

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/08/2026
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. Based on record review and interview, the facility failed to ensure a dependent resident received bathing at least twice a week, daily hygiene and oral care, for 1 of 4 residents reviewed for activities of daily living (ADL's). (Resident D) Finding includes:Resident D's closed record was reviewed on 7/7/26 at 6:58 a.m. The diagnoses included, but were not limited to, paraplegia related to trauma.A Care Plan, dated 6/17/26, indicated the resident was dependent for oral care, bathing, and hygiene.A Care Plan, dated 6/18/26, indicated the bathing type of preference was a shower.An admission Minimum Data Set assessment, dated 6/22/26, indicated maximum assistance was required for oral hygiene, set up assistance was required for hygiene, and was dependent for bathing.The CNA tasks record indicated hygiene had not been completed on June 20, 21, 28, and 30, 2026. Oral hygiene had not been completed on June 20, 21, 28, and 30, 2026.Bathing record forms were provided by the Nurse Consultant and indicated the type of bathing had not been documented on the bathing record form for 6/19/26, 6/24/26, and 6/30/26. The resident had been bathed only one time from 6/21/26 to 6/30/26.The ADL concern was discussed with the Nurse Consultant on 7/7/26 at 4:50 p.m., no further information was provided.This citation relates to Intakes 3012845, 3055048 and 3064613.410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)410 IAC 16.2-3.1(a)(3)(C)		

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 - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on record review and interview, the facility failed to ensure a resident received an intravenous antibiotic as ordered by the physician for 1 of 3 residents reviewed for antibiotic use. (Resident H) Finding includes: Resident H's record was reviewed on 7/8/26 at 10:17 a.m. The diagnoses included, but were not limited to, cellulitis of right lower limb. A Care Plan, dated 6/9/26, indicated an antibiotic was being administered. The interventions included the antibiotic would be administered as ordered by the physician. A Physician's Order, dated 6/23/26, indicated piperacillin sod - tozobactam (antibiotic) 3-0.375 grams (g) was to be administered intravenously (IV) every six hours for seven days. The Medication Administration Record, dated 6/2026, indicated the antibiotic had not been administered on 6/24/26 at 12:00 p.m. with no reason documented and on 6/30/26 at 12:00 a.m. due to the resident was sleeping. During an interview on 7/8/26 at 12:35 p.m., the Nurse Consultant acknowledged the antibiotic had not been administered. This citation relates to Intakes 3055048 and 3064613.410 IAC (Indiana Administrative Code) 16.2-3.1-37		

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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 residents with pressure ulcers received the necessary treatment and services to promote healing related to treatments not completed, a protein supplement not provided, and antibiotic medication not administered for a wound infection as ordered for 3 of 3 residents reviewed for pressure ulcers. (Residents D, E, and F) Findings include: 1. Resident D's closed record was reviewed on 7/7/26 at 6:58 a.m. The diagnoses included, but were not limited to, infected unstageable (unable to determine depth of ulcer) sacral pressure ulcer and stage three (full thickness of skin loss) pressure ulcer of the heel. A Care Plan, dated 6/17/26, indicated impairments to the skin were present. The interventions indicated the areas would be treated as ordered by the physician. A Care Plan, dated 6/18/26, indicated an antibiotic was to be administered related to infection. The interventions indicated the antibiotic would be administered as ordered by the physician. An admission Minimum Data Set (MDS) assessment, dated 6/22/26, indicated there were unhealed pressure areas on admission. There was one stage three and four unstageable wounds on admission. a) A Physician's Order, dated 6/17/26, indicated piperacillin sod-tazobactam (antibiotic) 3.375 grams was to be administered intravenously every six hours for infection for 14 days. The MAR, dated 6/2026, indicated the antibiotic had not been administered on 6/24/26 at 12:00 p.m. and 6/29/26 at 6:00 p.m. The MAR, dated 7/2026, indicated the antibiotic had not been administered on 7/1/26 at 12:00 p.m. and at 6:00 p.m. b) A Physician's Order, dated 6/18/26, indicated Critical Care Active Protein supplement, 30 milliliters (ml) was to be provided twice a day to promote wound healing. The Medication Administration Record (MAR), dated 6/2026, indicated the supplement had not been administered on 6/29/26 at 5:00 p.m. The MAR, dated 7/1/16, indicated the supplement had not been administered on 6/1/26 at 5:00 p.m. c) A Physician's Order, dated 6/18/26, indicated the pressure area on the left gluteal (buttocks) was to be cleansed with saline, patted dry, a nickel size of Santyl (debriding agent) was to be applied and covered with a moist gauze and then a dry dressing applied every day shift. The Treatment Administration Record (TAR), dated 6/2026, indicated the treatment had not been completed on 6/19/26. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 6/18/26, indicated betadine was to be applied to the left heel pressure area then cover the area with roll gauze daily and as needed. The TAR, dated 6/2026, indicated the treatment to the left heel had not been completed on 6/19/26 and 6/20/26. A Physician's Order, dated 6/18/26, indicated Santyl was to be applied to the coccyx area after cleansing and the area was to be covered by a moist gauze and dry dressing every day shift. The TAR, dated 6/2026, indicated the treatment to the coccyx had not been completed on 6/19/26 and 6/20/26. A Physician's Order, dated 6/18/26, indicated Santyl was to be applied to the sacrum pressure area every day shift after cleansing, then covered with a moist gauze and dry dressing. The TAR, dated 6/2026, indicated the sacrum treatment had not been completed on 6/19/26. A Physician's Order, dated 6/20/26, indicated the sacrum wound was to be cleansed with saline, patted dry, skin prep was to be applied to the peri-wound, and a wound vac was to be applied and changed every Tuesday, Thursday, and Saturday and as needed. The TAR, dated 6/2026, indicated the wound vac treatment had not been completed on 6/20/26. A Physician's Order, dated 6/30/26, indicated Iodosorb External Gel 0.9% (antimicrobial gel) was to be applied to the left heel every day shift and covered with a dry dressing. The TAR, dated 7/2026, indicated the left heel treatment had not been completed on 7/1/26. During an interview with the Nurse Consultant on 7/7/26 at 4:50 p.m., no further information was provided. An undated facility pressure wound policy, received as current on 7/7/26 at 3:48 p.m. from the Administrator, indicated implementation of appropriate interventions were to be documented and supplements were to be utilized as ordered. 2. The record for Resident E was reviewed on 7/7/26 at 9:43 a.m. Diagnoses included, but were not limited to, muscle weakness, acute kidney failure, and hypertension (high blood pressure). The 7/4/26 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had a stage three pressure ulcer on admission. A Nursing Progress Note, dated 6/30/26 at 8:09 a.m., indicated the resident's admitting assessment revealed a pressure injury to the coccyx. There was slough (moist, yellowish or white stringy dead tissue) and pale pink tissue noted. Orders were received and initiated. (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, dated 6/30/26, indicated the resident had been admitted to the facility with a pressure injury to the coccyx. Approaches were to treat per physician orders, and measure and assess per facility policy. A Physician's Order, dated 7/1/26, indicated to apply topical external triad paste to the coccyx every day shift for wound care. The Treatment Administration Record (TAR) for June and July 2026 indicated wound treatments were not signed out on the following dates: 6/30/26 7/1/26 7/4/26 7/6/26 During an interview on 7/8/26 at 11:33 p.m., the Nurse Consultant indicated she understood the concerns and had no further information to provide. 3. Resident F's record was reviewed on 7/7/26 at 2:35 p.m. The diagnoses included, but were not limited to, muscle weakness, abnormal gait and mobility, aphasia (difficulty speaking), obstructive and reflux uropathy (blockage and backward flow of urine), adjustment disorder, anemia (low iron), and hypertension (high blood pressure). The 6/16/26 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision-making and had a pressure injury. A Care Plan, dated 6/10/26, indicated the resident had actual impairment to skin integrity. Approaches were to evaluate and treat per physician's orders and follow facility protocol for treatment of injury. A Care Plan, dated 6/10/26, indicated the resident was in Enhanced Barrier Precautions (EBP) related to wounds. Approaches were to provide EBP as indicated, and use of personal protective equipment (PPE), specifically gowns and gloves during high contact resident care. A Physician's Order, dated 6/11/26 at 7:00 a.m., indicated to cleanse the left inner glute with saline, pat dry, apply medical honey to the wound bed and cover with a dry dressing every day shift and as needed. The Treatment Administration Record (TAR) for June 2026 indicated wound treatments were not signed out on the following dates: (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	6/11 6/14 6/20 6/21 6/22 6/26 6/27 During an interview on 7/8/26 at 11:33 p.m., the Nurse Consultant indicated she understood the concerns and had no further information to provide. This citation relates to Intakes 3055048 and 3064613. 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)		

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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 Foley (urinary) catheter care was provided, urine output was recorded and catheter bags and tubing were kept off of the floor for a resident with a Urinary Tract Infection (UTI) for 2 of 3 residents reviewed for catheters. (Residents E and F) Findings include: 1. On 7/7/26 at 10:30 a.m., Resident E was observed lying in bed. He had a Foley catheter that hung off the side of the bed. The record for Resident E was reviewed on 7/7/26 at 9:43 a.m. Diagnoses included, but were not limited to, muscle weakness, acute kidney failure, and hypertension (high blood pressure). The 7/4/26 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision-making and had a urinary catheter. A Care Plan, dated 6/29/26, indicated the resident had a urinary catheter. The approaches were to check placement of the tubing every shift, monitor/document pain or discomfort, and monitor/record/report signs and symptoms of a UTI. A Physician's Progress Note, dated 6/30/36 at 9:26 p.m., indicated the resident had a suspected UTI and recommended hot and cold packs to reduce abdominal/back pain associated with a UTI. A Physician's Order, dated 7/1/26, indicated to administer foley catheter care every shift and as needed. The Treatment Administration Record (TAR) for July 2026 lacked documentation that Foley catheter care had been provided from 7/1/26-7/7/26. During an interview on 7/8/26 at 11:33 p.m., the Nurse Consultant indicated the order had never transferred to the TAR and she would have the issue resolved. 2. During random observations on 7/7/26 at 8:35 a.m., 12:16 p.m. and 12:50 p.m., Resident F was observed sitting in a wheelchair. The bottom of the resident's urinary catheter bag was observed on the floor under the wheelchair. Resident F's record was reviewed on 7/7/26 at 2:35 p.m. The diagnoses included, but were not limited to, muscle weakness, abnormal gait and mobility, aphasia (difficulty speaking), obstructive and reflux uropathy (blockage and backward flow of urine), adjustment disorder, anemia (low iron), and hypertension (high blood pressure). The 6/16/26 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision-making and had a urinary catheter. A Care Plan, dated 6/10/26, indicated the resident had a urinary catheter. The approaches were to check placement of the tubing every shift, monitor/document pain or discomfort, and monitor/record/report signs and symptoms of a UTI which included urinary frequency, foul smelling urine, no output, fever, chills, cloudiness, mental status changes, and blood-tinged urine. A Care Plan, dated 6/12/26, indicated the resident was on antibiotic therapy. Approaches were to administer medications as ordered by a physician and monitor and report adverse reactions. A Physician's Order, dated 6/17/26 indicated to record output every shift. A Physician's Order, dated 6/17/26 indicated to change the Foley catheter drainage bag as needed. A Physician's Order, dated 6/26/26, indicated to obtain a urinalysis and culture (urine laboratory tests). The Urine Culture results, dated 6/29/26, indicated a urine infection was present. A Physician's Order, dated 6/30/26, indicated to administer Ciprofloxacin 500 milligrams (mg), one tablet by mouth every 24 hours for 10 days for infection. A Physician's Order, dated 7/7/26 at 7:00 a.m., indicated Foley catheter care to include anchoring tubing and checking skin integrity every shift. The record lacked Foley catheter care orders until 7/7/26. A Physician's Order, dated 7/7/26 at 7:00 a.m., indicated to check/ensure the Foley catheter was in place and intact. A Physician's Progress Note, dated 7/6/26 at 10:24 a.m., indicated the resident had a UTI and was on Ciprofloxacin (antibiotic) until 7/10/26. The June and July Treatment Administration Record (TAR) indicated there was no Foley catheter care recorded for June through July 7th, 2026. The urine output was not recorded on the following dates: 6/17/26 - am and (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pm6/18/26 - pm shift6/19/26 - pm shift6/20/26 - am shift6/21/26 - am and pm shift6/22/26 - am shift6/23/26 - am and pm shift6/24/26 - am shift6/25/26 - am and pm shift6/26/26 - am shift6/27/26 - am shift6/29/26 - am and pm shift6/30/26 - am and pm shift7/4/26 - am shift7/5/26 - am and pm shift7/6/26 - pm shift The current 2025 Catheter policy, provided by the Nurse Consultant on 7/7/26 at 3:48 p.m., indicated .provide routine perineal hygiene according to facility protocol . During an interview on 7/7/26 at 2:21 p.m., the Nurse Consultant indicated the resident's Foley bag should not have been on the floor. During an Interview on 7/8/26 at 11:33 a.m., the Nurse Consultant indicated she understood the output should have been documented and the catheter care orders should have been placed sooner. She had no further information to provide. This citation relates to Intakes 3055048 and 3064613. 410 IAC (Indiana Administrative Code) 16.2-3.1-41(a)(2)		

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. Based on record review and interview, the facility failed to provide colostomy care and assess the colostomy and skin surrounding the ostomy, for 1 of 1 resident with a colostomy. (Resident D) Finding includes: Resident D's closed record was reviewed on 7/7/26 at 6:58 a.m. The diagnoses included, but were not limited to, paraplegia related to trauma and colostomy. A Care Plan, dated 6/17/26, indicated an ostomy was present. The interventions included the stoma would be monitored for changes and ostomy care would be provided. An admission Minimum Data Set assessment, dated 6/22/26, indicated a colostomy was present. There was no documentation in the record that indicated colostomy care had been provided, the collection bag had been changed, stoma care had been completed, and the ostomy site had been assessed. There were no Physician's Orders for the care of the colostomy. During an interview 7/7/26 at 11:05 a.m., the Nurse Consultant had no further information on the care of the colostomy. A facility undated colostomy policy, received from the Administrator on 7/7/26 at 3:48 p.m., indicated a resident with a colostomy would receive care in accordance with physician's orders, the care plan, infection prevention standards, and accepted nursing practice. The stoma was to be assessed with care and as needed. The peristomal skin was to be cleansed with warm water and dried thoroughly. The stoma assessment was to be documented with output characteristics, skin condition, appliance changes, resident tolerance, and any abnormalities. This citation relates to Intakes 3055048 and 3064613.410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(3)		

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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. Based on observation, record review, and interview, the facility failed to care for peripherally inserted central catheters (PICC) (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 3 of 3 residents reviewed with a PICC. (Residents G, H, and D) Findings include: 1. During an observation on 7/8/26 at 10:30 a.m., LPN 1 administered Resident G's antibiotic through the PICC line in the left upper arm after flushing the line with 10 milliliters (ml) of normal saline. The dressing covering the PICC insertion site was dated 6/26/26. The Nurse Consultant verified the date at 6/26/26 and indicated the dressing was to be changed every seven days. Resident G's record was reviewed on 7/8/26 at 12:51 p.m. The diagnoses included, but were not limited to, urinary tract infection. The Nursing admission Assessment, dated 6/27/26 at 6:53 p.m., indicated a peripheral IV was present. A PICC line was not indicated. A Care Plan, dated 6/27/26, indicated the resident received IV medications. The interventions included the site would be observed every shift, the dressing would be changed every week, and the IV would be flushed per the physician's orders. An admission Minimum Data Set (MDS) assessment, dated 7/3/26, indicated the resident received an antibiotic, had IV medications and an IV access. There were no physician's orders for the PICC line flush or dressing changes. There was no documentation the PICC insertion site had been assessed, flushes had been completed, or the dressing had been changed every seven days. 2. During an observation on 7/8/26 at 1 p.m., the dressing over the PICC site on Resident H's right upper arm was dated 7/7/26. Resident H's record was reviewed on 7/8/26 at 10:17 a.m. The diagnoses included, but were not limited to, cellulitis of right lower limb. A Nursing admission Assessment, dated 6/8/26 at 7:23 p.m., indicated there was no venous access present. A PICC Insertion Form from the nursing service who inserted the PICC line, dated 6/16/26, indicated a line had been placed in the left upper arm. The size of the line and the length of the line and arm circumference were documented. The directions indicated a dressing change was to be completed 24 hours after insertion and then every seven days and as needed. There was no documentation that indicated the dressing had been changed 24 hours after the PICC line was inserted. A Physician's Order, dated 6/19/26, indicated the PICC line was to be flushed with 10 ml of normal saline every shift to keep the line patent. The Medication Administration Record (MAR) indicated the flush had not been completed on the day and night shifts on 6/29/26. There were no physician orders for changing the dressing. There was no documentation the dressing had been changed every seven days. A Care Plan, dated 7/2/26, indicated the resident received IV medications. The interventions included, the insertion site and dressing was to be assessed every shift, the dressing was to be changed weekly, and flushes were to be completed per the physician's orders. There were no assessments of the insertion site until 7/5/26 at 2:10 p.m. A Nurse's Note, dated 7/5/26 at 2:10 p.m., indicated the PICC line had been pulled out approximately 1/2 inch and the insertion site was reddened. The nursing service for PICC line insertion was notified. A new PICC line was inserted on 7/5/26 at 5:55 p.m. by the nursing service. There was no documentation that indicated the PICC line dressing had been changed 24 hours after the insertion on 7/5/26. There were no further assessments of the PICC insertion site. During an interview on 7/8/26 at 2:30 p.m., the Nurse Consultant indicated there were no orders to change the dressing every seven days or assessments completed. 3. Resident D's closed record was reviewed on 7/7/26 at 6:58 a.m. The diagnoses included, but were not limited to, infected unstageable (unable to determine depth of ulcer) sacral pressure ulcer and stage three (full thickness of skin loss) pressure ulcer of the heel. (continued on next page)		

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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 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nursing admission Assessment, dated 6/17/26 at 6:00 p.m., indicated there was no venous access.A Physician's Order, dated 6/17/26, indicated piperacillin sod-tazobactam (antibiotic) 3-0.375 grams was to be administered intravenously every six hours.A Care Plan, dated 6/18/26, indicated the resident received IV medications. The interventions included, the dressing was to be observed every shift and the dressing was to be changed every seven days.A Physician's Order, dated 6/19/26 indicated the PICC line was to be flushed with 10 ml of normal saline every shift to keep the line patent.There was no documentation when the PICC line was inserted or when the dressing changes had been completed. There was no documentation of the PICC line insertion site assessments.An undated central line (PICC) policy, received from the Nurse Consultant on 7/8/26 at 11:30 a.m., indicated the dressing change was to be completed every seven days and as needed.This citation relates to Intakes 3055048 and 3064613.410 IAC (Indiana Administrative Code) 16.2-3.1-47(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 07/08/2026
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. Based on observation, interview, and record review, the facility failed to ensure infection control practices were in place and implemented related to Enhanced Barrier Precautions (EBP) not followed and no glove change from dirty to clean care for 1 of 3 residents reviewed for infection control. (Resident E) Finding includes: During random observations on 7/7/26 at 10:30 a.m. and 12:11 p.m., Resident E was observed lying in bed. There was no Enhanced Barrier Precautions (EBP) sign on the door or inside the resident's room. On 7/7/26 at 10:32 a.m., CNA 1 was observed providing incontinence care to Resident E. CNA 1 had put gloves on and positioned the resident lying down. She indicated the resident had a bowel movement and needed to be changed. She removed the resident's brief and realized he did not have a bowel movement but provided peri care and a new brief. The resident had a wound dressing on his coccyx which remained intact. The CNA then began to get the resident dressed for therapy; she put his pants on and buttoned his shirt up and assisted the resident to his wheelchair. CNA 1 did not change her gloves after completing peri care to transfer into the wheelchair. The resident was supposed to be in enhanced barrier precautions due to having a catheter, feeding tube and a wound, and the CNA had only worn gloves during care. During an interview at the time, CNA 1 indicated she had never cared for Resident E and if he was in enhanced barrier precautions she would wear a gown, gloves, and a mask. She had indicated there was no EBP sign on the door. The record for Resident E was reviewed on 7/7/26 at 9:43 a.m. Diagnoses included, but were not limited to, muscle weakness, acute kidney failure, and hypertension (high blood pressure). The 7/4/26 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision-making and had a urinary catheter. A Care Plan, dated 6/29/26, indicated the resident was in Enhanced Barrier Precautions (EBP) related to wounds. Approaches were to provided EBP as indicated, and use of personal protective equipment (PPE), specifically gowns and gloves during high contact resident care. A Care Plan, dated 6/30/26, indicated the resident had been admitted to the facility with a pressure injury to the coccyx. Approaches were to treat per physician orders, and measure and assess per facility policy. A Physician's Order, dated 7/5/26, indicated the resident was in enhanced barrier precautions related to a wound. During an interview on 7/7/26 at 11:23 a.m., the Nurse Consultant indicated CNA 1 should have followed enhanced barrier precautions and changed her gloves after care. During an interview on 7/8/26 at 11:33 a.m., the Nurse Consultant indicated they had an infection control staff member, but she had been off for a while. They were going to check and ensure all doors were updated with appropriate signage. A facility policy titled, Enhanced Barrier Precautions and received as current from the Nurse Consultant on 7/7/26 at 3:48 p.m., indicated, .Gowns and gloves are used during high contact activities with increased risk for MDRO transmission to staff clothing and hands including but not limited to: dressing, bathing/showering, and transferring . This citation relates to Intakes 3055048 and 3064613. 410 IAC (Indiana Administrative Code) 16.2-3.1-18(b)		

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 07/08/2026
NAME OF PROVIDER OR SUPPLIER Ignite Medical Resort Chesterton		STREET ADDRESS, CITY, STATE, ZIP CODE 2775 Village Point Chesterton, IN 46304	
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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, record review and interview, the facility failed to ensure posted staffing information was current and failed to retain the posted daily nurse staffing data for a minimum of 18 months. This had the potential to affect all residents who reside in the facility. Finding includes: During an observation on 7/7/26 at 4:00 a.m., the posted staffing information was located at the front door. The date on the posting was 7/2/26. During an interview on 7/7/26 at 5:50 a.m., the Nurse Consultant indicated the posted information was to be changed out daily. During an interview on 7/7/26 at 4:55 p.m., the Nurse Consultant indicated the Scheduler had been shredding the daily postings. She started the position in February and was unaware she was required to keep the posting. This citation relates to Intakes 3012845 and 3055048.		