STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. BUILDING 00 B. WING	05/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT CROWN POINT LLC	1555 S MAIN STREET CROWN POINT, IN 46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00457153 and IN00458560. Complaint IN00457153 - Federal/State deficiencies related to the allegations are cited at F580, F677, F755, and F772. Complaint IN00458560 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: April 30 and May 1, 2025 Facility number: 013452 Provider number: 155835 Census Bed Type: SNF: 63 Residential: 28 Total: 91 Census Payor Type: Medicare: 59 Other: 4 Total: 63 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/8/25.	F 0000	The facility respectfully requests a desk review	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to notify a resident's physician and	F 0580	**Ignite Crown Point** **Compliant survey: 5/1/2025**	05/18/2025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Robert Petty	Administrator	05/19/2025

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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	responsible party that a medication was unavailable for 1 of 9 residents reviewed for physician/responsible party notification. (Resident D) Finding includes: Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia. A Social Service assessment, dated 4/30/25, indicated a severe cognitive impairment A family member was designated as the legal Power of Attorney (POA). A Physician's Order, dated 4/29/25 at 6:00 p.m., indicated IV (intravenous) ampicillin-sulbactam (antibiotic) 3 grams (gm) was to be administered every six hours due to a wound infection. The Medication Administration Record (MAR), dated 4/2025, indicated the antibiotic had not been available and was not given on 4/30/25 at 12:00 p.m. and 6:00 p.m. The MAR, dated 5/2025, indicated the antibiotic had not been available and was not given on 5/1/25 at 12:00 a.m. and 6:00 a.m. Cross reference F755. There was no documentation to indicate the resident's physician and POA had been notified of the missed antibiotic doses. During an interview on 5/1/25 at 10:56 a.m., the Director of Nursing indicated the POA and the		Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F580 Notify of changes** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** **Resident D's POA and Physician were notified of missing antibiotic** **Resident D antibiotic was delivered by pharmacy and administered as ordered.** **Resident D sustained no harm from alleged missing antibiotic.** **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by the same alleged deficient practice. MAR to cart audit was completed to ensure medications that have been ordered, are available to administer. **What measures will be put into place or what systemic changes will be made to**	

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	Physician should have been notified of the missed doses of the antibiotic A facility policy for physician notification, dated 10/2024 and received from the Director of Nursing as current, indicated the physician or nurse practitioner would be notified if it was deemed necessary or appropriate in the best interest of the resident. The communication with the responsible party as well as the physician was to be documented in the medical record. This citation relates to Complaint IN00457153. 3.1-5(a)(3)		**ensure that the deficient practice does not recur.** Nurses were re-educated on notifying and documenting physician and responsible party of any changes, new orders, and missing or delay in medication from pharmacy. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** CNO/designee will randomly audit 5 residents new/existing orders weekly to ensure mediations were delivered and being administered as ordered CNO/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/18/2025**	
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 provide incontinent care in a timely manner and failed to ensure	F 0677	**Ignite Crown Point Compliant Survey: 5/1/2025**	05/18/2025

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	Resident D was bathed after a large amount of urinary incontinence for 2 of 3 residents reviewed for activities of daily living (ADL's). (Residents D and E) Findings include: 1. During an observation on 4/29/25 from 9:07 a.m. through 9:32 a.m., Resident D was lying in bed with the head of the bed elevated. There was a yellow tinged color on the edge of the incontinence pad that was under the resident. LPN 3 and CNA 2 entered the room. CNA 2 indicated she came in to work at 6 a.m. and she had not checked the resident for urinary incontinence since she started work that morning. CNA 2 indicated the gown was wet with urine and there were two incontinence pads under the resident that were saturated with urine. The sheet under the incontinence pads was soaked with urine as well and there was a drying ring of urine on the bottom sheet of the bed. The top sheet and covers were also wet. CNA 2 indicated the gown and incontinence brief were saturated with urine. The resident's gown was removed and the bed linens were changed. The resident's peri area and buttocks area was cleansed with wipes. The other areas soaked by urine, the abdomen, back, arms and legs, were not washed. A clean brief was applied and the resident was dressed without the other areas of the body being cleansed. Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia. An Admission Nursing Assessment, dated 4/29/25 at 1:30 p.m., indicated an open wound on the right heel, urine and bowel incontinence,		Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident D's bedding was changed, and resident D received a shower. Resident Es bedding was changed, and resident E received a shower. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All incontinent residents have the potential to be affected by the same alleged deficient practice. House sweep of residents requiring assistance with activities of daily living, especially personal hygiene, was completed to ensure staff are providing care as needed including but not limited to showers/baths as scheduled and as needed, and proper cleansing of residents and bedding, if required, is completed after each	

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	assistance was required for ADL's, and a PICC (peripherally inserted central catheter) line was present. A Care Plan, dated 4/29/25, indicated assistance was required for ADL's. The intervention included maximum assistance would be required for bathing and toileting. The resident was incontinent and would be checked for incontinency every 2-3 hours. A Social Service assessment, dated 4/30/25, indicated a severe cognitive impairment. 2. During an observation on 4/30/25 at 8:30 a.m., there was an odor of urine outside Resident E's room and inside the room. Resident E was lying in bed with her eyes closed. CNA 5 entered the room with a covered breakfast tray. CNA 5 donned gloves and stated the bed covers were damp and the resident's clothing was wet. There was a large ring of urine on the incontinence pad under the resident with drying urine on the edges. The incontinence brief was saturated with urine. CNA 5 indicated she had not checked the resident for incontinence since she started work at 6:00 a.m. and it had been "a while" since the resident had been checked for incontinence. She then completed incontinence care with the wet wipes at the bedside and placed a new incontinence brief on the resident. The clothing was changed after the skin was washed with the wipes. Resident E's record was reviewed on 5/1/25 at 11:12 a.m. The diagnoses included, but were not limited to dementia. A Care Plan, dated 4/24/25, indicated assistance was required with ADL's. The interventions		incontinent episode. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nurses and nurse aides were re-educated on checking incontinent residents every 2-3 hours and providing peri care as needed including cleansing of skin after each incontinent episode and as needed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** CNO/designee will randomly observe 5 incontinent residents weekly to ensure residents are being checked and changed per plan of care and showers/baths and/or cleansing of surrounding skin from incontinent episodes are being provided as needed. CNO/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:**	

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	included moderate assistance would be provided for toileting and bathing. The resident would be checked for incontinence every 2-3 hours. During an interview on 4/30/25 at 10:17 a.m., the Director of Nursing indicated the residents should have been checked for incontinence and changed prior to the observation and they should have been showered or bathed due to the large amount of urine incontinence. During an interview on 5/1/25 at 8:39 a.m., LPN 4 indicated the night shift CNA's start their last rounds at 4:00-4:30 a.m. A facility incontinence care policy, dated 11/2024 and received from the Director of Nursing as current, indicated incontinent residents were changed every two hours and more frequently if needed. This citation relates to Complaint IN00457153. 3.1-38(a)(3)		**5/18/2025**	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids Based on observation, record review and interview, the facility failed to care for a midline catheter (inserted into a vein in the upper arm for intravenous [IV] treatments) in accordance with professional standards of practice related to a non-sterile dressing change and a lack of dressing changes to the site, assessments of the site, and flushes of the catheter for 2 random PICC line observations. (Residents D and J) Findings include:	F 0694	**Ignite Crown Point** **Compliant: 5/1/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F694 Parenteral / IV Fluids**	05/18/2025

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	1. During an observation on 4/29/25 at 9:46 a.m., Resident D was lying in bed with the head of the bed elevated. There was a PICC line in the left upper extremity. LPN 3 indicated there was blood on the PICC line dressing and the dressing needed to be changed. A sterile dressing kit was placed on the resident's bed and opened up. LPN 3 applied sterile gloves after using the alcohol based hand rub. She then lifted the resident's left arm up with the sterile gloves on and placed a sterile pad under the arm. She then put a face mask on herself and touched the top of her ears and hair with the sterile gloves. The soiled PICC line dressing was removed and the insertion area was cleansed with the alcohol cleaning utensil in the kit. She then removed the gloves and applied a second pair of sterile gloves without cleansing her hands. While the sterile gloves were applied, she touched the fingers of the right hand glove with her ungloved fingers of the left hand. She then applied the left sterile glove. She touched the underside of the kit wrap and moved the kit in the bed, then touched the resident's arm for positioning and placed a new dressing on the PICC line insertion site. Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia. An Admission Nursing Assessment, dated 4/29/25 at 1:30 p.m., indicated an open wound on the right heel, urine and bowel incontinence, assistance was required for ADL's, and a PICC (peripherally inserted central catheter) line was present. A Care Plan, dated 4/29/25, indicated an IV was present. The interventions indicated the dressing		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident D was assessed by due to non-sterile technique being used for PIC line dressing change with no signs of infection, or harm due to alleged deficient practice. LPN3 was educated on sterile technique for dressing changes with return demonstration. Resident J was assessed due to lack of monitoring orders, flush orders, dressing change orders to PIC line, with no signs of infection, or harm due to alleged deficient practice. Orders were immediately placed for care, monitoring, flushes, and dressing changes of PIC line. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with intravascular accesses have the potential to be affected by the same alleged deficient practice. Residents with intravascular access sites records were reviewed to ensure orders were placed for care of, required flushes, sterile dressing changes if required, and monitoring of sites. Assessments of current sites were completed to ensure the	

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	would be changed every week. During an interview on 4/30/25 at 10:17 a.m., the Director of Nursing indicated PICC line dressing changes were to be completed using a sterile dressing change process. 2. During an observation on 5/1/25 at 1:45 p.m., Resident J was sitting in a wheelchair in his room. There was a PICC line inserted into the right upper arm with date of 4/26/25 written on the dressing site. Resident J's record was reviewed on 5/1/25 at 1:10 p.m. The diagnoses included, but were not limited to, diabetes mellitus. The admission date was 4/2/25. A Physician's Order, dated 4/16/25, indicated a midline IV catheter was to be placed for IV antibiotic administration. A Nurse's Progress Note, dated 4/16/25 at 4:58 p.m., indicated a nurse from the IV insertion company was at the facility and a midline catheter was placed in the right arm. A Professional Nursing Service Note, dated 4/16/25, indicated a midline IV had been inserted. The nursing care indicated to flush the line with 10 cc's (cubic centimeters) of normal saline before and and right after all infusions per facility protocols. The dressing was to be changed within 24 hours of insertion, then weekly and as needed for soiling and looseness. A Care Plan, dated 4/17/25, indicated the resident was receiving an antibiotic through an IV. The interventions included the dressing over the IV		areas are clean, with no signs of infection, and dressing changes have been completed as ordered. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Licensed staff educated on intravascular access site requirements including but not limited to; Obtaining orders for monitoring, flushing, dressing changes, sterile dressing changes when required How to complete a “sterile” dressing change and what sites require sterile technique How to assess access site and what to look for when assessing to ensure there is no infection **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** CNO/designee will monitor 5 sterile dressing changes a week to ensure proper technique is being used, as applicable. CNO/designee will review 5 residents’ orders weekly to ensure orders to monitor, required flushes, dressing changes are in place and being completed, as	

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	would be observed every shift, the dressing would be changed weekly and flushed per the physician's orders. The IV insertion site was to be monitored for infection and other concerns. The Physician's antibiotic orders included the following: 4/16/25 to 4/21/25 - vancomycin, 1 gm (gram) daily for knee infection. 4/18/25 to 4/21/25 - meropenem - 1 gm every 12 hours 4/22/25 - ampicillin 2 gm to be given every 8 hours for a left knee infection. There were no orders to flush and monitor the midline IV or for the dressing changes written as a Physician's Order. There was no documentation that indicated the dressing had been changed 24 hours after the insertion or the midline had been flushed before and after the medication. There was no documentation the midline had been assessed for placement and signs and symptoms of infection. During an interview on 5/1/25 at 2:03 p.m., the Director of Nursing indicated there was an order for the midline, but there were no orders for the flush, dressing change, or the care of the midline. A PICC line/midline policy, dated 11/2024 and received from the Director of Nursing as current, indicated the treatments and dressing required a physician's order. The dressing was to be changes 24 hours after insertion and then at least weekly or any time the dressing became moist, loosened, or soiled. The PICC line must remain sterile. 3.1-47(a)(2)		applicable. CNO/designee will review new orders 5 days a week during clinical meeting for IV fluid/IV medication orders to ensure these residents have corresponding orders for required care, monitoring, and flushing of intravascular lines, as applicable. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/18/2025**	

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F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records Based on record review and interview, the facility failed to ensure a resident was provided with an intravenous (IV) antibiotic in a timely manner by the contracted pharmacy, related to the antibiotic not being available to be administered as ordered by the physician for 1 of 3 residents reviewed for antibiotic medications. (Resident D) Finding includes: Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia. A Care Plan, dated 4/29/25, indicated an IV antibiotic was ordered by the physician for a wound infection. The goal indicated there would be no complications related to the IV therapy. A Physician's Order, dated 4/29/25 at 6:00 p.m., indicated an IV of ampicillin-sulbactam (antibiotic) 3 grams (gm) was to be administered every six hours due to a wound infection. The Medication Administration Record (MAR), dated 4/2025, indicated the IV antibiotic was given on 4/29/25 at 6:00 p.m., 4/30/25 at 12:00 a.m. and 6:00 a.m. The MAR indicated the medication had not been available and was not given on 4/30/25 at 12:00 p.m. and 6:00 p.m. The MAR, dated 5/2025, indicated the antibiotic had not been available and was not given on 5/1/25 at 12:00 a.m. and 6:00 a.m. A Medication Administration Progress Note,	F 0755	**Ignite Crown Point** **Complaint Survey: 5/1/2025** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F755 Pharmacy Services** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident D medications were ordered and have been received from pharmacy and being administered as ordered. Resident D sustained no harm from the alleged missing antibiotic. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All facility residents that require pharmacy services have the potential to be affected by the same alleged deficient practice. MAR to cart audit was completed to ensure ordered medications are available and being administered as ordered.	05/18/2025

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	dated 4/30/25 at 11:37 a.m., indicated the antibiotic was not available in the Emergency Drug Kit (EDK). The pharmacy was notified and they expected the antibiotic to be delivered by 1 p.m. on 4/30/25. A Medication Administration Progress Note, dated 4/30/25 at 5:05 p.m., indicated the antibiotic was not available and the pharmacy was notified again and was ordered to bring the antibiotic as soon as possible. A Medication Administration Progress Note, dated 5/1/25 at 4:07 a.m., indicated the antibiotic was not administered and was on order. During an interview on 5/1/25 at 10:56 a.m., the Director of Nursing indicated the first three doses of the antibiotic were taken from the IV EDK (emergency drug kit). The pharmacy had been notified and would be delivering the antibiotic. A facility pharmacy delivery policy, dated 1/2023 and received from the Director of Nursing as current, indicated the pharmacy will have a daily delivery of medications and supplies. This citation relates to Complaint IN00457153. 3.1-25(a)		**What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nurses were re-educated on ordering medications through Pharmacy portal Nurses were re-educated on notifying physicians and family of any delay of medications from pharmacy and document any new orders received. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** CNO/designee will randomly audit 5 residents medications weekly to ensure mediations were delivered from pharmacy and being administered as ordered The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/18/2025**	

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	155835	A. BUILDING 00 B. WING	05/01/2025

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F 0772 SS=D Bldg. 00	483.50(a)(1)(iv) Lab Services Not Provided On-Site Based on record review and interview, the facility failed to ensure a resident received laboratory services as ordered by the physician for 1 of 3 residents reviewed for laboratory services. (Resident B) Finding includes: Resident B's record was reviewed on 4/30/25 at 2:12 p.m. The diagnoses included, but were not limited to, stroke and dementia. A Wound Physician Progress Note, dated 4/18/25, indicated a Stage IV (full thickness skin loss with extensive destruction) pressure ulcer was present on the coccyx. An order for a pre-albumin and a complete blood count (CBC) was received. The pre-albumin and complete blood count results were not in the medical record and there was no documentation the laboratory testing had been completed. During an interview on 4/30/25 at 4:42 p.m., Wound Nurse 1 indicated the laboratory testing had been ordered and sent to the lab. The pre-albumin and the CBC were not completed by the lab. It was scheduled to be completed on 4/20/25. The lab was notified and they indicated the testing had not been completed and were unable to provide a reason why the testing had not been done. This citation relates to Complaint IN00457153. 3.1-49(e)	F 0772	Ignite Crown Point Complaint Survey: 5/1/2025 **Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.** F772 Lab Services **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** No harm came to resident B related to this alleged deficient practice. The laboratory supervisor was notified of lab not being obtained. Resident (B) no longer resides in the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents requiring a physician's order for laboratory services have the potential to be affected by the same alleged deficient practice. Current lab orders were reviewed to ensure the lab was drawn and	05/18/2025

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			results are available. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Nurses were in-serviced on; ensuring all ordered labs are drawn/collected as ordered notify physician, responsible party, laboratory, and clinical manager if a lab is missed to obtain new orders **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place.** CNO/designee will audit 'lab due' reports 5 times per week to ensure ordered labs are drawn/collected as ordered. CNO/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which corrections will be completed: 5/18/2025	
F 0880 SS=D	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control			

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Bldg. 00	Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff members (LPN 3, CNA 2, CNA 6, and CNA 7) when providing care to a residents (Residents D and J) who were in Enhanced Barrier Precautions (EBP) for two random observations for infection control. Findings include: 1. During an observation on 4/29/25 from 9:07 a.m. through 9:32 a.m., Resident D was lying in bed with the head of the bed elevated. There was a peripherally inserted central catheter (PICC) inserted in the left upper arm and a wound dressing on the right heel. The resident had been incontinent of urine and LPN 3 and CNA 2 had gloves on and were starting to complete incontinence care and were stopped. LPN 3 indicated she was unsure if the resident required EBP and indicated there was no sign on the door that indicated he required EBP and EBP was not needed. LPN 3 then indicated the resident had a wound and EBP would be needed. CNA 2 and LPN 3 then donned a gown and changed gloves and began incontinence care. Resident D's record was reviewed on 5/1/25 at 10:00 a.m. The diagnoses included, but were not limited to, osteomyelitis left ankle/foot and dementia. An Admission Nursing Assessment, dated 4/29/25 at 1:30 p.m., indicated an open wound on the right heel, urine and bowel incontinence, assistance was required for ADL's, and a PICC line was present.	F 0880	Ignite Medical Resort Crown Point Complaint Survey: 5/1/2025 Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.** Resident D is on enhanced barrier precautions staff immediately donned proper PPE, no harm was sustained from the alleged deficient practice, enhanced barrier precautions sign was immediately placed on the room door Resident J is on enhanced barrier precautions staff immediately donned proper PPE. no harm was sustained from the alleged deficient practice. No residents were affected by the alleged deficient practice. LPN 3, C.N.A's' 2, 6, and 7 were educated on EBP signage and PPE requirements. **How the facility will identify other residents having the potential to be affected by the**	05/18/2025

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	A Care Plan, dated 4/29/25, indicated EBP was required due to the PICC line and gowns and gloves were to be worn during high contact care activities. 2. During an observation on 4/30/25 at 10:50 a.m., there was a sign on the outside door frame that indicated the resident required EBP. Resident J was lying in bed. There was a PICC line observed in the right upper arm. CNA 6 and CNA 7 were in the room and indicated they were giving a bed bath and getting ready to wash the resident's back. There was a wash basin with soapy water and washcloths sitting on the night stand. CNA 6 and CNA 7 had gloves on. CNA 6 indicated EBP was not required and only gloves were required with care. CNA 7 then read the sign on the door frame and both CNA's then place gowns on over their uniforms. Resident J's record was reviewed on 5/1/25 at 1:10 p.m. The diagnoses included, but were not limited to, diabetes mellitus. The admission date was 4/2/25. A Care Plan, dated 4/2/25, indicated EBP was required. The interventions included gowns and gloves would be used when providing high contact resident care. A Physician's Order, dated 4/16/25, indicated a midline IV catheter was to be placed for IV antibiotic administration. A facility EBP policy, dated 3/2024 and identified as current by the Vice President of Operations, indicated staff were to don a gown and gloves during high-contact resident care. EBP PPE was		**same deficient practice and what corrective action will be taken.** All residents have requiring isolation have the potential to be affected by the same alleged deficient practice. Facility sweep of current residents on isolation including EBP was completed to ensure signage was properly placed on residents' doors, PPE was available, and staff were donning appropriate PPE prior to entering rooms. Infection preventionist is updating isolation precaution list daily to ensure staff are aware of changes and signage is accurate for each resident. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.** Facility Infection Preventionist has re-educated staff on isolation precautions including but not limited to enhanced barrier precautions PPE Members of the leadership team were educated on completing Infection control surveillance rounds to ensure compliance. Facility medical director is also an infectious disease specialist and has provided the facility guidance on PPE and infection control. **How the corrective action(s) will be monitored to ensure the deficient practice will not**	

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	to be used for residents with wounds. 3.1-18(b)		**recur, i.e., what quality assurance programs will be put into place.** GM/designee will randomly audit facility staff members for compliance with PPE 5 times per week including week-end shifts, and on alternating shifts to ensure compliance. DON/Designee will randomly audit 5 staff members for PPE compliance during bathing, dressing changes, and other high contact resident care activities 5 times per week on alternating shifts to ensure compliance. The Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/18/2025**	