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	06/04/2025

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00458911, IN00459627, IN00459710 and IN00459761. Complaint IN00458911 - Federal/state deficiencies related to the allegation are cited at F755. Complaint IN00459627 - No deficiencies related to the allegations are cited. Complaint IN00459710 - Federal/state deficiencies related to the allegation are cited at F679. Complaint IN00459761 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: June 2, 3 and 4, 2025 Facility number: 013688 Provider number: 155844 Census Bed Type: SNF: 60 Residential: 21 Total: 81 Census Payor Type: Medicare: 34 Other: 26 Total: 60 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Please accept this plan of correction as a reflection of our compliance. We respectfully request a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly S Gee	Administrator	06/25/2025

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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	Quality review completed on 6/9/25.			
F 0628 SS=D Bldg. 00	483.15(c)(2)(iii)(3)-(6)(8)(d)(1)(2); 48 Discharge Process Based on record review and interview, the facility failed to ensure a copy of the resident transfer or discharge form was provided to the Office of the State Long Term Care Ombudsman's office prior to transfers or discharges as required. This had the potential to affect all discharged residents since May 2024. Finding includes: During an e-mail correspondence on 6/3/25, the State Ombudsman indicated the they had not received any notifications of transfers or discharges from the facility since May 2024. During an interview on 6/4/25 at 12:58 a.m., the Administrator indicated she was not aware the State Ombudsman notifications of transfers and discharges were still a requirement. She indicated the facility had not been sending them out. The policy, "Ombudsman Notification", updated 5/2024, indicated, "1. Transfers/discharges initiated by the facility require the Ombudsman be sent a copy of the notice before or as close possible to the actual time of the facility-initiated notification to the resident...."	F 0628	The month of May was submitted to the state ombudsman while survey was in process. There was no negative effect on residents discharged from the facility. Current discharges were added to the form for the current month to ensure Office of the State Long Term Carre Ombudsman is aware as required. Transitional Care Team was educated on the importance of completing the form as required. General Manager/Administrator Designee will audit the weekly discharges to ensure accurate and timely information is sent to the State Ombudsman office. The audits will review at weekly QAPI for 6 months to ensure compliance.	07/02/2025
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident Based on record review and interview, the facility failed to ensure cognitively impaired residents were provided with ongoing activities to meet their preferences for 3 of 3 residents reviewed for	F 0679	1 Activity aides were educated on the importance of documenting the details of the visits and refusals to ensure that all efforts to	07/02/2025

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	activities. (Residents E, J and B) Findings include: 1. Resident E's record was reviewed on 6/2/25 at 9:10 a.m. Diagnoses included, but were not limited to, metabolic encephalopathy, heart disease and fracture of the right pubis. The Admission Minimum Data Set (MDS) assessment, dated 5/8/25, indicated the resident had severe cognitive impairment and required maximum assistance for toileting and moderate assistance for transfers. The Admission Activity assessment, dated 5/2/25, indicated the resident enjoyed snacks between meals, Hallmark movies, game shows, going out with family, pet visits and to attend Catholic services. The Activity Director provided a list of residents who were scheduled to be seen for one-on-one visits on 5/6, 5/15, 5/28 and 5/29/25. On 5/15/25, Resident E was noted not to be in the room. There was no documentation if the one-on-one visits had occurred or what type of activity had been provided. A Group Programs log for the past 30 days was provided and indicated the resident was "active" in one event on 5/5/25. On 6/2/25 at 11:15 a.m., the resident was observed in the therapy room, not actively engaged. On 6/2/25 at 1:35 p.m., the resident was observed seated in a chair in her room with the blinds shut and the lights off. During an interview on 6/3/25 at 11:10 a.m., the Activity Director indicated the resident would		provide activities are reflected in the medical record. Interviews with the activities department did confirm offers were made and some participation took place with “active” participation noted, however description was lacking. 2 Current residents have had their activity assessments and preferences updated and care plans updated to reflect their current interests, abilities, and include measurable goals for their activity interests. 3 The Activity Director Designee has been educated on the assessment and preference process and delivering meaningful activities that align with the residents’ interests and abilities. The Director Designee has also created a new document to ensure the detail is captured on daily offers to ensure all efforts are reflected in the medical record. 4 The General Manager or designee will audit 5 residents weekly to ensure accurate documentation of the activities are offered and match the preference and assessment of the residents to meet the needs of the residents. The audits will be reviewed at monthly QAPI for recommendations and follow up to ensure compliance is upheld.	

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	vary day to day, she would participate some days and would want to be left alone at other times. They could document in the computer if the resident participated or not. The Executive Director indicated the one-on-one sheets should be updated to include what type of activity was provided. 2. Resident J's record was reviewed on 6/2/25 at 2:45 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, adult failure to thrive, dementia and alcohol dependence. The Admission Minimum Data Set (MDS) assessment, dated 5/21/25, indicated the resident had severe cognitive impairment and required partial assistance for bed mobility and transfers. The Leisure Preferences, dated 5/23/25, indicated the resident enjoyed creative arts, having visitors, crafts and cooking, music, outdoor activities, parties and socials, reading and writing, and spiritual activities. During an interview on 6/3/25 at 11:10 a.m., the Activity Director indicated the resident preferred independent activities like reading and coloring. She had just provided the resident with some activity material in her room. She indicated activities were documented in the computer. On 6/3/25 at 2:43 p.m., Resident J was observed in her room with the TV on. She indicated she didn't like singing programs but liked BINGO. A Group Programs log for the past 30 days indicated the resident was "active" on 5/27 and 5/28/25, and had refused on 5/16, 5/17, 5/19, 5/22, 5/23, 5/30 and 5/31/25. There was no			

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	documentation what type of activity had been provided or refused, and there was no documentation of independent activities provided. 3. The closed record for resident B was reviewed on 6/3/25 at 10:49 a.m. Diagnoses included but were not limited to, multiple fractures of the ribs, metabolic encephalopathy (a brain dysfunction resulting from underlying metabolic problems), and heart failure. A Care Plan, initiated 5/6/25, indicated the resident would participate in the leisure activities they preferred: having visitors, sewing, cleaning, oldies music, outdoor activities, and reading/writing. The 5/7/25 Admission Minimum Data Set (MDS) assessment indicated the resident had severe cognitive impairment, and required substantial / maximum assistance with activities of daily living and transfers. The 5/7/25 Activity Preferences Assessment indicated the following activities were very important to the resident: to have books, newspapers, and magazines to read, to listen to music, to be around animals such as pets, to keep up with the news, to do things with groups, to do their favorite activities, to go outside to get fresh air when the weather was good. The assessment indicated participating in religious services or practices was not important at all to the resident. The record lacked documentation of the resident participating in or being offered any of the activities that were important to them. During an interview on 6/3/25 at 11:04 a.m., the Activities Director indicated they only documented activities for the resident who were			

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	receiving communion. During an interview on 6/4/25 at 10:20 a.m., the Activities Director indicated the aides brought the resident word searches, but it was not documented. This citation relates to Complaint IN00459710. 3.1-33(a)			
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 initiate medication administration in a timely manner for 1 of 3 residents reviewed for pharmacy services. (Resident C) Finding includes: The record for Resident C was reviewed on 6/3/25 at 1:12 p.m. Diagnoses included, but were not limited to, congestive heart failure, COVID-19, and pneumonia. The 5/9/25 Admission Minimum Data Set (MDS) assessment indicated the resident had moderate cognitive impairment and required moderate assistance with activities of daily living and transfers. A Progress Note, dated 5/9/2025, indicated the resident tested positive for COVID-19. The May 2025 Medication Administration Record (MAR) indicated Paxlovid (an antiviral medication used to treat COVID-19 infection for those who are at a high risk of developing severe illness) was ordered for the resident on 5/9/2025. The	F 0755	1. Resident C is no longer in the facility. 2. Current Resident New Medication Order listing were audited to ascertain that their medications are available as ordered. Any discrepancies were addressed and documented. 3. The licensed staff will be educated regarding the procedure to communicate with the pharmacy and provider when there is an anticipated delay in receiving an ordered medication. 4.The DON/Designee will audit daily thru clinical meeting 5 days a week any new medication orders to ensure med is available and timely administration occurred. Audits will be reviewed in weekly QAPI and forwarded to the governing body for review and recommendations.	07/02/2025

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	medication was not initiated until 5/12/2025. During an interview on 6/4/25 at 11:30 a.m. the Director of Nursing indicated the Paxlovid was not started until 5/12/2025 because they were waiting for the medication to arrive from the pharmacy. Pharmacy deliveries were made twice daily, and once on Sundays. Paxlovid was not kept in floor stock. The medication arrived Sunday 5/11/2025, but was not started until Monday 5/12/2025. Their pharmacy was located in Indianapolis. They did not have a contract with a local pharmacy, but it was something they were working on. This citation relates to Complaint IN00458911. 3.1-25(a)			