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	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Chesterton	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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to ensure weights were monitored as ordered and/or reweights were checked for significant weight changes for 5 of 8 residents reviewed for nutrition. (Residents 5, 27, 58, 6 and 17)Findings include: 1.Resident 5's record was reviewed on 2/20/26 at 10:09 a.m. Diagnoses included, but were not limited to, dependence on renal dialysis and heart failure. The resident was admitted on [DATE]. A Physician's order, dated 1/31/26, indicated to weigh the resident one time a day for three days, then once a week for four weeks, then monthly. The only weight recorded in vitals since admission was on 1/31/26. During an interview on 2/20/26 at 2:00 p.m., the Director of Nursing (DON) indicated weights wouldn't be documented anywhere else and she was aware there were issues with weights not being monitored as scheduled. 2. Resident 27's record was reviewed on 2/19/26 at 10:10 a.m. Diagnoses included, but were not limited to, protein calorie malnutrition and dementia. The Quarterly Minimum Data Set assessment, dated 2/6/26, indicated the resident had moderate cognitive impairment, had weight loss and needed set up assistance for eating. The resident's weight on 8/21/25 was 166 pounds. The resident's weight on 9/22/25 was 149.8 pounds, a loss of 16.2 pounds in one month. There was no reweigh completed at that time. The next monthly weight was recorded on 10/24/25 and was 149 pounds. During an interview on 2/20/26 at 2:00 p.m., the Director of Nursing (DON) indicated weights wouldn't be documented anywhere else and she was aware there were issues with weights not being monitored as scheduled. If there was a significant weight change within a short period of time, a reweigh should be completed as soon as possible. 3. Resident 58's record was reviewed on 2/20/26 at 9:07 a.m. Diagnoses included, but were not limited to, adult failure to thrive and diabetes mellitus. A Physician's order, dated 12/27/25, indicated to weigh the resident one time a day for three days, then once a week for four weeks, then monthly. The resident's weight on 12/30/25 was 215.2 pounds. The resident's weight on 1/11/26 was 201.4 pounds, a loss of 13.8 pounds in less than two weeks. There was no documentation the resident was (continued on next page)

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

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	reweighed. During an interview on 2/20/26 at 2:00 p.m., the Director of Nursing (DON) indicated weights wouldn't be documented anywhere else and she was aware there were issues with weights not being monitored as scheduled. If there was a significant weight change within a short period of time, a reweigh should be completed as soon as possible. The current Weight Policy was provided by the DON on 2/20/26 and indicated, 1. Resident will be weighed upon admission, readmission, weekly for the first 4 weeks and then at least monthly and, .5. Weights, upon completion, will be given to the DON or designee to determine a list of reweighs 4. Record review for Resident 6 was completed on 2/20/26 at 9:18 a.m. Diagnoses included, but were not limited to, heart failure, hypertension, and end stage renal disease. The resident was discharged to the hospital on 2/18/26. The resident's weights indicated that on 12/5/25 the resident weighed 191.1 pounds. On 1/11/26 the resident weighed 175.6 pounds which was a weight loss of 8.11%. There was a lack of documentation to indicated the resident was re-weighed after the significant weight loss on 1/11/26. During an interview on 2/23/26 at 2:27 p.m., the Director of Nursing (DON) indicated the weight taken on 1/11/26 was incorrect. The staff should have done a re-weight on 1/11/26 since there was a significant weight loss. 5. Resident 17's record was reviewed on 2/19/26 at 11:15 a.m. The resident admitted to the facility on [DATE]. On 2/2/26, the resident weighed 265.6 pounds (lbs). On 2/17/26, the resident weighed 237.6 lbs which was a -10.54% loss. A Care Plan, revised on 2/11/26, indicated the resident had potential for alterations in nutrition and hydration. Interventions included, but were not limited to, monitor/record/report to the physician as needed any signs or symptoms of malnutrition including emaciation, muscle wasting, or significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, >10% in 6 months, obtain and document weights per orders and facility protocol. A Physician's Order, dated 1/31/26, indicated weights one time a day for three days, then one time a day every seven days for four weeks and then one time a day every month. The resident's weight was recorded on 1/31/26 with a weight of 265.6 lbs, on 2/2/26 with a weight of 265.6 lbs and on 2/17/26 with a weight of 237.6 lbs. There was no weight documented on 2/1/26 or any weights following 2/17/26 after a 10.54% weight loss was documented. During an interview on 2/23/26 at 2:27 p.m., the Director of Nursing indicated any weights that seemed abnormal should have been stricken from the record and there was a problem with obtaining weights by the CNAs as they were not weighing the residents correctly each time, so there were (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	discrepancies with some of the resident's weights. A facility policy titled, Weight Policy, indicated, .1. Residents will be weighed upon admission, readmission, weekly for the first 4 weeks and then at least monthly. 2. Weekly weights will be done with a physician order or as the facility deems appropriate .3. Short term residents with a diagnosis of CHF will be weighed twice weekly unless otherwise ordered by the physician .5. Weights, upon completion, will be given to the DON or designee to determine a list of reweights. 6. Once reweighs have occurred any resident with an unexplained significant to insidious weight loss will be reviewed and intervention implemented by the DON or designee . 3.1-46(a)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, record review and interview, the facility failed to label insulin pens with open dates in 1 of 2 medication carts observed. (Cart C1)Finding includes:On 2/23/26 at 11:50 a.m., Medication Cart C1 was observed with LPN1. There were 12 various insulin pens in plastic baggies that were labeled Refrigerate Until Opened. There were stickers on each insulin pen with space provided to write an opened-on date, none of the pens had opened-on dates documented. The LPN indicated there should be dates written on the pens when opened, and should be refrigerated if not opened. During an interview on 2/23/26, the Administrator indicated all the insulin pens had been opened but did not have opened-on dates. A document titled, Information Regarding Insulin Storage and Switching Between Products in an Emergency, was provided by the Director of nursing on 2/24/26 and indicated, .Insulin products .may be left unrefrigerated at a temperature between 59 and 86 degrees Fahrenheit for up to 28 days and continue to work 3.1-25(j)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents were assessed for self-administration of medications and had a physician's order to self-administer medications for 1 of 1 resident reviewed for self-administration of medication. (Resident 68)Finding includes:During an observation on 2/18/26 at 1:40 p.m., Resident 68 was observed sitting in his room. There were latanoprost eye drops on the bedside. The resident indicated he administered the eye drops himself.Resident 68's record was reviewed on 2/20/26 at 11:38 a.m. A Physician's Order, dated 2/10/26, indicated latanoprost ophthalmic emulsion 0.005% instill one drop in both eyes at bedtime for eye pressure. There was a lack of any Physician's Orders for self-administration of medications or any assessment for self-administration of medications.During an interview on 2/23/26 at 9:22 a.m., the Director of Nursing indicated she had no further information at the time.A facility policy titled, Self-Administration of Medications and Treatments, indicated, .1. If it is determined by a member of the interdisciplinary team, or if the resident requests to self-administer, it is documented in the chart, and the physician is called for an order to self-administer medications and keep the medications at bedside. 2. Assessment of the ability to self-administer medications will be done by nursing using the tool assessment for self-administration of medications. The assessment will review if the resident is fully capable, able with assist, or unable to perform assessment criteria .3.1-11(a)

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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 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 in place and implemented related to hypotension and splint use for 2 of 25 resident care plans reviewed. (Residents 5 and 38)Findings include:1.The record for Resident 5 was reviewed on 2/20/26 at 10:09 a.m. Diagnoses included, but were not limited to, heart failure and dependence on renal dialysis. A Physician's Order, dated 2/16/26, indicated to give midodrine (a medication used to treat hypotension) 10 milligrams, three times a day related to hypotension. A Hypotension Care Plan was initiated on 2/1/26, however, there were no goals or interventions included. During an interview on 2/20/26 at 2:00 p.m., the Director of Nursing was made aware the care plan was not completed. There was no additional information provided. 2. On 2/17/26 at 11:42 a.m. and 3:30 p.m., and 2/20/26 at 1:29 p.m., Resident 38 was observed sitting in a wheelchair and had a splinting device on her left hand. Resident 38's record was reviewed on 2/19/26 at 2:31 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness or paralysis) of the left non-dominant side. The admission Minimum Data Set assessment, dated 1/30/26, indicated the resident was moderately cognitively impaired and had an impairment in range of motion on one side of the upper and lower extremities. A Physician's Order, dated 1/24/26, indicated apply brace to left hand at bedtime and remove in the morning every day. The record lacked any care plans related to the resident's limited range of motion with splint use. During an interview on 2/23/26 at 9:33 a.m., the Director of Nursing indicated she had no further information to provide. 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 observation, record review and interview, the facility failed to ensure medications were administered as ordered for 1 of 5 residents reviewed for unnecessary medications, (Resident 5) and 1 of 2 residents reviewed for urinary catheter. (Resident 66) The facility also failed to ensure a physician's order was in place for a compression device for 1 of 3 residents reviewed for range of motion. (Resident 4)Findings include:1.Resident 5's record was reviewed on 2/20/26 at 10:09 a.m. Diagnoses included, but were not limited to, dependence on renal dialysis and heart failure. The admission Minimum Data Set assessment, dated 2/2/26, indicated the resident was cognitively intact and received renal dialysis. A Physician's Order, dated 2/16/26, indicated to give midodrine, (a medication used to treat hypotension) 10 milligrams, three times daily, for hypotension. Hold if blood pressure was greater than 130/90. The February 2026 Medication Administration Record (MAR) indicated the midodrine was given on the following days when the systolic pressure was greater than 130: 2/17 blood pressure 150/86 2/18 blood pressure 150/86 2/18 blood pressure 146/59 2/20 blood pressure 141/78 On 2/19, the medication was not given when the blood pressure was 119/64. The Medication Note indicated the blood pressure was outside of parameters. During an interview on 2/20/26 at 2:00 p.m., the Director of Nursing indicated the midodrine orders and parameters came from the hospital discharge orders. She indicated the parameters should be revised to hold the medication if the systolic was greater than 130 and the current order wasn't clear. She indicated some education needed to be provided to nursing staff. 2. On 2/18/26 at 1:22 p.m., Resident 4 was observed sitting in a wheelchair in his room. There were compression leg wraps folded up in a clear plastic bag on his bed. There was also a machine with tubes hooked to the end of the bed that connected to the compression leg wraps. The resident indicated he was unaware who brought them and placed them on his bed. He was unaware if he was supposed to apply them or if the facility staff were to apply them to his legs. On 2/19/26 at 2:35 p.m., Resident 4 was not in his room. The compression leg wraps were opened up and laying on the resident's bed. They were hooked to the tubing and the machine at the end of his bed. Record review for Resident 4 was completed on 2/19/26 at 1:02 p.m. Diagnoses included, but were not limited to, diabetes mellitus and left tibia fracture. The Quarterly Minimum Data Set (MDS) assessment, dated 2/3/26, indicated the resident was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cognitively intact. The resident had an impairment on both sides of his lower extremities. The resident received diuretic and anticoagulant medications. A Care Plan, dated 10/31/25, indicated the resident was on diuretic therapy related to edema. A Care Plan, dated 10/31/25, indicated the resident was on anticoagulant therapy related to DVT (deep vein thrombosis) (blood clot) prevention. There was lack of documentation for Physician Orders for the compression leg wraps. During an interview on 2/19/26 at 2:36 p.m., RN 1 indicated she was unaware there were compression leg wraps on the resident's bed. He did not have an order for them and she would have to look into it. During an interview on 2/19/26 at 2:50 p.m., the Director of Nursing (DON) indicated the resident was supposed to wear the legs wraps for swelling in his legs. The company must have dropped them off in his room and did not let the staff know. There should have been an order in the computer for the compression leg wraps. 3. Resident 66's record was reviewed on 2/20/26 at 10:32 a.m. Diagnoses included, but were not limited to, heart failure. A Physician's Order, dated 1/31/26, indicated midodrine (treatment for low blood pressure) oral tablet 2.5 milligrams, one tablet by mouth three times a day, hold medication if systolic blood pressure (top number) is greater than 110. The February 2026 Medication Administration Record indicated the midodrine was administered on the following dates and times with a systolic blood pressure (bp) greater than 110. - 2/2/26 at 8:00 a.m., bp 123/75 - 2/2/26 at 12:00 p.m., bp 136/74 - 2/3/26 at 8:00 a.m., bp 135/87 - 2/3/26 at 12:00 p.m., bp 129/72 - 2/6/26 at 12:00 p.m., bp 117/63 - 2/6/26 at 5:00 p.m., bp 117/63 During an interview on 2/23/26 at 2:20 p.m., the Director of Nursing indicated she had no further information to provide. 3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview, the facility failed to provide a treatment as ordered by the physician related to a splinting device on at the incorrect time for 1 of 2 residents reviewed for range of motion. (Resident 38)Finding includes:On 2/17/26 at 11:42 a.m. and 3:30 p.m. and 2/20/26 at 1:29 p.m., Resident 38 was observed sitting in a wheelchair and had a splinting device on her left hand. Resident 38's record was reviewed on 2/19/26 at 2:31 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness or paralysis) of the left non-dominant side. The admission Minimum Data Set assessment, dated 1/30/26, indicated the resident was moderately cognitively impaired and had an impairment in range of motion on one side of the upper and lower extremities. A Physician's Order, dated 1/24/26, indicated apply brace to left hand at bedtime and remove in the morning every day. During an interview on 2/23/26 at 9:33 a.m., the Director of Nursing indicated the family was involved with care and they may have put the splint on the resident. A facility policy titled, Splint Policy, indicated, .5. Nursing is responsible for applying and removing the splint per schedule . 3.1-35(a)

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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, interview, and record review, the facility failed to ensure an urinary indwelling catheter collection bag and tubing was kept off of the floor for a resident with a history of urinary tract infections and monitoring of urinary output was documented as ordered for 1 of 1 resident reviewed for urinary catheter. (Resident 66)Finding includes: On 2/17/26 at 3:28 p.m., Resident 66 was observed sitting up in a wheelchair with a catheter collection bag and tubing underneath on the floor. Resident 66's record was reviewed on 2/20/26 at 10:32 a.m. Diagnoses included, but were not limited to, history of urinary tract infection and neuromuscular dysfunction of the bladder. The admission Minimum Data Set assessment, dated 1/26/26, indicated the resident was cognitively intact and had an indwelling catheter. A Care Plan, dated 2/10/26, indicated the resident had a urinary catheter. Interventions included, but were not limited to, check placement of tubing each shift and monitor/record/report to the physician signs and symptoms of urinary tract infection such as no output, pain, burning, or blood-tinged urine. A Physician's Order, dated 2/10/26, indicated record output for every shift. The February 2026 Medication and Treatment Administration Record indicated the urinary catheter output was not documented and marked NA on the following dates and times: -Day shift: 2/11, 2/12, 2/13, 2/17, 2/18, 2/10/26 -Night shift: 2/12, 2/13, 2/14, 2/15, 2/18, 2/19/26 During an interview on 2/23/26 at 2:20 p.m., the Director of Nursing indicated the family had been emptying the catheter and the catheter should not have been on the floor. 3.1-41(a)(2)

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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 ensure a resident's record was complete and accurate related to unclear insulin administration documentation for 1 of 1 resident reviewed for insulin. (Resident 7)Finding includes:During an interview with Resident 7 on 2/17/26 at 10:25 a.m., he indicated he often did not get his insulin before meals as ordered.The resident's record was reviewed on 2/19/26 at 9:06 a.m. Diagnoses included, but was not limited to, diabetes mellitus.The admission Minimum Data Set assessment, dated 1/1/26, indicated the resident had moderate cognitive impairment and received insulin.A Physician's Order, dated 2/1/26, indicated to give Novolog (insulin) 10 units before meals for diabetes, hold if the blood sugar was below 200 mg/dL (milligrams per deciliter).The 2026 February Medication Administration Record indicated the resident's blood sugar level was below 200 before every meal except one on 2/2/26, indicating he should not be receiving the insulin. There were 42 entries that indicated blood sugar was out of parameters and not given, there were 14 entries that were check marked as given although the blood sugar was less than 200.During an interview on 2/20/26 at 2:00 p.m., the Director of Nursing indicated she needed to provide some education to the nursing staff regarding how to document holding the insulin.An insulin policy was requested but did not pertain to the above.3.1-50(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. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to personal protective equipment (PPE) not worn before entering a COVID-19 positive resident room during random observations for infection control. (Resident 92 and RN 2)Finding includes: During a random observation on 2/28/26 at 10:38 a.m., RN 2 was observed donning PPE to go into Resident 92's room. The resident's room had a sign on the door indicating that he was on contact/droplet precautions. RN 2 donned a gown and gloves and an N95 mask and then entered the resident's room. She did not don any protective eyewear prior to entering the room. On 2/28/26 at 10:41 a.m., RN 2 was observed leaving the resident's room. At the time, RN 2 indicated the resident was on contact/droplet precautions due to testing positive for COVID-19. She indicated that she would don a gown, gloves, and N95 mask to enter any contact/droplet rooms. During an interview on 2/19/26 at10:27 a.m., the Administrator was notified of RN 2 not wearing protective eyewear into a contact/droplet room. No further information was provided. A policy related to isolation precautions for a COVID-19 positive room was requested and not provided. The guidance, Infection Control Guidance: SARS-CoV-2, was retrieved on 2/25/26 from the Centers of Disease Control (CDC) website at https://www.cdc.gov/covid/hcp/infection-control/index.html. The guidance indicated, .2. Recommended infection prevention and control (IPC) practices when caring for a patient with suspected or confirmed SARS-CoV-2 infection .Personal Protective Equipment HCP (health care providers) who enter the room of a patient with suspected or confirmed SARS-CoV-2 infection should adhere to Standard Precautions and use a NIOSH Approved particulate respirator with N95 filters or higher, gown, gloves, and eye protection (i.e., goggles or a face shield that covers the front and sides of the face) . 3.1-18(b)