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	12/11/2025

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 - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure admission, skin, and accident assessments were completed as ordered and per policy for 1 of 3 residents reviewed for new admissions, for 2 of 3 residents reviewed for pressure ulcers, and for 1 of 3 residents reviewed for accidents. (Residents C,D, G, and H)Findings include:1. Resident C's record was reviewed on 12/10/25 at 1:00 p.m., The diagnoses included, but were not limited to, surgical care after digestive surgery, diabetes, COPD, high blood pressure, and respiratory failure. The resident was admitted on [DATE] at 4:35 p.m.The 11/23/25 5-day Minimum Data Set (MDS) assessment indicated the resident was independent with eating. Toileting required supervision, and the resident had a surgical wound. Cognition was not assessed.The Care Plan, dated 11/24/25, indicated the resident had actual skin impairment. Interventions were to provide facility protocols for treatment of injury, evaluate and treat per physician's order and consult for wound as needed.The record lacked an admission assessment and assessment of the resident's surgical wound.A Skin/Wound Progress Note, dated 11/23/25 at 9:00 a.m., indicated the wound nurse was at the bedside with the primary nurse to assess the right groin surgical wound. The right groin dressing had a scant amount of serosanguineous drainage and had no active drainage. The resident requested to be transferred to the hospital and for her plastic surgeon to be notified. The assessment was unable to be completed because transportation had arrived. Concerns were expressed and noted privately with Resident C's daughter.A Nurse's Progress Note, dated 11/23/25 at 9:15 a.m., indicated the resident was afebrile, had O2 saturation of 96% on 3 liters, steri strips were intact and two small incisions to the right groin had drained serous/bloody fluid. The resident indicated that the drainage was new, but had no reports of increased pain or discomfort to the area. The on call provider was notified and ordered the resident to be sent to the Emergency Department.During an interview on 12/10/25 at 2:20 p.m., the [NAME] President of Clinical Operations indicated there was no admission assessment completed for Resident C, only vitals were documented. The resident's surgical site was not assessed on admission. The resident and family had expressed care concerns. No additional information was provided. 2. Resident D's record was reviewed on 12/9/25 at 9:00 a.m., The diagnoses included, but were not limited to, fracture of right femur, stroke, dysphagia, acute respiratory failure with hypoxia, need for assistance with personal acre, epilepsy, bipolar, chronic pain syndrome, anxiety, heart failure and depression.The 11/21/25 5-day Minimum Data Set (MDS) assessment indicated the resident was cognitive intact for daily decision making. Eating and oral hygiene required set up. Toileting. lower body dressing, and showering required substantial maximum assistance.A Facility reported incident was submitted to the Indiana Department of Health (IDOH) on 11/24/25 and indicated a resident asked a nurses' aide to warm up her hot tea. The resident removed the lid from the cup and spilled hot tea on her right side, back and forearm. The resident was given Tylenol for pain and had treatment completed for blistered areas. The resident was later sent out to the hospital for evaluation of atrial fibrillation (abnormal heart rhythm).A Care Plan, dated 11/24/25, indicated the resident had actual impairment to skin integrity related to blisters on her right back and right forearm.During an interview on 12/9/25 at 3:01 p.m., CNA 1 indicated she was called to the resident's room to warm up her tea. The lid was on the tea when she left the resident's room. Not even three minutes later, she had heard the resident yell and the teacup was empty lying next her right side on the bed, and the lid was sitting on the bedside table. She had removed the lid. CNA 1 started getting her cleaned up with another aide and then LPN 1 came in a couple minutes later. At the time, Resident D's skin was just red, but there were no blisters. About 30 minutes later, the resident put on her light and asked to be changed and asked for pain medication because her side hurt. When she turned the resident to change her, she had then noted blisters on the resident's right side and on her right back. She then called for LPN 1 and left the room when she arrived.During an interview on 12/9/25 at 3:46 p.m., LPN 1 indicated she was told by CNA 1 that the resident had burned herself with the tea. There was redness on her side and back when she initially assessed her and Tylenol was given for pain. Resident D put on the call light about 20-30 minutes later and indicated she needed to be changed and had pain around the burn area. That's when CNA 1 called for her and reported the resident now had blistered areas. Resident D did not blister right away. Once LPN 1 assessed her and saw the blistering, she then contacted the after-hours physician to get verbal orders.The record lacked an initial assessment that reported the reddened skin to the right arm and right back.During an interview on 12/10/25 at 11:45 p.m., the [NAME] President of Clinical Operations indicated the initial

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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 maintain clinical records that were complete and accurately documented related to wound treatments for 1 of 3 residents reviewed for pressure ulcers. (Resident G and H)Finding includes:Resident G's record was reviewed on 12/9/25 at 3:55 p.m. The diagnoses included, but were not limited to, diabetes, fracture of left tibia, and spiral fracture of left fibula.The 11/3/25 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The resident was dependent with lower body dressing, putting on footwear, toileting, and showering. The resident had surgical wounds on admission.A Care Plan, dated 11/29/25, indicated the resident had obtained a pressure injury to the left heel. Interventions were to follow facility protocols for treatment of injury and to evaluate and treat per physician orders.The Treatment Administration Record (TAR) for the month of 12/2025 indicated wound care was not signed out on the following dates: 12/1/25 and 12/2/25.During an interview on 12/10/25 at 9:00 a.m., the [NAME] President of Clinical operations indicated she understood the concern and had no additional information to provide. During an interview on 12/10/25 at 12:22 p.m., the wound nurse indicated he had completed the treatments himself, but he forgot to sign them out. That week was crazy because the other wound nurse was off and he was the only wound nurse that week.This citation relates to Intake 2635631.3.1-50(a)(1)3.1-50(a)(2)