, record review, and interview, the facility failed to ensure a resident's feeding tube was infusing at the correct flow rate for 1 of 1 resident reviewed for feeding tube usage. (Resident F) Finding includes: Resident F was observed lying in bed with the head of the bed elevated on 3/11/25 at 10:50 a.m. and 3/12/25 at 2:56 p.m. The tube feeing of Jevity 1.5 was infusing at 55 cc/hr (cubic centimeters (cc) per hour). During an interview on 3/12/25 at 2:56 p.m., LPN 6 indicated the tube feeding was infusing at 55 cc/hr and the bottle of the feeding indicated the feeding should have been infusing at 20 cc/hr. Resident F's record was reviewed on 3/12/25 at 2:35 p.m. The diagnoses included, but were not limited to, blood stream infection due to central venous catheter and dementia. The resident was admitted into the facility on [DATE]. A Care Plan, dated 3/7/25, indicated a gastrostomy tube was present and he required enteral nutrition. The interventions included the tube feeding would infuse per current physician orders. A Physician Order, dated 3/7/25 and discontinued on 3/12/25, indicated Jevity 1.5 was to infuse at 20 cc/hr for 24 hours a day. A Physician's Order, dated 3/12/25, indicated Jevity 1.5 was to infuse at 20 cc/hr for 22 hours per day. A Registered Dietician's Progress Note, dated 3/11/25 at 6:48 p.m., indicated a recommendation to increase the tube feeding to 55 cc/hr for 22 hours. There were no Physician's Orders to increase the tube feeding to 55 cc/hr. A tube feeding policy, dated 10/2024 and received by the Administrator as current, indicated an order by the physician or nurse practitioner for the type of formula and rate was required. 3.1-44(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE 2775 Village Point Chesterton, IN 46304	

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 20580 Based on 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 lack of measurements of the catheter length, dressing changes to the site, assessments of the site and flushes of the catheter for 1 of 1 resident reviewed with a midline catheter. (Resident E) Finding includes: Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status. A Physician's Order, dated 3/6/25, indicated a midline catheter was to be inserted for IV antibiotic administration. A Physician's Order, dated 3/6/25, indicated Unasyn (antibiotic) 1.5 grams was to be given every 12 hours for seven days for a hand infection. The treatment was to start on 3/7/25 at 6:00 a.m. A Care Plan, dated 3/7/25, indicated IV antibiotics were ordered related to an infection of the right hand. The interventions included the IV would be flushed per the physician's orders and the site would be monitored for infection. A Care Plan, dated 3/10/25, indicated an antibiotic was ordered due to right lung infiltrates. There was no documentation when the midline catheter had been placed in the resident's clinical record. There were no physician's orders for flushing the midline, nor for the care of the midline. The Medication Administration Record and/or Treatment Administration Record, dated 3/2025, had no information that indicated the flushes were completed, dressing changes to the site had been completed, and the arm circumference and insertion site had been monitored. The Director of Nursing and [NAME] President of Operations were informed of the lack of care for the IV site and orders for the flushes on 3/12/25 at 2:26 p.m. No further information was provided. The [NAME] President of Operations presented a form from the Vascular Access Specialist on 3/12/25 at 3 p. m. that indicated a midline had been placed on 3/6/25. The arm circumference was 24 cm (centimeters). The nursing care was to include a 10 milliliter flush of normal saline before and right after all infusions and per facility protocols. The dressing was to be changed within 24 hours of insertion and then every seven days afterwards and as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Chesterton	2775 Village Point Chesterton, IN 46304

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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy for the administration of IV fluids, dated 6/2024 and received by the [NAME] President of Operations as current, indicated the type and amount of IV fluids must be ordered by a licensed practitioner. IV fluid administration must be documented and resident monitoring was to be documented in the the clinical record. The IV site was to be monitored. 3.1-47(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Chesterton	2775 Village Point Chesterton, IN 46304

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 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. 20580 Based on observation, record review, and interview, the facility failed to ensure a resident who required respiratory care received care consistent with profession standards and was administered oxygen as ordered by the physician for 1 of 1 resident reviewed for respiratory care. (Resident E) Finding includes: During observations on 3/11/25 at 11:24 a.m., 12:24 p.m., and 12:27 p.m., Resident E was sitting in the wheelchair at a table in the lounge by the Nurses' Station. There was a nasal cannula present and in place. The portable oxygen unit was turned off. During the observation on 3/11/25 at 12:27 p.m., the Assistant Director of Nursing turned the portable oxygen unit on. She indicated the oxygen was just turned on at two liters per minute. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. A Physician's Order, dated 3/8/25, indicated oxygen was to be administered at two liters per minute every shift. A Care Plan, dated 3/9/25, indicated oxygen therapy was required. The interventions included oxygen would be administered as ordered by the Physician. A facility policy for oxygen usage, dated 11/2018 and received as current from the Administrator, indicated residents who had orders for oxygen should have the oxygen administered per the physician's orders. 3.1-47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155844	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/13/2025
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE 2775 Village Point Chesterton, IN 46304	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 20580 Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff member (CNA 2) when providing care to a resident (Resident E) who was in Enhanced Barrier Precautions (EBP) for two random observation for infection control. Finding includes: During an observation on 3/11/25 at 2:44 p.m., CNA 2 applied gloves and placed Resident E in bed. The resident had been incontinent of a moderate amount of urine and a small bowel movement. Incontinent care was completed by CNA 2. There was no sign on the door that indicated the resident was on EBP. During an observation on 3/12/25 at 10:13 a.m., there was a sign on the door that indicated the resident was on EBP and a container for the PPE was located on the door of the room. CNA 2 was in the bathroom with the resident and had assisted her into the wheelchair from the toilet. CNA 2 wore gloves and indicated care had just been completed due to diarrhea. CNA 2 had not donned a protective gown for the care and stated she was unaware the resident was on EBP. CNA 2 indicated there would be a sign on the door and PPE supplies available if the resident required EBP. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. A Physician's Order, dated 1/18/25, indicated EBP was to be initiated. A Care Plan, dated 1/20/25, indicated EBP was required related to the wounds that were present upon admission. The interventions include protective gowns and gloves would be worn during high contact resident care activities. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status, was dependent for toileting, was occasionally incontinent of bladder and frequently incontinent of bowel, had an unstageable (pressure wound covered with slough or eschar) and venous/arterial ulcers, a surgical wound, moisture associated skin damage (MASD), and a surgical wound upon admission into the facility. A Physician's Order, dated 3/6/25, indicated a midline catheter for intravenous antibiotic therapy was to be inserted. A Vascular Access form, dated 3/6/25, indicated a midline catheter was inserted on 3/6/25. 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 a central line and with wounds. 3.1-18(b)