PRINTED: 12/04/2024
FORM APPROVED

| CENTERS FO | R MEDICARE & MEDI | CAID SERVICES | | | OMB NO. 0938-039 |
|--|--|---|---------------------|--|------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
| | PROVIDER OR SUPPLII | | 2775 V | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT ERTON, IN 46304 | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | Y STATEMENT OF DEFICIENCIE ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE COMPLETION |
| F 0000 | | | | | |
| Bldg. 00 | Licensure Survey Nursing Home Co IN00443841. This Licensure Survey. Complaint IN004 related to the alleg Complaint IN004 related to the alleg F761. | 42605 - Federal/state deficiencies gations are cited at F554. 43841 - Federal/state deficiencies gations are cited at F759 and ober 27, 28, 29, 30, 31 and 4 013688 155844 | F 0000 | | |
| | accordance with 4 | oe: s reflect State Findings cited in | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Kristina Herrera General Manager Admin 11/27/2024

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclodays 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.

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: JB0C11 Facility ID: 013688 If continuation sheet Page 1 of 65

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|-------|--|---|-------------------------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155844 | B. W | B. WING 11/01/2024 | | | /2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIER | 2 | | | | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | |
| | MEDIOAL NEOONT | OHEOTER TON | | OI ILST | 1 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) COMPLETION |
| PREFIX | `` | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA | CROSS-REFERENCED TO THE APPROPRIATE | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| F 0550 | 483.10(a)(1)(2)(b) | | | | | | |
| SS=D | Resident Rights/E | exercise of Rights | | | | | |
| Bldg. 00 | Danidan 1 d | | FA | 7.7.0 | 0 | | 12/06/2024 |
| | | on, record review, and | F 03 | 550 | Compliance Date 12/06/2024 | | 12/06/2024 |
| | | ty failed to ensure each | | | F550: | | |
| | | as maintained related to gown while in bed during the | | | The General Manager | | |
| | | ent reviewed for dignity. | | | (Administrator) notified the | 24 of | |
| | (Resident 30) | on reviewed for dignity. | | | Medical Director on 11/19/202 | | |
| | (Resident 30) | | | | the Annual Survey findings. A time the facility is requesting a | | |
| | Finding includes: | | | | desk review for the findings al | | |
| | i manig merades. | | | | in the annual survey. Chester | • | |
| | On 10/27/24 at 11:32 a.m., Resident 30 was | | | | Ignite Medical Resorts denies | | |
| | observed in his room in bed wearing a hospital | | | | implication of guilt relating to t | | |
| | gown. | in in sea wearing a nospital | | | deficiencies outlines in this pla | | |
| | g | | | | correction. The facilities' inten | | |
| | On 10/28/24 at 9:52 | 2 a.m., 12:09 p.m., and 4:35 p.m., | | | always to provide quality care | | |
| | | ain observed in his room in | | | its guests and residents. No h | | |
| | bed wearing a hospi | | | | came to any residents/guests | | |
| | | - | | | related to this alleged deficien | t | |
| | On 10/29/24 at 9:25 | 5 a.m., 11:28 a.m., and 2:20 p.m., | | | practice. | | |
| | the resident was obs | served in his room in bed | | | No harm came to any | | |
| | wearing a hospital g | gown. | | | residents/guests related to this | S | |
| | | | | | alleged deficient practice | | |
| | | 6 a.m., 10:36 a.m. and 3:30 p.m., | | | Resident #30 family meeting t | 0 | |
| | | served in his room in bed | | | discuss family's concerns. | | |
| | | gown. At 1:25 p.m., the | | | Resident chooses to be in a | | |
| | | in his broda chair by the | | | hospital gown at times while in | | |
| | | ontinued to wear a hospital | | | bed and during the day. Care | - | |
| | gown. | | | | updated to reflect person cent | | |
| | 0 10/21/24 : 0 12 | | | | care and preference of reside | nt. | |
| | | 2 a.m., the resident was in his | | | | | |
| | | ng television. The resident | | | | | |
| | was wearing a hosp | ital gown at that time. | | | Identification of Other | 4- | |
| | The magainst fam D ' | dant 20 year marriage 4 | | | Residents with the Potential | <u>το</u> | |
| | | dent 30 was reviewed on | | | be Affected: | | |
| | | .m. Diagnoses included, but | | | 1 Cuesto ware identified a | _ | |
| | | dementia without behavior | | | 1 Guests were identified as | _ | |
| | | onal disorder, anxiety, | | | wearing a hospital gown in be | a | |
| | dysphagia (difficult | y swallowing), and | | | and on the milieu. | | l |

PRINTED: 12/04/2024 FORM APPROVED

| CENTERS FO | R MEDICARE & MEDIC | CAID SERVICES | | | OMB NO. 0938-039 | |
|------------|---|-----------------------------------|-------------|---|------------------|--|
| STATEME | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIP | LE CONSTRUCTION | (X3) DATE SURVEY | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDIN | 4G <u>00</u> | COMPLETED | |
| | | 155844 | B. WING | | 11/01/2024 | |
| | PROVIDER OR SUPPLIEF | | 277 | EET ADDRESS, CITY, STATE, ZIP COD 75 VILLAGE POINT IESTERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | | (X5) | |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | PREF | PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR | HON | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAC | | DATE | |
| | gastrostomy status | (a tube inserted directly into | | 2 Guests were asked to | their | |
| | the stomach for nut | • | | preferences and Care pla | ins were | |
| | | , | | updated to reflect guests' | | |
| | The 9/13/24 Quarte | erly Minimum Data Set (MDS) | | and person-centered care | | |
| | | ed the resident was cognitively | | · | | |
| | | decision making and he required | | Systemic Changes: | | |
| | | im assistance with dressing. | | 3 On 11/21/2024 A Qa | аррі | |
| | | C | | meeting with CNO, ACNO | · · | |
| | A Care Plan, dated | 3/14/24 and reviewed on | | Transitions, Hospitality M | | |
| | 9/6/24, indicated th | e resident had self-care deficits | | Director, and General Ma | | |
| | which required limit | ited to extensive assist with | | IDT was educated on F5 | 50 | |
| | activities of daily living (ADL's). Interventions | | | residents rights and how | it relates | |
| | included, but were | not limited to, extensive assist | | to residents' rights, prefer | | |
| | of one to help with | dressing. | | and person-centered care | e plans. | |
| | | | | (related to hospital gowns | · • | |
| | There was no curre | nt care plan related to wearing | | of clothing) | | |
| | a gown in bed durin | ng the day. | | 4 Staff was educated of | on F550 | |
| | | | | resident rights and how it | relates | |
| | During an interview | v on 11/1/24 at 10:40 a.m., the | | to preferences and | | |
| | Vice President of C | Clinical Operations indicated the | | person-centered care pla | ns | |
| | resident's care plan | was being updated. | | (related to hospital gowns | s and | |
| | | | | dignity) | | |
| | 3.1-3(t) | | | Monitoring: | | |
| | | | | 5 CNO/ACNO/ Design | nee will | |
| | | | | complete visual observati | on | |
| | | | | rounds on six residents d | aily | |
| | | | | across either shift to ensu | ıre | |
| | | | | preferences on hospital g | owns are | |
| | | | | indicated on the care plar | n | |
| | | | | interventions. x 2 weeks, | then six | |
| | | | | observations three times | | |
| | | | | for 2 weeks, then six obse | ervations | |
| | | | | weekly x 4, then 6 resider | nts | |
| | | | | monthly four 4 months. C | orrective | |
| | | | | actions will be completed | | |
| | | | | immediately, and staff wil | l be | |
| | | | | re-educated to ensure ca | re plan | |
| | | | | interventions are in place | related | |
| | | | | to preferences for hospita | | |

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 155844 B. WING 11/01/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2775 VILLAGE POINT IGNITE MEDICAL RESORT CHESTERTON CHESTERTON, IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE F 0554 483.10(c)(7) SS=E Resident Self-Admin Meds-Clinically Approp Bldg. 00 Based on observation, record review, and Compliance Date 12/6/2024 F 0554 12/06/2024 interview, the facility failed to ensure residents F-554 Medication had Physician's Orders for medications and an Administration assessment to self-administer their own The General Manager medications for 8 of 8 residents reviewed for (Administrator) notified the self-administration of medication. (Residents C, E, Medical Director on 11/19/2024 of F, G, B, H, D, and J) the Annual Survey findings. At this time the facility is requesting a Findings include: desk review for the findings alleged in the annual survey. Chesterton 1. During random observations on 10/27/24 at Ignite Medical Resorts denies 10:39 a.m., and 1:14 p.m., Resident C was observed implication of guilt relating to the sitting in a chair in her room. At those times, there deficiencies outlines in this plan of was a plastic medication cup of a white powder correction. The facilities' intent is substance in the window sill. always to provide quality care to its guests and residents. No harm During an interview on 10/27/24 at 1:14 p.m., the came to any residents/quests resident indicated she had a rash on her upper left related to this alleged deficient shoulder and asked a nurse for something for it practice. and she came back with the white powder. No harm came to any resident/guest related to this During an observation on 10/29/24 at 10:25 a.m., deficient alleged deficient practice. the resident was in her room sitting in the Guest C was educated on keeping wheelchair. There was a facility labeled bottle of medication at bedside without an Ammonium Lactate on the over bed table. The order, medications were removed resident indicated the nurse had brought it into and orders placed to administer her room so she could apply the lotion to her foot. medication from nurse or qma. Guests E,F,G,H,D,J discharged The record for Resident C was reviewed on from the facility 10/28/24 at 3:05 p.m. The resident was admitted to Resident B was educated on the facility on 9/28/24. Diagnoses included, but using medication without were not limited to, orthopedic after care, difficulty physician's order, Resident orders walking, type 2 diabetes, acute respiratory failure, were updated and person-centered chronic obstructive pulmonary disease, end stage care plan indicated medication at

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renal disease, high blood pressure, heart disease,

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bedside and self-administration.

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
|--|--|--|--------------------------|---|---|
| | PROVIDER OR SUPPLIER | | 2775 V | ADDRESS, CITY, STATE, ZIP COD /ILLAGE POINT FERTON, IN 46304 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION |
| TAG | anxiety, and atrial for The Modification of Data Set (MDS) assindicated the resided daily decision maked. There was no care proceed and the resident to apply the resident to ap | of the Admission Minimum sessment, dated 10/2/24, and was cognitively intact for large. Dolan for the resident to cown medications. Cian's order for the powder. The dated 10/28/24, indicated the external Lotion 12 %, apply to topically every day shift for dry administration assessment for the lotion. The one of the powdered did not know the lotion was let. Deservations on 10/27/24 9:59 on 10/28/24 at 9:13 a.m. and 4:31 a.m. At those times, there were the counter vitamins on the re was one bottle of Vitamin lagnesium tablets and one | TAG | Identification of Other Residents with the Potential be Affected: 1 All current guest rooms were observed to ensure that medications are not left bedsign room without an order from physician. 2 Guests that were found to have medication at bedside we evaluated to see if they were appropriate to self-administer medication. If appropriate, a physician order was placed, a person center care plan was updated. Systemic Changes: 3 A Qappi meeting with Cland Acno, Care Transitions, Hospitality Medical Director at General Manager. IDT was educated on F554 and how it relates to self-administering medication. All staff were also educated on Medication storal policy and what to do if they observe medication bedside. Monitoring: CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily ace either shift to ensure medication or ound without a physician's order. | to were de or the or ere and a NO, and or ge cross ons an the |
| | the resident's room. | At that time, she was made pottles of vitamins on the over | | x 2 weeks, then 6 observation three times a week for 2 week | ns (S, |

then 6 residents monthly.

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | SURVEY | |
|--|--|---|----------------------------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155844 | B. W. | ING | | 11/01/ | 2024 |
| NAME OF F | PROVIDER OR SUPPLIER | | • | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | ROVIDER OR SUPPLIEF | | | | LLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | CHEST | ERTON, IN 46304 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` ` | ICY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION dent E was reviewed on | | TAG | Thereafter, if determined by | | DATE |
| | | n. The resident was admitted to | | | Quality Assurance Committee | that | |
| | | 24. Diagnoses included, but | | | further monitoring is needed, | triat | |
| | 1 | fracture around the internal | | | audits will continue. | | |
| | | right hip joint, type 2 diabetes, heart disease, high | | | | | |
| | blood pressure and | osteoarthritis. | | | | | |
| | The 10/10/24 Admi | ission Minimum Data Set | | | | | |
| | | indicated the resident was | | | | | |
| | | or daily decision making. | | | | | |
| | | | | | | | |
| | | olan indicating the resident | | | | | |
| | was able to self-adr | minister her own medications. | | | | | |
| | There was no self-administration of medication | | | | | | |
| | assessment availabl | | | | | | |
| | | | | | | | |
| | There were no Phys | sician's Orders for the over the | | | | | |
| | | s that were in the resident's | | | | | |
| | | e an order to self-administer her | | | | | |
| | own medications. | | | | | | |
| | During an interview | v on 10/29/24 10:42 a.m., LPN 1 | | | | | |
| | _ | nt had no orders for the above | | | | | |
| | over the counter vit | amins, nor was she able to | | | | | |
| | self-administer her | own medications. | | | | | |
| | | | | | | | |
| | 3. During random o | observations on 10/27/24 at | | | | | |
| | _ |) p.m., on 10/28/24 at 9:25 a.m., | | | | | |
| | | 3 p.m., and on 10/29/24 at 9:05 | | | | | |
| | | as observed in her bed. At | | | | | |
| | | was a bottle of over the counter | | | | | |
| | nasal spray on her o | | | | | | |
| | During an interview | v on 10/27/24 at 10:24 a.m., the | | | | | |
| | _ | he used the spray all the time | | | | | |
| | | t helped her breathe easier. | | | | | |
| | | 1 | | | | | |
| | On 10/29/24 at 10:3 | 34 a.m., LPN 1 was observed in | | | | | |

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| STATEMEN | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|-----------|--|---|----------------------------------|-------|--|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | | COMPLETED | |
| | | 155844 | B. WING | | | 11/01/2024 | |
| NAME OF P | DROWNER OF CHERT IS | | STR | EET A | DDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | C | | | LLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | СН | EST | ERTON, IN 46304 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) | |
| PREFIX | · · | ICY MUST BE PRECEDED BY FULL | PREFI | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | COMPLETION |
| TAG | | At that time, she was made | TAC | j | DEFICIENCY | | DATE |
| | | At that time, she was made spray on the over bed table. | | | | | |
| | aware of the hasal s | pray on the over bed table. | | | | | |
| | The record for Resi | dent F was reviewed on | | | | | |
| | | m The resident was admitted to | | | | | |
| | the facility on 10/17 | 7/24. Diagnoses included but | | | | | |
| | | heart failure, type 2 diabetes, | | | | | |
| | | disease, anemia, high blood | | | | | |
| | pressure, gout and r | migraines. | | | | | |
| | The 10/23/24 Admi | ssion Minimum Data Set | | | | | |
| | | indicated the resident was | | | | | |
| | | or daily decision making. | | | | | |
| | | · · | | | | | |
| | | plan indicating the resident | | | | | |
| | was able to self-adr | ninister her own medications. | | | | | |
| | Th 10 | Aministration of the 11 of | | | | | |
| | There was no self-a assessment available | dministration of medication | | | | | |
| | assessment availabl | e for review. | | | | | |
| | There was no Physi | cian's Order for the resident to | | | | | |
| | self-administer her | | | | | | |
| | | | | | | | |
| | 1 | r, dated 10/17/24, indicated | | | | | |
| | | on 0.65 %, 2 spray in both | | | | | |
| | | ours as needed for dry nasal | | | | | |
| | passage. | | | | | | |
| | During an interview | v on 10/29/24 10:34 a.m., LPN 1 | | | | | |
| | indicated the reside | | | | | | |
| | | own medications and she was | | | | | |
| | unaware the nasal s | pray was on the over bed | | | | | |
| | table. 4. On 10/28/2 | 24 at 10:52 a.m. and 1:18 p.m., a | | | | | |
| | bottle of chewable a | antacids and a bottle of nasal | | | | | |
| | 1 * * | d on Resident G's bedside | | | | | |
| | | at 9:44 a.m. and 3:53 p.m., the | | | | | |
| | | spray remained on the table. | | | | | |
| | The resident indicate when he needed the | ted he took the medications | | | | | |
| | when he needed the | ziii. | | | | | |
| | | | | | | | |

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Event ID:

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
|--------------------------|--|--|--|---|---------------------------------------|--|
| NAME OF P | PROVIDER OR SUPPLIEF | | | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT | - | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | ERTON, IN 46304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) | BE COMPLETION | |
| | 1:23 p.m. Diagnose limited to, cardiomy right buttock, heart | was reviewed on 10/29/24 at es included, but were not yopathy, pressure ulcer of the failure, and chronic pain. | | | | |
| | assessment, dated 8 was cognitively into | imum Data Set (MDS) /15/24, indicated the resident act, required moderate er body dressing and personal num assistance with | | | | |
| | medication adminis | nd the eMAR (electronic tration record) for 10/2024 e antacids, nasal spray, and of medications. | | | | |
| | There was no assess to self-administer n | sment of the resident's ability nedications. | | | | |
| | indicated a physicia resident to have me self-administer and | on 10/28/24 at 4:05 p.m., RN 2 in's order was needed for a dications at the bedside and to that she would take the t them in the medication cart leted. | | | | |
| | and two bottles of e Resident B's over b | 1:31 a.m., a cup with four pills ye drops were observed on ed table. On 10/27/24 at 1:25 at 11:01 a.m., the eye drops le. | | | | |
| | had a bottle of eye of used as needed, and | B p.m., Resident B indicated she drops in her purse that she that the nurse used to leave r her to take by herself, but for that." | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE | CONSTRUCTION | (X3) DATI | (X3) DATE SURVEY | |
|--|--|--|--------------|----------------------------------|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155844 | B. WING | | 11/01 | 1/2024 |
| | | | QTD E1 | ET ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | 5 VILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | STERTON, IN 46304 | | |
| IONITE | MEDIOAL NEOUNT | OHEOTER TON | | | | , |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECT | | (X5) |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | CRUSS-REFERENCED TO THE APPRI | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | | DATE |
| | | was reviewed on 10/28/24 at | | | | |
| | | es included, but were not | | | | |
| | | neuromuscular dysfunction of | | | | |
| | | disorders, depressive | | | | |
| | episodes, pain in rig | ght knee, and anxiety disorder. | | | | |
| | An Annual Minimus | um Data Sat (MDS) aggaggment | | | | |
| | An Annual Minimum Data Set (MDS) assessment, dated 10/13/24, indicated the resident was | | | | | |
| | | nd was dependent for most | | | | |
| | activities of daily li | • | | | | |
| | detivities of daily if | The and nanorois. | | | | |
| | Physician's orders a | and the eMAR (electronic | | | | |
| | medication administration record) for 10/2024 | | | | | |
| | lacked orders for th | | | | | |
| | | 1 | | | | |
| | A Care Plan, dated | 6/8/23, indicated the resident's | | | | |
| | ability to self admir | nister medications/treatments | | | | |
| | should be re-assess | ed Quarterly and with Change | | | | |
| | in Condition. | | | | | |
| | | | | | | |
| | | ne resident's ability to | | | | |
| | | lications had not been | | | | |
| | completed since 10 | /23/23. | | | | |
| | | 10/00/04 + 10 00 | | | | |
| | _ | v on 10/29/24 at 10:09 a.m., LPN | | | | |
| | | as not a current evaluation for | | | | 1 |
| | the resident to self a | administer any medications. | | | | |
| | During an interview | v on 10/29/24 at 2:03 p.m., the | | | | |
| | _ | v on 10/29/24 at 2:03 p.m., the vas informed of the findings | | | | |
| | and offered no furth | | | | | |
| | and offered no full | ici momation. | | | | |
| | | | | | | |
| | 6. On 10/29/24 at 1 | 10:14 a.m., a bottle of Biofreeze | | | | |
| | | f medication) was observed on | | | | |
| | | ed table. The resident | | | | |
| | | the medication as needed on | | | | |
| | her shoulders. | | | | | |
| | | | | | | |
| | Resident H's record | was reviewed on 10/29/24 at | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JB0C11

Facility ID: 013688

If continuation sheet Page 9 of 65

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | r í | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|---|----------------------------|---|--|------------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPL | |
| | | 155844 | B. W | ING | | 11/01/ | 2024 |
| NAME OF I | PROVIDER OR SUPPLIEF | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| ICNITE N | MEDICAL RESORT | CHESTERTON | | | LLAGE POINT ERTON, IN 46304 | | |
| | | | _ | <u> </u> | LITTOIN, IIN 40004 | | |
| (X4) ID PREFIX | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION |
| TAG | ` | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | DATE |
| | | es included, but were not | | | | | |
| | limited to, disruption of external operation (surgical) wound, muscle weakness, and chronic respiratory failure with hypoxia. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | An Admission Min | imum Data Set (MDS) | | | | | |
| | assessment, dated 10/1/24, indicated the resident | | | | | | |
| | was cognitively intact and required moderate to | | | | | | |
| | | e with activities of daily living | | | | | |
| | and transfers. | | | | | | |
| | Physician's orders a | and the eMAR (electronic | | | | | |
| | medication administration record) for 10/2024 | | | | | | |
| | lacked orders for Biofreeze and | | | | | | |
| | self-administration. | | | | | | |
| | There was no assess | sment of the resident's ability | | | | | |
| | to self-administer n | - | | | | | |
| | During an interview | v on 10/29/24 at 10:20 a.m., LPN | | | | | |
| | _ | ould be an order for the | | | | | |
| | | it to be kept at the bedside, | | | | | |
| | | to remove the medication from | | | | | |
| | the resident's room | until that was completed. | | | | | |
| | | 1:08 a.m., 3:24 p.m., and 4:20 | | | | | |
| | _ | as observed in his room, there | | | | | |
| | by the television. | lex cream inside a wash basin | | | | | |
| | by the television. | | | | | | |
| | The record for Resi | dent D was reviewed on | | | | | |
| | | .m. The diagnoses included, but | | | | | |
| | | , anxiety, insomnia (difficulty | | | | | |
| | | sion (high blood pressure), | | | | | |
| | | rial fibrillation (abnormal heart dney disease, and anemia (low | | | | | |
| | iron). | uncy disease, and allettilla (low | | | | | |
| | | | | | | | |
| | | y Minimum Data Set (MDS) | | | | | |
| | | 0/16/24, indicated the resident | | | | | |
| | was cognitively inta | act for daily decision making. | | | | | |

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Event ID:

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Facility ID: 013688

If continuation sheet Page 10 of 65

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | |
|--|---|---|-------|----------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155844 | B. W | ING | | 11/01/ | 2024 |
| | | <u> </u> | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF F | PROVIDER OR SUPPLIEF | 8 | | | LLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | | ERTON, IN 46304 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | impairment of the upper and | | | | | |
| | | nd used a wheelchair. The | | | | | |
| | | artial to moderate assistance | | | | | |
| | | rsonal hygiene and upper | | | | | |
| | | resident was dependent with | | | | | |
| | | off footwear and lower body | | | | | |
| | dressing. | | | | | | |
| | A Physician's Order | r dated 10/12/24 indicated to | | | | | |
| | A Physician's Order, dated 10/12/24, indicated to apply venelex ointment to right heel daily and as | | | | | | |
| | needed | nent to right neer daily and as | | | | | |
| | needed | | | | | | |
| | A Physician's Order | r, dated 10/12/24, indicated to | | | | | |
| | apply venelex ointment (Balsam Peru-Castor Oil) | | | | | | |
| | | pically every day shift and as | | | | | |
| | needed for wound o | | | | | | |
| | | | | | | | |
| | A Physician's Order | r, dated 10/26/24, indicated to | | | | | |
| | apply venelex ointn | nent to left ischial tuberosity | | | | | |
| | every day shift and | as needed for wound care. | | | | | |
| | | | | | | | |
| | | plan for the resident to | | | | | |
| | self-administer their | r own medications. | | | | | |
| | Tl | ::: | | | | | |
| | There were no phys self-administration | | | | | | |
| | sen-aummistration | or the inedications. | | | | | |
| | There was no self-a | dminister of medications | | | | | |
| | assessment complet | | | | | | |
| | ussessment complet | | | | | | |
| | During an interview | on 10/30/24 at 9:55 a.m., the | | | | | |
| | _ | (DON) indicated she | | | | | |
| | I - | cern about medication left at | | | | | |
| | | no additional information to | | | | | |
| | provide. | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | | 1:29 a.m. and 2:03 p.m., Resident | | | | | |
| | | is room, there was a tube of | | | | | |
| | portocort cream (cr | eam for itching) on his | | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JB0C11

Facility ID: 013688

If c

If continuation sheet Page 11 of 65

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
|--|---|---|--------------------------|--|---------------------|
| | | | | ADDRESS, CITY, STATE, ZIP COD | , |
| NAME OF P | PROVIDER OR SUPPLIEF | 2 | | /ILLAGE POINT | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | CHES. | TERTON, IN 46304 | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX TAG | | CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | PREFIX TAG | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | ATE COMPLETION DATE |
| TAG | nightstand. | CLSC IDENTIFTING INFORMATION | IAG | | DATE |
| | On 10/28/24 at 10:4 the resident was obstelevision, the portonightstand. On 10/29/24 at 9:51 bed watching television was on the nightstant had just finished ap The record for Resi 10/30/24 at 9:34 a.r were not limited to, hypertension (high weakness, need for and depression. The Admission Mir assessment, dated 1 was severely impair. The resident had no lower extremities and A Physician's Order apply Hydrocortiso cream) to the right shours as needed for | dent J was reviewed on m. The diagnoses included, but heart failure, dementia, blood pressure), muscle assistance with personal care, mimum Data Set (MDS) 0/13/24, indicated the resident red for daily decision making. The impairment of the upper and and used a wheelchair. The diagnoses included, but heart failure, as impairment of the upper and and used a wheelchair. The dated 10/25/24, indicated to me External Cream (portocort side flank topically every 8 and Itching. The diagnoses included, but heart failure, assistance with personal care, as included in the resident to rown medications. | | | |
| | There was no self-a assessment complete | dminister of medications red. | | | |
| | During an interview | on 10/30/24 at 9:55 a.m., the | | | |

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Event ID:

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Facility ID: 013688

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE S | | SURVEY | | | | | |
|---|---|--|-------|--------|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | | | COMPI | LETED |
| | | 155844 | B. W | ING | | 11/01 | /2024 |
| | | | | CTDEET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF P | PROVIDER OR SUPPLIEF | ₹ | | | ILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | | ERTON, IN 46304 | | |
| IGNITE | | CHESTERION | | CITEST | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | NTE. | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | 1 | (DON) indicated she | | | | | |
| | | cerns and had no additional | | | | | |
| | information to prov | ide. | | | | | |
| | | | | | | | |
| | _ | on 11/1/24, the Vice President | | | | | |
| | of Clinical Operations indicated the resident was | | | | | | |
| | cognitively impaired and should not have had | | | | | | |
| | medication at bedside. | | | | | | |
| | | | | | | | |
| | The current 6/2024 "Medication at Bedside" policy, provided by the Vice President of Clinical | | | | | | |
| | 1 | Operations on 10/29/24 at 3:10 p.m., indicated a | | | | | |
| | _ | - | | | | | |
| | | vide an order for medication at | | | | | |
| | the bedside. | | | | | | |
| | This citation relates to Complaint IN00442605. | | | | | | |
| | 3.1-11(a) | | | | | | |
| F 0677 | 483.24(a)(2) | | | | | | |
| SS=D | , , , , | ed for Dependent Residents | | | | | |
| Bldg. 00 | | on, record review, and | F 00 | 677 | Compliance Date: 12/06/2024 | 4 | 12/06/2024 |
| | | ty failed to ensure activities of | | 011 | F677: ADL Dependent | | 12,00,202 |
| | i i |) were completed for dependent | | | Residents | | |
| | | dirty and long fingernails, | | | The General Manager | | |
| | greasy hair, and the | removal of facial hair for 2 of 6 | | | (Administrator) notified the | | |
| | residents reviewed | for ADLs. (Residents F and | | | Medical Director on 11/19/202 | 24 of | |
| | 170) | | | | the Annual Survey findings. A | t this | |
| | | | | | time the facility is requesting a | a . | |
| | Findings include: | | | | desk review for the findings al | leged | |
| | | | | | in the annual survey. Chester | ton | |
| | I - | iew on 10/27/24 at 10:14 a.m., | | | Ignite Medical Resorts denies | | |
| | | d her hair had not been | | | implication of guilt relating to t | | |
| | | ad been at the facility. At that | | | deficiencies outlines in this pla | | |
| | time, her hair was g | greasy in appearance. | | | correction. The facilities' inten | | |
| | | | | | always to provide quality care | | |
| | | dent F was reviewed on | | | its guests and residents. No h | | |
| | | m The resident was admitted to | | | came to any residents/guests | | |
| | the facility on 10/1' | 7/24. Diagnoses included, but | | | related to this alleged deficien | it | |

PRINTED: 12/04/2024 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

| | | 155844 | B. WING | ADDRESS, CITY, STATE, ZIP COD | , 0 | 1/2024 |
|----------|--|-----------------------------------|---------|--|--------------|-----------|
| NAME OF | PROVIDER OR SUPPLIER | 8 | | /ILLAGE POINT | | |
| IGNITE I | MEDICAL RESORT | CHESTERTON | | TERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDERIC DI AN OF CORRECTIO | AT. | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI | BE | COMPLETIO |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | PRIATE | DATE |
| | were not limited to. | heart failure, type 2 diabetes, | | practice. | | |
| | | disease, anemia, high blood | | Guest F has discharged fro | m the | |
| | pressure, gout and r | | | facility. | | |
| | | | | Guest 170 has discharged | from | |
| | The 10/23/24 Admi | ssion Minimum Data Set | | the facility. | | |
| | (MDS) assessment | indicated the resident was | | Identification of Other | | |
| | cognitively intact for | or daily decision making. It was | | Residents with the Potent | ial to | |
| | - | he resident to choose between | | be Affected: | | |
| | | ath and the task of bathing | | | _ | |
| | was not attempted of | luring the observation period. | | 1 All guests who are | | |
| | A Care Plan, dated 10/17/24, indicated the resident | | | considered dependent for A | ADL | |
| | | | | were observed to ensure th | at skin, | |
| | had an ADL self care performance deficit related | | | nails and hair are clean as | | |
| | to physical mobility. The approaches indicated | | | preferred by guest and that | facial | |
| | the resident needed substantial/maximal assistance for showers and/or baths. | | | hair is trimmed as preferred | d. | |
| | | | | 2 Guests that prefer long | g nail | |
| | | | | or/ facial hair will have pers | on | |
| | The shower sheet for | or 10/2024 indicated the | | centered care plans indicat | ing | |
| | resident refused a sl | hower on 10/24 and had a bed | | their preferences. | | |
| | bath on 10/28/24, w | hich included her hair being | | | | |
| | washed. The resider | nt did not receive a bath or | | Systemic Changes: | | |
| | shower on 10/21/24 | l. | | 3 A Qappi meeting with | CNO, | |
| | | | | ACNO, Care Transitions, | | |
| | - | on 10/29/24 at 9:15 a.m., the | | Hospitality Medical Director | | |
| | _ | ated they attempted multiple | | General Manager. IDT was | | |
| | | o assist the resident with taking | | educated on F677 and how | | |
| | | she kept refusing due to the | | relates to ADLS and depen | dent | |
| | chair being too high | for her. | | guest/residents. Education | | |
| | | 10/00/01 10 10 | | provided to Staff on ADL po | olicy. | |
| | | on 10/30/24 at 9:48 a.m., the | | | | |
| | | cer indicated the resident did | | Monitoring: | | |
| | | er on 10/21/24 nor was there | | CNO/ACNO/ Designee wil | | |
| | | had refused. The resident's | | complete visual observation | | |
| | hair was to be wash | ed as needed. | | rounds on 6 residents daily | across | |
| | | | | either shift to ensure that | | |
| | 2 Danie 1 | 1 | | Dependent guests are prov | | |
| | | bservations on 10/27/24 at | | with ADLS as preferred in t | | |
| | | p.m., and on 10/28/24 at 9:40 | | person-centered care plan. | | |
| | | , Resident 170 was observed in | | weeks, then 6 observations | | |
| | bed. At those times, | , the resident's fingernails were | | times a week for 2 weeks, t | nen 6 | |

JB0C11

| | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE CO A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
|----------------|--|--|--|--|---|---------------------------------------|--|
| | PROVIDER OR SUPPLIER | | 2775 V | ADDRESS, CITY, STATE, ZIP CO ILLAGE POINT FERTON, IN 46304 | DD . | | |
| F 0684 SS=D | SUMMARY (EACH DEFICIEN REGULATORY OF long and dirty and I hair on his cheeks, The record for Resi 10/28/24 at 3:15 p.1 the facility on 10/10 were not limited to, stage renal disease, The 10/22/24 Admi (MDS) assessment cognitively intact for needed partial to m personal hygiene. A Care Plan, dated had an ADL self cat to physical mobility the resident needed with personal hygie The shower sheet for indicated the reside 10/19/24 and refuse There was no docur resident received no During an interview Chief Nursing Offic were long and dirty | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION The had a large amount of facial chin, and neck. Ident 170 was reviewed on Im. The resident was admitted to 6/24. Diagnoses included, but It, brain disorder, type 2 dm, end anemia, and stroke. Ission Minimum Data Set indicated the resident was not for daily decision making and orderate assistance with 10/16/24, indicated the resident for deficit performance related for the approaches indicated partial to moderate assistance for the month of 10/2024 for treceived a bed bath on for daily decision to indicate the for the month of 10/23 and 10/26/24. In the month of 10/23 and 10/26/24. In the month of 10/2024 for the month of 10/23 and 10/26/24. In the month of 10/23 and 10/26/24. In the month of 10/2024 for the month of 10/2024 for the month of 10/23 and 10/26/24. In the month of 10/2024 for the | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY) observations weekly x 4 residents monthly. Ther determined by Quality A Committee that further r is needed, audits will co Corrective actions will to completed immediately, will be re-educated to e plan interventions are in related to preferences for | A, then 6 reafter, if Assurance monitoring ontinue. be and staff nsure care n place | (X5) COMPLETION DATE | |
| Bldg. 00 | | | | | | | |

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Event ID:

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Facility ID: 013688

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|------------------------------------|----------------------------|---------------------------------|---|------------------|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | | COMPLETED | |
| | | 155844 | B. W | NG | | 11/01/ | /2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF | PROVIDER OR SUPPLIE | R | | | ILLAGE POINT | | | |
| IGNITE | MEDICAL RESORT | CHESTERTON | | | TERTON, IN 46304 | | | |
| | T. T | - CHESTER OF | | OHLOH | 121(1014, 114 1000) | | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION | |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE | |
| | | on, record review, and | F 06 | 584 | Compliance Date 12/06/2024 | | 12/06/2024 | |
| | | ity failed to ensure treatments | | | F-684 Quality of Care | | | |
| | _ | ordered for dry flaky skin and | | | The General Manager | | | |
| | | on were monitored for 2 of 4 | | | (Administrator) notified the | | | |
| | | for non pressure skin | | | Medical Director on 11/19/202 | | | |
| | | 1 of 1 resident reviewed for | | | the Annual Survey findings. A | | | |
| | constipation. (Resid | dents 31, F and 170) | | | time the facility is requesting a | | | |
| | | | | | desk review for the findings al | • | | |
| | Findings include: | | | | in the annual survey. Chester | | | |
| | | | | | Ignite Medical Resorts denies | | | |
| | 1. During an interview on 10/27/24 at 1:36 p.m., | | | | implication of guilt relating to t | | | |
| | Resident 31 indicated he had issues with | | | | deficiencies outlines in this pla | | | |
| | constipation and would go longer than three days | | | | correction. The facilities' inten | | | |
| | without having a bo | owel movement. | | | always to provide quality care | | | |
| | | | | | its guests and residents. No h | | | |
| | | ident 31 was reviewed on | | | came to any residents/guests | | | |
| | | m. Diagnoses included, but were | | | related to this alleged deficien | t | | |
| | _ | blood pressure, anxiety | | | practice. | | | |
| | _ | order, post traumatic stress | | | | | | |
| | disorder, and COPI | Э. | | | Guest 31, F and 170 have | | | |
| | | | | | discharged from the facility. | | | |
| | | ly Minimum Data Set (MDS) | | | Identification of Other | | | |
| | | ed the resident was cognitively | | Residents with the Potential to | | | | |
| | intact for daily deci | ision making. | | | be Affected: | | | |
| | TI C DI | . 1 0/9/22 : 1: 4 1.1 | | | | | | |
| | | ised on 9/8/23, indicated the | | | 1.All current guests with ord | | | |
| | | for constipation related to the | | | application of prescription skir | | | |
| | _ | approaches were to administer | | | lotion or cream were observed | I (O | | |
| | | ered by the doctor and monitor | | | ensure the treatment is being | | | |
| | effectiveness and si | ide effects. | | | provided and that the medicat | | | |
| | Dlavaiaia!- O1 | dated 2/4/21 and a - 41 - | | | is available for the nurse to pr | ovide | | |
| | 1 - | dated 2/4/21 and on the | | | the ordered treatment. If it is | 4 | | |
| | _ | Order Summary dated 10/2024, | | | identified that the treatment is | 1 O IT | | |
| | | S Tablet 8.6-50 milligrams (mg), | | | being provided as ordered, | ما م | | |
| | give 2 tablet by mo | outh at bedtime for constipation. | | | education will be provided to t | | | |
| | Dlavaiaia!- O1 | dated 1/21/21 and 41- | | | Nurse assigned to the guest. | ıne | | |
| | _ | dated 1/31/21 and on the | | | treatment will be immediately | 4 | | |
| | 1 | Order Summary dated 10/2024, | | | provided. If the prescription is | | | |
| | | e Solution 10 grams/15 milliliters | | | available for the guest, it will b | | | |
| (ml), give 30 ml by mouth every 24 hours as | | | | ordered and applied as soon a | 15 | I | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|---|--|----------------------------------|--|--------------|--|
| | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| THE TENN | o. conduction | 155844 | B. WING | 11/01/2024 | | |
| | | | _ | | 1 1/0 1/2021 | |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | ADDRESS, CITY, STATE, ZIP COD | | |
| 10N"TE : | AEDIOAL DECOST | OUEOTEDTON | | ILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | CHEST | TERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | needed for constipa | tion. | | possible, and the Physician w | ill be | |
| | | | | notified. | | |
| | | dated 7/28/23 and on the | | 2 All current guest that have | not | |
| | | Order Summary dated 10/2024, | | have a documented bowel | | |
| | | Laxative Rectal Suppository | | movement in 3 days assessed | d l | |
| | - | ppository rectally every 12 | | per | | |
| | hours as needed for | constipation. | | bowel protocol and MD notifie | d. If | |
| | | | | medication is ordered for | | |
| | 1 | dated 4/2/24, indicated | | constipation. Medication | will | |
| | • | deine Tablet 300-30 mg, give | | be administered. If a guest re | | |
| one tablet by mouth every four hours as needed | | | the MD will be notified and the | • | | |
| | for severe pain. | | | nurse will document the | | |
| | | | | interventions. The facility will | | |
| | | dated 10/2/24, indicated | | continue to provide notification | | |
| | | et Delayed Release 5 mg, give | | the MD until the guest has bo | wel | |
| | | ery 24 hours as needed for as | | movement. | | |
| | needed for constipa | tion. | | Systemic Changes: | _ | |
| | TEL 1 1 | . 6 4 1 420 1 | | 1. A Qappi meeting with CN | O, | |
| | | ents for the last 30 days were as | | ACNO, Care Transitions, | 1 | |
| | follows: | | | Hospitality Medical Director a | na | |
| | No howel mayers | et en 0/20 10/2 10/2 10/5 10/6 | | General Manager. IDT was | | |
| | | nt on 9/30, 10/2, 10/3, 10/5, 10/6, 10/15, 10/16, 10/17, 10/18, 10/20, | | educated on F684 treatment, | | |
| | 10/7, 10/10, 10/11, 10/22, 10/24, 10/25 | | | bowel protocol and documentation. All staff were | also | |
| | 10/22, 10/24, 10/23 | , and 10/2//27. | | educated on bowel procedure | | |
| | Blank (nothing reco | orded) on 10/1, 10/8,10/9, 10/12, | | treatments, and documentation | | |
| | 10/19, 10/23, and 1 | | | they relate to Quality of Care. | ni as | |
| | 10/17, 10/25, und 1 | 0. 20. 211 | | and relate to Quality of Gare. | | |
| | 1 large bowel move | ement on 10/4/24. | | Monitoring: | | |
| | _ | ement on 10/13 and 10/14/24. | | CNO/ACNO/ Designee will | | |
| | | ovement on 10/21/24. | | complete visual observation | | |
| | | | | rounds on 6 residents daily ad | cross | |
| | A Kidney, Ureter, a | and Bladder (KUB) X-ray was | | either shift to ensure treatmer | | |
| | | 4. The X-ray indicated there | | are being provided and | | |
| | | of retained fecal debris and air | | medications are available. x 2 | | |
| | noted in the rectum | and in portions of the colon | | weeks, then 6 observations th | | |
| | with slight gastric d | | | times a week for 2 weeks, the | | |
| | | | | observations weekly x 4, then | | |
| The Medication Administration Record (MAR) for | | | residents monthly. Staff will be | | | |

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the month of 10/2024 indicated the Lactulose,

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re-educated to ensure they follow

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | IULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|--|---|--|--------|-------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | UILDING | 00 | COMPL | LETED |
| | | 155844 | B. W | ING | | 11/01 | /2024 |
| NAME OF P | PROVIDER OR SUPPLIE | R. | | | ADDRESS, CITY, STATE, ZIP COD | | |
| | MEDICAL RESORT | | | | ILLAGE POINT ERTON, IN 46304 | | |
| | MEDICAL RESURT | CHESTERTON | | | ENTON, IN 40304 | | 1 |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION ories and the tablets were not | + | TAG | the facility's medication | | DATE |
| | | resident had refused the daily | | | administration policy. The fac | ility | |
| | | ion of Senokot 10/19-10/28. | | | will run a bowel movement report 5 | | |
| | | | | | days a week to ensure that al | - | |
| | | fits evaluation, dated 9/17/24, | | | guests are having bowel | | |
| | | of concern was the refusal of | | | movements at least once eve | ry | |
| | | e physician was notified on | | | three days. x for 6 months. | | |
| | 9/17/24 of this problem. | | | | | | |
| | There was no furth | er documentation the | | | | | |
| | physician had been notified the resident had been | | | | | | |
| | refusing his medication in the month of 10/2024. | | | | | | |
| | There was no documentation nursing staff had | | | | | | |
| | | t any as needed bowel relief | | | | | |
| | medications for cor | nstipation. | | | | | |
| | During an interview | w on 10/30/24 at 9:48 a.m., the | | | | | |
| | _ | cer indicated the resident had | | | | | |
| | _ | tions and was a private person. | | | | | |
| | | information to provide. | | | | | |
| | The current 7/2024 | "Bowel Protocol" policy, | | | | | |
| | | ce President of Clinical | | | | | |
| | - | 0/24 at 11:49 a.m., indicated the | | | | | |
| | | ility were assessed by shift for | | | | | |
| | | staff reporting in the charting | | | | | |
| | | protocol, if the resident had not | | | | | |
| | | nent or only small documented or days outside of baseline, the | | | | | |
| | | ermine if additional testing | | | | | |
| | - | were warranted. Refusals of | | | | | |
| | medications (stool | softener/laxatives) should be | | | | | |
| | documented, and education of risk versus benefit | | | | | | |
| | _ | t is cognitive enough to | | | | | |
| | understand. | | | | | | |
| | | | | | | | |
| | 2. During random of | observations on 10/27/24 at | | | | | |
| | 10:24 a.m. and 1:10 | 0 p.m., on 10/28/24 at 9:25 a.m. | | | | | |
| and 2:28 p.m., and on 10/29/24 at 9:05 a.m., | | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|--|---|--|--------------------------|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | |
| | | 155844 | B. WING | | 11/01/2024 |
| NAME OF P | DOMDED OF CURPUSE | | STREET | ADDRESS, CITY, STATE, ZIP COD | • |
| NAME OF P | PROVIDER OR SUPPLIER | C | | VILLAGE POINT | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | CHES | TERTON, IN 46304 | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | |
| TAG | | R LSC IDENTIFYING INFORMATION erved sitting in her bed. At | TAG | DEFICIENCE | DATE |
| | | ident's bilateral lower legs were | | | |
| | dry with flaky and r | _ | | | |
| | | | | | |
| | During an interview | v on 10/27/24 at 10:24 a.m., the | | | |
| | | he had an open area on her | | | |
| | · · | aled, and when the nurse came | | | |
| | | he would sometimes put | | | |
| | lotion on her legs, of | otherwise no other staff put | | | |
| | fotion on her legs. | | | | |
| | During an interview on 10/29/24 at 9:05 a.m., the | | | | |
| resident indicated no nursing staff had applied | | | | | |
| | lotion to her legs. | | | | |
| | TI ICD. | 1 (5 : 1 | | | |
| | | dent F was reviewed on m The resident was admitted to | | | |
| | | 7/24. Diagnoses included but | | | |
| | - | heart failure, type 2 diabetes, | | | |
| | | disease, anemia, high blood | | | |
| | pressure, gout and r | migraines. | | | |
| | The 10/23/24 Admi | ssion Minimum Data Set | | | |
| | | indicated the resident was | | | |
| | ` ' | or daily decision making and | | | |
| | had no skin issues. | , , | | | |
| | | | | | |
| | | 10/18/24, indicated the resident | | | |
| | was at risk for impa | - - | | | |
| | treatments as ordered | re to provide skin/wound | | | |
| | ucaunonts as ordere | zu. | | | |
| | A Nurse's Note, dat | ted 10/18/24 at 2:27 p.m., | | | |
| | | nt's bilateral lower legs were | | | |
| | | osiderin stained (a condition | | | |
| | | red patches on the skin that | | | |
| | appear as bruises, o | r were brownish or | | | |
| | rust-colored) | | | | |
| | A Physician's Order | r, dated 10/18/24, indicated | | | |
| | | • | 1 | I | 1 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | · ′ | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|--|----------------------------|--|---|------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING 00 COMPLETED | | | | |
| | | 155844 | B. WI | NG | | 11/01/ | 2024 |
| | PROVIDER OR SUPPLIER | | • | 2775 VI | ADDRESS, CITY, STATE, ZIP COD LLAGE POINT ERTON, IN 46304 | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | IE | DATE |
| | Ammonium Lactate Cream 12%, apply to bilateral lower legs topically every day shift for prevention and protection. | | | | | | |
| | The Treatment Adn | ninistration Record (TAR) for | | | | | |
| | the month of 10/202 | 24 indicated the Ammonium | | | | | |
| | Cream was signed of 10/18-10/27/24. | out as being completed on | | | | | |
| | During an interview on 10/29/24 at 1:45 p.m., the Chief Nursing Officer indicated the cream was to | | | | | | |
| | be administered as ordered by the physician. | | | | | | |
| | The current 3/2020 "Wound Policy and Procedure" policy, provided by the Vice President of Clinical Operations on 10/29/24 at 3:10 p.m., indicated the wound management program identified staff participation and accountability to include: staff involved in prevention and treatment and the expectation of all care givers to observe resident skin integrity during the daily provision of the resident's personal care. | | | | | | |
| | 11:23 a.m. and 1:20 a.m., Resident 170 times he was not we | observations on 10/27/24 at 0 p.m., and on 10/28/24 at 9:40 was observed in bed. At those earing any socks and his legs dry with flaky and scaly skin. | | | | | |
| | observed with RN 3 | 45 a.m., the treatment cart was 3 and there was no Balsum Peru cated inside the cart. | | | | | |
| | | v at that time, Wound Nurse 2 for the treatment should be eatment cart. | | | | | |
| | | and Nurse 2 was asked to ssment to the resident's legs | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | A. BU | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
|--|--|---|--|---------|--|---------------------------------------|----------------------------|
| | PROVIDER OR SUPPLIE | | | 2775 VI | LDDRESS, CITY, STATE, ZIP COD LLAGE POINT ERTON, IN 46304 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | BY FULL | | IID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY) | | (X5) COMPLETION DATE |
| | and feet. The resid | ent's legs and feet were h flakes of skin noted. | | | | | |
| | During an interview at that time, Wound Nurse 2 could not indicate if the resident's treatment was being completed as ordered every night. | | | | | | |
| | 10/28/24 at 3:15 p. the facility on 10/1 were not limited to | ident 170 was reviewed on m. The resident was admitted to 6/24. Diagnoses included, but b, brain disorder, type 2 diabetes, ease, anemia, and stroke. | | | | | |
| | (MDS) assessment | nission Minimum Data Set indicated the resident was not for daily decision making and ions. | | | | | |
| | A Care Plan, dated 10/16/24, indicated the resident was at risk for alteration in skin integrity. The approaches were to administer treatments as ordered. A Nursing Evaluation, dated 10/16/24, indicated the resident had dry skin to both upper and lower extremities. | | | | | | |
| | | | | | | | |
| | Balsam Peru-Casto | er, dated 10/16/24, indicated or Oil External Ointment, apply sels, topically every evening | | | | | |
| | month of 10/2024 | ministration Record for the indicated the cream was signed leted 10/17-10/27/24. | | | | | |
| | indicated she could cream for the resid | w on 10/28/24 at 3:40 p.m., RN 3 d not find the physician ordered tent earlier, however, pharmacy elex cream, which was the brand | | | | | |

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| OF CORRECTION | IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED | | | |
|--|--|--|---|---|--|
| | 155844 | B. WING 11/01/2024 | | | |
| | | STRI | EET ADDRESS, CITY, STATE, ZIP COD | | |
| PROVIDER OR SUPPLIER | | | | | |
| MEDICAL RESORT | CHESTERTON | CHI | ESTERTON, IN 46304 | | |
| SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | | ID | | | |
| | | | CROSS-REFERENCED TO THE APPROP | | |
| | | | | | |
| Wound Nurse 2 indicream was not able one immediately and changing the treatm could be assured it with the current 3/2020 Procedure" policy, pof Clinical Operation indicated the wound identifies staff particinclude: staff involvitreatment and the exposerve resident ski | icated the tube of Balsum to be located, so he ordered d indicated he would be ent to the day shift so he would get done. "Wound Policy and provided by the Vice President ns on 10/29/24 at 3:10 p.m., I management program cipation and accountability to red in prevention and expectation of all care givers to in integrity during the daily | | | | |
| 3.1-37(a) | | | | | |
| | ontinence, Catheter, UTI | | | | |
| interview, the facilit (urinary) catheter or orders for catheter or resident reviewed for Finding includes: On 10/27/24 at 1:30 observed in her room was observed drainic catheter tubing. The noted in the resident On 10/28/24 at 9:30 | ry failed to ensure Foley ders were obtained timely and are were obtained for 1 of 1 or catheters. (Resident 131) 1 p.m., Resident 131 was in in bed. Cloudy, yellow urine ing from the resident's Foley ere was also a urine odor it's room. | F 0690 | F690 Catheter Care The General Manager (Administrator) notified the Medical Director on 11/19/2 the Annual Survey findings. time the facility is requesting desk review for the findings in the annual survey. Cheste Ignite Medical Resorts denie implication of guilt relating to deficiencies outlines in this p correction. The facilities' inte always to provide quality ca | 024 of At this y a alleged erton es o the blan of ent is re to | |
| | SUMMARY S (EACH DEFICIENCE REGULATORY OR name for the balsame for came for came for the balsame for the balsam | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION name for the balsam peru/castor oil cream. During an interview on 10/28/24 at 4:30 p.m., Wound Nurse 2 indicated the tube of Balsum cream was not able to be located, so he ordered one immediately and indicated he would be changing the treatment to the day shift so he could be assured it would get done. The current 3/2020 "Wound Policy and Procedure" policy, provided by the Vice President of Clinical Operations on 10/29/24 at 3:10 p.m., indicated the wound management program identifies staff participation and accountability to include: staff involved in prevention and treatment and the expectation of all care givers to observe resident skin integrity during the daily provision of the resident's personal care. 3.1-37(a) 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure Foley (urinary) catheter orders were obtained timely and orders for catheter care were obtained for 1 of 1 resident reviewed for catheters. (Resident 131) | MEDICAL RESORT CHESTERTON SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION name for the balsam peru/castor oil cream. During an interview on 10/28/24 at 4:30 p.m., Wound Nurse 2 indicated the tube of Balsum cream was not able to be located, so he ordered one immediately and indicated he would be changing the treatment to the day shift so he could be assured it would get done. The current 3/2020 "Wound Policy and Procedure" policy, provided by the Vice President of Clinical Operations on 10/29/24 at 3:10 p.m., indicated the wound management program identifies staff participation and accountability to include: staff involved in prevention and treatment and the expectation of all care givers to observe resident skin integrity during the daily provision of the resident's personal care. 3.1-37(a) 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure Foley (urinary) catheter orders were obtained timely and orders for catheter care were obtained for 1 of 1 resident reviewed for catheters. (Resident 131) Finding includes: On 10/27/24 at 1:30 p.m., Resident 131 was observed in her room in bed. Cloudy, yellow urine was observed draining from the resident's Foley catheter tubing. There was also a urine odor noted in the resident's room. On 10/28/24 at 9:30 a.m. and 4:30 p.m., the resident | ### AFDICAL RESORT CHESTERTON SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING BNFORMATION name for the balsam peru/castor oil cream. During an interview on 10/28/24 at 4:30 p.m., Wound Nurse 2 indicated the tube of Balsum cream was not able to be located, so he ordered one immediately and indicated he would be changing the treatment to the day shift so he could be assured it would get done. The current 3/2020 "Wound Policy and Procedure" policy, provided by the Vice President of Clinical Operations on 10/29/24 at 3:10 p.m., indicated the wound management program identifies staff participation and accountability to include: staff involved in prevention and treatment and the expectation of all care givers to observe resident skin integrity during the daily provision of the resident's personal care. 3.1-37(a) 483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI Based on observation, record review, and interview, the facility failed to ensure Foley (urinary) catheter orders were obtained firmely and orders for catheter care were obtained for 1 of 1 resident reviewed for catheters. (Resident 131) Finding includes: On 10/27/24 at 1:30 p.m., Resident 131 was observed in her room in bed. Cloudy, yellow urine was observed draining from the resident's Foley catheter tubing. There was also a urine odor noted in the resident's room. On 10/28/24 at 9:30 a.m. and 4:30 p.m., the resident On 10/28/24 at 9:30 a.m. and 4:30 p.m., the resident on 10/28/24 at 9:30 a.m. and 4:30 p.m., the resident | |

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| i f | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | | |
|-----------|---|--|------|---------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | | | COMPLETED |
| | | 155844 | B. W | ING | | 11/01/2024 |
| NAME OF F | | | • | STREET. | ADDRESS, CITY, STATE, ZIP COD | • |
| NAME OF F | PROVIDER OR SUPPLIEF | < | | 2775 V | ILLAGE POINT | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | CHEST | TERTON, IN 46304 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | DATE |
| | | g cloudy, yellow urine. The | | | came to any residents/guests | |
| | urine odor remained | d in the resident's room. | | | related to this alleged deficier practice. | nt |
| | On 10/29/24 at 9:22 | 2 a.m., the resident was | | | ' | |
| | observed in bed and | d her Foley catheter tubing | | | | |
| | was draining cloudy | y, yellow urine. The urine odor | | | Guest 131 Discharge from the | e |
| | remained in the resi | ident's room. | | | facility | |
| | | | | | Identification of Other | |
| | The record for Resi | dent 131 was reviewed on | | | Residents with the Potential | to |
| | 10/29/24 at 10:41 a | .m. Diagnoses included, but | | | be Affected: | |
| | were not limited to, | , dementia without behavior | | | | |
| | disturbance and frac | cture of the the lower end of | | | 1.All current guests were | |
| | the right femur. The resident was admitted to the | | | | observed to identify if they ha | ve a |
| | facility on 10/14/24 | l. | | | foley catheter placed. If identi | fied, |
| | | | | | the auditor ensured that an or | der |
| | The Admission Mir | nimum Data Set (MDS) | | | is placed to have the catheter | , to |
| | assessment, dated 1 | 0/20/24, indicated the resident | | | care for the catheter and a pe | rson |
| | was cognitively imp | paired for daily decision making | | | centered care plan related to | the |
| | and she had an indv | welling urinary catheter. | | | catheter. | |
| | | | | | 2.The nurse assigned to the | ; |
| | | 10/15/24, indicated the resident | | | guest was educated. | |
| | · · | ter. Interventions included, but | | | Systemic Changes: | |
| | | , monitor/record/report to | | | A Qappi meeting with CNO, | |
| | 1 | and symptoms of urinary tract | | | ACNO, Care Transitions, | |
| | | in, burning, blood tinged urine, | | | Hospitality Medical Director a | |
| | _ | ut, deepening of urine color, | | | General Manager. IDT wa | |
| | | reased temperature, urinary | | | educated on F690 and how it | |
| | | elling urine, fever, chills, altered | | | relates to Foley Catheter Care | e. |
| | l ' | ge in behavior, and change in | | | Olivia al staff v | |
| | eating patterns. | | | | Clinical staff were also educate | lea |
| | A Dhygigianla O1. | n dated 10/24/24 indicated the | | | on F690 and how it relates to | |
| | | r, dated 10/24/24, indicated the e a 16 french, 10 cubic | | | Foley Catheter Care. | |
| | | oon indwelling catheter. There | | | - Monitoring: | |
| | was no order for car | | | | Monitoring: 1 CNO/ACNO/ Designee | arill |
| | was no order for ca | motor care. | | | 1 CNO/ACNO/ Designee complete visual observation | VVIII |
| | The October 2024 N | Medication and Treatment | | | rounds on 6 residents daily ac | eross |
| | | cords indicated there was no | | | either shift to ensure orders a | |
| | | atheter care being completed. | | | care plans are in place for all | iiu |
| | documentation of C | ameter care being completed. | | | 1 | v 2 |
| | l | | ı | | residents with foley catheters | ۸ ۷ |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 11/01/2024 | | | |
|---|--|--|---------------------|---|----------------------------------|
| | ROVIDER OR SUPPLIER | | 2775 V | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT FERTON, IN 46304 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OF During an interview Vice President of C resident should hav | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION V, on 10/29/24 at 1:54 p.m., the linical Operations indicated the e had an order for the catheter d orders for catheter care. | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) weeks, then 6 observations threating a week for 2 weeks, then observations weekly x 4, then observations weekly x 4, then observations would be residents monthly Thereafter, it determined by Quality Assuran Committee that further monitor is needed, audits will continue. Corrective actions will be completed immediately, and stawill be re-educated to ensure the follow the facility's policy on folicatheters. | ee 1 6 6 6 f ace ing aff hey |
| F 0692 SS=D Bldg. 00 | Based on record reversal failed to complete was underweight resident for nutrition. (Resident for nutrition.) (Resident fo | riew and interview, the facility weekly weights for an ant for 1 of 1 resident reviewed lent J) dent J was reviewed on an an ant failure, dementia, blood pressure), muscle assistance with personal care, animum Data Set (MDS) 0/13/24, indicated the resident red for daily decision making. In impairment of the upper and and used a wheelchair. Nutrition Assessment, dated a.m., indicated the resident was | F 0692 | Compliance 12/06/2024 F692 Nutrition/Hydration The General Manager (Administrator) notified the Medical Director on 11/19/2024 the Annual Survey findings. At time, the facility is requesting a desk review for the findings alle in the annual survey. Chesterto Ignite Medical Resorts denies implication of guilt relating to th deficiencies outlines in this plan correction. The facilities' intent always to provide quality care t its guests and residents. No ha came to any residents/guests related to this alleged deficient practice. Guest J Discharge from the facilidentification of Other | this a eged on ae n of is to arm |

FORM CMS-2567(02-99) Previous Versions Obsolete

underweight, not well nourished and at risk for

Event ID:

JB0C11

Facility ID: 013688

If continuation sheet

Residents with the Potential to

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | |
|--|----------------------|---|---------------------------------|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETED | | |
| | | 155844 | B. WING | | 11/01/2024 |
| | | <u> </u> | STREE | T ADDRESS, CITY, STATE, ZIP COD | |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | VILLAGE POINT | |
| IGNITE MEDICAL RESORT CHESTERTON | | | STERTON, IN 46304 | | |
| | 1 | | | 1 | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | ` | ICY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | |
| TAG | | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | | tion monitoring and evaluation | | be Affected: | |
| | • | veight, appetite, skin, labs, and | | | |
| | fluid status. | | | 1.All current guests' orders | |
| | | 1 . 110/12/24 : 1: . 16 | | reviewed to identify orders for | |
| | - | , dated 10/13/24, indicated for | | weekly weights. Guest Identif | |
| | weekly weights to t | be completed every Sunday. | | to have weekly weights audite | |
| | 771 | 11 | | ensure that weekly weights a | e |
| | | kly weights recorded after the | | completed. If a guest chart | |
| | 10/7/2024 admissio | on weight. | | indicates a weight has not be | |
| | Duning on the tree. | rr on 11/1/24 of 11:00 41- | | documented, the guest will be | |
| | _ | v on 11/1/24 at 11:00 a.m., the | | weighed and MD notified of c | urrent |
| | should have been w | ons indicated the resident | | weight. | |
| | snould have been w | reigned weekly. | | 2.The nurse assigned to the | ; |
| | 2.1.46(a) | | | guest will be educated. | |
| | 3.1-46(a) | | | Systemic Changes: | 10 |
| | | | | 1. A Qappi meeting with CN | 10, |
| | | | | ACNO, Care Transitions, | and |
| | | | | Hospitality Medical Director, a | |
| | | | | General Manager. IDT has be educated on F692 and how it | |
| | | | | relates to Nutrition Hydration. | |
| | | | | clinical staff were educated or | |
| | | | | Nutrition Hydration policy and | |
| | | | | it relates to weekly weights. | TIOW |
| | | | | it relates to weekly weights. | |
| | | | | Monitoring: | |
| | | | | 4 CNO/ACNO/ Designee v | vill |
| | | | | complete chart audits on 6 | **** |
| | | | | residents daily across either s | shift |
| | | | | to ensure weekly weight orde | |
| | | | | are followed x 2 weeks, then | |
| | | | | observations three times a we | |
| | | | | for 2 weeks, then 6 observation | ons |
| | | | | weekly x 4, then 6 residents | |
| | | | | monthly. Thereafter, if determ | ined |
| | | | | by Quality Assurance Commi | |
| | | | | that further monitoring is need | |
| | | | | audits will continue. Guests w | |
| | | | | weighed immediately, and sta | ıff will |
| | | | | be re-educated to ensure the | |

| | NT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | ľ | ILDING | ONSTRUCTION 00 | COMPI | 3) DATE SURVEY COMPLETED 11/01/2024 | |
|--------------------------|---|---|----------|---------------------|---|---|-------------------------------------|--|
| | PROVIDER OR SUPPLIER | | <u> </u> | 2775 V | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT FERTON, IN 46304 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | ATE | (X5) COMPLETION DATE | |
| F 0694 SS=D | 483.25(h) Parenteral/IV Fluid | | | | follow the facility's policy on nutrition hydration. | | | |
| Bldg. 00 | Based on observation interview, the facility intravenous (IV) can monitored and assert resident reviewed for Finding includes: During random obsta.m. and 1:14 p.m., a peripheral IV in h 10/23/24. On 10/28/24 at 9:30 observed with a bart the peripheral IV us visible at that time. The record for Resi 10/28/24 at 3:55 p.r. the facility on 10/3/were not limited to, recurrent and severe | on, record review, and ty failed to ensure a peripheral theter was maintained, ssed for patency for 1 of 1 or hydration. (Resident 41) ervations on 10/27/24 at 9:07 Resident 41 was observed with er right hand with a date of a.m., the resident was daid on her right hand where ed to be. The IV was not dent 41 was reviewed on m., The resident was admitted to 24. Diagnoses included, but major depressive disorder with e psychotic symptoms, heart oreast cancer, anemia, anxiety, | F 06 | 594 | Compliance 12/06/2024 F694 IV Fluids/ Parenteral The General Manager (Administrator) notified the Medical Director on 11/19/202 the Annual Survey findings. A time the facility is requesting a desk review for the findings al in the annual survey. Chester Ignite Medical Resorts denies implication of guilt relating to t deficiencies outlines in this pla correction. The facilities' inten always to provide quality care its guests and residents. No h came to any residents/guests related to this alleged deficien practice. Guest 41 Discharge from the facility Identification of Other Residents with the Potential | t this a lleged ton the an of t is to arm | 12/06/2024 | |
| | assessment indicate impaired for daily d frequently incontine received an antipsyd | sion Minimum Data Set (MDS) d the resident was moderately lecision making and was ent of urine. The resident chotic, antidepressant, etic while at the facility. | | | 1.All current guests were observed to identify if they har placed. If identified, the audito ensured that an order is place have the IV. to care for the IV | or ed to | | |

| NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CHESTERTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG A Nurse's Note, dated 10/23/24 at 5:00 p.m., indicated the physician was in the facility and gave new orders for 0.9% normal saline 500 milliliters at 70 cubic centimeters (cc) per hours until completed. A peripheral IV was placed and the diagnosis was for dehydration. There were no physician's orders to maintain the peripheral IV for saline flushes after use. There was no documentation of the IV site on a daily basis after the infusion. There was no documentation when the IV was discontinued or an assessment of the site after it was discontinued. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated three was no assessment of the peripheral IV on a daily basis, nor were there orders for a saline flush to keep it STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 (X5) (X5) PREFIX TAG Facility policy including orders to monitor and assess. person-centered care plan in medical record related to the IV. 2. Nurse assigned to the guest will be educated. Systemic Changes: 1. A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F694 and how it relates to Peripheral IV management policy. 2. Staff was educated on F694 and how it relates to Peripheral IV management policy. Monitoring: CNO/ACNO/ Designee will | |
|--|----|
| IGNITE MEDICAL RESORT CHESTERTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A Nurse's Note, dated 10/23/24 at 5:00 p.m., indicated the physician was in the facility and gave new orders for 0.9% normal saline 500 milliliters at 70 cubic centimeters (cc) per hours until completed. A peripheral IV was placed and the diagnosis was for dehydration. There were no physician's orders to maintain the peripheral IV for saline flushes after use. There was no documentation of the IV site on a daily basis after the infusion. There was no documentation when the IV was discontinued or an assessment of the site after it was discontinued. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated there was no assessment of the peripheral IV on a daily basis, | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A Nurse's Note, dated 10/23/24 at 5:00 p.m., indicated the physician was in the facility and gave new orders for 0.9% normal saline 500 milliliters at 70 cubic centimeters (cc) per hours until completed. A peripheral IV was placed and the diagnosis was for dehydration. There were no physician's orders to maintain the peripheral IV for saline flushes after use. There was no documentation of the IV site on a daily basis after the infusion. There was no documentation when the IV was discontinued. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated there was no assessment of the peripheral IV on a daily basis, TAG PREFIX TAG PREFIX TAG FACTIONSMICTION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE DATE DATE COMPLETIC TOTAL APPROPRIATE TAG FACTION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE DATE COMPLETIC TOTAL APPROPRIATE COMPLETIC TOTAL SOLUTION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE DEFICENCY TAG FACTION SIGUATION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE CROSS-REFERREDED TO HE APPROPRIATE COMPLETIC TOTAL SOLUTION SIGUATION S | |
| PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION A Nurse's Note, dated 10/23/24 at 5:00 p.m., indicated the physician was in the facility and gave new orders for 0.9% normal saline 500 milliliters at 70 cubic centimeters (cc) per hours until completed. A peripheral IV was placed and the diagnosis was for dehydration. There were no physician's orders to maintain the peripheral IV for saline flushes after use. There was no documentation of the IV site on a daily basis after the infusion. There was no documentation when the IV was discontinued. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated there was no assessment of the peripheral IV on a daily basis, TAG PREFIX TAG PREFIX TAG FACTIONSMICTION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE DATE DATE COMPLETIC TOTAL APPROPRIATE TAG FACTION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE DATE COMPLETIC TOTAL APPROPRIATE COMPLETIC TOTAL SOLUTION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE DEFICENCY TAG FACTION SIGUATION SIGUALD BE CROSS-REFERREDED TO HE APPROPRIATE CROSS-REFERREDED TO HE APPROPRIATE COMPLETIC TOTAL SOLUTION SIGUATION S | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION A Nurse's Note, dated 10/23/24 at 5:00 p.m., indicated the physician was in the facility and gave new orders for 0.9% normal saline 500 milliliters at 70 cubic centimeters (cc) per hours until completed. A peripheral IV was placed and the diagnosis was for dehydration. There were no physician's orders to maintain the peripheral IV for saline flushes after use. There was no documentation of the IV site on a daily basis after the infusion. There was no documentation when the IV was discontinued or an assessment of the site after it was discontinued. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated there was no assessment of the peripheral IV on a daily basis, | ON |
| A Nurse's Note, dated 10/23/24 at 5:00 p.m., indicated the physician was in the facility and gave new orders for 0.9% normal saline 500 milliliters at 70 cubic centimeters (cc) per hours until completed. A peripheral IV was placed and the diagnosis was for dehydration. There were no physician's orders to maintain the peripheral IV for saline flushes after use. There was no documentation of the IV site on a daily basis after the infusion. There was no documentation when the IV was discontinued or an assessment of the site after it was assessment of the peripheral IV on a daily basis, There was no documentation of the IV site on a dassessment of the peripheral IV on a daily basis, There was no documentation was discontinued or an assessment of the peripheral IV on a daily basis, There was no documentation was no documentation when the IV was discontinued or an assessment of the peripheral IV on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV was discontinued or an assessment of the peripheral IV on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV site on a daily basis, There was no documentation of the IV. There was no documentation of the IV site on a delicated to the IV. There was no documentation of the IV. There was no documentation of the IV site on a delicated to the IV. There was no documentation of the IV. There was no documentation of the IV site on a delicated to the IV. There was no documentation of the IV. There was no documentation of the I | |
| patent after the infusion. There was no documentation of an assessment after the IV was removed. The current 7/2024 "Peripheral IV Management" policy, provided by the Vice President of Clinical Operations on 10/30/24 at 11:49 a.m., indicated monitoring of the IV site for signs and symptoms of infection, and phlebitis will be completed by the licensed nurse. 3.1-47(a)(2) complete visual observation rounds on 6 residents daily across either shift to ensure orders and care plans are in place for all residents IV x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. Corrective actions will be completed immediately, and staff will be re-educated to ensure they follow the facility's policy on | ON |
| Peripheral IV Management. | |

| | | | <u> </u> | DATE SURVEY | | | |
|----------------------------------|------------------------|--|----------|---|---|-------------------------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | 1 | JILDING | 00 | COMPLETED 11/01/2024 | |
| | | 155844 | B. W | ING | | 11/01/ | /2024 |
| NAME OF PROVIDER OR SUPPLIER | | | | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT | | | |
| IGNITE MEDICAL RESORT CHESTERTON | | | CHEST | TERTON, IN 46304 | | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENC!) | | DATE |
| F 0695 SS=E | 483.25(i) | ocatamy Caro and | | | | | |
| 33-⊑ Bldg. 00 | Suctioning | eostomy Care and | | | | | |
| Diag. 00 | | on, record review, and | F 00 | 505 | Compliance 12/06/2024 | | 12/06/2024 |
| | | ty failed to ensure oxygen | 1 00 | 373 | F695 Respiratory/Tracheosto | omv | 12/00/2024 |
| | | te, oxygen concentrators were | | | The General Manager | • | |
| | set at the correct flo | w rate, and oxygen was | | | (Administrator) notified the | | |
| | signed out as being | in use for 4 of 4 residents | | | Medical Director on 11/19/202 | 24 of | |
| | reviewed for oxygen | n therapy. (Residents 130, C, F | | | the Annual Survey findings. A | t this | |
| | and 127) | | | | time the facility is requesting a | a | |
| | | | | | desk review for the findings al | • | |
| | Findings include: | | | | in the annual survey. Chester | | |
| | 1 0 10/27/24 41 | 20 P. 11 (120 | | | Ignite Medical Resorts denies | | |
| | | :20 p.m., Resident 130 was n in bed. The resident was | | | implication of guilt relating to t | | |
| | | the way of a nasal cannula at 3 | | | deficiencies outlines in this pla correction. The facilities' inten | | |
| | liters. | the way of a hasar camidia at 5 | | | always to provide quality care | | |
| | nters. | | | | its guests and residents. No h | | |
| | On 10/28/24 at 9:37 | a.m., 12:06 p.m., and 4:32 p.m., | | | came to any residents/guests | aiiii | |
| | | gen in place via a nasal | | | related to this alleged deficien | ıt | |
| | cannula at 3 liters. | | | | practice. | | |
| | The record for Resid | dent 130 was reviewed on | | | | | |
| | 10/29/24 at 9:43 a.n | n. Diagnoses included, but | | | Guest 130, F,127 discharged | from | |
| | | congestive heart failure (CHF), | | | the facility. | | |
| | type 2 diabetes, and | sleep apnea. | | | Guest C oxygen liter flow was | | |
| | | | | | discussed with respiratory | | |
| | | nimum Data Set (MDS) | | | therapist from PEL VIP. Liter f | | |
| | | 0/30/24, indicated the resident | | | order was reviewed, and gues | | |
| | was cognitively inta | ect. | | | were educated on the liter flow | V | |
| | A Com- Di 1 4 1 | 10/25/24 : | | | provided by the Respiratory | | |
| | | 10/25/24, indicated the resident | | | Therapist and the MD. Persor | 1 | |
| | | rapy. Interventions included, I to, administer oxygen per | | | centered care plan updated. | | |
| | physician's orders. | to, administer oxygen per | | | Identification of Other Residents with the Potential | to | |
| | physician's oracis. | | | | be Affected: | 10 | |
| | A Physician's Order | , dated 10/24/24, indicated | | | | | |
| | 1 | plemental oxygen as ordered. | | | 1.All current guests with | | |
| | | rate for the oxygen listed. | | | Oxygen were observed to ens | sure | |
| | | | | | that orders were placed in the | | |

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Facility ID: 013688

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12/04/2024 PRINTED: FORM APPROVED

OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/01/2024 155844 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2775 VILLAGE POINT IGNITE MEDICAL RESORT CHESTERTON CHESTERTON, IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The October 2024 Medication and Treatment medical record and Administration Records indicated the oxygen was person-centered care plan not signed out as being applied. indicated oxygen use. 2.Oxygen was observed to A Physician's Order, dated 10/28/24 at 3:00 p.m., ensure that the liter flow matched indicated the resident was to receive continuous the order in the medical record. If oxygen at 3 liters per nasal cannula. the flow does not match the order. the nurse will be educated, and During an interview, on 10/29/24 at 1:54 p.m., the the liter flow will be changed to Vice President of Clinical Operations indicated the match the order in the medical as needed (PRN) oxygen order should have record. specified the flow rate. 2. During random Systemic Changes: observations on 10/27/24 at 10:39 a.m. and 1:15 1. A Qappi meeting with CNO, p.m., and on 10/28/24 at 3:00 p.m., Resident C was ACNO, Care Transitions, observed sitting in her chair in the room. At those Hospitality Medical Director and times, the resident was wearing oxygen at 3.5 liters General Manager. IDT was per minute. educated on F695 and how it relates to Respiratory During a random observation on 10/29/24 at 10:25 management policy. a.m., the resident was observed wearing oxygen at All Staff and staff will be 4 liters per minute. re-educated to ensure they follow the facility's policy on During an observation on 10/29/24 at 10:40 a.m., respiratory Management. LPN 1 was in the resident's room and observed the oxygen at 4 liters per minute. Monitoring: The record for Resident C was reviewed on CNO/ACNO/ Designee will 10/28/24 at 3:05 p.m. The resident was admitted to complete visual observation the facility on 9/28/24. Diagnoses included, but rounds on 6 residents daily across were not limited to, orthopedic after care, difficulty either shift to ensure orders and walking, type 2 diabetes, acute respiratory failure, care plans are in place for all chronic obstructive pulmonary disease (COPD), guest with oxygen and liter flow end stage renal disease, high blood pressure, matches the order x 2 weeks. heart disease, anxiety, and atrial fibrillation. then 6 observations three times a week for 2 weeks, then 6 The Modification of the Admission Minimum observations weekly x 4, then 6 Data Set (MDS) assessment, dated 10/2/24, residents monthly. Education and

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resident.

indicated the resident was cognitively intact for

daily decision making and used oxygen while a

Event ID:

JB0C11

Facility ID: 013688

deficiencies.

correction will be completed

immediately with any identified

If continuation sheet

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | JLTIPLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|---|---|----------|------------------------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | BUILDING <u>00</u> COMPLETED | | ETED | |
| | | 155844 | B. WI | NG | | 11/01/ | 2024 |
| | | | <u> </u> | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIER | | | | LLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | | ERTON, IN 46304 | | |
| (X4) ID | SUMMARY S | STATEMENT OF DEFICIENCIE | | ID | PROVIDENCE NAME CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' | re | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | A Care Plan, dated had COPD. | 10/1/24, indicated the resident | | | | | |
| | | 10/1/24, indicated the resident | | | | | |
| | | erapy. The approaches were physician's orders. | | | | | |
| | 1 | dated 9/28/24, indicated | | | | | |
| | oxygen at 2 liters pe | er minute continuously. | | | | | |
| | 1 indicated the resid | on 10/29/24 at 10:40 a.m., LPN dent's oxygen level was to be | | | | | |
| | at 2 liters per nasal of the resident's oxyge | cannula. She had not checked n at all today. | | | | | |
| | 10:22 a.m., and 1:10 | bservations on 10/27/24 at 0 p.m., Resident F was observed nasal cannula at 2.5 liters per | | | | | |
| | a.m. and 2:28 p.m., | ervations on 10/28/24 at 9:26 and on 10/29/24 at 9:05 a.m., the ed wearing oxygen at 5 liters | | | | | |
| | 10/29/24 at 9:30 a.n the facility on 10/17 were not limited to, | dent F was reviewed on n The resident was admitted to 1/24. Diagnoses included but heart failure, type 2 diabetes, disease, anemia, high blood nigraines. | | | | | |
| | (MDS) assessment i | ssion Minimum Data Set indicated the resident was or daily decision making and a resident. | | | | | |
| | A Care Plan, dated | 10/18/24, indicated the resident | | | | | |

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JB0C11

Facility ID: 013688

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| | IT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 11/01/2024 |
|--------------------------|--|--|--|---|---------------------------------------|
| NAME OF F | PROVIDER OR SUPPLIER | | | ADDRESS, CITY, STATE, ZIP COD | • |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | ERTON, IN 46304 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY) | O BE COMPLETION |
| | required oxygen the | erapy. The approaches were to per physician's orders. | | | |
| | - | r, dated 10/17/24, indicated er minute every shift for | | | |
| | indicated the reside be set at 3 liters per the resident's oxyge 3:32 p.m., and 4:18 observed lying in be was wearing oxygen On 10/29/24 at 9:51 | on 10/29/24 10:34 a.m., LPN 1 nt's oxygen was supposed to minute. She had not checked in at all today.4. On 10/28/24 at p.m., Resident 127 was ed in a hospital gown and she in via nasal cannula at 2 liters. a.m. and 10:30 a.m., the ed asleep in bed, wearing innula at 2 liters. | | | |
| | 10/28/24 at 4:38 p.r were not limited to, pressure), bipolar, a The Admission Mir assessment, dated 1 was moderately imp | dent 127 was reviewed on m. The diagnoses included, but hypertension (high blood and kidney failure. himum Data Set (MDS) 0/25/24, indicated the resident baired for daily decision | | | |
| | administer supplem The Medication Ad indicated the oxyge and 10/29/24. During an interview | r, dated 10/14/24, indicated to ental oxygen as needed ministration Record (MAR), n was not signed out on 10/28 on 10/29/24 at 10:35 a.m., RN 1 nt had been wearing oxygen ine. | | | |

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| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | (X2) MULTIPI A. BUILDIN B. WING | LE CONSTRUCTION IG <u>00</u> | (X3) DATE SURVEY COMPLETED 11/01/2024 |
|--|--|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CHESTERTON | | 277 | EET ADDRESS, CITY, STATE, ZIP COD 75 VILLAGE POINT ESTERTON, IN 46304 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFI TAC | CROSS-REFERENCED TO THE APPRI | D BE COMPLETION |
| F 0698 SS=D Bldg. 00 | General Manager in oxygen concerns an respiratory therapist process to monitor orders. The current 11/2018 provided by the Vice Operations on 10/29 resident on oxygen the resident's chart. 3.1-47(a)(6) 483.25(l) Dialysis Based on record reversided to ensure ong dialysis center was a session for 1 of 1 resident 43) Finding includes: The record for Resident 43:37 p.r. were not limited to, muscle weakness, defined disease, anem (difficulty sleeping) hypertension (high the assessment, dated 1 was cognitively intagent of the assessment, dated 1 was cognitively intagent of the assessment of the admission of the assessment of the asses | blood pressure). nimum Data Set (MDS) 0/11/24, indicated the resident act for daily decision making. impairment of the upper and | F 0698 | Compliance 12/06/2024 F698 Dialysis The General Manager (Administrator) notified the Medical Director on 11/19 the Annual Survey finding time, the facility is request desk review for the finding in the annual survey. Che- Ignite Medical Resorts del implication of guilt relating deficiencies outlines in this correction. The facilities' in always to provide quality of its guests and residents. No came to any residents/gue related to this alleged defin practice. Guest 43 discharged from facility. | /2024 of s. At this ing a s alleged sterton nies to the s plan of ntent is care to lo harm ests cient |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY

| | OF CORRECTION | IDENTIFICATION NUMBER 155844 | l í | UILDING | 00 | COMPI 11/01 | LETED |
|-----------|-------------------------|--|-----|---------|---|----------------|------------|
| NAME OF I | PROVIDER OR SUPPLIEI | ₹ | | | ADDRESS, CITY, STATE, ZIP COD | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | | ILLAGE POINT TERTON, IN 46304 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCE | | DATE |
| | · · | 10/8/24, indicated the resident | | | Litary differentians and Oddans | | |
| | | lated to end stage renal ons were to check the | | | Identification of Other Residents with the Retential | t o | |
| | | y and upon dialysis return, and | | | Residents with the Potential | 10 | |
| | monitor vital signs | | | | be Affected: | | |
| | monitor vital signs | and iaos. | | | 1.All current guests with out | cido | |
| | A Physician's Orde | r, dated 10/9/24, indicated to | | | dialysis were reviewed to ensi | | |
| | 1 | weights and pre-vital signs | | | that orders placed in the medi | | |
| | | ry Monday, Wednesday, and | | | record were followed and a | oai | |
| | Friday. | y Wonday, Wednesday, and | | | person-centered care plan | | |
| | | | | | indicated dialysis. | | |
| | A Physician's Orde | r, dated 10/7/24, indicated to | | | 2.All Dialysis communication | n | |
| | 1 | o dialysis on Monday, | | | sheets are filled out per facility | | |
| | Wednesday, and Fr | | | | protocol and physicians' order | | |
| | , | , | | | Systemic Changes: | ·. | |
| | A Nurse's Note, dat | ted 10/16/2024 at 11:00 a.m., | | | 1.A Qappi meeting with CN0 | Э. | |
| | | ent was out at dialysis. | | | ACNO, Care Transitions, | - , | |
| | | • | | | Hospitality Medical Director a | nd | |
| | The Dialysis Comm | nunication binder included | | | General Manager. IDT was | | |
| | communication for | ms that had information for the | | | educated on F698 and how it | | |
| | facility to fill out pr | rior to the resident going to the | | | relates to the facilities Dialysis | 3 | |
| | dialysis center and | upon return. The information | | | policy. | | |
| | included last meal, | medications given, vital signs, | | | 4 All Staff and staff will be | | |
| | and other pertinent | information. | | | re-educated to ensure they fo | llow | |
| | | | | | the facility's policy on Dialys | sis. | |
| | | ysis Communication sheets for | | | - | | |
| | 10/11, 10/14, 10/16 | 5, 10/18, 10/23, and 10/28/2024. | | | - | | |
| | | 10/00/04 | | | Monitoring: | | |
| | _ | v on 10/29/24 at 1:55 p.m., the | | | 5 CNO/ACNO/ Designee v | vill | |
| | _ | ndicated she understood the | | | complete visual observation | | |
| | | nd had no further information | | | rounds on 6 residents daily ac | | |
| | to provide. | | | | either shift to ensure orders, o | are | |
| | Danie : | rr on 10/21/24 -+ 2:17 I DNI | | | plans and completion of | | |
| | _ | v on 10/31/24 at 3:17 p.m., LPN | | | communication binders are in | | |
| | | ysis binder should get filled | | | place for all guest with Dialysi | s X | |
| | _ | dent leaving for dialysis and | | | 2 weeks, then 6 observations | | |
| | upon return from d | iaiysis. | | | three times a week for 2 week | | |
| | 2 1 27(0) | | | | then 6 observations weekly x | 4 , | |
| | 3.1-37(a) | | | | then 6 residents monthly. | | |
| | | | | | Thereafter, if determined by | | |

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| | T OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | î í | ILDING | ONSTRUCTION 00 | (X3) DATE COMPI 11/01 | LETED |
|----------------------------|--|---|----------|--------------|---|---|--------------------|
| | ROVIDER OR SUPPLIER | | <u> </u> | 2775 V | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT FERTON, IN 46304 | 1 | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL | | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY | TE | (X5) COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | Quality Assurance Committee further monitoring is needed, audits will continue. Education will be comple immediately with any identified deficiencies. | eted | DATE |
| F 0757 SS=D Bldg. 00 | Drugs Based on record rev failed to ensure each regimen was manag not monitoring the r ordered for 2 of 5 re unnecessary medica Findings include: 1. Record review for on 10/29/24 at 3:56 were not limited to, operation (surgical) chronic respiratory The Admission Mir assessment, dated 1 was cognitively inta maximum assistance and transfers. The October 2024 F indicated an order for time daily for hyper | nimum Data Set (MDS) 0/1/24, indicated the resident act and required moderate to e with activities of daily living Physician's Order Summary or Diltiazem HCl 60 mg one | F 07 | 757 | Compliance 12/06/2024 F757 Unnecessary Drugs The General Manager (Administrator) notified the Medical Director on 11/19/202 the Annual Survey findings. A time the facility is requesting a desk review for the findings al in the annual survey. Chestert Ignite Medical Resorts denies implication of guilt relating to t deficiencies outlines in this pla correction. The facilities' inten always to provide quality care its guests and residents. No h came to any residents/guests related to this alleged deficien practice. Guest H, D have discharged fi the facility. Identification of Other Residents with the Potential be Affected: | t this a leged ton he an of t is to arm t | 12/06/2024 |
| | | 9/25/24, indicated the ssure, pulse, temperature, and | | | be Affected: | | |

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| AND PLAN OF CORRECTION DENTIFICATION NUMBER 155844 NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CHESTERTON (X4) ID SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG PREFIX (wice a day). The record lacked any documentation of blood pressure monitoring for 10/5/24, 10/10/24, 10/13/24, and 10/19/24. No morning blood pressure was documented on 10/1/24, 10/2/24, 10/10/24, 10/13/24, and 10/25/24. No evening blood pressure was documented on 10/1/24, 10/2/24, 10/10/24, 10/10/24, 10/13/24, and 10/25/24. No evening blood pressure was documented on 10/1/24, 10/2/24, 10/10/24, 10/10/24, 10/10/24, 10/10/24, 10/10/24, 10/10/24, and 10/25/24 No evening blood pressure was documented on 10/1/24, 10/10/20/24, 10/10/20/20/20/20/20/20/20/20/20/20/20/20/20 | STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY |
|---|-----------|---------------------|-----------------------------------|--------|------------|---------------------------------------|------------------|
| NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CHESTERTON ICA SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TO Administering medication were reviewed to ensure that vitals are documented on 10/1/24, 10/2/24, 10/1/24, 10/11/24, and 10/25/24. No evening blood pressure was documented on 10/1/24, 10/2/24. No evening blood pressure was documented on 10/30/24 at 3:30 p.m., the Vice President of Clinical Operations indicated the blood pressures should have been documented twice per day and offered no further documentation. NAME OF PROVIDER OR ALTE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 ID PROVIDERS PLAN OF CORRECTION (X5) COMPLETION SHOULD BE CROSS-REFERENCED TO ITE APPROPRIATE DEPARTMENT TAG DESCRIPTIVE ACTION SHOULD BE CROSS-REFERENCED TO ITE APPROPRIATE TO SHOULD | AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | UILDING | 00 | COMPLETED |
| CAN ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION To expiratory rate were to be checked every shift (twice a day). The record lacked any documentation of blood pressure monitoring for 10/5/24, 10/7/24, 10/15/24, and 10/13/24, and 10/25/24. No evening blood pressure was documented on 10/1/24, 10/124, 10/11/24, and 10/22/24. During an interview on 10/30/24 at 3:30 p.m., the Vice President of Clinical Operations indicated the blood pressures should have been documented twice per day and offered no further documentation. 2. The record for Resident D was reviewed on 10/29/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty) 10/13/24 for filling and the pressure was documented to not pressure was documented to not pressure was documented to not pressure was documented on 10/30/24 at 3:30 p.m., the Vice President of Clinical Operations indicated the blood pressures should have been documented twice per day and offered no further documentation. 2. The record for Resident D was reviewed on 10/29/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty) 2775 VILLAGE POINT (CHESTERTON, IN 46304 CHESTERTON, IN 46304 CASCHICAGE POINT (CHESTERTON, I | | | 155844 | B. W | ING | | 11/01/2024 |
| 2775 VILLAGE POINT CHESTERTON CHESTERTON CHESTERTON CHESTERTON, IN 46304 | | | | - | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> |
| CHESTERTON, IN 46304 CHESTERTON CHESTERTON CHESTERTON, IN 46304 | NAME OF F | PROVIDER OR SUPPLIE | R | | 1 | | |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION respiratory rate were to be checked every shift (twice a day). The record lacked any documentation of blood pressure monitoring for 10/5/24, 10/15/24, and 10/19/24. No morning blood pressure was documented on 10/1/24, 10/2/24, 10/8/24, 10/10/24, 10/13/24, and 10/25/24. No evening blood pressure was documented on 10/4/24, 10/11/24, and 10/22/24. During an interview on 10/30/24 at 3:30 p.m., the Vice President of Clinical Operations indicated the blood pressures should have been documented twice per day and offered no further documentation. During an interview on 10/30/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty) PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY TAG 1. All current guests with orders to complete vitals prior to administering medication were reviewed to ensure that vitals are documented, administering a sordered. 2. Any errors observed will be corrected immediately and assigned QMA, Nurse will be educated. Systemic Changes: 1. On 11/21/2024 A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F757 and how it relates to the facilities Medication Administration Policies. 2. All clinical staff will be | IGNITE N | MEDICAL RESORT | CHESTERTON | | | | |
| TAG REGULATORY OR LSC IDENTIFYING INFORMATION respiratory rate were to be checked every shift (twice a day). 1. All current guests with orders to complete vitals prior to administering medication were reviewed to ensure that vitals are documented, and notication is being administered as ordered. documented on 10/1/24, 10/2/24, 10/8/24, 10/10/24, 10/13/24, and 10/25/24. No evening blood pressure was documented on 10/4/24, 10/11/24, and 10/22/24. During an interview on 10/30/24 at 3:30 p.m., the Vice President of Clinical Operations indicated the blood pressures should have been documented twice per day and offered no further documentation. During an interview on 10/30/24 at 10/20 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty) 1. All current guests with orders to complete vitals prior to administering medication were reviewed to ensure that vitals are documented at to complete vitals prior to administering medication were reviewed to ensure that vitals are documented, and medication is being administered as ordered. 2. Any errors observed will be corrected immediately and assigned QMA, Nurse will be educated. Systemic Changes: 1. On 11/21/2024 A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F757 and how it relates to the facilities Medication Administration Policies. 2. All clinical staff will be | (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | | (X5) |
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| documentation. IDT was educated on F757 and how it relates to the facilities 2. The record for Resident D was reviewed on 10/29/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty IDT was educated on F757 and how it relates to the facilities Medication Administration Policies. 2. All clinical staff will be | | | | | | 1 | |
| how it relates to the facilities 2. The record for Resident D was reviewed on 10/29/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty how it relates to the facilities Medication Administration Policies. 2.All clinical staff will be | | | offered no further | | | _ | |
| 2. The record for Resident D was reviewed on 10/29/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty Medication Administration Policies. 2.All clinical staff will be | | documentation. | | | | | nd |
| 10/29/24 at 10:50 a.m. The diagnoses included, but were not limited to, anxiety, insomnia (difficulty Policies. 2.All clinical staff will be | | 0.751 1.0 1 | N 11 (B) | | | | |
| were not limited to, anxiety, insomnia (difficulty 2.All clinical staff will be | | | | | | | |
| | | | _ | | | | |
| | | | | | | | |
| sleeping), hypertension (high blood pressure), re-educated to ensure they follow | | | | | | - | |
| gout, depression, atrial fibrillation (abnormal heart the facility's policy on medication | | | | | | 1 | |
| rhythm), chronic kidney disease, and anemia (low iron). administration including follow medication administration with | | | idney disease, and aneima (low | | | _ | |
| | | iron). | | | | | .n |
| The Medicare 5-day Minimum Data Set (MDS) | | The Medicare 5 do | w Minimum Data Sat (MDS) | | | parameters. | |
| assessment, dated 10/16/24, indicated the resident | | | - | | | - | |
| was cognitively intact for daily decision making. Monitoring: | | | | | | - Monitoring: | |
| The resident had no impairment of the upper and 5 Starting on 11/22/2024 the | | | - | | | " | he |
| lower extremities and used a wheelchair. The CNO/ACNO/ Designee will | | | | | | _ | .110 |
| resident required partial to moderate assistance complete audits on 6 residents | | | | | | · · · · · · · · · · · · · · · · · · · | ts |
| for oral hygiene, personal hygiene and upper daily across either shift to ensure | | | | | | 1 | |
| body dressing. The resident was dependent with orders are being followed, care | | | | | | 1 | |
| toileting, putting on/off footwear and lower body toileting, putting on/off footwear and lower body plans and completion | | | | | | _ | |
| dressing. dressing. documentation of vitals of guest | | | in our town our und town of today | | | 1 - | est |
| with parameters x 2 weeks, then | | aressing. | | | | _ | |
| A Physician's Order, dated 10/11/24, indicated to 6 observations three times a week | | A Physician's Orde | er, dated 10/11/24, indicated to | | | I | |
| monitor blood pressure, pulse, respirations, for 2 weeks, then 6 observations | | | | | | | |
| temperature, and oxygen saturation every shift. weekly x 4, then 6 residents | | _ | | | | l · | |
| monthly. Thereafter, if determined | | 1, | ·y | | | 1 | nined |

| DEPARTMENT OF HEALTH AND HUM | IAN SERVICES | | FORM APPR |
|-------------------------------|----------------------------|----------------------------|------------------|
| CENTERS FOR MEDICARE & MEDICA | AID SERVICES | | OMB NO. 093 |
| STATEMENT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY |
| AND PLAN OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | COMPLETED |
| | 155011 | D WINC | 11/01/2024 |

| | OF CORRECTION | IDENTIFICATION NUMBER 155844 | A. BUILDING B. WING | 00 | COMPLETED 11/01/2024 |
|----------------------------|--|---|---------------------|--|--------------------------|
| | PROVIDER OR SUPPLIER | | 2775 \ | ADDRESS, CITY, STATE, ZIP COD VILLAGE POINT TERTON, IN 46304 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | 5.112 |
| F 0759 SS=D Bldg. 00 | give midodrine (blo mouth three times a (BP). The resident's blood documented on 10/9 pressures were doct 10/1, 10/5, 10/11, 11/10/17, 10/18, 10/19 and 10/29/24. During an interview Director of Nursing Clinical Operations should have been checked be given. 3.1-48(a)(3) 483.45(f)(1) | dated 10/12/24, indicated to od pressure medication) by day for low blood pressure I pressure was not 0, 10/10 and 10/23/24. Blood amented only once a day on 0/12, 10/13, 10/14, 10/15, 10/16, 10/21, 10/22, 10/25, 10/26, 10/28 To on 10/29/24 at 1:55 p.m., the (DON) and Vice President indicated the blood pressure necked at least twice a day. To on 10/31/24 at 3:20 p.m., the resident's blood pressure each time the midodrine was | | by Quality Assurance Committ that further monitoring is neede audits will continue. Education will be complet immediately with any identified deficiencies. | ed, |
| | interview, the facilitierror rate of less that observed during me were observed during during medication at a medication error relation. Eindings include: 1. On 10/28/24 at 1 | on, record review, and ty failed to ensure a medication in 5% for 2 of 6 residents dication pass. Two errors ag 34 opportunities for errors dministration. This resulted in ate of 5.88%. (Residents K and 0:23 a.m., LPN 4 was observed ster an antibiotic to a resident | F 0759 | Compliance 12/06/2024 F759 Medication error > 5% The General Manager (Administrator) notified the Medical Director on 11/19/2024 the Annual Survey findings. At time the facility is requesting a desk review for the findings all in the annual survey. Chesterte Ignite Medical Resorts denies implication of guilt relating to the deficiencies outlines in this pla correction. The facilities' intent | eged on ne n of |

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Event ID:

JB0C11 Facility ID: 013688

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155844 B. WING 11/01/2024 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2775 VILLAGE POINT IGNITE MEDICAL RESORT CHESTERTON CHESTERTON, IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE via a PICC (peripherally inserted central catheter) always to provide quality care to line. The LPN applied gloves, then opened and its guests and residents. attached new tubing to a medication bag with the Guest L's medication was ordered antibiotic Unasyn. She finished setting up the from Pharmacy and administered machine and started the antibiotic on the resident upon facility receiving, MD notified. at 10:30 a.m. She indicated the medication would LPN2 was educated on Medication administration policy, take 30 minutes to administer. including documentation of Record review for Resident K was completed on medication administration. 10/28/24 at 10:35 a.m. The October 2024 Guest K was discharged from the Physician's Order Summary indicated an order for Unasyn 3000 mg (milligrams) intravenously three LPN 4 was educated on Facilities times a day for a left foot wound for 6 weeks. The medication administration policy administration times were to be at 12:00 a.m., 8:00 including Medication a.m., and 4:00 p.m. administration times. Identification of Other During an interview on 10/28/24 at 10:40 a.m., LPN Residents with the Potential to 4 indicated the resident's antibiotic was supposed be Affected: to be started at 8:00 a.m. She started the medication late because she had been busy 1.All current guests with orders getting another resident's weight and "running to administer medication were around" administering other resident's pain reviewed to ensure that medications are available, and medications. 2. On 10/28/24 at 9:31 a.m., RN 2 was observed medication is being administered preparing Resident L's medications. She placed as ordered and documented. Vitamin C one tablet and Osteo Bi-flex (medication 2.All Guest receiving IV for joints) one tablet into a pouch, crushed them, medications were observed at and mixed them with applesauce in a medication different shifts during the day to cup. RN 2 confirmed she had crushed two pills, ensure that Iv medications are and administered them to the resident in their administered as ordered. room. 3.Any errors observed will be corrected immediately Nurse will Resident L's record was reviewed on 10/28/24 at be educated. 10:21 a.m. The Medication Administration Record Systemic Changes: (MAR) indicated RN 2 administered 1. A Qappi meeting with CNO, Methylsulfonylmethane (a supplement used for ACNO, Care Transitions, arthritis) 1000 milligrams (mg) tablet, as well as Hospitality Medical Director and Vitamin C and Osteo Bi-flex at 9:00 a.m. on General Manager. IDT was 10/28/24. educated on F759 and how it relates to the facilities Medication

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| CENTERS FOR MEDICARE & MEDICAID SERVICES | | | | | OMB NO. 0938-039 | |
|--|--|---|--|---|--|--|
| | NT OF DEFICIENCIES OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENT REGULATORY OF During an interview indicated she did not Methylsulfonylmet documented she has medication was not need to call the pharmacon the desired to call the pharmacon of the desired to call t | hane that morning and d in error. She indicated the in the drawer and she would | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAL DEFICIENCY) Administration Policies. 2. All clinical staff will be re-educated to ensure they fol the facility's policy medication administration including follow medication administration with errors and what to do if medication is not available or they are too busy to administer medication timely. | low nout ation s vill s ure tions st nen veek ins ined tee ed, | |
| F 0761 SS=E Bldg. 00 | 483.45(g)(h)(1)(2) Label/Store Drugs | | | | | |
| Č | interview, the facili were not prepared i were locked for 1 o | on, record review and ty failed to ensure medications n advance and treatment carts f 2 units. (The C Wing) This affect all residents receiving | F 0761 | Compliance 12/06/2024 F761 Labeling and Storage of Drugs The General Manager (Administrator) notified the | f 12/06/2024 | |

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medications from LPN 6 and wound treatments.

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Facility ID: 013688

Medical Director on 11/19/2024 of

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| DEPARTMEN' CENTERS FOI | | FORM APPROVED OMB NO. 0938-039 | | | | | |
|---------------------------|-----------------------|-----------------------------------|-----------------|---------------------------------|-----------------------|------------|--|
| | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE | CONSTRUCTION | (X3) DATE SURVEY | | |
| | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | | f 1 | COMPLETED | |
| THIEFE | or conduction | 155844 | B. WING | 00 | 11/01/2024 | | |
| | | 100044 | B. WING | | | 1/2024 | |
| NAME OF I | PROVIDER OR SUPPLIEF | 3 | | ET ADDRESS, CITY, STATE, ZIP CO | OD | | |
| | | | | VILLAGE POINT | | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | CHE | STERTON, IN 46304 | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORE | RECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | ICY MUST BE PRECEDED BY FULL | PREFIX | | OULD BE PPROPRIATE | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG DEFICIENCY) | | | DATE | |
| | | | | the Annual Survey findi | ings. At this | | |
| | Findings include: | | | time the facility is reque | esting a | | |
| | | | | desk review for the find | lings alleged | | |
| | 1. On 10/27/24 at 9 | 9:14 a.m., LPN 6 was seated in a | | in the annual survey. C | hesterton | | |
| | _ | nurse's station. The LPN was | | Ignite Medical Resorts | denies | | |
| | seated next to the m | nedication cart and five plastic | | implication of guilt relat | ing to the | | |
| | medication cups we | ere observed on top of the | | deficiencies outlines in | this plan of | | |
| | medication cart. Th | ne medication cups had room | | correction. The facilities | s' intent is | | |
| | numbers written on | them. | | always to provide quali | ty care to | | |
| | | | | its guests and residents | s. No harm | | |
| | During an interview | v at that time, the LPN indicated | | came to any residents/ | guests | | |
| | that she always "pre | e-poured" her medications, | | related to this alleged d | leficient | | |
| | then she quickly ch | anged her answer and | | practice. | | | |
| | indicated that she d | idn't always do that, but today | | | | | |
| | was a bad day. | | | LPN 6 was educated or | n | | |
| | | | | medication administrati | on policy | | |
| | During an interview | y, on 11/1/24 at 10:55 a.m., the | | and on preset medication | ons. | | |
| | Vice President of C | linical Operations indicated the | | Wound Nurse 1 was ed | lucated on | | |
| | | e a policy but the LPN should | | medication labeling and | d storage | | |
| | not have pre-poured | d the medications and | | and medication adminis | stration. | | |
| | education was going | g to be provided. 2. During a | | Wound Nurse 2 was ed | lucated on | | |
| | random observation | n on 10/27/24 at 9:16 a.m., | | medication labeling and | d storage. | | |
| | Wound Nurse 1 wa | s observed in a resident's | | The tubes of medication | ns in the | | |
| | room. At that time, | the wound treatment cart was | | treatment carts were re | moved and | | |
| | located outside of a | resident's room and was | | destroyed per the facilit | ties policy | | |
| | unlocked and easily | opened. There were at least | | | | | |
| | 20 opened tubes of | creams with no labels or | | Identification of Other | = | | |
| | resident names on t | hem inside the cart. There | | Residents with the Po | tential to | | |
| | were tubes of Silvas | sorb, Silvadene cream, nystatin | | be Affected: | | | |
| | powder and cream, | Iodoform, lidocaine cream and | | | | | |
| | a vial of lidocaine a | ll inside the cart. | | 1.All current guests ir | າ the | | |
| | | | | facility have the potenti | | | |
| | During an interview | v at that time, the Wound | | affected by the same de | | | |
| | Nurse indicated she | was aware her cart should | | practice. All carts were | | | |
| | have been locked. T | The numerous and multiple | | to ensure that all medic | ations had | | |
| | opened tubes of cre | am were house stock and | | the proper labeling per | the | | |
| | _ | dents when they did not have | | facilities policies. All nu | | | |

their creams available.

facilities policies. All nursing storage areas were checked

including carts and medication rooms to ensure that they are

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/01/2024 155844 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 2775 VILLAGE POINT **IGNITE MEDICAL RESORT CHESTERTON** CHESTERTON, IN 46304 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3. During a random observation on 10/28/24 at locked as per the facilities 10:55 a.m., Wound Nurse 2's treatment cart was policies. observed. At that time, there were numerous 2.Any errors observed will be opened tubes of lidocaine cream, iodosorb cream, corrected immediately and will be mupirax cream, venelex cream, and ammonium staff educated. acetate cream, that had no resident names on **Systemic Changes:** 1.On 11/21/2024 A Qappi them. There were 3 boxes of creams inside the cart for which the resident had been discharged meeting with CNO, ACNO, Care months ago. Transitions, Hospitality Medical Director and General Manager. During an interview at that time, Wound Nurse IDT was educated on F761 and (WN) 2 indicated his cart was locked up in his how it relates to the facilities office every night and no nurse had access to it. Medication Storage and He used the creams for the residents out of the Destruction Policies. treatment cart and would not indicate if he had 2.All clinical staff will be used the creams inside his wound treatment cart re-educated to ensure they follow for other residents. WN 2 indicated the facility the facility's policy on medication had no house stock ointments for residents to storage and labeling. use. The multiple tubes of creams should have been destroyed and thrown away and he just had **Monitoring:** not had time to do it. Starting on 11/22/2024 the CNO/ACNO/ Designee will During an interview on 10/29/24 at 1:45 p.m., the complete observations on both Chief Nursing Officer (CNO) indicated the units daily across either shift to treatment cart should have been locked and the ensure medication storage and creams should have been labeled with specific labeling is being followed, x 2 residents' names on them. weeks, then 6 observations three times a week for 2 weeks, then 6 The 1/2023 "Medication Labeling and Storage" observations weekly x 4, then 6 policy, provided by the Vice President of Clinical residents monthly. Thereafter, if Operations on 10/29/24 at 3:10 p.m., indicated determined by Quality Assurance medications were to be labeled in accordance with Committee that further monitoring facility requirements and stage and federal laws. is needed, audits will continue. All drug containers will be labeled and drug labels Education will be completed must be clear, consistent, legible, and in immediately with any identified compliance with state and federal requirements. deficiencies. There will be a standard method for appropriately and safely labeling medications dispensed to all residents. Floor stock medications were labeled "Floor Stock or "House Supply" and kept in the

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE C A. BUILDING B. WING | onstruction <u>00</u> | (X3) DATE SURVEY COMPLETED 11/01/2024 | |
|--|--|--|--|---|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) | (X5) COMPLETION DATE |
| | regulatory or original manufactur expiration date and This citation relates 3.1-25(m) 483.60(i)(1)(2) Food Procurement, Store Based on observation interview, the facilic clean and in good refood preparation equivers, food not labor test strips not availabuckets for 1 of 1 k 1 of 2 resident refrigerator) This has 67 residents who rereceived food from Findings include: 1. During the Initiation 10/27/24 at 9:47 a.m. was observed: a. There was food of the stainless steel lies to age bins for the c. An accumulation observed on top of the stainless of the stainless of the c. An accumulation observed on top of the stainless of the stainless of the c. An accumulation observed on top of the stainless of the stainless of the c. An accumulation observed on top of the stainless of the stainless of the c. An accumulation observed on top of the stainless of the stainless of the c. An accumulation observed on top of the stainless of the stainless of the c. An accumulation observed on top of the stainless of the stainless of the control o | es container with the lot number. to Complaint IN00443841. e/Prepare/Serve-Sanitary on, record review, and ty failed to keep the kitchen epair related to food debris on uipment, dirty convection eled and dated, and the proper eled and dated, and the proper eled and main Kitchen) and gerators. (The D Wing and the potential to affect 67 of esided in the facility and the kitchen. al Kitchen Sanitation Tour on an. with Cook 1, the following debris underneath and behind d for the salad bar. exy residue on the lid of the flour and sugar. a of dust and debris was the convection oven and the | | Compliance 12/06/2024 F812 Food Procurement. Store/Prepare The General Manager (Administrator) notified the Medical Director on 11/19/2024 the Annual Survey findings. At time the facility is requesting a desk review for the findings alle in the annual survey. Chesterte Ignite Medical Resorts denies implication of guilt relating to th deficiencies outlines in this plan correction. The facilities' intent always to provide quality care to its guests and residents. No ha came to any residents/guests related to this alleged deficient practice. A The food debris underneat and behind the stainless-steel for the salad bar was removed the area cleaned. B The sticky residue on the food of the storage bins for the flour sugar were cleaned and replace | DATE 12/06/2024 4 of this eged on lee in of is to larm h liid and liid and liid and leed. |
| | convection oven. | stand that housed the | | C The accumulation of dust debris observed on top of the convection oven and the bottom shelf of the stand that housed to | m |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY | | | SURVEY | | | |
|--|-----------------------|---|------|--|--|---|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. B | A. BUILDING <u>00</u> COMPLETEI | | | ETED | |
| | | 155844 | B. W | 'ING | | 11/01/ | 2024 | |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | | |
| NAME OF I | PROVIDER OR SUPPLIER | 8 | | | ILLAGE POINT | | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | CHESTERTON, IN 46304 | | | | |
| | T | | - | | 1 | ı | (X5) | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | |
| PREFIX | ` | CH DEFICIENCY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | TE | COMPLETION | |
| TAG | | | - | TAG | | | DATE | |
| | dry storage room. | | | | convection oven was dusted a | and | | |
| | The second in Co. | | | | cleaned. | _ | | |
| | | ezer contained a bag of onion | | | D The bag of cocoa that wa | s | | |
| | - | dated when opened. There | | | opened on a shelf in the dry | | | |
| | | gs of frozen food that had been | | | storage room was removed a | na | | |
| | opened and not date | zu. | | | thrown away. | tho | | |
| | f A plastic cont-:- | er of lemon slices in the reach | | | E The opened onion ring in | | | |
| | in cooler were not o | | | | reach in opened and not date | | | |
| | in cooler were not c | covered. | | | were removed and thrown aw | - 1 | | |
| | a The test string for | or 2 of 2 sanitation buckets did | | | and the two brown bags of fro food that had been opened ar | | | |
| | - | hen the sanitation solution | | | · · | | | |
| | was tested. | their the samtation solution | | | dated were also thrown away. F The lemons in the plastic | | | |
| | was tested. | | | | container in the reach in coole | | | |
| | During on interview | v, on 11/1/24 at 9:50 a.m., the | | | were thrown out. | ^{‡1} | | |
| | _ | icated all of the above had | | | G 2 of 2 sanitation buckets | | | |
| | | or were in need of cleaning. | | | | h tha | | |
| | | ne Cook was testing the | | | were dumped and remade wit | | | |
| | | with the wrong test strips on | | | correct sanitation amount place the bucket. Cook was also | Je III | | |
| | | was using bleach strips instead | | | educated on the proper sanita | tion | | |
| | of quat testing strip | | | | test strips. | ilion | | |
| | or quar testing strip | | | | On the unit D wing | | | |
| | | | | | The container of food from a | | | |
| | 2 On 11/1/24 at 10 |):14 a.m., the following was | | | fast-food restaurant that was i | not | | |
| | observed in the D V | _ | | | labeled with a resident's name | | | |
| | Sobolived in the D v | · | | | date was removed. The plasti | | | |
| | a. A container of fo | ood from a fast food restaurant | | | container of food labeled with | | | |
| | | h a resident's name or date. | | | resident's name was not dated | | | |
| | | | | | was removed. The plastic | - | | |
| | b. A plastic contain | ner of food labeled with a | | | container of cantaloupe was | | | |
| | resident's name was | | | | labeled with a room number b | _{ut} | | |
| | | | | | not dated was removed. The I | | | |
| | c. A plastic contain | ner of cantaloupe was labeled | | | of fast food that was labeled v | - | | |
| | with a room numbe | | | | resident's name and room nur | | | |
| | | | | | but not dated was removed. T | | | |
| | d. A bag of fast foo | od was labeled with a resident's | | | leftover food that was wrappe | | | |
| | name and room nur | | | | aluminum foil and the plastic | | | |
| | | | | | container of food labeled with | the | | |
| | e. Left over food w | vas wrapped in aluminum foil | | | resident's room number but no | | | |
| | | stic container of food labeled | | | dated was removed. | | | |

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Event ID:

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Facility ID: 013688

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE CO A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED 11/01/2024 | | | | |
|--|--|---|--|--|--|--|--|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| | with the resident's r There was a sign or indicating resident to the food should have been do the food s | oom number but not dated. It the door of the refrigerator food must be dated. It on 11/1/24 at 10:17 a.m., CNA I inside of the refrigerator ated. If on 11/1/24 at 11:07 a.m., the licated dietary staff should have the refrigerator. It policy titled, "Personal Food" ght from outside resources by r family would be stored in a and labeled as such, litty food. Labeling would the, received date, use by date, | | Identification of Other Residents with the Potential be Affected: 1.All current guests and staf members have the potential to affected by this alleged deficie practice. Systemic Changes: 1. A Qappi meeting with CN ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F812 and how it relates to the facilities Food procurement and food storage Education on homelike clean environment. 2.Staff will be re-educated to ensure they follow the facility's policy on food storage and labeling. All staff also, educate on homelike clean environment Kitchen staff were re-educated checklist for cleaning and sanitation practices. Monitoring: 1 General Manager (Administrator) Designee will complete visual audits on all refrigerators daily across eithe shift to ensure the policy on labeling and storage of foods being followed x 2 weeks, the observations three times a we for 2 weeks, then 6 observation weekly x 4, then 6 residents monthly. Thereafter, if determ | f beent O, and on one of the control | | |

JB0C11

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) M | (X2) MULTIPLE CONSTRUCTION (X3) DA | | (X3) DATE S | URVEY | |
|--|----------------------|----------------------------------|------------------------------------|---------------------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> COM | | | ETED |
| | | 155844 | B. W | NG | | 11/01/2 | 2024 |
| | | | - | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | R | | 2775 VILLAGE POINT | | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | CHESTERTON, IN 46304 | | | |
| | | | 1 | GILEGILICION, IN 40304 | | г | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE | | (X5) |
| PREFIX | • | CY MUST BE PRECEDED BY FULL | | PREFIX | CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | + | TAG | | 4 | DATE |
| | | | | | by Quality Assurance Commit | | |
| | | | | | that further monitoring is need audits will continue. | ea, | |
| | | | | | audits will continue. | | |
| | | | | | Education will be completed | | |
| | | | | | immediately with any identified | ۱ ۱ | |
| | | | | | deficiencies. | 1 | |
| | | | | | delicionese. | | |
| | | | | | | | |
| | | | | | ⁻ | | |
| F 0842 | 483.20(f)(5), 483.7 | 70(i)(1)-(5) | | | | | |
| SS=D | Resident Records | - Identifiable Information | | | | | |
| Bldg. 00 | | | | | | | |
| | | view and interview, the facility | F 08 | 342 | Compliance Date 12/06/2024 | | 12/06/2024 |
| | | linical records that were | | | F842 Resident Records | | |
| | - | ately documented related to | | | The General Manager | | |
| | | istration for 1 of 1 resident | | | (Administrator) notified the | | |
| | | eeding. The facility also failed | | | Medical Director on 11/19/202 | | |
| | | ian notification was completed | | | the Annual Survey findings. At | | |
| | _ | ar parameters and insulin | | | time the facility is requesting a | | |
| | | 2 of 5 residents reviewed for | | | desk review for the findings al | - | |
| | | ations. (Residents 30, H, and | | | in the annual survey. Chestert | | |
| | 43) | | | | Ignite Medical Resorts denies implication of guilt relating to t | | |
| | Findings include: | | | | deficiencies outlines in this pla | | |
| | i manigs metade. | | | | correction. The facilities' inten | | |
| | 1. The record for R | esident 30 was reviewed on | | | always to provide quality care | | |
| | | .m. Diagnoses included, but | | | its guests and residents. No h | | |
| | | dementia without behavior | | | came to any residents/guests | | |
| | · | onal disorder, anxiety, | | | related to this alleged deficien | t l | |
| | dysphagia (difficult | | | | practice. | | |
| | gastrostomy status (| (a tube inserted directly into | | | | | |
| | the stomach for nut | rition). | | | Guests H and 43 discharged f | rom | |
| | | | | | the Facility. | | |
| | | rly Minimum Data Set (MDS) | | | Residents external feeding ord | der | |
| | | d the resident was cognitively | | | was reviewed with MD. No ne | w | |
| | | lecision making and he received | | | orders | | |
| | a tube feeding while | e a resident of the facility. | | | Identification of Other | | |
| | | | | | Residents with the Potential | <u>to</u> | |
| | A Care Plan, dated | 3/21/23 and reviewed on | | | be Affected: | | |

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Event ID:

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Facility ID: 013688

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | (X2) MULTIPLE CO A. BUILDING B. WING | ONSTRUCTION 00 | (X3) DATE SURVEY COMPLETED 11/01/2024 | | |
|--|--|---|--|---|--|--|
| | PROVIDER OR SUPPLIEI | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | |
| (X4) ID PREFIX | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL | ID PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | | |
| TAG | 9/6/24, indicated the feeding related to refailure to thrive, and included, but were would receive tube physician orders. A Physician's Order current on the Octor Summary (POS), in receive Jevity 1.5 to per hour, start at bethe morning (6:00 at The July 2024 Med (MAR) indicated the out as being started 7/14/24. The stop to out as being compleand 7/15/24. The August 2024 Med (MAR) and 8/23, was not signed out on 8/1/24 and 8/23, was not signed out 8/6/24, 8/20/24, and The September 202 feeding was not signed out 9/3/24, 9/7/24, 9/8/ During an interview Vice President of Country the September of Country and the signed out as Resident H was considered the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed out as Resident H was considered to the signed to the | dication Administration Record at 10:00 p.m. on 7/4/24 and sime of 6:00 a.m. was not signed eted on 7/1/24, 7/2/24, 7/10/24, MAR indicated the tube feeding as being started at 10:00 p.m. (24. The stop time of 6:00 a.m. as being completed on 8/2/24, d 8/30/24. MAR indicated the tube ned out as being started at 4. The stop time of 6:00 a.m. as being completed on 9/2/24, d 8/30/24. | TAG | 1.All current guests with ord for feed tube orders were revito ensure that feeding administrations are being sign and out and that the facilities medical record policies and be followed. If deficiencies observed will be corrected immediately corrected immediately, and physician notified for blood suparameters outside the specification. 1.All current guests with ord for insulin administration have been reviewed to ensure that facilities' medical record policiare being followed and that the documentation is accurate. If deficiencies were identified the would be immediately corrected systemic Changes: 1. A Qappi meeting with CN ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F842 and how it relates to the facilities Medical Administration Policies. 2. Clinical staff will be re-educated to ensure they for the facility's policy medication administration with parameters. Monitoring: | ewed n in eing ved, ted. ive igar ders the ies e ey ed. iO, ind tion llow | |

disruption of external operation (surgical) wound,

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CNO/ACNO/ Designee will

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|--|-------|--|--|----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> COMPLET | | | LETED |
| | | 155844 | B. W | ING | | 11/01 | /2024 |
| | | l | | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | | | |
| ICNITE A | MEDICAL RESORT | CHESTERTON | | 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | |
| IGNITE | MEDICAL RESURT | - CILOTERTON | | CHEST | LICEOIN, IIN 40004 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID PROVIDER'S PLAN OF CORRECTION | | | (X5) |
| PREFIX | (EACH DEFICIENCY MUST BE PRECEDED BY FULL | | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | | | TAG | DEFICIENCY) | | DATE |
| muscle weakness, and chronic respiratory failure | | | | complete audits on 6 residents | | | |
| | with hypoxia. | | | | daily across either shift to ens | | |
| | | | | | orders including insulin, exterr | | |
| | | imum Data Set (MDS) | | | feeding are being documented | | |
| | | 0/1/24, indicated the resident | | | outlines in the facilities medica | | |
| | | act and required moderate to | | | record policies, x 2 weeks, the | | |
| | | ee with activities of daily living | | | observations three times a we | | |
| | and transfers. | | | | for 2 weeks, then 6 observation | ns | |
| | | | | | weekly x 4, then 6 residents | | |
| | | onic Medication Administration | | | monthly. Thereafter, if determi | | |
| | Record) for 10/2024 indicated the following sliding | | | | by Quality Assurance Commit | | |
| | insulin scale was to be used for the resident's | | | | that further monitoring is need | ed, | |
| | | twice daily: HumaLOG | | | audits will continue. | | |
| | 1 - | 100 UNIT/ML (Insulin) Inject as | | | - | | |
| | | f 0 - 70 call MD and initiate | | | | | |
| | | ocol; 71 - 150 = 0 units; 151 - | | | | | |
| | | - 250 = 5 units; 251 - 300 = 7 | | | | | |
| | | 0 units; $351+=12$ units 351 and | | | | | |
| | > give 12 units and | call MD, Order Date 9/27/2024. | | | | | |
| | Th | 1 | | | | | |
| | | documentation of physician old outside | | | | | |
| | | 4 at 7 a.m. BS was 66, 10/14/24 | | | | | |
| | 1 ^ | 4, 10/15/24 at 7 a.m. BS was 56, | | | | | |
| | and 10/27/24 at 5 p | | | | | | |
| | and 10/2//24 at 3 p | .m. 10 was 3/3. | | | | | |
| | During an interview | v on 10/30/24 at 3:30 p.m., the | | | | | |
| | _ | rations indicated that sliding | | | | | |
| | _ | ve been in the record and it | | | | | |
| | | ally come over from the | | | | | |
| | | ere was different sliding scale | | | | | |
| | | | | | | | |
| | protocol that should have been used which didn't require physician notification unless the blood | | | | | | |
| | sugar was less than 60 or greater than 400. She | | | | | | |
| | said the nurses were used to that protocol and | | | | | | |
| | that's why they did | | | | | | |
| | | - | | | | | |
| | The record indicate | ed on 10/17/24 at a.m., for a | | | | | |
| | | LPN 3 administered 3 units of | | | | | |
| | insulin. | | | | | | |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
|--|--|---|-------------|--|------------|--|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED | |
| | | 155844 | B. WING | 11/01/2024 | | |
| | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF P | PROVIDER OR SUPPLIEF | R | | ILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | TERTON, IN 46304 | | |
| IOIVITE | MEDIONE NEODIN | - CHESTER TON | OTILO | 121(1014, 114 40004 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) | |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE | |
| | During an interview on 10/30/24 at 3:50 p.m., LPN | | | | | |
| | | umented the insulin | | | | |
| | | error, and that she did not give | | | | |
| | - | sulin at that time.3. The record | | | | |
| | | s reviewed on 10/28/24 at 3:37 | | | | |
| | | included, but were not limited | | | | |
| | | etoacidosis, muscle weakness, | | | | |
| | * | al dialysis, renal disease, insomnia (difficulty sleeping), | | | | |
| | , | | | | | |
| | heart failure, and hypertension (high blood pressure). | | | | | |
| | pressure). | | | | | |
| | The Admission Min | nimum Data Set (MDS) | | | | |
| | assessment, dated 1 | 0/11/24, indicated the resident | | | | |
| | was cognitively into | act for daily decision making. | | | | |
| | | impairment of the upper and | | | | |
| | | was on dialysis and received | | | | |
| | insulin. | | | | | |
| | A Care Plan, dated | 10/8/24, indicated the resident | | | | |
| | | terventions were to monitor | | | | |
| | blood glucose as pe | er physician order and to | | | | |
| | administer medicati | ion as ordered. | | | | |
| | A Cara Plan dated | 10/8/24, indicated the resident | | | | |
| | | tetoacidosis (DKA). | | | | |
| | | to monitor, document, and | | | | |
| | | l symptoms of hyperglycemia. | | | | |
| | Port for bigins und | y or my pergry commu. | | | | |
| | A Physician's order | , dated 10/6/24, indicated to | | | | |
| | - | o per sliding scale before meals | | | | |
| | and at bedtime and to notify the physician when | | | | | |
| | the blood sugar was | | | | | |
| | | | | | | |
| | | , dated 10/15/24, indicate to | | | | |
| | - | sulin Glargine subcutaneously | | | | |
| | at bedtime for diabe | etes. | | | | |
| | The Medication Ad | lministration Record (MAR) | | | | |

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Facility ID: 013688

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155844 | | X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING (X3) DATE SURVEY COMPLETED 11/01/2024 | | | |
|---|--|--|--|--|--|
| | | 155844 | B. WING | | 11/01/2024 |
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | |
| F 0880 SS=E Bldg. 00 | indicated the resider than 400 on 10/8, 10/21, and 10/24. There was no docur physician was notifit than 400. During an interview General Manager in concerns and had no provide. During an interview Vice President of C physician had been the resident's blood did not document the 3.1-50(a)(1) 483.80(a)(1)(2)(4) Infection Prevention Prevention Prevention of the facility control guidelines were related to handling thands for 3 of 6 resimedication administ observation, enhance not in use for a residinserted central cathed sinfecting of the guidelines were glucometer observed. | (e)(f) | F 0880 | Compliance Date 12/06/2024 F880 Infection Control The General Manager (Administrator) notified the Medical Director on 11/19/202 the Annual Survey findings. A time, the facility is requesting desk review for the findings al in the annual survey. Chester Ignite Medical Resorts denies implication of guilt relating to the | 24 of t this a lleged tton |
| | 170) Findings include: 1. On 10/27/24 at 9 | 9:14 a.m., LPN 6 was seated in a | | deficiencies outlines in this pla correction. The facilities' inten always to provide quality care its guests and residents. No h came to any residents/guests | t is to arm |

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Event ID:

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Facility ID: 013688

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| | | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION A. BUILDING 00 | | | (X3) DATE SURVEY COMPLETED | |
|-----------|---|---|---|----------|---|-------------------------------|------------|
| | | 155844 | B. W | ING | | 11/01 | /2024 |
| | | _ | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | R | | | ILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | CHEST | ERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | ` | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | _ | TAG | DEFICIENCY) | | DATE |
| | | g nurse's station. The LPN was | | | related to this alleged deficier | nt | |
| | | nedication cart and five plastic | | | practice. | | |
| | | ere observed on top of the | | | K,21, G have | | |
| | | he medication cups had room | | | discharged from the facility | | |
| | numbers written on them. | | | | RN 2 was educated or | 1 | |
| | Th. I DNI 4: | 14 | | | Infection control practices for | | |
| | | d to prepare medications at that | | | medication pass for guest L a | ina | |
| | _ | the pills from the medication and then placed them into | | | all other facility guest Guest #170 was | | |
| | the medication cup | - | | | | | |
| | the medication cup | 5. | | | discharged from the facility | | |
| | During an interview, on 11/1/24 at 10:55 a.m., the | | | | Identification of Other Residents with the Potential | 40 | |
| | Vice President of Clinical Operations indicated the | | | | be Affected: | 10 | |
| | LPN should not have touched the medications | | | | 1.All current guests were | | |
| | with her bare hands | | | | observed to identify if they me | aat | |
| | | 0:23 a.m. LPN 4 was observed | | | the criteria for EBP. If identifie | | |
| | | ister an antibiotic to a resident | | | the auditor ensured that an o | • | |
| | | erally inserted central catheter) | | | is placed. The signage, suppl | | |
| | | lied gloves, then opened and | | | and education on infection | 100 | |
| | | g to a medication bag with the | | | prevention provided to the sta | aff | |
| | | She finished setting up the | | | LPN 4 was educated on Enha | | |
| | - | d the antibiotic on the resident | | | barrier procedures. | | |
| | at 10:30 a.m. She i | indicated the medication would | | | 2.LPN 5 was educated on | | |
| | take 30 minutes to | administer. The nurse did not | | | cleaning glucose monitors an | d | |
| | apply a gown when | she hooked up the medication | | | where to find the proper clear | | |
| | via the PICC line. | There was no sign on the door | | | solution. | - | |
| | | room that indicated the | | | 3.LPN 6 was educated on | | |
| | resident was on EB | SP (enhanced barrier | | | infection control practices for | | |
| | | e was no bin observed inside | | | medication administration. | | |
| | | om with PPE (personal | | | 4.RN 2 was provided with | | |
| | protective equipme | ent) that included gowns. | | | education on infection control | | |
| | | | | | practices for medication | | |
| | | Resident K was completed on | | | administration. | | |
| | | i.m. The October 2024 | | | 5.All glucose monitors were | | |
| | 1 | Summary (POS) indicated the | | | cleaned with the correct solut | ion | |
| | | C line and was to receive | | | and for the correct time. | | |
| | | milligrams) intravenously three | | | | | |
| | | ft foot wound for 6 weeks. The | | | Systemic Changes: | | |
| | POS lacked an orde | er for EBP. | | | A Qappi meeting with CN | IO, | |
| | I | | ı | | ACNO Care Transitions | | I |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | | |
|--|-----------------------|--------------------------------|--------------------------------|------------------|---|--------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> COMPLETI | | | ETED | |
| | | 155844 | B. W | ING | | 11/01/ | 2024 |
| | | | | CTREET | ADDRESS CITY STATE ZID COD | | |
| NAME OF P | ROVIDER OR SUPPLIER | L | | | ADDRESS, CITY, STATE, ZIP COD | | |
| IONUTE N | AEDIOAL DECODE | OUECTEDTON | | | LLAGE POINT | | |
| IGNITEN | MEDICAL RESORT | CHESTERTON | | CHEST | ERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | During an interview | on 10/28/24 at 10:40 a.m., LPN | | | Hospitality Medical Director ar | nd | |
| | 4 indicated the resid | lent did not have an order for | | | General Manager. IDT was | | |
| | EBP. She would ha | ave only applied a gown if she | | | educated on F880 and how it | | |
| | was changing the Pl | ICC bandage and not when | | | relates to Infection Control. All | ı | |
| | she was administeri | ng the medication or flushing | | | staff were also educated on th | ie | |
| | the line. | | | | facilities infection control polic | y as | |
| | | | | | it relates to hand washing, | | |
| | During an interview | on 10/28/24 at 11:12 a.m., the | | | medication administration and | 1 | |
| | Infection Prevention | nist indicated there should | | | cleaning DME. | | |
| | have been an order | for EBP since the resident had | | | | | |
| | a PICC. The nurse | should have put on a gown | | | CNO/ACNO/ Designee will | | |
| | when she started the | e medication via the PICC. | | | complete visual observation | | |
| | | | | | rounds on 2 nurse med passe | s | |
| | A policy titled, "En | hanced Barrier Precautions" | | | daily across either shift to ens | ure | |
| | and received as curr | rent from the General Manager | | | that infection control practices | are | |
| | on 10/28/24, indicat | ted, "EBP is used in | | | being followed and the EBP a | | |
| | conjunction with sta | andard precautions and | | | placed and follow per facilities | | |
| | expand the use of P | ersonal Protective Equipment | | | policies x 2 weeks, then 6 | | |
| | (PPE) to donning of | f gown and gloves during | | | observations three times a we | ek | |
| | high-contact resider | nt care activities" "Gowns | | | for 2 weeks, then 6 observation | ns | |
| | and gloves are used | during high-contact activities | | | weekly x 4, then 6 residents | | |
| | with increased risk | for MDRO transmission to | | | monthly. 1 Thereafter, if | | |
| | staff clothing and ha | ands including but not limited | | | determined by Quality Assura | nce | |
| | to:" "Device car | re or use including but not | | | Committee that further monito | ring | |
| | limited to: Central l | ine" | | | is needed, audits will continue |). | |
| | | | | | Corrective actions will be | | |
| | | | | | completed immediately, and s | taff | |
| | 3. On 10/28/24 at 1 | 2:01 p.m., LPN 5 was observed | | | will be re-educated to ensure | they | |
| | administering a glud | cometer test on Resident 21. | | | follow the facility's policy on | | |
| | The LPN applied gl | oves, wiped the resident's | | | infection control. | | |
| | finger with an alcoh | nol wipe and proceeded to poke | | | | | |
| | the finger with a lar | ncet. The blood was then | | | | | |
| | transferred to the gl | ucometer strip attached to the | | | | | |
| | glucometer. After t | he blood sugar was read on | | | | | |
| | the glucometer, the | LPN disposed of the lancet | | | | | |
| | into the sharps cont | ainer. She disposed of the | | | | | |
| | glucometer strip and | d her gloves into the garbage. | | | | | |
| | She took the glucon | neter back to the medication | | | | | |
| | cart and then proceed | eded to open up 2 alcohol | | | | | |
| | wipes and wipe dov | vn the glucometer with the | | | | | |
| | | | | | | , | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JB0C11

Facility ID: 013688

If continuation sheet Page 50 of 65

| STATEMEN | NT OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTI | PLE CO | NSTRUCTION | (X3) DATE | SURVEY |
|-----------|---|---|------------|--------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILD | ING | 00 | COMPL | |
| | | 155844 | B. WING | | | 11/01/ | /2024 |
| NAME OF F | PROVIDER OR SUPPLIEI | R | | | DDRESS, CITY, STATE, ZIP COD | | |
| | | | | | LLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | С | HESTE | ERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | II | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | * | NCY MUST BE PRECEDED BY FULL | PRE | | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | | R LSC IDENTIFYING INFORMATION | TA | AG | DEFICIENCY) | | DATE |
| | • | er she wiped down the | | | | | |
| | - | e alcohol wipes she placed the | | | | | |
| | glucometer back into her medication cart. During an interview at that time, the LPN indicated she | | | | | | |
| | | e a germicidal bleach wipe and | | | | | |
| | - | e, but she did not have any | | | | | |
| | bleach wipes in the | | | | | | |
| | oreach wipes in the | medication eart. | | | | | |
| | During an interview on 10/28/24 at 12:17 p.m., the | | | | | | |
| | Infection Preventio | nist indicated the staff were | | | | | |
| | expected to use a bleach wipe and not an alcohol | | | | | | |
| | wipe to clean the glucometers after use. | | | | | | |
| | A policy titled, "Blood Glucose Monitoring" and | | | | | | |
| | | from the Vice President of | | | | | |
| | | s on 11/1/24, indicated, "The | | | | | |
| | _ | cleaned prior to each use and | | | | | |
| | after each use per n | - | | | | | |
| | recommendation' | | | | | | |
| | 4 0 10/00/04 | 0.16 | | | | | |
| | | 9:16 a.m., RN 2 was observed | | | | | |
| | | 170's medications. She | | | | | |
| | | 4 pills out of their cards into re placing them into a medicine | | | | | |
| | | ned the pills, mixed them with | | | | | |
| | _ | ministered them to the | | | | | |
| | resident. | ministered them to the | | | | | |
| | Tosident. | | | | | | |
| | No hand hygiene or | r donning of gloves was | | | | | |
| | | ndling the medication. | | | | | |
| | | - | | | | | |
| | 5 On 10/29/24 -+ | 0.22 a.m. DN 2 was absorved | | | | | |
| | | 9:22 a.m., RN 2 was observed G's medications. She popped | | | | | |
| | | out of their cards into her bare | | | | | |
| | _ | g them into a medicine cup. | | | | | |
| | | red the pills to the resident. | | | | | |
| | one then administe | rea the pins to the resident. | | | | | |
| | No hand hygiene on | r donning of gloves was | | | | | |
| | | ndling the medication. | | | | | |

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Event ID:

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Facility ID: 013688

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PRINTED: 12/04/2024

| | | | | | | 1 10110 | 1ED. 12/01/2021 | |
|----------------------------------|---------------------|-----------------------------|--------------------------------------|------------|-----------------------------------|------------------|-----------------|--|
| DEPARTMENT | OF HEALTH AND HUM | MAN SERVICES | | | | FOI | RM APPROVED | |
| CENTERS FOR | MEDICARE & MEDICA | AID SERVICES | | | | OM | IB NO. 0938-039 | |
| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) MU | JLTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | | |
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | a. building <u>00</u> | | | COMPLETED | | |
| | | 155844 | B. WING | | 11/01/2024 | | | |
| | | | | | | | | |
| NAME OF P | ROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD | | | | | |
| | | | | 2775 VI | LLAGE POINT | | | |
| IGNITE MEDICAL RESORT CHESTERTON | | | CHESTERTON, IN 46304 | | | | | |
| | | | | | | | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID PR | | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | | COMPLETION | |

| IGNITE | MEDICAL RESORT CHESTERTON | CHESTERTON, IN 46304 | | | | | |
|----------------------------|--|----------------------|--|----------------------------|--|--|--|
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE | | | |
| | 6. On 10/28/24 at 9:31 a.m., RN 2 was observed preparing Resident L's medications. She popped each of the 2 pills out of their cards into her bare hand before placing them into a medicine cup. She then crushed the pills, mixed them with applesauce, and administered them to the resident. No hand hygiene or donning of gloves was observed before handling the medication. During an interview on 10/28/24 at 9:32 a.m., RN 2 indicated she usually sanitized her hands when leaving the patient's room, but not before handling medications. She stated she knew she | | | | | | |
| | should probably empty the pills from the card directly into the cup, but that she wasn't good at it and needed more practice. 3.1-18(b) | | | | | | |
| F 0881 SS=D Bldg. 00 | 483.80(a)(3) Antibiotic Stewardship Program | | | | | | |
| J.43. 00 | Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring the appropriate use of antibiotic therapy and a system of monitoring to improve resident outcomes and reduce antibiotic resistance related to a practitioner prescribing antibiotics for not true infections based on the McGeer Criteria for 1 of 5 residents reviewed unnecessary medications. (Resident 41) Finding includes: | F 0881 | Compliance Date: 12/06/2024 F881 Antibiotic Stewardship program The General Manager (Administrator) notified the Medical Director on 11/19/2024 of the Annual Survey findings. At this time, the facility is requesting a desk review for the findings alleged in the annual survey. Chesterton Ignite Medical Resorts denies implication of guilt relating to the | 12/06/2024 | | | |
| | The record for Resident 41 was reviewed on 10/28/24 at 3:55 p.m., The resident was admitted to | | deficiencies outlines in this plan of correction. The facilities' intent is | | | | |

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

JB0C11

Facility ID: 013688

If continuation sheet

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CO | ONSTRUCTION | (X3) DATE SURVEY | |
|--|--|---|-------------|---|------------|
| | OF CORRECTION | IDENTIFICATION NUMBER | A. BUILDING | 00 | COMPLETED |
| ANDILAN | OF CORRECTION | 155844 | B. WING | 00 | 11/01/2024 |
| | | 100044 | | | 11/01/2024 |
| NAME OF I | PROVIDER OR SUPPLIEF | R | | ADDRESS, CITY, STATE, ZIP COD | |
| IONUTE I | AEDIOAL DECORT | CUESTERTON | | ILLAGE POINT | |
| IGNITE | MEDICAL RESORT | CHESTERION | CHEST | ERTON, IN 46304 | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | ID | PROVIDER'S PLAN OF CORRECTION | (X5) |
| PREFIX | (EACH DEFICIEN | NCY MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | TAG | DEFICIENCY) | DATE |
| | the facility on 10/3/ | /24. Diagnoses included, but | | always to provide quality care | to |
| | | , major depressive disorder with | | its guests and residents. No h | arm |
| | | e psychotic symptoms, heart | | came to any residents/guests | |
| | · · | breast cancer, anemia, anxiety, | | related to this alleged deficien | t |
| | and high blood pres | ssure. | | practice. | |
| | | | | Guest 41 discharge fro | m |
| | | ssion Minimum Data Set (MDS) | | the facility | |
| | assessment indicated the resident was moderately | | | Identification of Other | |
| | | decision making and was | | Residents with the Potential | <u>to</u> |
| | | ent of urine. The resident | | be Affected: | |
| | received an antipsychotic, antidepressant, | | | | |
| | antibiotic, and diuretic while at the facility. | | | 1.All current guests' orders v | |
| | | | | reviewed to Identify if they have | |
| | | 10/22/24, indicated the resident | | orders to receive antibiotics. If | |
| | | therapy related to an urinary | | guest has an order. The chart | |
| | tract infection. | | | reviewed to ensure that the fa | - |
| | | | | is following the McGeers and | |
| | | r, dated 10/18/24, indicated to | | antibiotic stewardship policies | |
| | 1 | s related to major depressive | | Systemic Changes: | |
| | disorder with sever | e psychotic symptoms. | | Qappi meeting with CNO, AC | NO, |
| | | | | Care Transitions, Hospitality | |
| | 1 | ated 10/19/24, indicated a urine | | Medical Director, and General | |
| | • | ed and placed in the refrigerator | | Manager. IDT was educated o | |
| | for lab to pick up. | | | F881and how it relates to Infe | ction |
| | TT 11 1.0 d | . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 . 1 | | Control and Mcgreers. All | |
| | | ne urinalysis, dated 10/21/24 | | Physicians and Nursing staff v | |
| | | re dated 10/22/24, indicated the | | also educated on the facilities | |
| | | nad a large amount leukocytes, | | infection control policy as it | |
| | 1 - | trates and blood, and had 5 to cells. The urine culture indicated | | relates to antibiotic stewardsh | ıp |
| | | | | program. | |
| | | 10,000 enterococcus faecalis tivity was not performed. | | 1.Monitoring: CNO/ACNO/ Designee will re | viou |
| | species and a sensit | livity was not performed. | | all new antibiotic orders to ens | |
| | The resident did no | t have a true urinary tract | | that the Antibiotic Stewardship | |
| | infection. | nave a nuc urmary nact | | program is being practiced for | |
| | miccion. | | | weeks, then 6 observations th | |
| | A Nursing Note, dated 10/22/24 at 12:33 p.m., | | | times a week for 2 weeks, the | |
| | | cian was notified of the urine | | observations weekly x 4, then | |
| | | w orders to start Keflex 500 | | residents monthly. Thereafter, | |
| | | ree times a day times seven days | | determined by Quality Assura | |
| | s.us (iiig) till | ice annes a day annes seven days | I | Lacronninea by Quality Assulat | 100 |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | l ′ | (X2) MULTIPLE CONSTRUCTION (X3) DATE SU A. BUILDING (0) COMPLET | | | | |
|---|---|---|--|---|---|----------------|--------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER 155844 | A. BU B. WI | | 00 | COMPL 11/01 | |
| | | 100044 | D. WI | | | 11/01/ | 2024 |
| NAME OF P | ROVIDER OR SUPPLIER | 3 | | | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | | ERTON, IN 46304 | | |
| (X4) ID | | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX TAG | ` | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | | PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | COMPLETION DATE |
| TAG | | back and changes needed to | | TAG | Committee that further monito | rina | DATE |
| | | nurse was made aware and | | | is needed, audits will continue | • | |
| | initiated the antibio | tic. | | | | | |
| | A Physician's Order | r, dated 10/22/24, indicated | | Corrective actions will be completed immediately, and sta | | | |
| | Keflex (an antibiotic medication) 500 mg, give one capsule by mouth three times a day for an urinary tract infection for seven days. | | | | will be re-educated to ensure | | |
| | | | | | follow the facility's policy on | • | |
| | | | | | infection control. | | |
| | The Physician's Pro | gress Note, identified as a late | | | | | |
| | - | at 9:11 a.m. and created on | | | | | |
| | 10/30/24 at 12:33 p.m., indicated the urinalysis was reviewed and the cultures were insignificant. "Keflex continued since patient's symptoms of confusion and urinary frequency and urgency | | | | | | |
| | | | | | | | |
| | | | | | | | |
| | better with antibioti | | | | | | |
| | | | | | | | |
| | | mentation in nursing notes of | | | | | |
| | | n, urinary frequency and | | | | | |
| | urgency. | | | | | | |
| | _ | v on 10/30/24 at 9:48 a.m., the | | | | | |
| | ~ | cer (CNO) indicated the | | | | | |
| | * * | e a late entry on 10/30/24 | | | | | |
| | - | e to continue the antibiotic nfusion, frequency and | | | | | |
| | | indicated there was no | | | | | |
| | | ursing progress notes of the | | | | | |
| | | s of increased frequency and | | | | | |
| | | n. The facility followed | | | | | |
| | McGeer's criteria fo | or all infections. | | | | | |
| | 3.1-18(b) | | | | | | |
| F 0921 | 483.90(i) | | | | | | |
| SS=F | , , | anitary/Comfortable Environ | | | | | |
| Bldg. 00 | | | | | | | |
| | | on and interview, the facility en areas clean related to debris | F 09 | 921 | Compliance 12/06/2024 F921 Safe Functional | | 12/06/2024 |
| | _ | umulation of a dried substance | | | The General Manager | | |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | | |
|--|--|---|-------|---------|---|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | ETED |
| | | 155844 | B. W | NG | | 11/01/ | /2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | | |
| NAME OF I | PROVIDER OR SUPPLIE | ER | | | ILLAGE POINT | | |
| IGNITE N | MEDICAL RESOR | T CHESTERTON | | | TERTON, IN 46304 | | |
| IOIVIIL | TEDIONE NEGOT | - GILOTERTON | | OHLO | 121(1014, 114 40004 | | |
| (X4) ID | SUMMARY | Y STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | NCY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | ΛΤΕ. | COMPLETION |
| TAG | | OR LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | posal, and an accumulation of | | | (Administrator) notified the | | |
| | dust and dead insects inside the plastic light covers for 1 of 1 kitchen observed. (The Main | | | | Medical Director on 11/19/202 | | |
| | | | | | the Annual Survey findings. A | | |
| | Kitchen) | | | | time the facility is requesting a | | |
| | F' 1' ' 1 1 | | | | desk review for the findings al | - | |
| | Findings include: | | | | in the annual survey. Chester | | |
| | | | | | Ignite Medical Resorts denies | | |
| | _ | tial Kitchen Sanitation Tour on | | | implication of guilt relating to t | | |
| | | .m. with Cook 1, the following | | | deficiencies outlines in this pla | | |
| | was observed: | | | | correction. The facilities' inten | | |
| | | | | | always to provide quality care | | |
| | a. There was an accumulation of food debris on | | | | its guests and residents. No h | | |
| | | lk in freezer and underneath the | | | came to any residents/guests | | |
| | shelf. | | | | related to this alleged deficien | t | |
| | 1 251 1 1 | | | | practice. | | |
| | | sposal, located next to the | | | | | |
| | | thick accumulation of an | | | Identification of Other | | |
| | orange substance of | on the outside. | | | Residents with the Potential | <u>to</u> | |
| | | | | | be Affected: | | |
| | 4 D 1 1 17 | 1 G : : : T 10/01/04 | | | A The food debris undernea | | |
| | _ | chen Sanitation Tour on 10/31/24 | | | and behind the stainless-steel | | |
| | _ | the Executive Chef, five plastic | | | for the salad bar was removed | i and | |
| | | d above the steam table and | | | the area cleaned. | | |
| | | rea had an accumulation of dust | | | B The sticky residue on the | | |
| | and dead insects o | n the inside. | | | of the storage bins for the flou | | |
| | Dumin a c ! | vv. on 11/1/24 at 0.50 41 - | | | sugar were cleaned and repla | | |
| | _ | w on 11/1/24 at 9:50 a.m., the dicated all of the above had | | | C The accumulation of dust | . and | |
| | | dicated all of the above had dor were in need of cleaning. | | | debris observed on top of the | | |
| | either been cleane | u or were in need of cleaning. | | | convection oven and the botto | | |
| | 3.1-19(f) | | | | shelf of the stand that housed | | |
| | 3.1-19(1) | | | | convection oven was dusted a cleaned. | ai iU | |
| | | | | | | rated | |
| | | | | | D The garbage disposal, loc next to the dishwasher, had a | | |
| | | | | | 1 | 11 | |
| | | | | | orange substance that was | | |
| | | | | | removed. | | |
| | | | | | Systemic Changes: | 2 | |
| | | | | | 1.A Qappi meeting with CNO | J, | |
| | | | | | ACNO, Care Transitions, | ad | |
| | | | 1 | | Hospitality Medical Director a | ıu | I |

JB0C11

PRINTED: 12/04/2024
FORM APPROVED
OMB NO. 0938-039

| | IT OF DEFICIENCIES OF CORRECTION | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155844 | (X2) MULTIPLE CO A. BUILDING B. WING | onstruction 00 | (X3) DATE SURVEY COMPLETED 11/01/2024 |
|--------------------------|--|---|--|---|--|
| | ROVIDER OR SUPPLIER | | 2775 VI | ADDRESS, CITY, STATE, ZIP COD LLAGE POINT ERTON, IN 46304 | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
| | | | | General Manager. IDT was educated on F 921 and how it relates to Safe functional environment. All staff were all educated on the facilities' safe and sanitation policies. 2.Monitoring: 3 General Manager/ Design will complete visual observation rounds around the facility acroeither shift to ensure sanitation and safety practices are being followed per facilities policies: weeks, then 6 observations that times a week for 2 weeks, then observations weekly x 4, then residents monthly. Thereafter, determined by Quality Assural Committee that further monitor is needed, audits will continued. Corrective actions will be completed immediately, and swill be re-educated to ensure follow the facility's policy on infection control. | so ety Innee on oss on Ix 2 ree on 6 of if once rring |
| R 0000 Bldg. 00 | Survey. This visit in State Licensure Sur | State Residential Licensure acluded a Recertification and wey and the Investigation of applaints IN00442605 and | R 0000 | | |
| | Complaint IN00442 the allegations are c | 605 - No deficiencies related to ited. | | | |

State Form Event ID: JB0C11 Facility ID: 013688 If continuation sheet Page 56 of 65

PRINTED: 12/04/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER) 155844 | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI A. BUILDING 00 COMPLET B. WING 11/01/20 | | | ETED | | |
|---|---|---|--|--------------------|---|--|----------------------------|
| | PROVIDER OR SUPPLIER | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION | P. | ID REFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| R 0154 Bldg. 00 | the allegations are consumers of the survey dates: Octobe November 1, 2024 Facility number: 01 Residential Census: These State Resider accordance with 410 Quality review community and Samuer of the survey of | ore 27, 28, 29, 30, 31 and 3688 24 Atial Findings are cited in 0 IAC 16.2-5. pleted on 11/13/24. 5(k) fety Standards - Deficiency on and interview, the facility en areas clean related to debris amulation of a dried substance osal, and an accumulation of ts inside the plastic light chen observed. (The Main 1 Kitchen Sanitation Tour on m. with Cook 1, the following cumulation of food debris on a in freezer and underneath the cosal, located next to the nick accumulation of an | R 015 | 54 | Compliance 12/06/2024 R-0154 Safe Functional The General Manager (Administrator) notified the Medical Director on 11/19/202 the Annual Survey findings. At time the facility is requesting a desk review for the findings all in the annual survey. Chestert Ignite Medical Resorts denies implication of guilt relating to to deficiencies outlines in this pla correction. The facilities' intent always to provide quality care its guests and residents. No ha came to any residents/guests related to this alleged deficient practice. Identification of Other Residents with the Potential | eged on he in of t is to arm | 12/06/2024 |

State Form Event ID: JB0C11 Facility ID: 013688 If continuation sheet Page 57 of 65

PRINTED: 12/04/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | | | | r ′ | X3) DATE SURVEY | |
|--|---|--|------|---------|---|--|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | JILDING | 00 | COMPL | |
| | | 155844 | B. W | ING | | 11/01/ | 2024 |
| | PROVIDER OR SUPPLIER | | | 2775 V | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT ERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | DROWIDER'S BY AN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TC | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | at 12:10 p.m. with t light covers located food preparation are dust and dead insec During an interview Executive Chef indi | hen Sanitation Tour on 10/31/24 he Executive Chef, five plastic above the steam table and ea, had an accumulation of ts on the inside. 7, on 11/1/24 at 9:50 a.m., the icated all of the above had or were in need of cleaning. | | | be Affected: A The food debris undernear and behind the stainless-steel for the salad bar was removed the area cleaned. B The sticky residue on the of the storage bins for the flour sugar were cleaned and replated. C The accumulation of dust debris observed on top of the convection oven and the botton shelf of the stand that housed convection oven was dusted a cleaned. D The garbage disposal, locanext to the dishwasher, had a orange substance that was removed. Systemic Changes: 1.A Qappi meeting with CNO ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F 921 and how it relates to Safe functional environment. All staff were all educated on the facilities' safe and sanitation policies. 2.Monitoring: 3 General Manager/ Designillowed per facilities policies weeks, then 6 observations the times a week for 2 weeks, the observations weekly x 4, then residents monthly. Thereafter, determined by Quality Assura | lid d and lid r and ced. d and lid r and ced. d and lid r and ced. d and lid r and lid | |

State Form Event ID: JB0C11 Facility ID: 013688 If continuation sheet Page 58 of 65

PRINTED: 12/04/2024 FORM APPROVED OMB NO. 0938-039

| | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | ` ′ | | ONSTRUCTION | (X3) DATE | |
|----------|--|---|-------|--------|--|---|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | ILDING | 00 | COMPL | |
| | | 155844 | B. WI | NG | | 11/01/ | 2024 |
| | PROVIDER OR SUPPLIER | | | 2775 V | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT 'ERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | OF CORRECTION (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OR | LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | Committee that further monito is needed, audits will continue Corrective actions will be completed immediately, and s will be re-educated to ensure follow the facility's policy on infection control. | taff | |
| R 0217 | 410 IAC 16.2-5-2(Evaluation - Defici | , , | | | | | |
| Bldg. 00 | failed to ensure a se updated to include the residents reviewed the residents reviewed the Finding includes: Record review for Finding includes: A record review for Finding includes: A Health Status Not indicated the resident hurt her wrist. She room. A Physician's Order order for Physical Timerapy (OT) to every finding includes includes included included includes included included includes included included includes included included included include | riew and interview, the facility revice plan was revised and therapy services for 1 of 7 for service plans. (Resident 2) Resident 2 was completed on m. Diagnoses included, but left wrist fracture, dementia, te, dated 9/4/24 at 10:22 p.m., and had a fall in her room and was sent to the emergency r, dated 9/6/24, indicated an Therapy (PT) and Occupational aduate and treat the resident. note for the resident was on the recent OT note for the 25/24. ed 10/16/24, indicated the | R 02 | 217 | Compliance 12/06/2024 R-217 Service plan The General Manager (Administrator) notified the Medical Director on 11/19/202 the Annual Survey findings. At time the facility is requesting a desk review for the findings al in the annual survey. Chestert Ignite Medical Resorts denies implication of guilt relating to t deficiencies outlines in this pla correction. The facilities' inten- always to provide quality care its guests and residents. No h came to any residents/guests related to this alleged deficien practice. Resident 2 service plan was updated with therapy Identification of Other Residents with the Potential be Affected: | t this a leged ton he an of t is to arm t | 12/06/2024 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA | | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE | | | | | |
|--|---|--|-------|---------------------|---|---|----------------------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | | ILDING | 00 | COMPL | |
| | | 155844 | B. WI | NG | | 11/01/ | 2024 |
| | PROVIDER OR SUPPLIER | | | 2775 VI | ADDRESS, CITY, STATE, ZIP COD ILLAGE POINT ERTON, IN 46304 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE | (X5) COMPLETION DATE |
| | resident was at risk independent with m daily living). The S resident. The Service Plan la resident received P During an interview General Manager in received therapy ser Plan was completed. | for falls. The resident was sost of her ADLs (activities of Service Plan was signed by the cked documentation the For OT services. You 10/31/24 at 9:45 a.m., the adicated the resident had rvices when the latest Service I. The Service Plan was not he resident's therapy status | | | 1.All current with the need for skilled therapy has the potention be affected by the same allegor deficiency. 2.All residents that reside or Luxe have been reviewed to identify the need for updated service plans. If resident was identified to need a service planydate, the service planydate, the service planydated Systemic Changes: 1.A Qappi meeting with CNC ACNO, Care Transitions, Hospitality Medical Director ar General Manager. IDT was educated on R-217 and how it relates to the services plans Clinical staff will be re-educate ensure they follow the facility's policy on service plans. Monitoring: 4 CNO/ACNO/ Designee we complete audits on 3 residents daily across either shift to ensure service plans are in place for the residents, x 2 weeks, then 3 residents weeks, then 3 residents monthly. Thereafter, if determined by Quality Assurance Committee further monitoring is needed, audits will continue. Education will be complete immediately with any identified deficiencies. | al to ed an O, an or or or or or or or or or o | |

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| STATEMEN | T OF DEFICIENCIES | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIPLE CO | ONSTRUCTION | (X3) DATE | SURVEY |
|-----------|--|---------------------------------|-------------------------------------|--------------------------------------|--|-----------|------------|
| AND PLAN | OF CORRECTION | IDENTIFICATION NUMBER | A. BU | JILDING | 00 | COMPL | LETED |
| | | 155844 | B. W | ING | | 11/01 | /2024 |
| | | | | STREET | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | 2 | | | ILLAGE POINT | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | | ERTON, IN 46304 | | |
| (X4) ID | SUMMARY | STATEMENT OF DEFICIENCIE | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | | | | | | | |
| R 0273 | 410 IAC 16.2-5-5. | 1(f) | | | | | |
| 11.0270 | | nal Services - Deficiency | | | | | |
| Bldg. 00 | | | | | | | |
| 3 | Based on observation, record review, and | | R 0 | 273 | Compliance 12/06/2024 | | 12/06/2024 |
| | interview, the facility failed to keep the kitchen | | 100 | 273 | R273 Food Procurement. | | 12,00,2021 |
| | clean and in good re | epair related to food debris on | | | Store/Prepare | | |
| | food preparation eq | uipment, dirty convection | | | The General Manager | | |
| | ovens, food not labo | eled and dated, and the proper | | | (Administrator) notified the | | |
| | test strips not availa | able to check the sanitation | | | Medical Director on 11/19/202 | 24 of | |
| | buckets for 1 of 1 k | itchen. (The Main Kitchen) | the Annual Survey findings. At this | | | | |
| | | | | | time the facility is requesting a | | |
| | Findings include: | | | | desk review for the findings al | _ | |
| | | | | | in the annual survey. Chester | | |
| | - | itchen Sanitation Tour on | | Ignite Medical Resorts denies | | | |
| | | m. with Cook 1, the following | | implication of guilt relating to the | | | |
| | was observed: | | | | deficiencies outlines in this pla | | |
| | a Thomas recorded | debris underneath and behind | | | correction. The facilities' inten | | |
| | the stainless steel li | | | | always to provide quality care its guests and residents. No h | | |
| | the stanness steel in | d for the salad bar. | | | came to any residents/guests | allii | |
| | h There was a stici | ky residue on the lid of the | | | related to this alleged deficien | t | |
| | storage bins for the | | | | practice. | • | |
| | | | | | A The food debris undernea | th | |
| | c. An accumulation | n of dust and debris was | | | and behind the stainless-steel | | |
| | observed on top of | the convection oven and the | | | for the salad bar was removed | | |
| | bottom shelf of the | stand that housed the | | | the area cleaned. | | |
| | convection oven. | | | | B The sticky residue on the | lid | |
| | | | | | of the storage bins for the flou | | 1 |
| | d. A bag of cocoa v | was opened on a shelf in the | | | sugar were cleaned and repla | ced. | |
| | dry storage room. | | | | C The accumulation of dust | and | |
| | | | | | debris observed on top of the | | |
| | | ezer contained a bag of onion | | | convection oven and the botto | | |
| | • | dated when opened. There | | | shelf of the stand that housed | | |
| | | n bags of frozen food that had | | | convection oven was dusted a | and | |
| | been opened and no | ot dated. | | | cleaned. | | |
| | | 61 1 1 1 1 | | | D The bag of cocoa that was | S | |
| | _ | er of lemon slices in the reach | | | opened on a shelf in the dry | 1 | |
| | in cooler were not o | covered. | 1 | | storage room was removed ar | nd | 1 |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | | (X3) DATE SURVEY | |
|--|---|--|--|-----|---|--|------|
| | | IDENTIFICATION NUMBER | A. BUILDING <u>00</u> | | COMPLETED | | |
| | | 155844 | B. WING | | 11/01/2024 | | |
| NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CHESTERTON | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | YION (X5) | |
| PREFIX | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL | PROVIDER'S PLAN OF CORRECTION PREFIX (REACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE | | TE | COMPLETION | |
| TAG | REGULATORY OR | R LSC IDENTIFYING INFORMATION | | TAG | DEFICIENCY) | | DATE |
| | not change color wl was tested. During an interview Executive Chef indi- either been cleaned He indicated the Co- buckets with the wr | or 2 of 2 sanitation buckets did then the sanitation solution or on 11/1/24 at 9:50 a.m., the licated all of the above had or were in need of cleaning. The sanitation ong test strips on 10/27/24, the each strips instead of quat | | | thrown away. E The opened onion ring in reach in opened and not dated were removed and thrown away and the two brown bags of frost food that had been opened and dated were also thrown away. F The lemons in the plastic container in the reach in cooled were thrown out. G 2 of 2 sanitation buckets were dumped and remade wit correct sanitation amount place the bucket. Cook was also educated on the proper sanitatest strips. On the unit D wing The container of food from a fast-food restaurant that was relabeled with a resident's name date was removed. The plastic container of food labeled with resident's name was not dated was removed. The plastic container of cantaloupe was labeled with a room number be not dated was removed. The sof fast food that was labeled were sident's name and room numbut not dated was removed. The leftover food that was wrapped aluminum foil and the plastic container of food labeled with resident's room number but not dated was removed. Identification of Other Residents with the Potential be Affected: | d ay, zen d not cr h the se in tion d to ag with a mber he d in the ot | |

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PRINTED: 12/04/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) MULTIPLE CONSTRUCTION | | ONSTRUCTION | (X3) DATE SURVEY | |
|----------------------------------|-------------------------------------|-------------------------------|----------------------------|------------|--|------------------|------------|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | | 00 | COMPLETED | |
| | 155844 B. WING | | | 11/01/2024 | | | |
| | | | _ | STREET A | ADDRESS, CITY, STATE, ZIP COD | <u> </u> | |
| NAME OF F | PROVIDER OR SUPPLIEF | ₹ | | | ILLAGE POINT | | |
| IGNITE MEDICAL RESORT CHESTERTON | | | | CHEST | ERTON, IN 46304 | | |
| (X4) ID | ID SUMMARY STATEMENT OF DEFICIENCIE | | ID | | PROVIDER'S PLAN OF CORRECTION | | (X5) |
| PREFIX | | ICY MUST BE PRECEDED BY FULL | PREFIX | | CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | - | TAG | DEFICIENCY) | _ | DATE |
| | | | | | 1.All current guests and staf | | |
| | | | | | members have the potential to | | |
| | | | | | affected by this alleged deficie | ent | |
| | | | | | practice. | | |
| | | | | | Systemic Changes: | _ | |
| | | | | | 1. A Qappi meeting with CN | O, | |
| | | | | | ACNO, Care Transitions, Hospitality Medical Director ar | nd | |
| | | | | | General Manager. IDT was | IU | |
| | | | | | educated on F812 and how it | | |
| | | | | | relates to the facilities Food | | |
| | | | | | procurement and food storage |). | |
| | | | | | Education on homelike clean | | |
| | | | | | environment. | | |
| | | | | | 2.Staff will be re-educated to |) | |
| | | | | | ensure they follow the facility's | 3 | |
| | | | | | policy on food storage and | | |
| | | | | | labeling. All staff also, educate | ed | |
| | | | | | on homelike clean environmer | | |
| | | | | | Kitchen staff were re-educated | d on | |
| | | | | | checklist for cleaning and | | |
| | | | | | sanitation practices. | | |
| | | | | | Monitoring: | | |
| | | | | | 1 General Manager | | |
| | | | | | (Administrator) Designee will | | |
| | | | | | complete visual audits on all | | |
| | | | | | refrigerators daily across eithe | er | |
| | | | | | shift to ensure the policy on | | |
| | | | | | labeling and storage of foods | | |
| | | | | | being followed x 2 weeks, then observations three times a we | | |
| | | | | | for 2 weeks, then 6 observation | | |
| | | | | | weekly x 4, then 6 residents | 0110 | |
| | | | | | monthly. Thereafter, if determine | ined | |
| | | | | | by Quality Assurance Commit | | |
| | | | | | that further monitoring is need | | |
| | | | | | audits will continue. | - | |
| | | | | | | | |
| | | | | | Education will be completed | | |

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| STATEMENT OF DEFICIENCIES | | X1) PROVIDER/SUPPLIER/CLIA | (X2) M | X2) MULTIPLE CONSTRUCTION | | (X3) DATE SURVEY | | |
|------------------------------|----------------------------------|--|--------------|---|---|------------------|------------|--|
| AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | A. BU | A. BUILDING <u>00</u> | | | COMPLETED | |
| | | 155844 | B. WING 11/0 | | 11/01 | /2024 | | |
| | | | | STREET A | ADDRESS, CITY, STATE, ZIP COD | | | |
| NAME OF PROVIDER OR SUPPLIER | | | | 2775 V | ILLAGE POINT | | | |
| IGNITE N | MEDICAL RESORT | CHESTERTON | | CHEST | ERTON, IN 46304 | | | |
| (X4) ID | SUMMARY STATEMENT OF DEFICIENCIE | | | ID | PROVIDER'S PLAN OF CORRECTION | | (X5) | |
| PREFIX | | CY MUST BE PRECEDED BY FULL | | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | λΤΕ | COMPLETION | |
| TAG | REGULATORY OF | R LSC IDENTIFYING INFORMATION | | TAG | | _1 | DATE | |
| | | | | | immediately with any identified deficiencies. | a | | |
| | | | | | deliciencies. | | | |
| | | | | | | | | |
| | | | | | - | | | |
| R 0349 | 410 IAC 16.2-5-8. | 1(a)(1-4) | | | | | | |
| | Clinical Records - | Noncompliance | | | | | | |
| Bldg. 00 | D 1 , | 114 1 4 6 99 | | 2.40 | | | 10/06/2021 | |
| | | view and interview, the facility | R 0 | 349 | Compliance Date 40/00/000 | | 12/06/2024 | |
| | | ical records were complete and nedications not signed out as | | | Compliance Date 12/06/2024 R-349 Resident Records | , | | |
| | | of 7 records reviewed. | | | The General Manager | | | |
| | (Resident 5) | , 1000140 10 110 110 110 | | | (Administrator) notified the | | | |
| | | | | | Medical Director on 11/19/202 | 24 of | | |
| | Finding includes: | | | | the Annual Survey findings. A | t this | | |
| | | | | | time the facility is requesting a | à | | |
| | | Resident 5 was completed on | | | desk review for the findings al | - | | |
| | _ | m. Diagnoses included, but | | | in the annual survey. Chester | | | |
| | dementia. | acute kidney failure and | | | Ignite Medical Resorts denies | | | |
| | dementia. | | | | implication of guilt relating to t deficiencies outlines in this pla | | | |
| | A Service Plan, date | ed 10/28/24, indicated the | | | correction. The facilities' inten | | | |
| | resident was on Ho | | | | always to provide quality care | | | |
| | | | | | its guests and residents. No h | | | |
| | 1 | r, dated 10/24/24 and | | | came to any residents/guests | | | |
| | | 29/24, was for Norco (pain | | | related to this alleged deficien | it | | |
| | · / | ng (milligrams) to give one | | | practice. | | | |
| | tablet by mouth eve | ery six hours for pain. | | | Basidant 5 mas assessed for | | | |
| | The October 2024 N | Medication Administration | | | Resident 5 was accessed for and given pain medications | pain | | |
| | | e Norco was not signed out as | | | Identification of Other | | | |
| | | and 6:00 a.m., on 10/25, 10/27, | | | Residents with the Potential | to | | |
| | and 10/28/24. | , , | | | be Affected: | <u></u> | | |
| | | | | | | | | |
| | _ | on 11/1/24 at 10:40 a.m., the | | | 1.All current guests with ord | ers | | |
| | _ | indicated she was unable to | | | for pain medications were revi | iewed | | |
| | 1 - | entation the Norco had been | | | to ensure that medication | | | |
| | administered on the | above dates and times. | | | administrations are being | | | |
| | | | | | completed and out and that th | | | |
| | I | | | | facilities medical record policie | 3 8 | I | |

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| 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 11/01/2024 | | |
|---|----------------|---|--|---|---|--|--|
| NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT CHESTERTON | | | STREET ADDRESS, CITY, STATE, ZIP COD 2775 VILLAGE POINT CHESTERTON, IN 46304 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE | | |
| | | | | and being followed. If deficien observed, they were immediate corrected. Any errors observe be corrected immediately, and physician notified. Systemic Changes: | tely d will | | |
| | | | | CNO, ACNO, Care Transitions, Hospitality Medica Director and General Manage IDT was educated on R-349 a how it relates to the facilities Medication Administration | r. | | |
| | | | | Policies. 2.Clinical staff will be re-educated to ensure they for the facility's policy medication administration including follow medication administration. | | | |
| | | | | Monitoring: 4 CNO/ACNO/ Designee of complete audits on 3 residents daily across either shift to ensimedication orders are complete and being documented as out in the facilities medical record policies, x 2 weeks, then 3 residents three times a week of weeks, then 3 residents week weeks, then 6 residents monthly. Thereafter, if determined by Quality Assurance Committee further monitoring is needed, audits will continue. | s ure ted lines for 2 ly x | | |

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