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	04/28/2025

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 to the bathroom upon request by the resident for 1 of 10 residents reviewed for respect and dignity. (Resident B) Finding includes: During an interview and observation on 4/23/25 at 4:42 p.m., Resident B's call light had been activated. She was sitting in her wheelchair in her room and two family members were also present. The resident indicated she needed to use the bathroom and began to propel her wheelchair to the bathroom. At 4:50 p.m., LPN 1 entered the room and the resident informed the nurse she really needed to use the bathroom. The LPN indicated she would be a second and left the room. At 4:54 p.m., the resident stated, I guess they forgot I needed to go, then stated, come on. At 4:55 p.m. the resident wanted to know where the staff was and indicated she was told they would be right back. CNA 2 and CNA 3 then entered the room and assisted the resident to the bathroom. The resident then voided on the toilet. Resident B's record was reviewed on 4/24/25 at 9:24 a.m. The diagnoses included, but were not limited to right femur fracture, pressure wound, and falls. A Care Plan, dated 4/7/25, indicated assistance was required for activities of daily living. The interventions included the resident was dependent for toileting. An Admission Minimum Data Set (MDS) assessment, dated 4/12/25, indicated a severely impaired cognition, no impairment to the upper and lower extremities, was dependent for toileting and transfers, had a fall prior to admission, and was occasionally incontinent of urine. A Care Card, located in the Shower Book, indicated the resident was a one person assistance for transfers. During an interview with the Executive Director on 4/24/25 at 10:59 a.m., she indicated the call light was activated at 4:38 p.m. per the call light log. During an interview on 4/24/25 at 11:11 a.m., Physical Therapy Assistant (PTA) 4 indicated the resident was able to transfer with one staff member. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaint IN00457192. 3.1-3(t)

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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 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. 20580 Based on observation, record review, and interview, the facility failed to ensure bladder training and post void residuals (urine amount in the bladder after voiding) were completed and documented after a urinary catheter was discontinued. The facility also failed to ensure the amount of urinary output was recorded for 3 of 3 residents reviewed for urinary catheters. (Residents D, H, and L) Findings include: 1. During an observation and interview on 4/23/25 at 7:05 p.m., Resident D was sitting on the side of her bed. A urinary catheter was present with clear urine in the tubing. She indicated she voided constantly and has an appointment with a urologist. Resident D's record was reviewed on 4/24/25 at 2:25 p.m. The diagnoses included, but were not limited to, right femur fracture, stroke, and urinary tract infection. An Admission Minimum Data Set (MDS) assessment, dated 4/10/25, indicated a moderately impaired cognitive status, no behaviors, required maximum assistance for toileting, moderate assistance for transfers, a urinary catheter was present, and no bladder training had been completed. A Care Plan, dated 4/14/25, indicated a urinary catheter was present. The interventions indicated to monitor for signs and symptoms of a urinary tract infection, which included no urinary output and urinary frequency. A Nurse's Progress Note, dated 4/5/25 at 2:08 p.m., indicated a family member had contacted the facility and requested the urinary catheter be clamped every six hours during the day and left unclamped at night. The physician was notified and orders were received for the catheter clamping and bladder scans. A Physician's Order, dated 4/5/25 and discontinued on 4/9/25, indicated bladder training was to be attempted. The urinary catheter was to be clamped every six hours during the day and the resident was to alert the staff when she felt the urge to void. The urinary catheter was to be unclamped during the night. The Medication Administration Record (MAR), dated 4/2025, indicated on 4/8/25 at 5:59 p.m. a bladder scan had been completed. A Bladder Scan Documentation form, dated 4/5/25 at 5:47 p.m., indicated the scan was completed as ordered by the physician and the total volume scanned was 68-132 cc's (cubic centimeters). There was no documentation of the amount of urine in the urinary catheter drainage bag at the time of the scan. A Nurse Practitioner's (NP) Progress Note, dated 4/7/25 at 4:49 p.m., indicated the resident's abdomen was soft and non-tender and a urinary catheter was present. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There was no documentation on the 4/2025 MAR or in the Nurses' Progress Notes from 4/5/25 through 4/8/25 that verified the urinary catheter had been clamped as ordered and if the resident had alerted the staff of the urge to void. An NP Progress Note, dated 4/8/25 at 9:09 a.m., indicated the resident continued bladder training for 48 hours prior to the removal of the urinary catheter for voiding trial on 4/10/25. A Physician's Order, dated 4/8/25 at 2:53 p.m. and discontinued on 4/11/25, indicated a bladder scan was to be completed every six hours and if the post void residual was over 300 cc's, the urinary catheter was to be re-inserted. The bladder scans were to be completed for three days. A Bladder Scan Documentation form, dated 4/9/25 at 6:22 p.m., indicated a post urinary catheter removals/residual check scan had been completed by the NP due to abdominal distention and there was 287 cc's of urine in the bladder. An NP Progress Note, dated 4/10/25 at 11:06 a.m., indicated the urinary catheter had been discontinued on 4/9/25, there were no bladder scan results in the resident's record, and a bladder scan had been completed at the time of the NP visit and 201 cc's of urine had been scanned. Bladder scans were to be completed every six hours for voiding trial on 4/10/25 and would be monitored closely. The 4/2025 MAR indicated the first bladder scan had not been completed until 4/10/25 at 6:00 a.m., 12:00 p. m., and 6:00 p.m. There was no documentation that indicated if the scans were a post void scan or the amount of urine scanned. There was no documentation in the Nurses' Progress Notes that indicated the scans had been completed. A Physician's Order, dated 4/10/25 at 6:24 p.m. and discontinued on 4/11/25 at 7:45 p.m., indicated bladder scans were to be completed every six hours for 48 hours for urinary retention. A Radiology Results Report, dated 4/10/25 at 5:10 p.m., indicated a urinary bladder ultrasound had been completed and the calculated bladder volume was 48 cc's. There was no documentation on the 4/2025 MAR or the Nurses' Progress Notes 4/8/25 through 4/10/25 at 6:00 a.m. to indicate the clamping of the urinary catheter was being continued, the bladder scans had been completed by the nurse, or if the urinary catheter had been discontinued. There was no documentation of the urinary output amount on the output record for April 6, 2025 after 2:51 a.m. through April 11, 2025 at 5:59 p. m. The 4/2025 MAR indicated a bladder scan had been completed on 4/11/25 at 4:00 a.m. and there was no residual in the bladder. An NP Progress Note, dated 4/11/25 at 6:30 a.m., indicated the resident's abdomen was distended and the bladder was palpated. The resident indicated she had not urinated the last time a bladder scan had been completed, which was around 8:00 p.m. the previous evening. A bladder scan had been completed by the NP which estimated 641 cc's of urine and an order to re-insert the urinary catheter was written. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The urinary output amounts had not been documented every shift/daily from 4/5/25 through 4/28/25. During an interview on 4/28/25 at 8:32 a.m., the Director of Nursing (DON) indicated there was no documentation that indicated the clamping and unclamping of the catheter, the resident's reported urge to void, the amount of voids, and the bladder scans with the pre and post urine amounts had been completed as ordered. The catheter had been discontinued on 4/9/25 as documented on the bladder scan form and there had been no documentation in the Nurses' Progress Notes indicating the bladder training, scans, and discontinuation of the urinary catheter had been completed. She indicated there were several orders written and there was no consistent record of the urine output documented. A catheter removal policy, dated 7/2024 and received by the DON as current, indicated the date and time of the urinary catheter removal was to be documented. A bladder scan policy, dated 9/2024 and received by the DON as current, indicated post void residuals will be completed via the bladder scan device with a physician's order. The provider would be notified of abnormal results. 2. During an observation on 4/24/25 at 8:00 a.m., Resident H was sitting at a table by the Nurses' Station. A covered urinary catheter bag was observed. Resident H's record was reviewed on 4/28/25 at 9:51 a.m. The diagnoses included, but were not limited to, obstructive uropathy and dementia. A Care Plan, dated 4/11/25, indicated a urinary catheter was present related to obstructive uropathy. The interventions included to monitor for signs and symptoms of a urinary tract infection, which included the amount of urine output. A Care Plan, dated 4/11/25, indicated an enlarged prostate. The interventions included, urine retention would be monitored. A Physician's Order, dated 4/11/25, indicated the urinary output was to be monitored every shift. An Admission MDS assessment, dated 4/15/25, indicated a severely impaired cognitive status and a urinary catheter was utilized. The urinary output monitoring log indicated there had been urinary output documented on April 14, 15, 16, 18, 19, 20, 21, and 22, 2025. There was only one documented urinary output on April 13 at 2:14 p.m. with 750 cc's of urine, 4/17/25 at 12:15 p.m. with 500 cc's of urine, 4/23/25 at 5:59 p.m. with 100 cc's of urine, and 4/27/25 at 4:08 a.m. with 500 cc's of urine. 3. During an interview and observation on 4/23/25 at 7:45 p.m., Resident L was lying in bed. There was a urinary catheter present. She indicated the catheter was used because she had a sore they wanted to keep clean. Resident L's record was reviewed on 4/28/25 at 10:49 a.m. The diagnoses included, but were not limited to abscess of the groin. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 4/14/25, indicated a urinary catheter was present. The interventions included to monitor for signs and symptoms of a urinary tract infection, which included no urinary output. An Admission MDS assessment, dated 4/18/25, indicated an intact cognitive status and a urinary catheter was present. The urinary output monitoring indicated there were no urinary outputs documented on April 13, 15, 26, 17, 20, 21, 22, 26, and 27, 2025. There was only one urinary output documented on 4/18/25 at 3:21 p.m. with 650 cc's of urine, 4/19/25 at 3:11 a.m. with 600 cc's of urine, 4/23/25 at 4:27 p.m. with 500 cc's of urine, 4/24/25 at 1:28 a.m. with 800 cc's of urine, 4/24/25 at 1:28 a.m. with 800 cc's urine and 4/25/25 at 5:59 a.m. with 250 cc's of urine. A catheter care policy, dated 5/2024 and received from the DON as current, indicated the urinary drainage bag was to be emptied at the end of each shift or more often if needed and the total amount of urine was to be documented in the clinical record. This citation relates to Complaint IN00457659. 3.1-41(a)(2)

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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 members (CNA 2 and CNA 3) when providing care to a resident (Resident B) who was in Enhanced Barrier Precautions (EBP) for one random observation for infection control. Finding includes: During an interview and observation on 4/23/25 at 4:42 p.m., Resident B's call light had been activated. Upon entering the room, a magnetic sign was on the outside door frame that indicated EBP was required when providing care. At 4:55 p.m., CNA 2 and CNA 3 entered the room, donned gloves and began to assist the resident to the toilet. The CNA's were stopped and asked if the resident required EBP and both CNA's stated, no and continued to assist the resident to transfer to the toilet. The resident's incontinent brief was changed after incontinence care had been completed. She was then dressed in a clean pair of slacks and transferred back to the wheelchair. Resident B's record was reviewed on 4/24/25 at 9:24 a.m. The diagnoses included, but were not limited to right femur fracture, pressure wound, and falls. A Physician's Order, dated 4/7/25, indicated EBP was to be implemented due to wounds being present. A Care Plan, dated 4/7/25, indicated EBP was required related to a wound. The interventions included PPE of gowns and gloves were to be worn during high contact care activities. A facility EBP policy, dated 3/2024 and identified as current by the Executive Director, indicated staff were to don a gown and gloves during high-contact resident care. EBP PPE was to be used for residents with wounds. 3.1-18(b)