STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	11/01/2024

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00442605 and IN00443841. This visit included a State Residential Licensure Survey. Complaint IN00442605 - Federal/state deficiencies related to the allegations are cited at F554. Complaint IN00443841 - Federal/state deficiencies related to the allegations are cited at F759 and F761. Survey dates: October 27, 28, 29, 30, 31 and November 1, 2024 Facility number: 013688 Provider number: 155844 AIM number: 201352370 Census Bed Type: SNF/NF: 4 SNF: 61 Residential: 24 Total: 89 Census Payor Type: Medicare: 57 Medicaid: 4 Other: 4 Total: 65 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/13/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kristina Herrera	General Manager Admin	11/27/2024

Any defiencystatement 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 disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights Based on observation, record review, and interview, the facility failed to ensure each resident's dignity was maintained related to wearing a hospital gown while in bed during the day for 1 of 1 resident reviewed for dignity. (Resident 30) Finding includes: On 10/27/24 at 11:32 a.m., Resident 30 was observed in his room in bed wearing a hospital gown. On 10/28/24 at 9:52 a.m., 12:09 p.m., and 4:35 p.m., the resident was again observed in his room in bed wearing a hospital gown. On 10/29/24 at 9:25 a.m., 11:28 a.m., and 2:20 p.m., the resident was observed in his room in bed wearing a hospital gown. On 10/30/24 at 9:26 a.m., 10:36 a.m. and 3:30 p.m., the resident was observed in his room in bed wearing a hospital gown. At 1:25 p.m., the resident was seated in his broda chair by the nurses' station, he continued to wear a hospital gown. On 10/31/24 at 9:12 a.m., the resident was in his room in bed watching television. The resident was wearing a hospital gown at that time. The record for Resident 30 was reviewed on 10/30/24 at 10:52 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, delusional disorder, anxiety, dysphagia (difficulty swallowing), and	F 0550	**Compliance Date 12/06/2024** **F550:** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. No harm came to any residents/guests related to this alleged deficient practice Resident #30 family meeting to discuss family's concerns. Resident chooses to be in a hospital gown at times while in bed and during the day. Care plan updated to reflect person centered care and preference of resident. **Identification of Other Residents with the Potential to be Affected:** 1 Guests were identified as wearing a hospital gown in bed and on the milieu.	12/06/2024

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	gastrostomy status (a tube inserted directly into the stomach for nutrition). The 9/13/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and he required substantial/maximum assistance with dressing. A Care Plan, dated 3/14/24 and reviewed on 9/6/24, indicated the resident had self-care deficits which required limited to extensive assist with activities of daily living (ADL's). Interventions included, but were not limited to, extensive assist of one to help with dressing. There was no current care plan related to wearing a gown in bed during the day. During an interview on 11/1/24 at 10:40 a.m., the Vice President of Clinical Operations indicated the resident's care plan was being updated. 3.1-3(t)		2 Guests were asked their preferences and Care plans were updated to reflect guests' choice and person-centered care. **Systemic Changes:** 3 On 11/21/2024 A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director, and General Manager. IDT was educated on F550 residents rights and how it relates to residents' rights, preferences, and person-centered care plans. (related to hospital gowns) (choice of clothing) 4 Staff was educated on F550 resident rights and how it relates to preferences and person-centered care plans (related to hospital gowns and dignity) **Monitoring:** 5 CNO/ACNO/ Designee will complete visual observation rounds on six residents daily across either shift to ensure preferences on hospital gowns are indicated on the care plan interventions. x 2 weeks, then six observations three times a week for 2 weeks, then six observations weekly x 4, then 6 residents monthly four 4 months. Corrective actions will be completed immediately, and staff will be re-educated to ensure care plan interventions are in place related to preferences for hospital gowns.	

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F 0554 SS=E Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 8 of 8 residents reviewed for self-administration of medication. (Residents C, E, F, G, B, H, D, and J) Findings include: 1. During random observations on 10/27/24 at 10:39 a.m., and 1:14 p.m., Resident C was observed sitting in a chair in her room. At those times, there was a plastic medication cup of a white powder substance in the window sill. During an interview on 10/27/24 at 1:14 p.m., the resident indicated she had a rash on her upper left shoulder and asked a nurse for something for it and she came back with the white powder. During an observation on 10/29/24 at 10:25 a.m., the resident was in her room sitting in the wheelchair. There was a facility labeled bottle of Ammonium Lactate on the over bed table. The resident indicated the nurse had brought it into her room so she could apply the lotion to her foot. The record for Resident C was reviewed on 10/28/24 at 3:05 p.m. The resident was admitted to the facility on 9/28/24. Diagnoses included, but were not limited to, orthopedic after care, difficulty walking, type 2 diabetes, acute respiratory failure, chronic obstructive pulmonary disease, end stage renal disease, high blood pressure, heart disease,	F 0554	**Compliance Date 12/6/2024** **F-554 Medication Administration** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. No harm came to any resident/guest related to this deficient alleged deficient practice. Guest C was educated on keeping medication at bedside without an order, medications were removed and orders placed to administer medication from nurse or qma. Guests E,F,G,H,D,J discharged from the facility Resident B was educated on using medication without physician's order, Resident orders were updated and person-centered care plan indicated medication at bedside and self-administration.	12/06/2024

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	anxiety, and atrial fibrillation. The Modification of the Admission Minimum Data Set (MDS) assessment, dated 10/2/24, indicated the resident was cognitively intact for daily decision making. There was no care plan for the resident to self-administer her own medications. There was no physician's order for the powder. A Physician's Order, dated 10/28/24, indicated Ammonium Lactate External Lotion 12 %, apply to the right lower leg topically every day shift for dry skin. There was no self-administration assessment for the resident to apply the lotion. During an interview on 10/29/24 at 10:40 a.m., LPN 1 indicated she was unaware what the powdered substance was and did not know the lotion was on her over bed table. 2. During random observations on 10/27/24 9:59 a.m. and 1:06 p.m., on 10/28/24 at 9:13 a.m. and 4:31 p.m., and on 10/29/24 at 9:05 a.m., Resident E was observed in her room. At those times, there were three bottles of over the counter vitamins on the over bed table. There was one bottle of Vitamin D3, one bottle of Magnesium tablets and one bottle of a Probiotic. On 10/29/24 at 10:42 a.m., LPN 1 was observed in the resident's room. At that time, she was made aware of the three bottles of vitamins on the over bed table.		**Identification of Other Residents with the Potential to be Affected:** 1 All current guest rooms were observed to ensure that medications are not left bedside or in room without an order from the physician. 2 Guests that were found to have medication at bedside were evaluated to see if they were appropriate to self-administer medication. If appropriate, a physician order was placed, and a person center care plan was updated. **Systemic Changes:** **3** A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F554 and how it relates to self-administering medication. All staff were also educated on Medication storage policy and what to do if they observe medication bedside. **Monitoring:** CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily across either shift to ensure medications are not left at the bedside or in the room without a physician's order. x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly.	

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	The record for Resident E was reviewed on 10/29/25 at 9:10 a.m. The resident was admitted to the facility on 10/4/24. Diagnoses included, but were not limited to, fracture around the internal right hip joint, type 2 diabetes, heart disease, high blood pressure and osteoarthritis. The 10/10/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no care plan indicating the resident was able to self-administer her own medications. There was no self-administration of medication assessment available for review. There were no Physician's Orders for the over the counter medications that were in the resident's room, nor was there an order to self-administer her own medications. During an interview on 10/29/24 10:42 a.m., LPN 1 indicated the resident had no orders for the above over the counter vitamins, nor was she able to self-administer her own medications. 3. During random observations on 10/27/24 at 10:24 a.m. and 1:10 p.m., on 10/28/24 at 9:25 a.m., 10:17 a.m. and 2:28 p.m., and on 10/29/24 at 9:05 a.m., Resident F was observed in her bed. At those times, there was a bottle of over the counter nasal spray on her over bed table. During an interview on 10/27/24 at 10:24 a.m., the resident indicated she used the spray all the time during the day, as it helped her breathe easier. On 10/29/24 at 10:34 a.m., LPN 1 was observed in		Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	

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	the resident's room. At that time, she was made aware of the nasal spray on the over bed table. The record for Resident F was reviewed on 10/29/24 at 9:30 a.m.. The resident was admitted to the facility on 10/17/24. Diagnoses included but were not limited to, heart failure, type 2 diabetes, peripheral vascular disease, anemia, high blood pressure, gout and migraines. The 10/23/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. There was no care plan indicating the resident was able to self-administer her own medications. There was no self-administration of medication assessment available for review. There was no Physician's Order for the resident to self-administer her own medications. A Physician's Order, dated 10/17/24, indicated Nasal Moist Solution 0.65 %, 2 spray in both nostrils every 48 hours as needed for dry nasal passage. During an interview on 10/29/24 10:34 a.m., LPN 1 indicated the resident had no orders to self-administer her own medications and she was unaware the nasal spray was on the over bed table. 4. On 10/28/24 at 10:52 a.m. and 1:18 p.m., a bottle of chewable antacids and a bottle of nasal spray were observed on Resident G's bedside table. On 10/28/24 at 9:44 a.m. and 3:53 p.m., the antacids and nasal spray remained on the table. The resident indicated he took the medications when he needed them.			

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	Resident G's record was reviewed on 10/29/24 at 1:23 p.m. Diagnoses included, but were not limited to, cardiomyopathy, pressure ulcer of the right buttock, heart failure, and chronic pain. An Admission Minimum Data Set (MDS) assessment, dated 8/15/24, indicated the resident was cognitively intact, required moderate assistance with upper body dressing and personal hygiene, and maximum assistance with transferring. Physician's orders and the eMAR (electronic medication administration record) for 10/2024 lacked orders for the antacids, nasal spray, and self-administration of medications. There was no assessment of the resident's ability to self-administer medications. During an interview on 10/28/24 at 4:05 p.m., RN 2 indicated a physician's order was needed for a resident to have medications at the bedside and to self-administer and that she would take the medications and put them in the medication cart until that was completed. 5. On 10/27/24 at 11:31 a.m., a cup with four pills and two bottles of eye drops were observed on Resident B's over bed table. On 10/27/24 at 1:25 p.m. and 10/28/24 at 11:01 a.m., the eye drops remained on the table. On 10/28/24 at 3:43 p.m., Resident B indicated she had a bottle of eye drops in her purse that she used as needed, and that the nurse used to leave her pills in a cup for her to take by herself, but they "got in trouble for that."			

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	Resident B's record was reviewed on 10/28/24 at 3:00 p.m. Diagnoses included, but were not limited to, COPD, neuromuscular dysfunction of bladder, delusional disorders, depressive episodes, pain in right knee, and anxiety disorder. An Annual Minimum Data Set (MDS) assessment, dated 10/13/24, indicated the resident was cognitively intact and was dependent for most activities of daily living and transfers. Physician's orders and the eMAR (electronic medication administration record) for 10/2024 lacked orders for the eye drops. A Care Plan, dated 6/8/23, indicated the resident's ability to self administer medications/treatments should be re-assessed Quarterly and with Change in Condition. An assessment of the resident's ability to self-administer medications had not been completed since 10/23/23. During an interview on 10/29/24 at 10:09 a.m., LPN 5 indicated there was not a current evaluation for the resident to self administer any medications. During an interview on 10/29/24 at 2:03 p.m., the General Manager was informed of the findings and offered no further information. 6. On 10/29/24 at 10:14 a.m., a bottle of Biofreeze (a topical pain relief medication) was observed on Resident H's over bed table. The resident indicated she used the medication as needed on her shoulders. Resident H's record was reviewed on 10/29/24 at			

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	3:56 p.m. Diagnoses included, but were not limited to, disruption of external operation (surgical) wound, muscle weakness, and chronic respiratory failure with hypoxia. An Admission Minimum Data Set (MDS) assessment, dated 10/1/24, indicated the resident was cognitively intact and required moderate to maximum assistance with activities of daily living and transfers. Physician's orders and the eMAR (electronic medication administration record) for 10/2024 lacked orders for Biofreeze and self-administration. There was no assessment of the resident's ability to self-administer medications. During an interview on 10/29/24 at 10:20 a.m., LPN 1 indicated there should be an order for the medication and for it to be kept at the bedside, and she was going to remove the medication from the resident's room until that was completed. 7. On 10/28/24 at 11:08 a.m., 3:24 p.m., and 4:20 p.m., Resident D was observed in his room, there was a tube of Venelex cream inside a wash basin by the television. 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 sleeping), hypertension (high blood pressure), gout, depression, atrial fibrillation (abnormal heart rhythm), chronic kidney disease, and anemia (low iron). The Medicare 5-day Minimum Data Set (MDS) assessment, dated 10/16/24, indicated the resident was cognitively intact for daily decision making.			

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	The resident had no impairment of the upper and lower extremities and used a wheelchair. The resident required partial to moderate assistance for oral hygiene, personal hygiene and upper body dressing. The resident was dependent with toileting, putting on/off footwear and lower body dressing. A Physician's Order, dated 10/12/24, indicated to apply venelex ointment to right heel daily and as needed A Physician's Order, dated 10/12/24, indicated to apply venelex ointment (Balsam Peru-Castor Oil) to the left 3rd toe topically every day shift and as needed for wound care. A Physician's Order, dated 10/26/24, indicated to apply venelex ointment to left ischial tuberosity every day shift and as needed for wound care. There was no care plan for the resident to self-administer their own medications. There were no physician orders for self-administration of the medications. There was no self-administer of medications assessment completed. During an interview on 10/30/24 at 9:55 a.m., the Director of Nursing (DON) indicated she understood the concern about medication left at the bedside and had no additional information to provide. 8. On 10/27/24 at 11:29 a.m. and 2:03 p.m., Resident J was observed in his room, there was a tube of portocort cream (cream for itching) on his			

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	nightstand. On 10/28/24 at 10:43 a.m., 3:21 p.m., and 4:22 p.m., the resident was observed in his bed watching television, the portocort cream remained on the nightstand. On 10/29/24 at 9:51 a.m., the resident was lying in bed watching television and the portocrot cream was on the nightstand. Resident J indicated he had just finished applying the cream. The record for Resident J was reviewed on 10/30/24 at 9:34 a.m. The diagnoses included, but were not limited to, heart failure, dementia, hypertension (high blood pressure), muscle weakness, need for assistance with personal care, and depression. The Admission Minimum Data Set (MDS) assessment, dated 10/13/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. A Physician's Order, dated 10/25/24, indicated to apply Hydrocortisone External Cream (portocort cream) to the right side flank topically every 8 hours as needed for Itching. There was no care plan for the resident to self-administer their own medications. There were no physician orders for self-administration of the medications. There was no self-administer of medications assessment completed. During an interview on 10/30/24 at 9:55 a.m., the			

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	Director of Nursing (DON) indicated she understood the concerns and had no additional information to provide. During an interview 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 Operations on 10/29/24 at 3:10 p.m., indicated a physician must provide an order for medication at the bedside. This citation relates to Complaint IN00442605. 3.1-11(a)			
F 0677 SS=D Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to dirty and long fingernails, greasy hair, and the removal of facial hair for 2 of 6 residents reviewed for ADLs. (Residents F and 170) Findings include: 1. During an interview on 10/27/24 at 10:14 a.m., Resident F indicated her hair had not been washed since she had been at the facility. At that time, her hair was greasy in appearance. The record for Resident F was reviewed on 10/29/24 at 9:30 a.m.. The resident was admitted to the facility on 10/17/24. Diagnoses included, but	F 0677	**Compliance Date: 12/06/2024** **F677: ADL Dependent Residents** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient	12/06/2024

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	155844	A. BUILDING 00 B. WING	11/01/2024

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	were not limited to, heart failure, type 2 diabetes, peripheral vascular disease, anemia, high blood pressure, gout and migraines. The 10/23/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. It was very important for the resident to choose between a shower or a bed bath and the task of bathing was not attempted during the observation period. A Care Plan, dated 10/17/24, indicated the resident had an ADL self care performance deficit related to physical mobility. The approaches indicated the resident needed substantial/maximal assistance for showers and/or baths. The shower sheet for 10/2024 indicated the resident refused a shower on 10/24 and had a bed bath on 10/28/24, which included her hair being washed. The resident did not receive a bath or shower on 10/21/24. During an interview on 10/29/24 at 9:15 a.m., the Unit Manager indicated they attempted multiple times on 10/24/24 to assist the resident with taking a shower, however, she kept refusing due to the chair being too high for her. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated the resident did not receive a shower on 10/21/24 nor was there documentation she had refused. The resident's hair was to be washed as needed. 2. During random observations on 10/27/24 at 11:23 a.m. and 1:20 p.m., and on 10/28/24 at 9:40 a.m. and 10:45 a.m., Resident 170 was observed in bed. At those times, the resident's fingernails were		practice. Guest F has discharged from the facility. Guest 170 has discharged from the facility. **Identification of Other Residents with the Potential to be Affected:** 1 All guests who are considered dependent for ADL were observed to ensure that skin, nails and hair are clean as preferred by guest and that facial hair is trimmed as preferred. 2 Guests that prefer long nail or/ facial hair will have person centered care plans indicating their preferences. **Systemic Changes:** **3** A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F677 and how it relates to ADLS and dependent guest/residents. Education provided to Staff on ADL policy. **Monitoring:** CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily across either shift to ensure that Dependent guests are provided with ADLS as preferred in their person-centered care plan. x 2 weeks, then 6 observations three times a week for 2 weeks, then 6	

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	long and dirty and he had a large amount of facial hair on his cheeks, chin, and neck. The record for Resident 170 was reviewed on 10/28/24 at 3:15 p.m. The resident was admitted to the facility on 10/16/24. Diagnoses included, but were not limited to, brain disorder, type 2 dm, end stage renal disease, anemia, and stroke. The 10/22/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed partial to moderate assistance with personal hygiene. A Care Plan, dated 10/16/24, indicated the resident had an ADL self care deficit performance related to physical mobility. The approaches indicated the resident needed partial to moderate assistance with personal hygiene. The shower sheet for the month of 10/2024 indicated the resident received a bed bath on 10/19/24 and refused baths on 10/23 and 10/26/24. There was no documentation to indicate the resident received nail care or a shave. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated the resident's nails were long and dirty and he was in need of shave. The resident wanted his electric razor, so they were waiting on that from his home. 3.1-38(a)(3)(D) 3.1-38(a)(a)(E)		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 care plan interventions are in place related to preferences for ADLS.	
F 0684 SS=D Bldg. 00	483.25 Quality of Care			

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	Based on observation, record review, and interview, the facility failed to ensure treatments were completed as ordered for dry flaky skin and signs of constipation were monitored for 2 of 4 residents reviewed for non pressure skin conditions and for 1 of 1 resident reviewed for constipation. (Residents 31, F and 170) Findings include: 1. During an interview on 10/27/24 at 1:36 p.m., Resident 31 indicated he had issues with constipation and would go longer than three days without having a bowel movement. The record for Resident 31 was reviewed on 10/29/24 at 9:00 a.m. Diagnoses included, but were not limited to, high blood pressure, anxiety disorder, panic disorder, post traumatic stress disorder, and COPD. The 9/4/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making. The Care Plan, revised on 9/8/23, indicated the resident was at risk for constipation related to the use of opioids. The approaches were to administer medications as ordered by the doctor and monitor effectiveness and side effects. Physician's Orders, dated 2/4/21 and on the current Physician Order Summary dated 10/2024, indicated Senokot S Tablet 8.6-50 milligrams (mg), give 2 tablet by mouth at bedtime for constipation. Physician's Orders, dated 1/31/21 and on the current Physician Order Summary dated 10/2024, indicated Lactulose Solution 10 grams/15 milliliters (ml), give 30 ml by mouth every 24 hours as	F 0684	**Compliance Date 12/06/2024** **F-684 Quality of Care** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest 31, F and 170 have discharged from the facility. **Identification of Other Residents with the Potential to be Affected:** 1.All current guests with orders application of prescription skin lotion or cream were observed to ensure the treatment is being provided and that the medication is available for the nurse to provide the ordered treatment. If it is identified that the treatment is not being provided as ordered, education will be provided to the Nurse assigned to the guest. The treatment will be immediately provided. If the prescription is not available for the guest, it will be ordered and applied as soon as	12/06/2024

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	needed for constipation. Physician's Orders, dated 7/28/23 and on the current Physician Order Summary dated 10/2024, indicated Bisacodyl Laxative Rectal Suppository 10 mg insert one suppository rectally every 12 hours as needed for constipation. Physician's Orders, dated 4/2/24, indicated Acetaminophen-Codeine Tablet 300-30 mg, give one tablet by mouth every four hours as needed for severe pain. Physician's Orders dated 10/2/24, indicated Bisacodyl EC Tablet Delayed Release 5 mg, give 10 mg by mouth every 24 hours as needed for as needed for constipation. The bowel movements for the last 30 days were as follows: No bowel movement on 9/30, 10/2, 10/3, 10/5, 10/6, 10/7, 10/10, 10/11, 10/15, 10/16, 10/17, 10/18, 10/20, 10/22, 10/24, 10/25, and 10/27/24. Blank (nothing recorded) on 10/1, 10/8,10/9, 10/12, 10/19, 10/23, and 10/26/24. 1 large bowel movement on 10/4/24. 1 small bowel movement on 10/13 and 10/14/24. 1 medium bowel movement on 10/21/24. A Kidney, Ureter, and Bladder (KUB) X-ray was obtained on 10/7/24. The X-ray indicated there was some amount of retained fecal debris and air noted in the rectum and in portions of the colon with slight gastric dilatation with air. The Medication Administration Record (MAR) for the month of 10/2024 indicated the Lactulose,		possible, and the Physician will be notified. 2 All current guest that have not have a documented bowel movement in 3 days assessed per bowel protocol and MD notified. If medication is ordered for constipation. Medication will be administered. If a guest refuses the MD will be notified and the nurse will document the interventions. The facility will continue to provide notification to the MD until the guest has bowel movement. **Systemic Changes:** 1. A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F684 treatment, bowel protocol and documentation. All staff were also educated on bowel procedure, treatments, and documentation as they relate to Quality of Care. **Monitoring:** CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily across either shift to ensure treatments are being provided and medications are available. x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly. Staff will be re-educated to ensure they follow	

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	Bisacodyl suppositories and the tablets were not administered. The resident had refused the daily scheduled medication of Senokot 10/19-10/28. A risk versus benefits evaluation, dated 9/17/24, indicated the area of concern was the refusal of medications and the physician was notified on 9/17/24 of this problem. There was no further 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 offered the resident any as needed bowel relief medications for constipation. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer indicated the resident had refused his medications and was a private person. She had no further information to provide. The current 7/2024 "Bowel Protocol" policy, provided by the Vice President of Clinical Operations on 10/30/24 at 11:49 a.m., indicated the residents at the facility were assessed by shift for bowel patterns per staff reporting in the charting system. Per bowel protocol, if the resident had not had a bowel movement or only small documented bowel movement for days outside of baseline, the provider would determine if additional testing and/or medications were warranted. Refusals of medications (stool softener/laxatives) should be documented, and education of risk versus benefit provided if resident is cognitive enough to understand. 2. During random observations on 10/27/24 at 10:24 a.m. and 1:10 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.,		the facility's medication administration policy. The facility will run a bowel movement report 5 days a week to ensure that all guests are having bowel movements at least once every three days. x for 6 months.	

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	Resident F was observed sitting in her bed. At those times, the resident's bilateral lower legs were dry with flaky and red skin observed. During an interview on 10/27/24 at 10:24 a.m., the resident indicated she had an open area on her ankle, but it was healed, and when the nurse came to do the treatment, he would sometimes put lotion on her legs, otherwise no other staff put lotion 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. The record for Resident F was reviewed on 10/29/24 at 9:30 a.m.. The resident was admitted to the facility on 10/17/24. Diagnoses included but were not limited to, heart failure, type 2 diabetes, peripheral vascular disease, anemia, high blood pressure, gout and migraines. The 10/23/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and had no skin issues. A Care Plan, dated 10/18/24, indicated the resident was at risk for impaired skin integrity. The approaches were to provide skin/wound treatments as ordered. A Nurse's Note, dated 10/18/24 at 2:27 p.m., indicated the resident's bilateral lower legs were dry, scaly, and hemosiderin stained (a condition that caused discolored patches on the skin that appear as bruises, or were brownish or rust-colored) A Physician's Order, dated 10/18/24, indicated			

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	Ammonium Lactate Cream 12%, apply to bilateral lower legs topically every day shift for prevention and protection. The Treatment Administration Record (TAR) for the month of 10/2024 indicated the Ammonium Cream was signed out as being completed on 10/18-10/27/24. 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. 3. During random observations on 10/27/24 at 11:23 a.m. and 1:20 p.m., and on 10/28/24 at 9:40 a.m., Resident 170 was observed in bed. At those times he was not wearing any socks and his legs and feet were very dry with flaky and scaly skin. On 10/28/24 at 10:45 a.m., the treatment cart was observed with RN 3 and there was no Balsum Peru Castor Oil cream located inside the cart. During an interview at that time, Wound Nurse 2 indicated the cream for the treatment should be inside the nurses' treatment cart. At 10:55 a.m., Wound Nurse 2 was asked to perform a skin assessment to the resident's legs			

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	and feet. The resident's legs and feet were extremely dry, with 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. The record for Resident 170 was reviewed on 10/28/24 at 3:15 p.m. The resident was admitted to the facility on 10/16/24. Diagnoses included, but were not limited to, brain disorder, type 2 diabetes, end stage renal disease, anemia, and stroke. The 10/22/24 Admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had no skin conditions. 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. A Physician's Order, dated 10/16/24, indicated Balsam Peru-Castor Oil External Ointment, apply to bilateral feet/ heels, topically every evening shift. The Treatment Administration Record for the month of 10/2024 indicated the cream was signed out as being completed 10/17-10/27/24. During an interview on 10/28/24 at 3:40 p.m., RN 3 indicated she could not find the physician ordered cream for the resident earlier, however, pharmacy just delivered Venelex cream, which was the brand			

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	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)			
F 0690 SS=D Bldg. 00	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 was observed in bed and her Foley catheter	F 0690	**Compliance Date 12/06/2024** **F690 Catheter Care** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm	12/06/2024

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	tubing was draining cloudy, yellow urine. The urine odor remained in the resident's room. On 10/29/24 at 9:22 a.m., the resident was observed in bed and her Foley catheter tubing was draining cloudy, yellow urine. The urine odor remained in the resident's room. The record for Resident 131 was reviewed on 10/29/24 at 10:41 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and fracture of the the lower end of the right femur. The resident was admitted to the facility on 10/14/24. The Admission Minimum Data Set (MDS) assessment, dated 10/20/24, indicated the resident was cognitively impaired for daily decision making and she had an indwelling urinary catheter. A Care Plan, dated 10/15/24, indicated the resident had a urinary catheter. Interventions included, but were not limited to, monitor/record/report to physician for signs and symptoms of urinary tract infection (UTI): pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temperature, urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, and change in eating patterns. A Physician's Order, dated 10/24/24, indicated the resident was to have a 16 french, 10 cubic centimeter (cc) balloon indwelling catheter. There was no order for catheter care. The October 2024 Medication and Treatment Administration Records indicated there was no documentation of catheter care being completed.		came to any residents/guests related to this alleged deficient practice. Guest 131 Discharge from the facility **Identification of Other Residents with the Potential to be Affected:** 1.All current guests were observed to identify if they have a foley catheter placed. If identified, the auditor ensured that an order is placed to have the catheter, to care for the catheter and a person centered care plan related to the catheter. 2.The nurse assigned to the guest was educated. **Systemic Changes:** A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F690 and how it relates to Foley Catheter Care. Clinical staff were also educated on F690 and how it relates to Foley Catheter Care. **Monitoring:** **1** CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily across either shift to ensure orders and care plans are in place for all residents with foley catheters x 2	

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	During an interview, on 10/29/24 at 1:54 p.m., the Vice President of Clinical Operations indicated the resident should have had an order for the catheter upon admission and orders for catheter care. 3.1-41(a)(1)		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 foley catheters.	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance Based on record review and interview, the facility failed to complete weekly weights for an underweight resident for 1 of 1 resident reviewed for nutrition. (Resident J) Finding includes: The record for Resident J was reviewed on 10/30/24 at 9:34 a.m. The diagnoses included, but were not limited to, heart failure, dementia, hypertension (high blood pressure), muscle weakness, need for assistance with personal care, and depression. The Admission Minimum Data Set (MDS) assessment, dated 10/13/24, indicated the resident was severely impaired for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. A Comprehensive Nutrition Assessment, dated 10/10/24 at 11:47 a.m., indicated the resident was underweight, not well nourished and at risk for	F 0692	**Compliance 12/06/2024** **F692 Nutrition/Hydration** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest J Discharge from the facility **Identification of Other Residents with the Potential to**	12/06/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING 00 B. WING	11/01/2024

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

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	malnutrition. Nutrition monitoring and evaluation included, monitor weight, appetite, skin, labs, and fluid status. A Physician's order, dated 10/13/24, indicated for weekly weights to be completed every Sunday. There were no weekly weights recorded after the 10/7/2024 admission weight. During an interview on 11/1/24 at 11:00 a.m., the VP clinical operations indicated the resident should have been weighed weekly. 3.1-46(a)		**be Affected:** 1.All current guests' orders reviewed to identify orders for weekly weights. Guest Identified to have weekly weights audited to ensure that weekly weights are completed. If a guest chart indicates a weight has not been documented, the guest will be weighed and MD notified of current weight. 2.The 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 has been educated on F692 and how it relates to Nutrition Hydration. All clinical staff were educated on Nutrition Hydration policy and how it relates to weekly weights. **Monitoring:** 4 CNO/ACNO/ Designee will complete chart audits on 6 residents daily across either shift to ensure weekly weight orders are followed 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. Guests will be weighed immediately, and staff will be re-educated to ensure they	

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			follow the facility's policy on nutrition hydration.	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review, and interview, the facility failed to ensure a peripheral intravenous (IV) catheter was maintained, monitored and assessed for patency for 1 of 1 resident reviewed for hydration. (Resident 41) Finding includes: During random observations on 10/27/24 at 9:07 a.m. and 1:14 p.m., Resident 41 was observed with a peripheral IV in her right hand with a date of 10/23/24. On 10/28/24 at 9:30 a.m., the resident was observed with a bandaid on her right hand where the peripheral IV used to be. The IV was not visible at that time. The record for Resident 41 was reviewed on 10/28/24 at 3:55 p.m., The resident was admitted to the facility on 10/3/24. Diagnoses included, but were not limited to, major depressive disorder with recurrent and severe psychotic symptoms, heart disease, history of breast cancer, anemia, anxiety, and high blood pressure. The 10/9/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was frequently incontinent of urine. The resident received an antipsychotic, antidepressant, antibiotic, and diuretic while at the facility.	F 0694	**Compliance 12/06/2024** **F694 IV Fluids/ Parenteral** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest 41 Discharge from the facility **Identification of Other Residents with the Potential to be Affected:** 1.All current guests were observed to identify if they have IV placed. If identified, the auditor ensured that an order is placed to have the IV, to care for the IV per	12/06/2024

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	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, nor were there orders for a saline flush to keep it 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)		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 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 Peripheral IV Management.	

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F 0695 SS=E Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review, and interview, the facility failed to ensure oxygen orders were complete, oxygen concentrators were set at the correct flow rate, and oxygen was signed out as being in use for 4 of 4 residents reviewed for oxygen therapy. (Residents 130, C, F and 127) Findings include: 1. On 10/27/24 at 1:20 p.m., Resident 130 was observed in his room in bed. The resident was wearing oxygen by the way of a nasal cannula at 3 liters. On 10/28/24 at 9:37 a.m., 12:06 p.m., and 4:32 p.m., the resident had oxygen in place via a nasal cannula at 3 liters. The record for Resident 130 was reviewed on 10/29/24 at 9:43 a.m. Diagnoses included, but were not limited to, congestive heart failure (CHF), type 2 diabetes, and sleep apnea. The Admission Minimum Data Set (MDS) assessment, dated 10/30/24, indicated the resident was cognitively intact. A Care Plan, dated 10/25/24, indicated the resident required oxygen therapy. Interventions included, but were not limited to, administer oxygen per physician's orders. A Physician's Order, dated 10/24/24, indicated may administer supplemental oxygen as ordered. There was no flow rate for the oxygen listed.	F 0695	**Compliance 12/06/2024** **F695 Respiratory/Tracheostomy** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest 130, F,127 discharged from the facility. Guest C oxygen liter flow was discussed with respiratory therapist from PEL VIP. Liter flow order was reviewed, and guests were educated on the liter flow provided by the Respiratory Therapist and the MD. Person centered care plan updated. **Identification of Other Residents with the Potential to be Affected:** 1.All current guests with Oxygen were observed to ensure that orders were placed in the	12/06/2024

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	The October 2024 Medication and Treatment Administration Records indicated the oxygen was not signed out as being applied. A Physician's Order, dated 10/28/24 at 3:00 p.m., indicated the resident was to receive continuous oxygen at 3 liters per nasal cannula. During an interview, on 10/29/24 at 1:54 p.m., the Vice President of Clinical Operations indicated the as needed (PRN) oxygen order should have specified the flow rate. 2. During random observations on 10/27/24 at 10:39 a.m. and 1:15 p.m., and on 10/28/24 at 3:00 p.m., Resident C was observed sitting in her chair in the room. At those times, the resident was wearing oxygen at 3.5 liters per minute. During a random observation on 10/29/24 at 10:25 a.m., the resident was observed wearing oxygen at 4 liters per minute. During an observation on 10/29/24 at 10:40 a.m., LPN 1 was in the resident's room and observed the oxygen at 4 liters per minute. The record for Resident C was reviewed on 10/28/24 at 3:05 p.m. The resident was admitted to the facility on 9/28/24. Diagnoses included, but were not limited to, orthopedic after care, difficulty walking, type 2 diabetes, acute respiratory failure, chronic obstructive pulmonary disease (COPD), end stage renal disease, high blood pressure, heart disease, anxiety, and atrial fibrillation. The Modification of the Admission Minimum Data Set (MDS) assessment, dated 10/2/24, indicated the resident was cognitively intact for daily decision making and used oxygen while a resident.		medical record and person-centered care plan indicated oxygen use. 2.Oxygen was observed to ensure that the liter flow matched the order in the medical record. If the flow does not match the order, the nurse will be educated, and the liter flow will be changed to match the order in the medical record. **Systemic Changes:** 1. A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F695 and how it relates to Respiratory management policy. 4 All Staff and staff will be re-educated to ensure they follow the facility's policy on respiratory Management. - - **Monitoring:** CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily across either shift to ensure orders and care plans are in place for all guest with oxygen and liter flow matches the order x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly. Education and correction will be completed immediately with any identified deficiencies.	

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A Care Plan, dated 10/1/24, indicated the resident had COPD.

A Care Plan, dated 10/1/24, indicated the resident required oxygen therapy. The approaches were administer oxygen per physician's orders.

A Physician's Order, dated 9/28/24, indicated oxygen at 2 liters per minute continuously.

During an interview on 10/29/24 at 10:40 a.m., LPN 1 indicated the resident's oxygen level was to be at 2 liters per nasal cannula. She had not checked the resident's oxygen at all today.

3. During random observations on 10/27/24 at 10:22 a.m., and 1:10 p.m., Resident F was observed wearing oxygen per nasal cannula at 2.5 liters per minute.

During random observations on 10/28/24 at 9:26 a.m. and 2:28 p.m., and on 10/29/24 at 9:05 a.m., the resident was observed wearing oxygen at 5 liters per minute.

The record for Resident F was reviewed on 10/29/24 at 9:30 a.m.. The resident was admitted to the facility on 10/17/24. Diagnoses included but were not limited to, heart failure, type 2 diabetes, peripheral vascular disease, anemia, high blood pressure, gout and migraines.

The 10/23/24 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and used oxygen while a resident.

A Care Plan, dated 10/18/24, indicated the resident

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	required oxygen therapy. The approaches were to administer oxygen per physician's orders. A Physician's Order, dated 10/17/24, indicated oxygen at 3 liters per minute every shift for shortness of breath. During an interview on 10/29/24 10:34 a.m., LPN 1 indicated the resident's oxygen was supposed to be set at 3 liters per minute. She had not checked the resident's oxygen at all today.4. On 10/28/24 at 3:32 p.m., and 4:18 p.m., Resident 127 was observed lying in bed in a hospital gown and she was wearing oxygen via nasal cannula at 2 liters. On 10/29/24 at 9:51 a.m. and 10:30 a.m., the resident was observed asleep in bed, wearing oxygen via nasal cannula at 2 liters. The record for Resident 127 was reviewed on 10/28/24 at 4:38 p.m. The diagnoses included, but were not limited to, hypertension (high blood pressure), bipolar, and kidney failure. The Admission Minimum Data Set (MDS) assessment, dated 10/25/24, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 10/14/24, indicated to administer supplemental oxygen as needed The Medication Administration Record (MAR), indicated the oxygen was not signed out on 10/28 and 10/29/24. During an interview on 10/29/24 at 10:35 a.m., RN 1 indicated the resident had been wearing oxygen daily since her decline.			

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	During an interview on 10/29/24 at 1:55 p.m., the General Manager indicated she understood the oxygen concerns and said they spoke with the respiratory therapist and will be starting a new process to monitor oxygen administration and orders. The current 11/2018, "Door Signs" policy, provided by the Vice President of Clinical Operations on 10/29/24 at 3:10 p.m., indicated a resident on oxygen would have orders recorded in the resident's chart. 3.1-47(a)(6)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis Based on record review and interview, the facility failed to ensure ongoing communication with the dialysis center was completed with each dialysis session for 1 of 1 resident reviewed for dialysis. (Resident 43) Finding includes: The record for Resident 43 was reviewed on 10/28/24 at 3:37 p.m. The diagnoses included, but were not limited to, diabetes with ketoacidosis, muscle weakness, dependence on renal dialysis, renal disease, anemia (low iron), insomnia (difficulty sleeping), heart failure, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 10/11/24, indicated the resident was cognitively intact for daily decision making. The resident had no impairment of the upper and lower extremities and was on dialysis. .	F 0698	**Compliance 12/06/2024** **F698 Dialysis** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest 43 discharged from the facility.	12/06/2024

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	A Care Plan, dated 10/8/24, indicated the resident required dialysis related to end stage renal disease. Interventions were to check the permacath site daily and upon dialysis return, and monitor vital signs and labs. A Physician's Order, dated 10/9/24, indicated to obtain dialysis pre-weights and pre-vital signs in the morning every Monday, Wednesday, and Friday. A Physician's Order, dated 10/7/24, indicated to transport resident to dialysis on Monday, Wednesday, and Friday. A Nurse's Note, dated 10/16/2024 at 11:00 a.m., indicated the resident was out at dialysis. The Dialysis Communication binder included communication forms that had information for the facility to fill out prior to the resident going to the dialysis center and upon return. The information included last meal, medications given, vital signs, and other pertinent information. There were no Dialysis Communication sheets for 10/11, 10/14, 10/16, 10/18, 10/23, and 10/28/2024. During an interview on 10/29/24 at 1:55 p.m., the General Manager indicated she understood the dialysis concerns and had no further information to provide. During an interview on 10/31/24 at 3:17 p.m., LPN 6 indicated the dialysis binder should get filled out prior to the resident leaving for dialysis and upon return from dialysis. 3.1-37(a)		**Identification of Other Residents with the Potential to be Affected:** 1.All current guests with outside dialysis were reviewed to ensure that orders placed in the medical record were followed and a person-centered care plan indicated dialysis. 2.All Dialysis communication sheets are filled out per facility protocol and physicians' orders. **Systemic Changes:** 1.A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F698 and how it relates to the facilities Dialysis policy. **4** All Staff and staff will be re-educated to ensure they follow the facility's policy on Dialysis. **Monitoring:** **5** CNO/ACNO/ Designee will complete visual observation rounds on 6 residents daily across either shift to ensure orders, care plans and completion of communication binders are in place for all guest with Dialysis 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	

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			Quality Assurance Committee that further monitoring is needed, audits will continue. - Education will be completed immediately with any identified deficiencies.	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored related to not monitoring the resident's blood pressure as ordered for 2 of 5 residents reviewed for unnecessary medications. (Residents H and D) Findings include: 1. Record review for Resident H was completed on 10/29/24 at 3:56 p.m. Diagnoses included, but were not limited to, disruption of external operation (surgical) wound, muscle weakness, and chronic respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 10/1/24, indicated the resident was cognitively intact and required moderate to maximum assistance with activities of daily living and transfers. The October 2024 Physician's Order Summary indicated an order for Diltiazem HCl 60 mg one time daily for hypertension. A Care Plan, dated 9/25/24, indicated the resident's blood pressure, pulse, temperature, and	F 0757	**Compliance 12/06/2024** **F757 Unnecessary Drugs** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest H, D have discharged from the facility. **Identification of Other Residents with the Potential to be Affected:**	12/06/2024

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	respiratory rate were to be checked every shift (twice a day). The record lacked any documentation of blood pressure monitoring for 10/5/24, 10/7/24, 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. 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 sleeping), hypertension (high blood pressure), gout, depression, atrial fibrillation (abnormal heart rhythm), chronic kidney disease, and anemia (low iron). The Medicare 5-day Minimum Data Set (MDS) assessment, dated 10/16/24, indicated the resident was cognitively intact for daily decision making. The resident had no impairment of the upper and lower extremities and used a wheelchair. The resident required partial to moderate assistance for oral hygiene, personal hygiene and upper body dressing. The resident was dependent with toileting, putting on/off footwear and lower body dressing. A Physician's Order, dated 10/11/24, indicated to monitor blood pressure, pulse, respirations, temperature, and oxygen saturation every shift.		1.All current guests with orders 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 re-educated to ensure they follow the facility's policy on medication administration including follow medication administration with parameters. **Monitoring:** **5** Starting on 11/22/2024 the CNO/ACNO/ Designee will complete audits on 6 residents daily across either shift to ensure orders are being followed, care plans and completion documentation of vitals of guest with parameters 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	

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	155844	A. BUILDING 00 B. WING	11/01/2024

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	A Physician's Order, dated 10/12/24, indicated to give midodrine (blood pressure medication) by mouth three times a day for low blood pressure (BP). The resident's blood pressure was not documented on 10/9, 10/10 and 10/23/24. Blood pressures were documented only once a day on 10/1, 10/5, 10/11, 10/12, 10/13, 10/14, 10/15, 10/16, 10/17, 10/18, 10/19, 10/21, 10/22, 10/25, 10/26, 10/28 and 10/29/24. During an interview on 10/29/24 at 1:55 p.m., the Director of Nursing (DON) and Vice President Clinical Operations indicated the blood pressure should have been checked at least twice a day. During an interview on 10/31/24 at 3:20 p.m., the LPN 2 indicated the resident's blood pressure should be checked each time the midodrine was given. 3.1-48(a)(3)		by Quality Assurance Committee that further monitoring is needed, audits will continue. - Education will be completed immediately with any identified deficiencies.	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 6 residents observed during medication pass. Two errors were observed during 34 opportunities for errors during medication administration. This resulted in a medication error rate of 5.88%. (Residents K and L) Findings include: 1. On 10/28/24 at 10:23 a.m., LPN 4 was observed preparing to administer 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 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 deficiencies outlines in this plan of correction. The facilities' intent is	12/06/2024

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	via a PICC (peripherally inserted central catheter) line. The LPN applied gloves, then opened and attached new tubing to a medication bag with the antibiotic Unasyn. She finished setting up the machine and started the antibiotic on the resident at 10:30 a.m. She indicated the medication would take 30 minutes to administer. Record review for Resident K was completed on 10/28/24 at 10:35 a.m. The October 2024 Physician's Order Summary indicated an order for Unasyn 3000 mg (milligrams) intravenously three times a day for a left foot wound for 6 weeks. The administration times were to be at 12:00 a.m., 8:00 a.m., and 4:00 p.m. During an interview on 10/28/24 at 10:40 a.m., LPN 4 indicated the resident's antibiotic was supposed to be started at 8:00 a.m. She started the medication late because she had been busy getting another resident's weight and "running around" administering other resident's pain medications. 2. On 10/28/24 at 9:31 a.m., RN 2 was observed preparing Resident L's medications. She placed Vitamin C one tablet and Osteo Bi-flex (medication for joints) one tablet into a pouch, crushed them, and mixed them with applesauce in a medication cup. RN 2 confirmed she had crushed two pills, and administered them to the resident in their room. Resident L's record was reviewed on 10/28/24 at 10:21 a.m. The Medication Administration Record (MAR) indicated RN 2 administered Methylsulfonylmethane (a supplement used for arthritis) 1000 milligrams (mg) tablet, as well as Vitamin C and Osteo Bi-flex at 9:00 a.m. on 10/28/24.		always to provide quality care to its guests and residents. Guest L's medication was ordered from Pharmacy and administered upon facility receiving, MD notified. LPN2 was educated on Medication administration policy, including documentation of medication administration. Guest K was discharged from the Facility. LPN 4 was educated on Facilities medication administration policy including Medication administration times. **Identification of Other Residents with the Potential to be Affected:** 1.All current guests with orders to administer medication were reviewed to ensure that medications are available, and medication is being administered as ordered and documented. 2.All Guest receiving IV medications were observed at different shifts during the day to ensure that Iv medications are administered as ordered. 3.Any errors observed will be corrected immediately Nurse will be educated. **Systemic Changes:** 1. A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F759 and how it relates to the facilities Medication	

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	During an interview on 10/28/24 at 11:11 a.m., RN 2 indicated she did not administer the Methylsulfonylmethane that morning and documented she had in error. She indicated the medication was not in the drawer and she would need to call the pharmacy. This citation relates to Complaint IN00443841. 3.1-48(c)(1)		Administration Policies. 2.All clinical staff will be re-educated to ensure they follow the facility's policy medication administration including follow medication administration without errors and what to do if medication is not available or they are too busy to administer medications timely. **Monitoring:** **6** CNO/ACNO/ Designee will complete audits on 6 residents daily across either shift to ensure orders being followed, medications are timely and completion documentation of vitals of guest with parameters 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. Education will be completed immediately with any identified deficiencies.	
F 0761 SS=E Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation, record review and interview, the facility failed to ensure medications were not prepared in advance and treatment carts were locked for 1 of 2 units. (The C Wing) This had the potential to affect all residents receiving medications from LPN 6 and wound treatments.	F 0761	**Compliance 12/06/2024** **F761 Labeling and Storage of Drugs** The General Manager (Administrator) notified the Medical Director on 11/19/2024 of	12/06/2024

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	Findings include: 1. On 10/27/24 at 9:14 a.m., LPN 6 was seated in a chair at the C Wing nurse's station. The LPN was seated next to the medication cart and five plastic medication cups were observed on top of the medication cart. The medication cups had room numbers written on them. During an interview at that time, the LPN indicated that she always "pre-poured" her medications, then she quickly changed her answer and indicated that she didn't always do that, but today was a bad day. During an interview, on 11/1/24 at 10:55 a.m., the Vice President of Clinical Operations indicated the facility did not have a policy but the LPN should not have pre-poured the medications and education was going to be provided. 2. During a random observation on 10/27/24 at 9:16 a.m., Wound Nurse 1 was observed in a resident's room. At that time, the wound treatment cart was located outside of a resident's room and was unlocked and easily opened. There were at least 20 opened tubes of creams with no labels or resident names on them inside the cart. There were tubes of Silvasorb, Silvadene cream, nystatin powder and cream, Iodoform, lidocaine cream and a vial of lidocaine all inside the cart. During an interview at that time, the Wound Nurse indicated she was aware her cart should have been locked. The numerous and multiple opened tubes of cream were house stock and used for all the residents when they did not have their creams available.		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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. LPN 6 was educated on medication administration policy and on preset medications. Wound Nurse 1 was educated on medication labeling and storage and medication administration. Wound Nurse 2 was educated on medication labeling and storage. The tubes of medications in the treatment carts were removed and destroyed per the facilities policy **Identification of Other Residents with the Potential to be Affected:** 1.All current guests in the facility have the potential to be affected by the same deficient practice. All carts were reviewed to ensure that all medications had the proper labeling per the facilities policies. All nursing storage areas were checked including carts and medication rooms to ensure that they are	

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	3. During a random observation on 10/28/24 at 10:55 a.m., Wound Nurse 2's treatment cart was observed. At that time, there were numerous opened tubes of lidocaine cream, iodosorb cream, mupirax cream, venelex cream, and ammonium acetate cream, that had no resident names on them. There were 3 boxes of creams inside the cart for which the resident had been discharged months ago. During an interview at that time, Wound Nurse (WN) 2 indicated his cart was locked up in his office every night and no nurse had access to it. He used the creams for the residents out of the treatment cart and would not indicate if he had used the creams inside his wound treatment cart for other residents. WN 2 indicated the facility had no house stock ointments for residents to use. The multiple tubes of creams should have been destroyed and thrown away and he just had not had time to do it. During an interview on 10/29/24 at 1:45 p.m., the Chief Nursing Officer (CNO) indicated the treatment cart should have been locked and the creams should have been labeled with specific residents' names on them. The 1/2023 "Medication Labeling and Storage" policy, provided by the Vice President of Clinical Operations on 10/29/24 at 3:10 p.m., indicated medications were to be labeled in accordance with facility requirements and stage and federal laws. All drug containers will be labeled and drug labels must be clear, consistent, legible, and in compliance with state and federal requirements. 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		locked as per the facilities policies. 2.Any errors observed will be corrected immediately and will be staff 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 F761 and how it relates to the facilities Medication Storage and Destruction Policies. 2.All clinical staff will be re-educated to ensure they follow the facility's policy on medication storage and labeling. **Monitoring:** **5** Starting on 11/22/2024 the CNO/ACNO/ Designee will complete observations on both units daily across either shift to ensure medication storage and labeling is being followed, 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. Education will be completed immediately with any identified deficiencies.	

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	original manufactures container with the expiration date and lot number. This citation relates to Complaint IN00443841. 3.1-25(m)			
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food debris on food preparation equipment, dirty convection ovens, food not labeled and dated, and the proper test strips not available to check the sanitation buckets for 1 of 1 kitchen. (The Main Kitchen) and 1 of 2 resident refrigerators. (The D Wing refrigerator) This had the potential to affect 67 of 67 residents who resided in the facility and received food from the kitchen. Findings include: 1. During the Initial Kitchen Sanitation Tour on 10/27/24 at 9:47 a.m. with Cook 1, the following was observed: a. There was food debris underneath and behind the stainless steel lid for the salad bar. b. There was a sticky residue on the lid of the storage bins for the flour and sugar. c. An accumulation of dust and debris was observed on top of the convection oven and the bottom shelf of the stand that housed the convection oven. d. A bag of cocoa was opened on a shelf in the	F 0812	**Compliance 12/06/2024** **F812 Food Procurement. Store/Prepare** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. A The food debris underneath and behind the stainless-steel lid for the salad bar was removed and the area cleaned. B The sticky residue on the lid of the storage bins for the flour and sugar were cleaned and replaced. C The accumulation of dust and debris observed on top of the convection oven and the bottom shelf of the stand that housed the	12/06/2024

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	dry storage room. e. The reach in freezer contained a bag of onion rings that were not dated when opened. There were two brown bags of frozen food that had been opened and not dated. f. A plastic container of lemon slices in the reach in cooler were not covered. g. The test strips for 2 of 2 sanitation buckets did not change color when the sanitation solution was tested. During an interview, on 11/1/24 at 9:50 a.m., the Executive Chef indicated all of the above had either been cleaned or were in need of cleaning. He also indicated the Cook was testing the sanitation buckets with the wrong test strips on 10/27/24, the Cook was using bleach strips instead of quat testing strips. 2. On 11/1/24 at 10:14 a.m., the following was observed in the D Wing refrigerator: a. A container of food from a fast food restaurant was not labeled with a resident's name or date. b. A plastic container of food labeled with a resident's name was not dated. c. A plastic container of cantaloupe was labeled with a room number but not dated. d. A bag of fast food was labeled with a resident's name and room number but not dated. e. Left over food was wrapped in aluminum foil and there was a plastic container of food labeled		convection oven was dusted and cleaned. D The bag of cocoa that was opened on a shelf in the dry storage room was removed and thrown away. E The opened onion ring in the reach in opened and not dated were removed and thrown away, and the two brown bags of frozen food that had been opened and not dated were also thrown away. F The lemons in the plastic container in the reach in cooler were thrown out. G 2 of 2 sanitation buckets were dumped and remade with the correct sanitation amount place in the bucket. Cook was also educated on the proper sanitation test strips. **On the unit D wing** The container of food from a fast-food restaurant that was not labeled with a resident's name or date was removed. The plastic container of food labeled with a resident's name was not dated was removed. The plastic container of cantaloupe was labeled with a room number but not dated was removed. The bag of fast food that was labeled with a resident's name and room number but not dated was removed. The leftover food that was wrapped in aluminum foil and the plastic container of food labeled with the resident's room number but not dated was removed.	

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	with the resident's room number but not dated. There was a sign on the door of the refrigerator indicating resident food must be dated. During an interview on 11/1/24 at 10:17 a.m., CNA 1 indicated the food inside of the refrigerator should have been dated. During an interview on 11/1/24 at 11:07 a.m., the Executive Chef indicated dietary staff should have labeled the items in the refrigerator. The current facility policy titled, "Personal Food" indicated food brought from outside resources by residents, friends, or family would be stored in a designated location and labeled as such, separately from facility food. Labeling would include product name, received date, use by date, and resident's name. 3.1-21(i)(3)		**Identification of Other Residents with the Potential to be Affected:** 1.All current guests and staff members have the potential to be affected by this alleged deficient practice. **Systemic Changes:** 1. A Qappi meeting with CNO, 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, educated on homelike clean environment. Kitchen staff were re-educated on checklist for cleaning and sanitation practices. **Monitoring:** **1** General Manager (Administrator) Designee will complete visual audits on all refrigerators daily across either shift to ensure the policy on labeling and storage of foods is being followed 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	

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			by Quality Assurance Committee that further monitoring is needed, audits will continue. - Education will be completed immediately with any identified deficiencies. -	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to maintain clinical records that were complete and accurately documented related to tube feeding administration for 1 of 1 resident reviewed for tube feeding. The facility also failed to document physician notification was completed related to blood sugar parameters and insulin documentation for 2 of 5 residents reviewed for unnecessary medications. (Residents 30, H, and 43) Findings include: 1. The record for Resident 30 was reviewed on 10/30/24 at 10:52 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance, delusional disorder, anxiety, dysphagia (difficulty swallowing), and gastrostomy status (a tube inserted directly into the stomach for nutrition). The 9/13/24 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and he received a tube feeding while a resident of the facility. A Care Plan, dated 3/21/23 and reviewed on	F 0842	**Compliance Date 12/06/2024** **F842 Resident Records** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guests H and 43 discharged from the Facility. Residents external feeding order was reviewed with MD. No new orders **Identification of Other Residents with the Potential to be Affected:**	12/06/2024

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	9/6/24, indicated the resident required a tube feeding related to resisting eating, weight loss, failure to thrive, and malnutrition. Interventions included, but were not limited to, the resident would receive tube feeding and water flushes per physician orders. A Physician's Order, dated 3/4/24 and listed as current on the October 2024 Physician's Order Summary (POS), indicated the resident was to receive Jevity 1.5 tube feeding at 80 milliliters (ml) per hour, start at bedtime (10:00 p.m.) and stop in the morning (6:00 a.m.) The July 2024 Medication Administration Record (MAR) indicated the tube feeding was not signed out as being started at 10:00 p.m. on 7/4/24 and 7/14/24. The stop time of 6:00 a.m. was not signed out as being completed on 7/1/24, 7/2/24, 7/10/24, and 7/15/24. The August 2024 MAR indicated the tube feeding was not signed out as being started at 10:00 p.m. on 8/1/24 and 8/23/24. The stop time of 6:00 a.m. was not signed out as being completed on 8/2/24, 8/6/24, 8/20/24, and 8/30/24. The September 2024 MAR indicated the tube feeding was not signed out as being started at 10:00 p.m. on 9/7/24. The stop time of 6:00 a.m. was not signed out as being completed on 9/2/24, 9/3/24, 9/7/24, 9/8/24, and 9/14/24. During an interview on 11/1/24 at 10:40 a.m., the Vice President of Clinical Operations indicated the tube feeding start and finish times should have been signed out as ordered. 2. Record review for Resident H was completed on 10/29/24 at 3:56 p.m. Diagnoses included, but were not limited to, disruption of external operation (surgical) wound,		1.All current guests with orders for feed tube orders were reviewed to ensure that feeding administrations are being sign in and out and that the facilities medical record policies and being followed. If deficiencies observed, they were immediately corrected. 2.Any errors observed will be corrected immediately, and physician notified for blood sugar parameters outside the specification. 1.All current guests with orders for insulin administration have been reviewed to ensure that the facilities' medical record policies are being followed and that the documentation is accurate. If deficiencies were identified they would be immediately corrected. **Systemic Changes:** 1. A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on F842 and how it relates to the facilities Medication Administration Policies. 2.Clinical staff will be re-educated to ensure they follow the facility's policy medication administration including follow medication administration with parameters. **Monitoring:** **6** CNO/ACNO/ Designee will	

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	155844	A. BUILDING 00 B. WING	11/01/2024

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	muscle weakness, and chronic respiratory failure with hypoxia. An Admission Minimum Data Set (MDS) assessment, dated 10/1/24, indicated the resident was cognitively intact and required moderate to maximum assistance with activities of daily living and transfers. The eMAR (electronic Medication Administration Record) for 10/2024 indicated the following sliding insulin scale was to be used for the resident's blood sugar levels twice daily: HumaLOG Injection Solution 100 UNIT/ML (Insulin) Inject as per sliding scale: if 0 - 70 call MD and initiate hypoglycemia protocol; 71 - 150 = 0 units; 151 - 200 = 3 units; 201 - 250 = 5 units; 251 - 300 = 7 units; 301 - 350 = 10 units; 351+ = 12 units 351 and > give 12 units and call MD, Order Date 9/27/2024. The record lacked documentation of physician notification of the following blood sugars outside parameters: 10/4/24 at 7 a.m. BS was 66, 10/14/24 at 7 a.m. BS was 64, 10/15/24 at 7 a.m. BS was 56, and 10/27/24 at 5 p.m. BS was 375. During an interview on 10/30/24 at 3:30 p.m., the VP of Clinical Operations indicated that sliding scale should not have been in the record and it may have accidentally come over from the hospital orders. There 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 didn't call. The record indicated on 10/17/24 at a.m., for a blood sugar of 118, LPN 3 administered 3 units of insulin.		complete audits on 6 residents daily across either shift to ensure orders including insulin, external feeding are being documented as outlines in the facilities medical record policies, 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. -	

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	During an interview on 10/30/24 at 3:50 p.m., LPN 3 indicated she documented the insulin administration in error, and that she did not give the resident any insulin at that time.3. The record for Resident 43 was reviewed on 10/28/24 at 3:37 p.m. The diagnoses included, but were not limited to, diabetes with ketoacidosis, muscle weakness, dependence on renal dialysis, renal disease, anemia (low iron), insomnia (difficulty sleeping), heart failure, and hypertension (high blood pressure). The Admission Minimum Data Set (MDS) assessment, dated 10/11/24, indicated the resident was cognitively intact for daily decision making. The resident had no impairment of the upper and lower extremities, was on dialysis and received insulin. A Care Plan, dated 10/8/24, indicated the resident received insulin. Interventions were to monitor blood glucose as per physician order and to administer medication as ordered. A Care Plan, dated 10/8/24, indicated the resident had diabetes with ketoacidosis (DKA). Interventions were to monitor, document, and report for signs and symptoms of hyperglycemia. A Physician's order, dated 10/6/24, indicated to inject Insulin Lispro per sliding scale before meals and at bedtime and to notify the physician when the blood sugar was greater than 400. A Physician's order, dated 10/15/24, indicate to inject 15 units of Insulin Glargine subcutaneously at bedtime for diabetes. The Medication Administration Record (MAR)			

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	indicated the resident had a blood sugar greater than 400 on 10/8, 10/10, 10/14, 10/15, 10/18, 10/20, 10/21, and 10/24. There was no documentation that indicated the physician was notified for blood sugars greater than 400. During an interview on 10/29/24 at 1:55 p.m., the General Manager indicated she understood the concerns and had no further information to provide. During an interview on 10/29/24 at 3:55 p.m., the Vice President of Clinical Operations indicate the physician had been notified and made aware of the resident's blood sugars, however, the nurses did not document the conversations. 3.1-50(a)(1)			
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, related to handling of medications with bare hands for 3 of 6 residents observed during medication administration and one random observation, enhanced barrier precautions (EBP) not in use for a resident with a peripherally inserted central catheter (PICC), and incorrect disinfecting of the glucometer for 1 of 1 glucometer observed. (Residents K, 21, G, L and 170) Findings include: 1. On 10/27/24 at 9:14 a.m., LPN 6 was seated in a	F 0880	**Compliance Date 12/06/2024** **F880 Infection Control** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests	12/06/2024

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	chair at the C Wing nurse's station. The LPN was seated next to the medication cart and five plastic medication cups were observed on top of the medication cart. The medication cups had room numbers written on them. The LPN continued to prepare medications at that time. She punched the pills from the medication card into her bare hand and then placed them into the medication cups. During an interview, on 11/1/24 at 10:55 a.m., the Vice President of Clinical Operations indicated the LPN should not have touched the medications with her bare hands. 2. On 10/28/24 at 10:23 a.m. LPN 4 was observed preparing to administer an antibiotic to a resident via a PICC (peripherally inserted central catheter) line. The LPN applied gloves, then opened and attached new tubing to a medication bag with the antibiotic Unasyn. She finished setting up the machine and started the antibiotic on the resident at 10:30 a.m. She indicated the medication would take 30 minutes to administer. The nurse did not apply a gown when she hooked up the medication via the PICC line. There was no sign on the door or anywhere in the room that indicated the resident was on EBP (enhanced barrier precautions). There was no bin observed inside or outside of the room with PPE (personal protective equipment) that included gowns. Record review for Resident K was completed on 10/28/24 at 10:35 a.m. The October 2024 Physician's Order Summary (POS) indicated the resident had a PICC line and was to receive Unasyn 3000 mg (milligrams) intravenously three times a day for a left foot wound for 6 weeks. The POS lacked an order for EBP.		related to this alleged deficient practice. K,21, G have discharged from the facility RN 2 was educated on Infection control practices for medication pass for guest L and all other facility guest Guest #170 was discharged from the facility **Identification of Other Residents with the Potential to be Affected:** 1.All current guests were observed to identify if they meet the criteria for EBP. If identified, the auditor ensured that an order is placed. The signage, supplies and education on infection prevention provided to the staff. LPN 4 was educated on Enhanced barrier procedures. 2.LPN 5 was educated on cleaning glucose monitors and where to find the proper cleaning solution. 3.LPN 6 was educated on infection control practices for medication administration. 4.RN 2 was provided with education on infection control practices for medication administration. 5.All glucose monitors were cleaned with the correct solution and for the correct time. **Systemic Changes:** 1. A Qappi meeting with CNO, ACNO, Care Transitions,	

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	During an interview on 10/28/24 at 10:40 a.m., LPN 4 indicated the resident did not have an order for EBP. She would have only applied a gown if she was changing the PICC bandage and not when she was administering the medication or flushing the line. During an interview on 10/28/24 at 11:12 a.m., the Infection Preventionist indicated there should have been an order for EBP since the resident had a PICC. The nurse should have put on a gown when she started the medication via the PICC. A policy titled, "Enhanced Barrier Precautions" and received as current from the General Manager on 10/28/24, indicated, "...EBP is used in conjunction with standard precautions and expand the use of Personal Protective Equipment (PPE) to donning of gown and gloves during high-contact resident care activities..." "...Gowns and gloves are used during high-contact activities with increased risk for MDRO transmission to staff clothing and hands including but not limited to:..." "...Device care or use including but not limited to: Central line..." 3. On 10/28/24 at 12:01 p.m., LPN 5 was observed administering a glucometer test on Resident 21. The LPN applied gloves, wiped the resident's finger with an alcohol wipe and proceeded to poke the finger with a lancet. The blood was then transferred to the glucometer strip attached to the glucometer. After the blood sugar was read on the glucometer, the LPN disposed of the lancet into the sharps container. She disposed of the glucometer strip and her gloves into the garbage. She took the glucometer back to the medication cart and then proceeded to open up 2 alcohol wipes and wipe down the glucometer with the		Hospitality Medical Director and General Manager. IDT was educated on F880 and how it relates to Infection Control. All staff were also educated on the facilities infection control policy as it relates to hand washing, medication administration and cleaning DME. **2.Monitoring:** CNO/ACNO/ Designee will complete visual observation rounds on 2 nurse med passes daily across either shift to ensure that infection control practices are being followed and the EBP are placed and follow per facilities policies x 2 weeks, then 6 observations three times a week for 2 weeks, then 6 observations weekly x 4, then 6 residents monthly. **1** 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 infection control.	

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	alcohol wipes. After she wiped down the glucometer with the alcohol wipes she placed the glucometer back into her medication cart. During an interview at that time, the LPN indicated she would normally use a germicidal bleach wipe and not an alcohol wipe, but she did not have any bleach wipes in the medication cart. During an interview on 10/28/24 at 12:17 p.m., the Infection Preventionist 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 received as current from the Vice President of Clinical Operations on 11/1/24, indicated, "...The glucometer will be cleaned prior to each use and after each use per manufacturer recommendation..." 4. On 10/28/24 at 9:16 a.m., RN 2 was observed preparing Resident 170's medications. She popped each of the 4 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. 5. On 10/28/24 at 9:22 a.m., RN 2 was observed preparing Resident G's medications. She popped each of the 3 pills out of their cards into her bare hand before placing them into a medicine cup. She then administered the pills to the resident. No hand hygiene or donning of gloves was observed before handling the medication.			

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	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 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: The record for Resident 41 was reviewed on 10/28/24 at 3:55 p.m., The resident was admitted to	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 deficiencies outlines in this plan of correction. The facilities' intent is	12/06/2024

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	the facility on 10/3/24. Diagnoses included, but were not limited to, major depressive disorder with recurrent and severe psychotic symptoms, heart disease, history of breast cancer, anemia, anxiety, and high blood pressure. The 10/9/24 Admission Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for daily decision making and was frequently incontinent of urine. The resident received an antipsychotic, antidepressant, antibiotic, and diuretic while at the facility. A Care Plan, dated 10/22/24, indicated the resident received antibiotic therapy related to an urinary tract infection. A Physician's Order, dated 10/18/24, indicated to obtain an urinalysis related to major depressive disorder with severe psychotic symptoms. A Nursing Note, dated 10/19/24, indicated a urine sample was collected and placed in the refrigerator for lab to pick up. The lab result for the urinalysis, dated 10/21/24 with the final culture dated 10/22/24, indicated the urine was cloudy, had a large amount leukocytes, was negative for nitrates and blood, and had 5 to 10 of white blood cells. The urine culture indicated there was less than 10,000 enterococcus faecalis species and a sensitivity was not performed. The resident did not have a true urinary tract infection. A Nursing Note, dated 10/22/24 at 12:33 p.m., indicated the physician was notified of the urine results and gave new orders to start Keflex 500 milligrams (mg) three times a day times seven days		always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Guest 41 discharge from the facility **Identification of Other Residents with the Potential to be Affected:** 1.All current guests' orders were reviewed to Identify if they have orders to receive antibiotics. If a guest has an order. The chart was reviewed to ensure that the facility is following the McGeers and the antibiotic stewardship policies. **Systemic Changes:** Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director, and General Manager. IDT was educated on F881and how it relates to Infection Control and Mcgreers. All Physicians and Nursing staff were also educated on the facilities infection control policy as it relates to antibiotic stewardship program. **1.Monitoring:** CNO/ACNO/ Designee will review all new antibiotic orders to ensure that the Antibiotic Stewardship program is being practiced for 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	

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	or until culture was back and changes needed to be made. The floor nurse was made aware and initiated the antibiotic. A Physician's Order, dated 10/22/24, indicated Keflex (an antibiotic medication) 500 mg, give one capsule by mouth three times a day for an urinary tract infection for seven days. The Physician's Progress Note, identified as a late entry for 10/22/24 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 antibiotics." There was no documentation in nursing notes of increased confusion, urinary frequency and urgency. During an interview on 10/30/24 at 9:48 a.m., the Chief Nursing Officer (CNO) indicated the physician had made a late entry on 10/30/24 indicating she chose to continue the antibiotic due to increased confusion, frequency and urgency. The CNO indicated there was no documentation in nursing progress notes of the resident's symptoms of increased frequency and urgency of urination. The facility followed McGeer's criteria for all infections. 3.1-18(b)		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 infection control.	
F 0921 SS=F Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ Based on observation and interview, the facility failed to keep kitchen areas clean related to debris on the floor, an accumulation of a dried substance	F 0921	**Compliance 12/06/2024** **F921 Safe Functional** The General Manager	12/06/2024

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	on the garbage disposal, and an accumulation of dust and dead insects inside the plastic light covers for 1 of 1 kitchen observed. (The Main Kitchen) Findings include: 1. During the Initial Kitchen Sanitation Tour on 10/27/24 at 9:47 a.m. with Cook 1, the following was observed: a. There was an accumulation of food debris on the floor of the walk in freezer and underneath the shelf. b. The garbage disposal, located next to the dishwasher, had a thick accumulation of an orange substance on the outside. 2. During the Kitchen Sanitation Tour on 10/31/24 at 12:10 p.m. with the Executive Chef, five plastic light covers located above the steam table and food preparation area had an accumulation of dust and dead insects on the inside. During an interview on 11/1/24 at 9:50 a.m., the Executive Chef indicated all of the above had either been cleaned or were in need of cleaning. 3.1-19(f)		(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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. **Identification of Other Residents with the Potential to be Affected:** A The food debris underneath and behind the stainless-steel lid for the salad bar was removed and the area cleaned. B The sticky residue on the lid of the storage bins for the flour and sugar were cleaned and replaced. C The accumulation of dust and debris observed on top of the convection oven and the bottom shelf of the stand that housed the convection oven was dusted and cleaned. D The garbage disposal, located next to the dishwasher, had an orange substance that was removed. **Systemic Changes:** 1.A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and	

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			General Manager. IDT was educated on F 921 and how it relates to Safe functional environment. All staff were also educated on the facilities' safety and sanitation policies. **2.Monitoring:** **3** General Manager/ Designee will complete visual observation rounds around the facility across either shift to ensure sanitation and safety practices are being followed per facilities policies 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 infection control.	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00442605 and IN00443841. Complaint IN00442605 - No deficiencies related to the allegations are cited.	R 0000		

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	155844	A. BUILDING 00 B. WING	11/01/2024

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	Complaint IN00443841 - No deficiencies related to the allegations are cited. Survey dates: October 27, 28, 29, 30, 31 and November 1, 2024 Facility number: 013688 Residential Census: 24 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/13/24.			
R 0154 Bldg. 00	410 IAC 16.2-5-1.5(k) Sanitation and Safety Standards - Deficiency Based on observation and interview, the facility failed to keep kitchen areas clean related to debris on the floor, an accumulation of a dried substance on the garbage disposal, and an accumulation of dust and dead insects inside the plastic light covers for 1 of 1 kitchen observed. (The Main Kitchen) Findings include: 1. During the Initial Kitchen Sanitation Tour on 10/27/24 at 9:47 a.m. with Cook 1, the following was observed: a. There was an accumulation of food debris on the floor of the walk in freezer and underneath the shelf. b. The garbage disposal, located next to the dishwasher, had a thick accumulation of an orange substance on the outside.	R 0154	**Compliance 12/06/2024** **R-0154 Safe Functional** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. **Identification of Other Residents with the Potential to**	12/06/2024

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	2. During the Kitchen Sanitation Tour on 10/31/24 at 12:10 p.m. with the Executive Chef, five plastic light covers located above the steam table and food preparation area, had an accumulation of dust and dead insects on the inside. During an interview, on 11/1/24 at 9:50 a.m., the Executive Chef indicated all of the above had either been cleaned or were in need of cleaning.		**be Affected:** A The food debris underneath and behind the stainless-steel lid for the salad bar was removed and the area cleaned. B The sticky residue on the lid of the storage bins for the flour and sugar were cleaned and replaced. C The accumulation of dust and debris observed on top of the convection oven and the bottom shelf of the stand that housed the convection oven was dusted and cleaned. D The garbage disposal, located next to the dishwasher, had an 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 also educated on the facilities' safety and sanitation policies. **2.Monitoring:** **3** General Manager/ Designee will complete visual observation rounds around the facility across either shift to ensure sanitation and safety practices are being followed per facilities policies 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	

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			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 infection control.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency Based on record review and interview, the facility failed to ensure a service plan was revised and updated to include therapy services for 1 of 7 residents reviewed for service plans. (Resident 2) Finding includes: Record review for Resident 2 was completed on 10/30/24 at 9:10 a.m. Diagnoses included, but were not limited to, left wrist fracture, dementia, and anxiety. A Health Status Note, dated 9/4/24 at 10:22 p.m., indicated the resident had a fall in her room and hurt her wrist. She was sent to the emergency room. A Physician's Order, dated 9/6/24, indicated an order for Physical Therapy (PT) and Occupational Therapy (OT) to evaluate and treat the resident. The most recent PT note for the resident was on 10/28/24. The most recent OT note for the resident was on 10/25/24. A Service Plan, dated 10/16/24, indicated the	R 0217	**Compliance 12/06/2024** **R-217 Service plan** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Resident 2 service plan was updated with therapy **Identification of Other Residents with the Potential to be Affected:**	12/06/2024

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	resident was at risk for falls. The resident was independent with most of her ADLs (activities of daily living). The Service Plan was signed by the resident. The Service Plan lacked documentation the resident received PT or OT services. During an interview on 10/31/24 at 9:45 a.m., the General Manager indicated the resident had received therapy services when the latest Service Plan was completed. The Service Plan was not updated to reflect the resident's therapy status but should have been revised.		1.All current with the need for skilled therapy has the potential to be affected by the same alleged deficiency. 2.All residents that reside on Luxe have been reviewed to identify the need for updated service plans. If resident was identified to need a service plan update, the service plan was updated **Systemic Changes:** 1.A Qappi meeting with CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on R-217 and how it relates to the services plans Clinical staff will be re-educated to ensure they follow the facility's policy on service plans. - **Monitoring:** **4** CNO/ACNO/ Designee will 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 three times a week for 2 weeks, then 3 residents weekly x 4, then 3 residents monthly. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. - Education will be completed immediately with any identified deficiencies.	

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R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food debris on food preparation equipment, dirty convection ovens, food not labeled and dated, and the proper test strips not available to check the sanitation buckets for 1 of 1 kitchen. (The Main Kitchen) Findings include: During the Initial Kitchen Sanitation Tour on 10/27/24 at 9:47 a.m. with Cook 1, the following was observed: a. There was food debris underneath and behind the stainless steel lid for the salad bar. b. There was a sticky residue on the lid of the storage bins for the flour and sugar. c. An accumulation of dust and debris was observed on top of the convection oven and the bottom shelf of the stand that housed the convection oven. d. A bag of cocoa was opened on a shelf in the dry storage room. e. The reach in freezer contained a bag of onion rings that were not dated when opened. There were also two brown bags of frozen food that had been opened and not dated. f. A plastic container of lemon slices in the reach in cooler were not covered.	R 0273	**Compliance 12/06/2024** **R273 Food Procurement. Store/Prepare** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. A The food debris underneath and behind the stainless-steel lid for the salad bar was removed and the area cleaned. B The sticky residue on the lid of the storage bins for the flour and sugar were cleaned and replaced. C The accumulation of dust and debris observed on top of the convection oven and the bottom shelf of the stand that housed the convection oven was dusted and cleaned. D The bag of cocoa that was opened on a shelf in the dry storage room was removed and	12/06/2024

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	g. The test strips for 2 of 2 sanitation buckets did not change color when the sanitation solution was tested. During an interview on 11/1/24 at 9:50 a.m., the Executive Chef indicated all of the above had either been cleaned or were in need of cleaning. He indicated the Cook was testing the sanitation buckets with the wrong test strips on 10/27/24, the Cook was using bleach strips instead of quat testing strips.		thrown away. E The opened onion ring in the reach in opened and not dated were removed and thrown away, and the two brown bags of frozen food that had been opened and not dated were also thrown away. F The lemons in the plastic container in the reach in cooler were thrown out. G 2 of 2 sanitation buckets were dumped and remade with the correct sanitation amount place in the bucket. Cook was also educated on the proper sanitation test strips. **On the unit D wing** The container of food from a fast-food restaurant that was not labeled with a resident's name or date was removed. The plastic container of food labeled with a resident's name was not dated was removed. The plastic container of cantaloupe was labeled with a room number but not dated was removed. The bag of fast food that was labeled with a resident's name and room number but not dated was removed. The leftover food that was wrapped in aluminum foil and the plastic container of food labeled with the resident's room number but not dated was removed. **Identification of Other Residents with the Potential to be Affected:** -	

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			1.All current guests and staff members have the potential to be affected by this alleged deficient practice. **Systemic Changes:** 1. A Qappi meeting with CNO, 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, educated on homelike clean environment. Kitchen staff were re-educated on checklist for cleaning and sanitation practices. **Monitoring:** **1** General Manager (Administrator) Designee will complete visual audits on all refrigerators daily across either shift to ensure the policy on labeling and storage of foods is being followed 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. Education will be completed	

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			immediately with any identified deficiencies. -	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure clinical records were complete and accurate related to medications not signed out as administered for 1 of 7 records reviewed. (Resident 5) Finding includes: Record review for Resident 5 was completed on 10/30/24 at 3:00 p.m. Diagnoses included, but were not limited to, acute kidney failure and dementia. A Service Plan, dated 10/28/24, indicated the resident was on Hospice. A Physician's Order, dated 10/24/24 and discontinued on 10/29/24, was for Norco (pain medication) 5-325 mg (milligrams) to give one tablet by mouth every six hours for pain. The October 2024 Medication Administration Record indicated the Norco was not signed out as given at 12:00 a.m., and 6:00 a.m., on 10/25, 10/27, and 10/28/24. During an interview on 11/1/24 at 10:40 a.m., the Director of Nursing indicated she was unable to provide any documentation the Norco had been administered on the above dates and times.	R 0349	**Compliance Date 12/06/2024** **R-349 Resident Records** 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 deficiencies outlines in this plan of correction. The facilities' intent is always to provide quality care to its guests and residents. No harm came to any residents/guests related to this alleged deficient practice. Resident 5 was accessed for pain and given pain medications **Identification of Other Residents with the Potential to be Affected:** 1.All current guests with orders for pain medications were reviewed to ensure that medication administrations are being completed and out and that the facilities medical record policies	12/06/2024

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			and being followed. If deficiencies observed, they were immediately corrected. Any errors observed will be corrected immediately, and physician notified. **Systemic Changes:** 1. CNO, ACNO, Care Transitions, Hospitality Medical Director and General Manager. IDT was educated on R-349 and how it relates to the facilities Medication Administration Policies. 2.Clinical staff will be re-educated to ensure they follow the facility's policy medication administration including follow medication administration. **Monitoring:** **4** CNO/ACNO/ Designee will complete audits on 3 residents daily across either shift to ensure medication orders are completed and being documented as outlines in the facilities medical record policies, x 2 weeks, then 3 residents three times a week for 2 weeks, then 3 residents weekly x 4, then 6 residents monthly. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue.	