

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

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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 07/28/2026
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 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 care plans were developed for residents related to perentral fluids/medications, urinary catheter usage, and risk for constipation, for 2 of 7 residents reviewed for care plans. (Residents C and E) Findings include: 1. During an observation on 7/27/26 at 9:45 a.m., Resident C was ambulating with his walker. A urinary catheter and a peripheral intravenous (IV) line were observed. Resident C's record was reviewed on 7/27/26 at 10:39 a.m. The diagnoses included, but were not limited to, dehydration, fractures of the sacrum and spine, urinary retention, and constipation. a) The Physician's Order dated 7/7/26 to 7/9/26, indicated hydrocodone-acetaminophen (narcotic pain medication) 5-325 milligrams (mg), one to two tablets every four hours as needed for pain. A Physician's Order, dated 7/9/26, indicated oxycodone (narcotic pain medication) five mg every four hours. A Physician's Order, dated 7/14/26 to 7/22/26, indicated Tramadol (narcotic pain medication) 50 mg, one tablet every 12 hours for pain. The bowel movement record, dated 7/2026 indicated there had been no bowel movement from 7/8/26 through 7/24/26. There was no care plans for the risk of constipation due to the narcotic pain medications and no bowel movements. b) An admission Minimum Data Set (MDS) assessment, dated 7/9/26, indicated an indwelling urinary catheter was present. A Physician's Order, dated 7/13/26, indicated an indwelling urinary catheter was present and output was to be recorded every shift. There was no care plan for the indwelling urinary catheter. During an interview on 7/28/26 at 2:16 p.m., the Nurse Consultant indicated the care plans were not (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	completed. 2. The record for Resident E was reviewed on 7/28/26 at 9:36 a.m. Diagnoses included, but were not limited to, COPD, hypertension (high blood pressure), chronic kidney disease, and tremors. The Baseline Care Plan, dated 7/20/26, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance for toileting. A Physician's Order, dated 7/20/26, indicated to check intravenous (IV) dressing every shift. A Physician's Order, dated 7/20/26, indicated to change the peripherally inserted central catheter (PICC) line dressing every seven days. A Physician's Order, dated 7/20/26, indicated to administer two Bisacodyl (laxative) tablets by mouth two times a day for a laxative. The Bowel and Bladder Elimination Task for the past 30 days indicated the resident did not have a bowel movement (BM) from 7/19/26 through 7/28/26. The current Care Plan did not address the resident's IV/PICC line or constipation. During an interview on 7/28/26 at 4:00 p.m., the Nurse Consultant indicated she understood the concerns regarding resident E's care plans. The care plans would be updated. This citation relates to Intake 3110454. 410 IAC (Indiana Administrative Code) 16.2-3.1-35(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. Based on record review and interview, the facility failed to ensure residents received treatment and care in accordance with professional standards related to bowel management and treatment to a non-pressure wound, for 3 of 7 residents reviewed for quality of care. (Residents C, D, and E) Findings include: 1. Resident C's record was reviewed on 7/27/26 at 10:39 a.m. The diagnoses included, but were not limited to, constipation. An admission Minimum Data Set (MDS) assessment, dated 7/9/26, indicated an intact cognitive status, dependent for toileting, and always continent of bowel movement. A Physician's Order, dated 7/7/26, indicated polyethylene glyco (laxative) 17 grams daily for constipation. The bowel movement record, dated 7/2026, indicated there had been no bowel movement from 7/8/26 through 7/24/26. A Physician's Progress Note, dated 7/21/26 at 2:22 p.m., indicated the resident had not had a bowel movement since 7/3/26 and denies any abdominal pain, nausea or vomiting. A Physician's Order, dated 7/21/26, indicated bisacodyl suppository (laxative) 10 milligrams (mg) was to be administered every 24 hours as needed for constipation and Senna oral tablet (laxative) 8.6 mg, 1 tablet twice a day was to be initiated for constipation. A Nurse's Progress Note, dated 7/21/26 at 5:03 p.m., indicated the resident has been administered stool softeners and polyethylene glyco for constipation and he has not had a bowel movement. A suppository was administered. If there was no bowel movement after the suppository, he has requested to go to the hospital. A Nurse's Progress Note, dated 7/21/26 at 6:18 p.m., indicated the resident had a bowel movement. There was no documentation of the amount/size of the resident's bowel movement. A Nurse's Note, dated 7/21/26 at 7:05 p.m., indicated the resident insisted on going to the emergency room (ER). Orders were obtained to transfer to the ER. The Hospital Progress Notes, dated 7/21/26 through 7/22/26, indicated the resident had not had a bowel movement since 7/3/26. He had mild abdominal discomfort and diminished appetite. An enema and good bowel regimen was recommended. The CT of the abdomen indicated moderate to large volume of stool throughout the colon. The resident had a large bowel movement. There was no assessment of bowel sounds documented from 7/7/26 to 7/21/26. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The physician had not been notified of the resident's constipation until 7/21/26. During an interview on 7/28/26 at 2:16 p.m., the Nurse Consultant indicated there had been no physical assessments of the resident with no bowel movement and no documentation the physician had been notified. The physician was aware of the no bowel movements. A facility bowel management policy, dated 4/2026 and received from the Nurse Consultant as current, indicated the facility was to maintain an effective bowel management program that included assessment, monitoring, documentation, intervention and evaluation of bowel function for each resident. The physician was to be notified if there was no bowel movement for more than three days unless otherwise ordered. Bowel movements were to be documented. 2. The record for Resident D was reviewed on 7/27/26 at 12:27 p.m. Diagnoses included, but were not limited to, acquired absence of leg above the knee, chronic pain syndrome, osteomyelitis left femur, assistance with personal care, and difficulty walking. The Medicaid 5-day Minimum Data Set (MDS) assessment, dated 7/21/26, indicated the resident was cognitively intact for daily decision making. Toileting, shower/bathing, and lower body dressing required substantial/maximum assistance. A Care Plan, dated 7/16/26, indicated the resident moved in with a left above the knee amputation (LAKA). Interventions were to treat per physician orders and assess per facility policy. A Physician's Order, dated 7/16/26, indicated to cleanse the LAKA with saline and pat dry, apply maxorb to the wound bed and cover with a dry dressing every day shift for wound care. The Treatment Administration Record (TAR) indicated the wound treatment had not been signed out on 7/25/26. During an interview on 7/27/26 at 4:45 p.m., the Nurse Consultant indicated the resident's wound treatment should have been signed out. 3. Resident E was observed on 7/28/26 at 10:20 a.m. sitting in his wheelchair waiting for therapy. The resident indicated nah when asked if he had been having bowel movements. The record for Resident E was reviewed on 7/28/26 at 9:36 a.m. Diagnoses included, but were not limited to, COPD, hypertension (high blood pressure), chronic kidney disease, and tremors. The Baseline Care Plan, dated 7/20/26, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance for toileting. The Bowel and Bladder Elimination Task for the past 30 days indicated the resident did not have a bowel movement (BM) from 7/19/26 through 7/28/26. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician's Order, dated 7/20/26, indicated to administer two Bisacodyl (laxative) tablets by mouth two times a day for a laxative. A Physician's Order, dated 7/20/26, indicated to administer one Bisacodyl suppository rectally every 24 hours as needed for laxative. The was no documentation that the physician was notified of the resident lack of BMs. There was no care plan for constipation. The Medication Administration Record indicated the rectal suppository was not given during the month of July 2026. During an interview on 7/28/26 at 3:55 p.m., the Assistant Chief Nursing Officer (ACNO) indicated the physician had been made aware of the resident's constipation and he would receive a suppository today. This citation relates to Intakes 3074217 and 3110454. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		

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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 ensure an intravenous (IV) access and fluids were initiated timely, flush orders were obtained from the physician, the flush was completed per policy, and the insertion site was monitored for signs and symptoms of adverse reaction, for 1 of 3 residents reviewed for parenteral fluids. (Resident C) Finding includes: During an observation on 7/27/26 at 11:50 a.m., RN 1 entered Resident C's room with a 10 cubic centimeters (cc) syringe of 0.9% normal saline (NS). She indicated the tubing needed to be flushed due to observing blood in the tubing. The resident was lying in bed and IV fluids were infusing at 60 cc's an hour into a peripheral IV access site in the right forearm. The dressing on the insertion site was dated 7/22/26. The IV fluid bag of 1000 cc's of 0.9% NS was almost empty. RN 1 indicated a new IV bag of 0.9% NS needed to be administered. RN 1 then detached the IV tubing from the insertion tubing, inserted the syringe of NS into the insertion tubing without using an alcohol prep pad to clean the port, and administered the 10 cc's of 0.9% NS flush. She then clamped the tubing, obtained a new 1000 cc bag of 0.9 NS and tubing. She primed the tubing and set the rate at 60 cc per hour, used an alcohol prep pad to clean the insertion tubing and attached the IV tubing. During an interview on 7/27/26 at 12:15 p.m., RN 1 indicated she had not used the alcohol prep pad with the flush because it was a closed system. Resident C's record was reviewed on 7/27/26 at 10:39 a.m. The diagnoses included, but were not limited to, dehydration. A Physician's Progress Note, dated 7/21/26 at 2:22 p.m., indicated the lips, mucosa, and tongue were normal. The mucosa appeared dry, the skin turgor was normal. IV fluids of 1000 cc NS was to be administered over 24 hours and then re-evaluate. The Blood Urea Nitrate (BUN) levels were progressively going up secondary to dehydration. A Nurse's Progress Note, dated 7/21/26 at 6:18 p.m., indicated the physician had visited and an IV of 1000 cc's normal saline was to be administered for 24 hours. The PICC (central line) team would come to insert the peripheral line. A Nurse's Progress Note, dated 7/21/26 at 7:05 p.m., indicated the resident requested to be transferred to the hospital due to constipation and a Physician's Order was obtained. A Nurse's Progress Note, dated 7/21/26 at 9:10 p.m., indicated the resident was transferred to the hospital at 9:10 p.m. A Nurse's Progress Note, dated 7/22/26 at 2:59 p.m., indicated the resident returned from the Hospital Emergency Room. There was no documentation to indicate a peripheral IV had been initiated prior to the resident's transfer to or upon return to the facility from the Emergency Room. There was no documentation the peripheral IV had been initiated on 7/22/26 per the dressing date. A Physician's Order had not been written until 7/23/26 for NS 0.9% at 100 cc's and hour per IV one time a day for urinary tract infection symptoms. There was no documented diagnosis of a urinary tract infection symptoms. A Nurse's Progress Note, dated 7/23/26 at 1:25 p.m., indicated the IV had been initiated in the right forearm and IV fluids of 0.9% NS was initiated at 100 cc per hour as ordered. A Nurse Practitioner's (NP) Progress Note, dated 7/23/26 at 1:38 p.m., indicated the resident returned from the hospital Emergency Room. IV fluids were initiated per orders on 7/23/26. The Medication Administration Record (MAR), dated 7/2026, indicated the 0.9% NS had been administered on 7/23/26. There was no time documented when the IV had infused. There was no Physician's Order for the IV NS flush or dressing changes. There was no documentation the IV had been discontinued after the initial bag of NS had been infused. There was no documentation the IV had been flushed for patency or assessments of the IV insertion site. A Physician's Order, dated 7/26/26, indicated NS 0.9% was to be infused at 60 cc's per hour every shift for dehydration. The MAR indicated the IV fluids of 0.9% NS at 60 cc per hour had been initiated on 7/26/26 on the night shift. There were no assessments of the insertion site after the IV fluids of 0.9% NS at 60 cc per hour had been initiated. During an (continued on next page)		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interview on 7/28/26 at 2:16 p.m., the Nurse Consultant indicated the IV insertion site should have been assessed every shift. The resident was transferred to the hospital on 7/21/26 when the original order had been received and she was unsure why the fluids had not been started upon return from the hospital. She was unable to validate if the IV had remained inserted from 7/23/26 to 7/26/26 and, if it remained inserted, was unable to validate what care had been completed. She also acknowledged there were no flush orders for the IV site. A facility peripheral IV policy, dated 4/2026 and received from the Nurse Consultant as current, indicated, staff was to complete verification of the physician's order and clinical indication upon insertion. The site was to be assessed each shift, before and after medication administration and during continuous infusions. The IV was to be removed upon completion of therapy or if the catheter was no longer clinically indicated. The removal of the IV was to be documented. This citation is related to Intake 3110454.410 IAC (Indiana Administrative Code) 16.2-3.1-47(a)(2)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, record review and interview, the facility failed to ensure pain management regimens were followed as ordered by the physicians and failed to provide a pain medication in a timely manner upon request, for 3 of 3 residents reviewed for pain. (Residents C, G, and D) Findings include: 1. During an interview on 7/27/26 at 9:45 a.m., Resident D indicated he was supposed to receive oxycodone (narcotic pain medication) every four hours, the medication was received late on several occasions and sometimes he did not get the medication at all. Resident C's record was reviewed on 7/27/26 at 10:39 a.m. The diagnoses included, but were not limited to, fractured sacrum and wedge compression fractures of the spine. A Care Plan, dated 7/7/26, indicated an alteration in the musculoskeletal status related to a fracture of the sacrum and spinal wedge fractures. The interventions included pain medication would be administered as ordered by the physician. An admission Minimum Data Set (MDS) assessment, dated 7/9/26, indicated an intact cognitive status, no behaviors, and pain was frequently present that effected his sleep, therapy activities, and day to day activities. The pain was rated a 5 out of 10 and he received opioid medications daily. A Nurse Practitioner's (NP) Progress Note, dated 7/9/26 at 5:45 p.m., indicated the resident reported severe sacral pain due to a sacral fracture. The worst the pain had been rated was a 10 out of 10. Frequent opioid analgesics were required. The pain medication was switched to oxycodone five milligrams (mg) every four hours for better pain control. A Physician's Order, dated 7/9/26, indicated oxycodone five mg was to be administered every four hours for pain due to fractures. The oxydocone was scheduled for 12:00 a.m., 4:00 a.m., 8:00 a.m., 12:00 p.m., 4:00 p.m., and 8:00 p.m. and the pain was to be evaluated with the administering of the medication. Review of the administration details for the oxycodone with the actual administration times, received on 7/27/26 at 3:00 p.m. from the Nurse Consultant, indicated the oxycodone was administered and the pain assessment at the following times for July 2026:- 7/12/26 the 4:00 a.m. dose was administered at 5:32 a.m. with a pain rating of four.- 7/12/26 the 4:00 p.m. dose was administered at 5:51 p.m. with a pain rating of zero.- 7/12/26 the 8:00 p.m. dose was administered at 10:53 p.m., five hours between doses, with a pain rating of eight.- 7/13/26 the 12:00 a.m. dose was administered at 11:50 p.m., less than an hour from the from the 8:00 p.m. dose.- 7/13/26 the 4:00 p.m. dose was administered at 6:14 p.m. with a pain rating of seven.- 7/13/26 the 8:00 p.m. dose was given at 9:01 p.m., 2 3/4 hours since the last administration, with a pain rating of four. - 7/14/26 the 8:00 a.m. dose was administered at 9:16 a.m. with a pain rating of four.- 7/14/26 the 12:00 p.m. dose was administered at 1:28 p.m. with a pain rating of seven.- 7/14/26 the 4:00 p.m. dose was administered at 5:40 p.m. with a pain rating of zero.- 7/14/26 the 8:00 p.m. dose was administered at 10:30 p.m. with a pain rating of four.- 7/15/26 the 12:00 a.m. dose was administered at 12:35 a.m., two hours between doses, with a (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pain rating of four.- 7/15/26 the 4:00 a.m. dose was administered at 6:05 a.m., five and a half hours between doses, with a pain rating of three.- 7/15/26 the 8:00 a.m. dose was offered at 11:28 a.m. and documented as refused.- 7/17/26 the 8 a.m. dose was documented as administered at 8:25 a.m., the oxycodone had not been signed out on the narcotic record that would indicate the resident received the medication.- 7/18/26 the 4:00 a.m. dose was administered at 4:04 a.m. with a pain rating of seven.- 7/18/26 the 8:00 a.m. dose was administered at 11:53 a.m., seven hours between doses, with a pain rating of zero.- 7/18/26 the 12:00 p.m. dose was administered at 12:15 p.m., less than a half hour between doses, with a pain rating of 3.- 7/18/26 the 4:00 p.m. dose was administered at 5:27 p.m., the pain was not assessed.- 7/18/26 the 8:00 p.m. dose was administered at 11:24 p.m., six hours between doses, with a pain rating of two.- 7/19/26 the 12:00 a.m. dose was administered at 12:45 a.m., one hour and 15 minutes between doses, with a pain rating of four.- 7/24/26 the 8:00 a.m. dose was administered at 10:39 a.m. and the pain rating was not assessed.- 7/24/26 the 12:00 p.m. dose was administered at 11:48 a.m., one hour and nine minutes between doses. The pain was not assessed.- 7/26/26 the 12:00 p.m. dose was administered at 11:39 a.m., with a zero pain rating.- 7/26/26 the 4:00 p.m. dose was administered at 6:21 p.m., over six hours from last dose, with a zero pain rating.- 7/26/26 the 8:00 p.m. dose was administered at 7:45 p.m., one hour and 15 minutes between doses, with the pain rated at an eight. During an interview on 7/27/26 at 9:30 a.m., Resident C indicated if the pain medications were administered at the correct time, he could push through his pain. It made the pain easier to live with. Sometimes he received the pain medications too close together and sometimes he never received them at all. If the pain medications were not administered as ordered, the pain was often unbearable. During an interview on 7/28/26 at 10:30 a.m., QMA 1 indicated when they are preparing the medications for administration, they check off the medication on the Medication Administration Record (MAR), the medications are then administered, and the save button on the MAR is clicked when they return to the medication cart to indicate the medications had been administered. During an interview on 7/28/26 at 2:16 p.m., the Nurse Consultant indicated the first time located on the medication administrative details was the time the medication was administered. No further information was provided after going over the documented times of the administration of the oxycodone. 2. During a morning medication pass observation on 7/28/26 at 8:25 a.m., Resident G indicated he was having pain and asked QMA 3 for Tylenol and indicated the Tylenol relieved the pain in the past. QMA 3 exited the room, looked in the medication cart, and indicated the resident had no Tylenol available. She then reported to RN 1 that the resident was in pain and requested Tylenol and the resident had no Tylenol available. RN 1 then checked the Emergency Drug Kit (Pixus) and indicated there was no Tylenol available. RN 1 then assessed the resident's pain at an eight out of 10 located in his back. She indicated she would notify the physician to get something stronger than Tylenol since the pain was rated at an eight. RN 1 texted the Nurse Practitioner and requested a pain medication order. RN 1 then notified the Physician at 8:45 a.m. and received an order for ibuprofen. At 8:50 a.m., RN 1 (continued on next page)		

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated there was no ibuprofen in the Pixus. The Assistant Director of Nursing notified the Physician on 7/28/26 at 9:05 a.m., that the ibuprofen was not available and requested another pain medication. Resident G's record was reviewed on 7/28/26 at 1:00 p.m. The diagnoses included, but were not limited to, stroke. A Care Plan, dated 6/8/26, indicated a potential for pain. The interventions indicated they would respond immediately to any complaint of pain and identify the resident's previous response to analgesia including pain relief. An admission MDS assessment, dated 6/11/26, indicated a moderately impaired cognitive status and no pain. A Physician's Order, dated 7/2/26, indicated acetaminophen (Tylenol) 650 mg, one tablet every four hours as needed for pain. The MAR, dated 7/2026, indicated the acetaminophen 650 mg had been administered on 7/26/26 at 3:50 a.m. for a pain level of four out of 10 and was effective. A Physician's order was received on 7/28/26 at 9:26 a.m. for hydrocodone -acetaminophen (narcotic pain medication), one 5-325 mg tablet was to be administered every four hours as needed for pain. The MAR, dated 7/2026, indicated QMA 3 had administered the medication on 7/28/26 at 9:30 a.m. During an interview on 7/28/26 at 1:42 p.m., the Nurse Consultant indicated the acetaminophen was not stocked in the Pixus since it was an over the counter medication and she was unsure where the acetaminophen 650 mg was obtained from on 7/26/26 at 3:50 a.m. A pain management policy, dated 5/2023 and received as current from the Nurse Consultant, indicated optimal management of the resident experiencing pain enhanced the healing and promoted both physical and psychological wellness. A medication administration policy, dated 4/2026 and received as current from the Nurse Consultant, indicated to .Click 'confirm on the EMAR once the medication is removed form the package . 3. During a random observation on 7/27/26 at 4:20 p.m., Resident D was sitting in the dining room waiting for dinner. She indicated she was in pain and needed her fentanyl patch changed, she pulled her shirt over her left shoulder, and her fentanyl patch was dated 7/23/26. At 4:25 p.m., the Assistant Chief Nursing Officer (ACNO) and the Nurse Consultant asked the resident to see her fentanyl patch and confirmed it was dated 7/23/26 and should have already been removed. The record for Resident D was reviewed on 7/27/26 at 12:27 p.m. Diagnoses included, but were not (continued on next page)		

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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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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	limited to, acquired absence of leg above the knee, chronic pain syndrome, osteomyelitis left femur, assistance with personal care, and difficulty walking. The Medicaid 5-day Minimum Data Set (MDS) assessment, dated 7/21/26, indicated the resident was cognitively intact for daily decision making. Toileting, shower/bathing, and lower body dressing required substantial/maximum assistance. A Care plan, reviewed on 7/16/26, indicated the resident received opioid medication. Interventions were to administer analgesic medication as ordered by a physician and assess if pain intensity was acceptable to resident. A Physician's Order, dated 7/23/26, indicated for a Fentanyl patch to be administered transdermally (on the skin) one time a day, every three days. Remove the old patch before a new patch was applied and record the site of the old patch. Remove per schedule. The MAR for 7/2026 was signed out as an eight for removal and placement on 7/26/26, which indicated the resident was nauseated. During an interview on 7/28/26 at 4:00 p.m., the Nurse Consultant indicated the old patch was removed and a new patch was placed on the resident. This citation relates to Intake 3110454. 410 IAC (Indiana Administrative Code) 16.2-3.1-37(a)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, record review and interview, the facility failed to ensure residents were provided with routine medications by the contracted pharmacy as ordered by the physician related to medications not available to be administered, for 2 of 7 residents reviewed for medications. (Residents G and H) Findings include: 1. During a morning Medication Pass Observation on 7/28/26 at 8 a.m., QMA 3 prepared Resident G's medication. The Certivite (supplement) one tablet and vitamin B12 (supplement) 500 micrograms (mcg) were not found in the cart and were unavailable to administer. QMA 3 indicated the Certivite was last received on 7/14/26 and only 14 doses were sent, the vitamin B12 was last received on 7/9/26 and only 13 doses were received. She was unable to find where the medications had been re-ordered when the supply lessened. QMA 3 reported this to RN 1. RN 1 then went to the Emergency Drug Kit (Pixus) and was unable to find the medications in the Pixus. RN 1 notified the pharmacy and indicated they would send the medication out with next order. 2. During a morning Medication Pass Observation on 7/28/26 at 8:25 a.m. Resident G indicated he was having pain and asked QMA 3 for Tylenol and indicated the Tylenol relieved the pain in the past. QMA 3 exited the room, looked in the Medication Cart, and indicated the resident had no Tylenol available. She then reported to RN 1 the resident was in pain and requested Tylenol and the resident had no Tylenol available. RN 1 then checked the Emergency Drug Kit (Pixus) and indicated there was no Tylenol available. RN 1 then assessed the resident's pain at an eight out of 10 and it was located in his back. She indicated she would notify the Physician to get something stronger than Tylenol since the pain was rated at an eight. RN 1 texted the Nurse Practitioner and requested a pain medication order. RN 1 then notified the Physician at 8:45 a.m. and received an order for ibuprofen. At 8:50 a.m., RN 1 indicated there was no ibuprofen in the Pixus. The Assistant Director of Nursing notified the Physician on 7/28/26 at 9:05 a.m., that the ibuprofen was not available and requested another pain medication. Resident G's record was reviewed on 7/28/26 at 1:00 p.m. The diagnoses included, but were not limited to, stroke. A Care Plan, dated 6/8/26, indicated a potential for pain. The interventions indicated they would respond immediately to any complaint of pain and identify previous response to analgesia including pain relief. An admission MDS assessment, dated 6/11/26, indicated a moderately impaired cognitive status and no pain. A Physician's Order, dated 7/2/26, indicated acetaminophen (Tylenol), 650 mg, one tablet every four hours as needed for pain. The MAR, dated 7/2026, indicated the acetaminophen 650 mg had been administered on 7/26/26 at 3:50 a.m. for a pain level of four out of 10 and was effective. A Physician's order was received on 7/28/26 at 9:26 a.m. for hydrocodone -acetaminophen (narcotic pain medication), one 5-325 mg tablet was to be administered every four hours as needed for pain. The MAR, dated 7/2026, indicated QMA 3 had administered the medication on 7/28/26 at 9:30 a.m. During an interview on 7/28/26 at 1:42 p.m., the Nurse Consultant indicated the acetaminophen was not stocked in the Pixus since it was an over the counter medication and was unsure where the acetaminophen 650 mg was obtained from on 7/26/26 at 3:50 a.m. 2. During a morning Medication Pass Observation on 7/28/26 at 10:25 a.m., QMA 1 prepared Resident H's medication. She indicated the Mirilax (laxative) 17 grams, thiamine (supplement) 100 milligrams (mg), and the Lasix (diuretic) 40 mg was not available to administer and would need to be re-ordered. During an interview on 7/28/26 at 1:42 p.m., the Nurse Consultant indicated the Pharmacy used to send a 30 day supply out, then they went to a 15 day supply with auto-refill and she was unsure if this had been changed. During an interview on 7/28/26 at 3:58 p.m., the Nurse Consultant indicated there was no policy for medication deliveries. The pharmacy had changed the procedure and was no longer doing (continued on next page)		

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	auto refill but sending only a 15 day supply. They had not informed the facility the auto refill was discontinued.This citation relates to Intake 3110454.410 IAC (Indiana Administrative Code) 16.2-3.1-25(a)		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 7 residents observed during medication pass. Five errors were observed during 33 opportunities for errors during medication administration. This resulted in a medication error rate of 15.151%. (Resident H) Finding includes: During an observation on 7/28/26 at 10:35 a.m., QMA 1 prepared Resident H's morning medications, which consisted of the following medications per the labels: atorvastatin (cholesterol medication) 40 milligrams (mg), one tablet by mouth nifedipine (heart medication) 30 mg, one tablet by mouth Ocuvite (supplement), one tablet by mouth Eliquis (blood thinner) 2.5 mg, one tablet by mouth Carvedilol (anti-hypertensive) 3.25 mg two tablets by mouth omeprazole (stomach medication) 20 mg, two tablets by mouth potassium chloride (supplement) liquid, 20 milliequivalents (meq), 15 cubic centimeters (cc) by mouth thiamine (supplement) 100 mg Lasix (diuretic) 40 mg, one tablet by mouth. QMA 1 indicated the thiamine and Lasix were not available and needed to be reordered. She placed the atorvastatin, nifedipine, Ocuvite, Eliquis in the medication cup. She placed only one tablet of the Carvedilol and omeprazole in the medication cup. She then poured 20 cc's of potassium chloride in the a plastic medication cup and indicated she was ready to administer the medications. QMA 1 counted six tablets in the medication cup and was stopped prior to the administration. During the interview, she indicated there should be two Carvedilol and omeprazole medications and placed another tablet of each in the cup. She indicated the resident was to receive 20 cc's of the potassium chloride, then re-read the order and indicated the dosage was 15 cc's. Upon re-counting of the medication she indicated there were eight tablets in the medication cup. She then indicated the medications needed to be crushed. The medications were crushed and placed in applesauce and administered to the resident. Resident H's medication orders were reviewed on 7/28/26 at 11:45 a.m. The Physician's Orders indicated ferrous sulfate (iron) 325 mg one tablet and lactobacillus (supplement) one tablet was also to be administered. The ferrous sulfate and lactobacillus had been omitted. Review of the Medication Administration Record, dated 7/2026, indicated QMA 1 had documented the medications as administered at the same time of the other medications, though they had not been administered. A facility administration of medication policy, dated 4/2026, and received from the Nurse Consultant as current, indicated the medication was to be removed from the drawer and the label read upon removal from the drawer, upon pouring the medication and after pouring the medication. A physician or nurse practitioner order is required for administration of all medications. The order was to be read entirely, check the medication for the right medication, right dose, right route, right patient and time. This citation relates to Intake 3110454.410 IAC (Indiana Administrative Code) 16.2-3.1-48(c)(1)		

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to ensure a resident was provided with ordered laboratory services related to a wound culture not completed as ordered for 1 of 3 residents reviewed for laboratory services. (Resident E) Finding includes: The record for Resident E was reviewed on 7/28/26 at 9:36 a.m. Diagnoses included, but were not limited to, COPD, hypertension (high blood pressure), chronic kidney disease, and tremors. The Baseline Care Plan, dated 7/20/26, indicated the resident was moderately impaired for daily decision making. The resident required partial to moderate assistance for toileting. A Care Plan, dated 7/19/26, indicated the resident was admitted with a surgical incision to the abdomen and left flank. Intervention was to treat per physician orders. A Physician's Order, dated 7/26/26, indicated a culture and sensitivity of wounds may be obtained if indicated. A Skin/Wound Note, dated 7/26/26 at 5:15 p.m., indicated the wound culture needed to be obtained before intravenous (IV) antibiotics could be started. A Skin/Wound Note, dated 7/26/26 at 4:38 p.m., indicated the resident was having green drainage from his wound vac located on his left rib. The physician assessed the wound and ordered a wound culture and vancomycin and aztreonam (IV antibiotics). The wound culture to be collected on 7/26/26 was cancelled due to a red cap viral tube being used instead of the appropriate pink cap culture swab. The wound was not re-cultured. During an interview on 7/28/26 at 11:26 a.m. the Wound Nurse indicated she would get a hold of the physician that day and get an order to have the wound re-cultured. It was cancelled because they sent the culture in the wrong tube. She had just swabbed the fluid for a culture but not the surgical site. She thought it had been completed and she would need to obtain a new order. The resident could not start his antibiotics without the culture being completed. During an interview on 7/28/26 at 4:00 p.m., the Nurse Consultant indicated she understood the concerns regarding resident E's wound culture and had no additional information to provide. This citation relates to Intake 3074217. 410 IAC (Indiana Administrative Code) 16.2-3.1-49(c)		