STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT CHESTERTON	2775 VILLAGE POINT CHESTERTON, IN 46304

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00447280, IN00452124, IN00454481, and IN00455073. Complaint IN00447280 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00452124 - Federal/state deficiencies related to the allegations are cited at F677. Complaint IN00454481 - Federal/state deficiencies related to the allegations are cited at F557 and F677. Complaint IN00455073 - Federal/state deficiencies related to the allegations are cited at F580, F677, F684, and F689. Unrelated deficiencies are cited. Survey dates: March 11, 12, and 13, 2025 Facility number: 013688 Provider number: 155844 Census Bed Type: SNF: 65 Residential: 26 Total: 91 Census Payor Type: Medicare: 37 Other: 28 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. Ignite Medical Resorts of Chesterton respectfully request a desk review for these alleged deficient practices. If there are additional documents required, please feel free to reach out and we will provide. Respectfully, Renee Christ, RN VPCO	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Renee Christ, RN	Vice President of Clinical Operations	04/03/2025

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F 0557 SS=D Bldg. 00	Quality review competed on 3/21/25. 483.10(e)(2) Respect, Dignity/Right to have Prsnl Property Based on observation, record review, and interview, the facility failed to ensure a resident was treated with respect and dignity, related to a delay in assisting a resident out of bed upon request by the resident for 1 of 8 residents reviewed for respect and dignity. (Resident J) Finding includes: During an observation on 3/11/25 at 12:30 p.m., Resident J activated the call light. RN 1 responded to the call light and the resident indicated she wanted her meal tray removed and assistance to get out of bed. RN 1 informed the resident the staff were with another resident and when they were done, someone would assist her out of bed. During observations on 3/11/25 at 12:44 p.m., 1:21 p.m., 1:21 p.m., and 2:37 p.m., the resident remained in bed. During an interview on 3/11/25 at 2:37 p.m., the resident indicated she had been informed someone would be in to help her out of bed and no one had come to assist her. She indicated this happened often and she had things she had planned to do, but was unable to do them since she still remained in bed. During an interview on 3/11/25 at 2:39 p.m., RN 1 indicated she had informed the CNA the resident needed help to get out of bed. The resident required a mechanical lift and a second person	F 0557	**F557-Respect/Dignity RT providing resident assistance timely** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to resident J related to this alleged deficient practice. Resident was assisted from bed to chair by staff. Grievance was completed, investigated, and resolved. RN 1 was educated on assisting residents timely. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents requiring assistance have the potential to be affected by this alleged deficient practice. House sweep completed	04/11/2025

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	was needed to assist with the transfer. She indicated she would assist with the transfer. Resident J's record was reviewed on 3/12/25 at 3:24 p.m. The diagnoses included, but were not limited to, congestive heart failure. A Care Plan, revised on 1/2/25, indicated assistance was required for activities of daily living. The interventions included a mechanical lift and two staff were required for transfers. A Quarterly Minimum Data Set assessment, dated 1/13/25, indicated an intact cognitive status, was dependent for transfers, and had sustained a fall. This citation relates to Complaint IN00454481. 3.1-3(t)		and interviews conducted to ensure residents are being provided with assistance timely as needed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing department was educated on; Assisting residents requiring assistance timely. Asking supervisor for help if they are unable to complete a task timely. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** GM/Designee will interview 10 residents/resident families who require assistance weekly on alternating shifts to ensure; Care and/or requested assistance is being provided timely. Grievances will be completed with resolution completed, and education to staff member/s responsible will be provided for any non-compliance	

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			identified. GM/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure a resident's Power of Attorney (POA) was notified of falls for 1 of 3 residents reviewed for physician/responsible party notification. (Resident E) Finding includes: Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. The record indicated the resident had a POA who was the first contact person in case of changes/emergency. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status.	F 0580	**POC for F580- Notify of Changes** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to resident E related to this alleged deficient practice and emergency contact #1 was notified of fall at the time of the fall. Resident E no longer resides here in facility POA was made aware of fall. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be	04/11/2025

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	Fall Investigations, dated 2/1/25 at 4:09 p.m., 2/9/25 at 7:40 a.m., and 2/15/25 at 5:34 p.m., indicated the resident had fallen. The person listed as number two for contact had been notified and not the POA. There was no documentation in the record that indicated the POA had been notified or why the second person was the one notified of the falls. During an interview on 3/13/25 at 10:50 a.m., the Clinical Vice President and Director of Nursing were unsure why the POA was not notified. A facility policy for Physician and Responsible Party Notification, dated 10/2024 and received from the Vice President of Operations as current, indicated the communication with the responsible party would be documented in the resident's record. The Responsible Party would be notified after the physician was notified. This citation relates to Complaint IN00455073. 3.1-5(a)(2)		affected by this alleged deficient practice. House audit of current falls has been completed to ensure POA was notified as warranted. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff was educated on ensuring that residents who have an active POA and have any change in condition or new order, including but not limited to a fall, that the POA is the one who is notified and not a different family member if POA is active on resident's profile. Nursing staff was educated on POA criteria, and when the POA should be notified of changes. Nursing staff was educated on documenting attempts made when POA is unavailable and what to do if they are unable to reach POA. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** DON/designee will monitor 10 residents who have active POA weekly to ensure that the POA is the one who is notified when there is a change in condition, changes in plan of care, or fall occurs. DON/Designee will present the summaries of the audits to the Quality Assurance committee	

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			monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure a resident who was dependent for care received incontinent care in a timely manner for 1 of 3 residents reviewed for incontinent care. (Resident F) Finding includes: During an observation on 3/11/25 at 10:50 a.m., Resident F's call light had been activated by a visitor in the room. RN 4 answered the call light and was informed by the visitor that the resident needed his incontinent brief changed. RN 4 and CNA 5 began the incontinence care. The resident's gown and top sheet were wet and the incontinent brief was saturated with urine. The incontinent pad under the resident was soaked with urine and under the pad were two large dried yellow/brownish rings from urine. The abdominal binder worn by the resident was also wet. RN 4 acknowledged the urine saturation and dried urine rings. The resident indicated he was last changed "yesterday". During an interview on 3/11/25 at 11:16 a.m., CNA 2 indicated she was assigned to Resident F. She started work at 6 a.m. and had not yet checked on Resident F. She indicated she was still completing her morning rounds. During an interview on 3/11/25 at 11:36 a.m., the	F 0677	**F677 POC- Incontinent care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to resident F related to this alleged deficient practice. Resident F was provided with incontinent care. RN4 and C.N.A 2 were both provided with education related to providing incontinent care timely. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House sweep completed to ensure residents were provided with incontinent care as needed.	04/11/2025

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	Administrator indicated the resident had his call light on at 2 a.m. on 3/11/25 and had probably been checked at that time. Resident F's record was reviewed on 3/12/25 at 2:35 p.m. The diagnoses included, but were not limited to, blood stream infection due to central venous catheter and dementia. The resident was admitted into the facility on 3/7/25. A Care Plan, dated 3/7/25, indicated assistance was required for activities of daily living. The interventions indicated he was dependent for hygiene and toileting. A Care Plan, dated 3/7/25, indicated incontinence of bowel and bladder. The interventions included he would be checked every 2-3 hour and as needed for incontinence. A mental status assessment, dated 3/10/25 at 11:16 a.m., indicated his cognition was moderately impaired. This citation relates to Complaints IN00447280, IN00452124, IN00454481, and IN00455073. 3.1-38(a)(3)		**What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing department was educated on; Completing rounds upon start of shift for every resident by C.N.A. and nurse. Completing check and change/offer check and change to dependent and non-dependent residents throughout scheduled shift when call lights are triggered and when call lights are not triggered by residents. Reporting to the supervisor and documenting refusals for care. Families and nursing leadership are notified for residents who frequently refuse and are in need of ADL care including but not limited to incontinent care. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit 10 residents weekly on alternating shifts to ensure; ADL care was provided as	

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			needed including but not limited to incontinent care for dependent and non-dependent residents. DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure residents received necessary care and services, related to skin assessments not completed as ordered by the Physician for residents with a brace and a immobilizer for 2 of 8 residents reviewed for quality of care. (Residents E and H) Findings include: 1. During an observation on 3/11/25 at 11:24 a.m., resident E was sitting in the wheelchair. There was a brace on the right wrist/forearm. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia	F 0684	**F684 Quality of care R/T Skin assessment not completed as ordered** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm came to resident H related to this alleged deficient practice. Resident H no longer resides in this facility. No harm came to resident E related to this alleged deficient practice. Resident E no longer resides in this facility. Staff responsible were educated on following physician	04/11/2025

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	An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status and had a fall with a fracture prior to the admission into the facility. A Physician's Order, dated 1/17/25, indicated skin checks were to be completed weekly on day shift every Monday and Thursday and a Skin Evaluation must be completed when each assessment was completed. A Physician's Order, dated 1/18/25, indicated the staff were to monitor the non-removable surgical splint to the right arm every shift and all abnormal findings were to be reported to the physician. A Care Plan, dated 1/20/25, indicated a fracture of the right radius and post internal fixation for stabilization of the fracture. The goal indicated the fracture would heal without complications. The interventions indicated the physician's orders would be followed and the resident would be monitored for complications. The Treatment Administration Record (TAR), dated 1/2025 & 2/2025, indicated the weekly skin checks had not been completed on January 20, 23, 27, and 30, 2025 and February 3, 6, 17, 20, and 24, 2025. The TAR, dated 1/2025 and 2/2025, indicated the splint had not been monitored on night shift on January 21, 22, 23, 25, 28, 30, and 31, 2025 and February 4, 13, 24, 15, 21, 23, 26, and 28, 2025. The splint had not been monitored on day shift on February 19, 2025. The Clinical Vice President was informed of the missed assessments on 3/11/25 at 4:00 p.m. No		orders and documenting completion in MAR/TAR. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. House audit was completed to ensure skin assessments and ordered skin checks are being completed and documented as ordered. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were educated on; Documenting skin assessments as ordered upon completion, addressing and assessing changes in skin condition, documenting changes in skin condition, immediately obtaining and implementing orders for treatment, and initiating interventions per physician orders. Direct care staff were educated on; Immediately notifying the nurse of any observed change in skin condition weather or not a staff member thinks it has been	

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	further information was received by the facility.2. Resident H's record was reviewed on 3/12/25 at 3:45 p.m. The diagnoses included, but were not limited to, anemia (low iron), dementia, fracture of humerus, and muscle weakness. The Admission Minimum Data Set (MDS) assessment, dated 2/15/25, indicated the resident was severely impaired for daily decision making. A Care Plan, dated 2/11/25, indicated the resident was at risk for alteration in skin integrity related to decreased mobility and anticoagulant use. Interventions were to provide skin and wound treatments as ordered. A Care Plan, dated 2/11/25, indicated the resident had an alteration in musculoskeletal status related to a left humerus fracture. Interventions were to follow physician's orders for weight bearing status and see the Physician Orders and Physical Therapy Treatment Plan. A Physician's Order, dated 2/11/25, indicated for the resident to always wear the left arm immobilizer and could be removed for showers. A Physician's Order, dated 2/11/25, indicated to administer weekly skin checks every evening shift on Tuesday and Friday. Staff must open and document a Skin Evaluation for each assessment and include no new areas found. There were no Skin Evaluations completed for the following dates: 2/11, 2/14, 2/21, 2/25, 2/28, 3/4, 3/7, and 3/11/25. The Treatment Administration Record (TAR) for 2/2025 indicated skin checks were not signed out on 2/11, 2/14, and 2/21/25.		addressed, assessed, and documented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/ designee will audit MAR/TAR documentation in clinical meeting 5 days a week to ensure skin checks/assessments are signed out and completed as ordered, orders are obtained and carried out when needed, and interventions are put into place and documented when needed. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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	During an interview on 3/13/25 at 10:54 a.m., the Director of Nursing (DON) indicated she understood the concern regarding weekly skin checks not being signed out on the TAR and weekly Skin Evaluations not being completed. This citation relates to Complaint IN00455073. 3.1-37(a)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on observation, record review and interview, the facility failed to ensure care plan interventions were in place to prevent falls for 1 of 3 residents reviewed for falls. (Resident E) Finding includes: During observations on 3/11/25 at 10:49 a.m., 2:44 p.m. and on 3/12/25 at 10:13 a.m., there was no stop sign in Resident E's room to remind the resident to call for assistance and no floor mat in the room. During an interview on 3/12/25 at 10:13 a.m., RN 3 indicated there was no stop sign or floor mat located in the room. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. An Admission Fall Risk Assessment, dated 1/17/25, indicated a high risk for falls. An Admission Minimum Data Set assessment,	F 0689	**F689- fall interventions** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to any residents related to this alleged deficient practice. Resident E no longer resides in facility. Fall interventions were placed in Resident E's room per plan of care. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	04/11/2025

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	dated 1/23/25, indicated a severely impaired cognitive status, required maximum assistance with transfers, was dependent for toileting and wheelchair mobility, was occasionally incontinent of bladder and frequently incontinent of bowel, and had a fall with a fracture prior to admission into the facility. A Care Plan, dated 2/9/25, indicated an actual fall and a history of falls. The interventions included on 2/1/25, a floor mat would be placed next to the bed and on 2/9/25, a stop sign wound be placed in the room as a visual reminder to stop and wait for assistance with transfers. The Nursing Progress Notes, dated 2/1/25 at 4:35 p.m., 2/9/25 at 7:00 a.m., and 2/15/25 at 6:42 p.m., indicated the resident had fallen. A fall prevention policy, dated 10/2024 and received from the Vice President of Operations as current, indicated the interdisciplinary team would develop interventions to reduce the resident's risk for falls. This citation relates to Complaint IN00455073. 3.1-45(a)(2)		Resident rooms who have had falls were assessed to ensure fall interventions are in place. Current residents who have had room changes were assessed to ensure fall interventions were moved with residents. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff was educated on ensuring that residents fall interventions are in place per plan of care. Staff was educated on observing rooms during their angel rounds to ensure fall prevention interventions are in place. Staff was educated on moving the fall interventions, resident belongings, and signage when a room move is completed for a resident.	

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			How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON/designee will monitor 5 residents who have had a room move weekly to ensure that residents with fall interventions added to plan of care, have corresponding fall interventions in place. DON/designee will monitor 5 residents with fall interventions in plan of care, have corresponding fall interventions in place. DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, record review, and interview, the facility failed to ensure a resident's feeding tube was infusing at the correct flow rate	F 0693	**F693 Tube Feeding Management** **What corrective action(s) will**	04/11/2025

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	for 1 of 1 resident reviewed for feeding tube usage. (Resident F) Finding includes: Resident F was observed lying in bed with the head of the bed elevated on 3/11/25 at 10:50 a.m. and 3/12/25 at 2:56 p.m. The tube feeing of Jevity 1.5 was infusing at 55 cc/hr (cubic centimeters (cc) per hour). During an interview on 3/12/25 at 2:56 p.m., LPN 6 indicated the tube feeding was infusing at 55 cc/hr and the bottle of the feeding indicated the feeding should have been infusing at 20 cc/hr. Resident F's record was reviewed on 3/12/25 at 2:35 p.m. The diagnoses included, but were not limited to, blood stream infection due to central venous catheter and dementia. The resident was admitted into the facility on 3/7/25. A Care Plan, dated 3/7/25, indicated a gastrostomy tube was present and he required enteral nutrition. The interventions included the tube feeding would infuse per current physician orders. A Physician Order, dated 3/7/25 and discontinued on 3/12/25, indicated Jevity 1.5 was to infuse at 20 cc/hr for 24 hours a day. A Physician's Order, dated 3/12/25, indicated Jevity 1.5 was to infuse at 20 cc/hr for 22 hours per day. A Registered Dietician's Progress Note, dated 3/11/25 at 6:48 p.m., indicated a recommendation to increase the tube feeding to 55 cc/hr for 22 hours.		**be accomplished for those residents found to have been affected by the deficient practice;** Resident F's feeding tube rate was readjusted immediately upon notification to the correct rate. No harm was caused to Resident F related to the alleged deficient practice LPN 6 was educated on following physician orders related to tube feeding rate. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** Residents with a feeding tube (gastrostomy/Peg tube) have the potential to be affected by the same alleged deficient practice. House audit of residents with enteral feedings was completed to ensure the rate of tube feeding formula matched the physician orders. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses have been Re-educated on verifying the tube feeding pump is set at the correct rate per orders and prior to administration of nutritional feedings. Nurses have been educated	

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	There were no Physician's Orders to increase the tube feeding to 55 cc/hr. A tube feeding policy, dated 10/2024 and received by the Administrator as current, indicated an order by the physician or nurse practitioner for the type of formula and rate was required. 3.1-44(a)(2)		that when there is a change in tube feeding rate, the order is to be changed in PCC, and tube feeding is updated at the time the order is given. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will observe 10 residents weekly on alternating shifts with a (gastrostomy /Peg tube) to ensure the feeding pump rate is running as ordered. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on record review and interview, the facility failed to care for a midline catheter (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 1 of 1 resident reviewed	F 0694	**POC for F694 – Parenteral/IV orders and documentation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?**	04/11/2025

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	with a midline catheter. (Resident E) Finding includes: Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status. A Physician's Order, dated 3/6/25, indicated a midline catheter was to be inserted for IV antibiotic administration. A Physician's Order, dated 3/6/25, indicated Unasyn (antibiotic) 1.5 grams was to be given every 12 hours for seven days for a hand infection. The treatment was to start on 3/7/25 at 6:00 a.m. A Care Plan, dated 3/7/25, indicated IV antibiotics were ordered related to an infection of the right hand. The interventions included the IV would be flushed per the physician's orders and the site would be monitored for infection. A Care Plan, dated 3/10/25, indicated an antibiotic was ordered due to right lung infiltrates. There was no documentation when the midline catheter had been placed in the resident's clinical record. There were no physician's orders for flushing the midline, nor for the care of the midline. The Medication Administration Record and/or Treatment Administration Record, dated 3/2025,		No harm came Resident E related to this alleged deficient practice. Resident E no longer resides in facility. Orders for midline and required documentation were obtained and carried out. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Residents with intra-vascular access have the potential to be affected by this alleged deficient practice. House audit of residents completed to ensure that residents with intravascular access including but not limited to midline/PICC lines have required orders and documentation in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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	had no information that indicated the flushes were completed, dressing changes to the site had been completed, and the arm circumference and insertion site had been monitored. The Director of Nursing and Vice President of Operations were informed of the lack of care for the IV site and orders for the flushes on 3/12/25 at 2:26 p.m. No further information was provided. The Vice President of Operations presented a form from the Vascular Access Specialist on 3/12/25 at 3 p.m. that indicated a midline had been placed on 3/6/25. The arm circumference was 24 cm (centimeters). The nursing care was to include a 10 milliliter flush of normal saline before and right after all infusions and per facility protocols. The dressing was to be changed within 24 hours of insertion and then every seven days afterwards and as needed. A facility policy for the administration of IV fluids, dated 6/2024 and received by the Vice President of Operations as current, indicated the type and amount of IV fluids must be ordered by a licensed practitioner. IV fluid administration must be documented and resident monitoring was to be documented in the the clinical record. The IV site was to be monitored. 3.1-47(a)(2)		**practice does not recur?** Nursing staff was educated on ensuring that residents with intravascular access including but not limited to midline/PICC lines have required orders and documentation in place. Nursing staff was educated on ensuring that residents with new orders for intravascular access including but not limited to midline/PICC lines have required orders and documentation in place at time of placement. Nursing staff was educated on ensuring that residents with intravascular access including but not limited to midline/PICC lines have required orders and documentation in place while they are doing scheduled head to toe assessments and during admission assessment. Nursing staff was educated on ensuring that residents with orders for IV fluids or IV medications/treatments, have required corresponding orders matching the intravascular access being used. **How will the corrective actions(s) be monitored to**	

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? DON/designee will review new orders daily during clinical meeting to ensure new orders for intravascular access, and fluids/treatments requiring intravascular access have corresponding required orders to; access with type and measurements when needed, flush, change dressings, monitor area, and change as needed. DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning	F 0695	**POC for F695 –**	04/11/2025

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	Based on observation, record review, and interview, the facility failed to ensure a resident who required respiratory care received care consistent with profession standards and was administered oxygen as ordered by the physician for 1 of 1 resident reviewed for respiratory care. (Resident E) Finding includes: During observations on 3/11/25 at 11:24 a.m., 12:24 p.m., and 12:27 p.m., Resident E was sitting in the wheelchair at a table in the lounge by the Nurses' Station. There was a nasal cannula present and in place. The portable oxygen unit was turned off. During the observation on 3/11/25 at 12:27 p.m., the Assistant Director of Nursing turned the portable oxygen unit on. She indicated the oxygen was just turned on at two liters per minute. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. A Physician's Order, dated 3/8/25, indicated oxygen was to be administered at two liters per minute every shift. A Care Plan, dated 3/9/25, indicated oxygen therapy was required. The interventions included oxygen would be administered as ordered by the Physician. A facility policy for oxygen usage, dated 11/2018 and received as current from the Administrator, indicated residents who had orders for oxygen should have the oxygen administered per the physician's orders.		**Respiratory/Tracheostomy Care and Suctioning** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came resident E related to this alleged deficient practice. Resident E no longer resides in facility Resident E's oxygen was immediately changed to correct rate. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Residents with oxygen have the potential to be affected by this alleged deficient practice. House audit of residents completed to ensure that oxygen is being administered at ordered flow rate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing staff was educated on ensuring that residents on oxygen therapy have orders in place and are receiving oxygen at the ordered flow rate. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?**	

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	3.1-47(a)(6)		DON/designee will monitor 10 residents weekly to ensure that residents wearing oxygen have orders in place and are receiving oxygen at ordered flow rate. DON/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue.	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff member (CNA 2) when providing care to a resident (Resident E) who was in Enhanced Barrier Precautions (EBP) for two random observation for infection control. Finding includes: During an observation on 3/11/25 at 2:44 p.m., CNA 2 applied gloves and placed Resident E in bed. The resident had been incontinent of a moderate amount of urine and a small bowel movement. Incontinent care was completed by CNA 2. There was no sign on the door that indicated the resident was on EBP. During an observation on 3/12/25 at 10:13 a.m., there was a sign on the door that indicated the resident was on EBP and a container for the PPE was located on the door of the room. CNA 2 was	F 0880	**POC for F880- Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to resident E related to this alleged deficient practice. Resident E no longer resides in facility. EPB sign is on the door. C.N.A. 2 immediately educated on ensuring correct PPE is used when providing care to residents on enhanced barrier precautions.	04/11/2025

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	in the bathroom with the resident and had assisted her into the wheelchair from the toilet. CNA 2 wore gloves and indicated care had just been completed due to diarrhea. CNA 2 had not donned a protective gown for the care and stated she was unaware the resident was on EBP. CNA 2 indicated there would be a sign on the door and PPE supplies available if the resident required EBP. Resident E's record was reviewed on 3/11/25 at 3:11 p.m. The diagnoses included, but were not limited to, pneumonia, fracture of the right arm, infection of the right hand, and dementia. A Physician's Order, dated 1/18/25, indicated EBP was to be initiated. A Care Plan, dated 1/20/25, indicated EBP was required related to the wounds that were present upon admission. The interventions include protective gowns and gloves would be worn during high contact resident care activities. An Admission Minimum Data Set assessment, dated 1/23/25, indicated a severely impaired cognitive status, was dependent for toileting, was occasionally incontinent of bladder and frequently incontinent of bowel, had an unstageable (pressure wound covered with slough or eschar) and venous/arterial ulcers, a surgical wound, moisture associated skin damage (MASD), and a surgical wound upon admission into the facility. A Physician's Order, dated 3/6/25, indicated a midline catheter for intravenous antibiotic therapy was to be inserted. A Vascular Access form, dated 3/6/25, indicated a		**How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** Any residents on EPB precautions have the potential to be affected by this alleged deficient practice. House audit of residents requiring isolation precautions was completed including but not limited to EBP, to ensure proper signage is in place and PPE is being used correctly. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Facility staff was educated to ensure staff understand meaning of each type of isolation sign, when a resident meets criteria for EBP or other types of isolation, and appropriate PPE to use when entering a room and/or	

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	midline catheter was inserted on 3/6/25. A facility EBP policy, dated 3/2024 and identified as current by the Vice President of Operations, indicated staff were to don a gown and gloves during high-contact resident care. EBP PPE was to be used for residents with a central line and with wounds. 3.1-18(b)		providing care. Nursing staff educated to ensure staff understand which high-contact care activities would require PPE for residents in enhanced barrier precautions. Staff educated on new isolation signage for EBP with listed high-contact care activities that would require PPE. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/designee will audit 10 staff members weekly on random shifts to ensure appropriate PPE is worn based on isolation status. CNO/Designee to test 10 staff members weekly on random shifts to ensure they understand which high-contact care activities would require PPE for residents in EBP. CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the	

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			quality Assurance Committee that further monitoring is needed, audit will continue.	