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	04/28/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Nursing Home Complaints IN00457192 and IN00457659. This visit included the Investigation of Residential Complaint IN00456560. Complaint IN00457192 - Federal/State deficiencies related to the allegations are cited at F557. Complaint IN00457659 - Federal/State deficiencies related to the allegations are cited at F690. Complaint IN00456560 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: April 23, 24, and 28, 2025 Facility number: 013688 Provider number: 155844 Census Bed Type: SNF: 56 Residential: 26 Total: 82 Census Payor Type: Medicare: 29 Other: 27 Total: 56 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/5/25.	F 0000	We respectfully request a desk review and will be submitting all the documentation we have worked on and will continue to work on thru date of compliance to ensure compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Kimberly S Gee	Administrator	05/16/2025

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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F 0557 SS=D Bldg. 00	483.10(e)(2) Respect, Dignity/Right to have Prsnl Property Based on observation, record review, and interview, the facility failed to ensure a resident was treated with respect and dignity related to a delay in assisting a resident to the bathroom upon request by the resident for 1 of 10 residents reviewed for respect and dignity. (Resident B) Finding includes: During an interview and observation on 4/23/25 at 4:42 p.m., Resident B's call light had been activated. She was sitting in her wheelchair in her room and two family members were also present. The resident indicated she needed to use the bathroom and began to propel her wheelchair to the bathroom. At 4:50 p.m., LPN 1 entered the room and the resident informed the nurse she "really needed to use the bathroom". The LPN indicated she would be a "second" and left the room. At 4:54 p.m., the resident stated, "I guess they forgot I needed to go", then stated, "come on". At 4:55 p.m. the resident wanted to know where the staff was and indicated she was told they would be right back. CNA 2 and CNA 3 then entered the room and assisted the resident to the bathroom. The resident then voided on the toilet. Resident B's record was reviewed on 4/24/25 at 9:24 a.m. The diagnoses included, but were not limited to right femur fracture, pressure wound, and falls. A Care Plan, dated 4/7/25, indicated assistance was required for activities of daily living. The interventions included the resident was dependent for toileting.	F 0557	IGNITE MEDICAL RESORT CHESTERTON makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. IGNITE MEDICAL RESORT CHESTERTON is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT CHESTERTON's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that residents have the right to be treated with respect and dignity, including the right to receive timely assistance with toileting needs upon request. **Corrective Action for Affected Residents**: Resident B was assessed for any adverse effects related to the delayed toileting assistance. LPN 1, CNA 2, and CNA 3 received one-on-one education regarding the	05/21/2025

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	An Admission Minimum Data Set (MDS) assessment, dated 4/12/25, indicated a severely impaired cognition, no impairment to the upper and lower extremities, was dependent for toileting and transfers, had a fall prior to admission, and was occasionally incontinent of urine. A Care Card, located in the Shower Book, indicated the resident was a one person assistance for transfers. During an interview with the Executive Director on 4/24/25 at 10:59 a.m., she indicated the call light was activated at 4:38 p.m. per the call light log. During an interview on 4/24/25 at 11:11 a.m., Physical Therapy Assistant (PTA) 4 indicated the resident was able to transfer with one staff member. This citation relates to Complaint IN00457192. 3.1-3(t)		importance of providing prompt assistance with toileting needs. **Identifying other Residents having the Potential to be Affected**: A facility-wide audit of current residents was completed to identify those requiring assistance with toileting. Response times to call lights were audited via interviews and observations with residents/resident family members to identify any patterns of delayed response. **Measures put into place or Systemic Changes**: Education was provided for nursing staff regarding: ·Timely response to resident requests for assistance ·Proper communication when immediate assistance cannot be provided ·Seeking help from other staff members when needed ·Dignity and respect in resident care A buddy system has been established to ensure coverage when staff members are occupied with other residents or unable to respond timely to requested toileting assistance. **Plan to Monitor Performance**: The CNO/designee will audit staff response times of 10 residents requiring assistance weekly for 6 months. The GM/designee will interview 10 residents/resident family members	

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			weekly for 6 months who require assistance to ensure timely assistance is provided.	
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 bladder training and post void residuals (urine amount in the bladder after voiding) were completed and documented after a urinary catheter was discontinued. The facility also failed to ensure the amount of urinary output was recorded for 3 of 3 residents reviewed for urinary catheters. (Residents D, H, and L) Findings include: 1. During an observation and interview on 4/23/25 at 7:05 p.m., Resident D was sitting on the side of her bed. A urinary catheter was present with clear urine in the tubing. She indicated she voided constantly and has an appointment with a urologist. Resident D's record was reviewed on 4/24/25 at 2:25 p.m. The diagnoses included, but were not limited to, right femur fracture, stroke, and urinary tract infection. An Admission Minimum Data Set (MDS) assessment, dated 4/10/25, indicated a moderately impaired cognitive status, no behaviors, required maximum assistance for toileting, moderate assistance for transfers, a urinary catheter was present, and no bladder training had been completed. A Care Plan, dated 4/14/25, indicated a urinary	F 0690	IGNITE MEDICAL RESORT CHESTERTON makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. IGNITE MEDICAL RESORT CHESTERTON is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT CHESTERTON's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure that residents who enter the facility with or without an indwelling catheter receive appropriate care and services, including proper assessment, documentation, and monitoring of urinary output. **Corrective Action for Affected**	05/21/2025

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	catheter was present. The interventions indicated to monitor for signs and symptoms of a urinary tract infection, which included no urinary output and urinary frequency. A Nurse's Progress Note, dated 4/5/25 at 2:08 p.m., indicated a family member had contacted the facility and requested the urinary catheter be clamped every six hours during the day and left unclamped at night. The physician was notified and orders were received for the catheter clamping and bladder scans. A Physician's Order, dated 4/5/25 and discontinued on 4/9/25, indicated bladder training was to be attempted. The urinary catheter was to be clamped every six hours during the day and the resident was to alert the staff when she felt the urge to void. The urinary catheter was to be unclamped during the night. The Medication Administration Record (MAR), dated 4/2025, indicated on 4/8/25 at 5:59 p.m. a bladder scan had been completed. A Bladder Scan Documentation form, dated 4/5/25 at 5:47 p.m., indicated the scan was completed as ordered by the physician and the total volume scanned was 68-132 cc's (cubic centimeters). There was no documentation of the amount of urine in the urinary catheter drainage bag at the time of the scan. A Nurse Practitioner's (NP) Progress Note, dated 4/7/25 at 4:49 p.m., indicated the resident's abdomen was soft and non-tender and a urinary catheter was present. There was no documentation on the 4/2025 MAR or in the Nurses' Progress Notes from 4/5/25		**Residents**: The following corrective actions were implemented: ·Resident D's bladder training program was reassessed and new physician orders were obtained. ·Resident H's urinary output monitoring was updated to reflect accurate documentation. ·Resident L's urinary output monitoring was updated to reflect accurate documentation. **Identifying other Residents having the Potential to be Affected**: An audit of all current residents with indwelling catheters was completed to identify any similar documentation deficiencies. Residents with catheters have the potential to be affected by this practice. **Measures put into place or Systemic Changes:** 1.Licensed clinical staff was in-serviced regarding; ·Proper documentation of bladder training programs ·Documentation requirements for bladder scanning ·Accurate recording of urinary output every shift ·Implementation and documentation of physician orders related to catheter care 2. A new monitoring tool was developed and implemented to track compliance with catheter care documentation requirements. **Plan to Monitor Performance:** 1.The Unit Managers will audit	

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	through 4/8/25 that verified the urinary catheter had been clamped as ordered and if the resident had alerted the staff of the urge to void. An NP Progress Note, dated 4/8/25 at 9:09 a.m., indicated the resident continued bladder training for 48 hours prior to the removal of the urinary catheter for voiding trial on 4/10/25. A Physician's Order, dated 4/8/25 at 2:53 p.m. and discontinued on 4/11/25, indicated a bladder scan was to be completed every six hours and if the post void residual was over 300 cc's, the urinary catheter was to be re-inserted. The bladder scans were to be completed for three days. A Bladder Scan Documentation form, dated 4/9/25 at 6:22 p.m., indicated a post urinary catheter removals/residual check scan had been completed by the NP due to abdominal distention and there was 287 cc's of urine in the bladder. An NP Progress Note, dated 4/10/25 at 11:06 a.m., indicated the urinary catheter had been discontinued on 4/9/25, there were no bladder scan results in the resident's record, and a bladder scan had been completed at the time of the NP visit and 201 cc's of urine had been scanned. Bladder scans were to be completed every six hours for voiding trial on 4/10/25 and would be monitored closely. The 4/2025 MAR indicated the first bladder scan had not been completed until 4/10/25 at 6:00 a.m., 12:00 p.m., and 6:00 p.m. There was no documentation that indicated if the scans were a post void scan or the amount of urine scanned. There was no documentation in the Nurses' Progress Notes that indicated the scans had been		10 residents weekly with indwelling catheters for 6 months to ensure: ·Proper documentation of urinary output ·Implementation of physician orders related to catheter care ·Accurate documentation of bladder training programs when ordered ·Appropriate documentation of bladder scans when ordered Results will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for review and recommendations for 6 months. The QAPI Committee will determine the need for ongoing monitoring based on compliance.	

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	completed. A Physician's Order, dated 4/10/25 at 6:24 p.m. and discontinued on 4/11/25 at 7:45 p.m., indicated bladder scans were to be completed every six hours for 48 hours for urinary retention. A Radiology Results Report, dated 4/10/25 at 5:10 p.m., indicated a urinary bladder ultrasound had been completed and the calculated bladder volume was 48 cc's. There was no documentation on the 4/2025 MAR or the Nurses' Progress Notes 4/8/25 through 4/10/25 at 6:00 a.m. to indicate the clamping of the urinary catheter was being continued, the bladder scans had been completed by the nurse, or if the urinary catheter had been discontinued. There was no documentation of the urinary output amount on the output record for April 6, 2025 after 2:51 a.m. through April 11, 2025 at 5:59 p.m. The 4/2025 MAR indicated a bladder scan had been completed on 4/11/25 at 4:00 a.m. and there was no residual in the bladder. An NP Progress Note, dated 4/11/25 at 6:30 a.m., indicated the resident's abdomen was distended and the bladder was palpated. The resident indicated she had not urinated the last time a bladder scan had been completed, which was around 8:00 p.m. the previous evening. A bladder scan had been completed by the NP which estimated 641 cc's of urine and an order to re-insert the urinary catheter was written. The urinary output amounts had not been documented every shift/daily from 4/5/25 through 4/28/25.			

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	During an interview on 4/28/25 at 8:32 a.m., the Director of Nursing (DON) indicated there was no documentation that indicated the clamping and unclamping of the catheter, the resident's reported urge to void, the amount of voids, and the bladder scans with the pre and post urine amounts had been completed as ordered. The catheter had been discontinued on 4/9/25 as documented on the bladder scan form and there had been no documentation in the Nurses' Progress Notes indicating the bladder training, scans, and discontinuation of the urinary catheter had been completed. She indicated there were several orders written and there was no consistent record of the urine output documented. A catheter removal policy, dated 7/2024 and received by the DON as current, indicated the date and time of the urinary catheter removal was to be documented. A bladder scan policy, dated 9/2024 and received by the DON as current, indicated post void residuals will be completed via the bladder scan device with a physician's order. The provider would be notified of abnormal results. 2. During an observation on 4/24/25 at 8:00 a.m., Resident H was sitting at a table by the Nurses' Station. A covered urinary catheter bag was observed. Resident H's record was reviewed on 4/28/25 at 9:51 a.m. The diagnoses included, but were not limited to, obstructive uropathy and dementia. A Care Plan, dated 4/11/25, indicated a urinary catheter was present related to obstructive uropathy. The interventions included to monitor			

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	for signs and symptoms of a urinary tract infection, which included the amount of urine output. A Care Plan, dated 4/11/25, indicated an enlarged prostate. The interventions included, urine retention would be monitored. A Physician's Order, dated 4/11/25, indicated the urinary output was to be monitored every shift. An Admission MDS assessment, dated 4/15/25, indicated a severely impaired cognitive status and a urinary catheter was utilized. The urinary output monitoring log indicated there had been urinary output documented on April 14, 15, 16, 18, 19, 20, 21, and 22, 2025. There was only one documented urinary output on April 13 at 2:14 p.m. with 750 cc's of urine, 4/17/25 at 12:15 p.m. with 500 cc's of urine, 4/23/25 at 5:59 p.m. with 100 cc's of urine, and 4/27/25 at 4:08 a.m. with 500 cc's of urine. 3. During an interview and observation on 4/23/25 at 7:45 p.m., Resident L was lying in bed. There was a urinary catheter present. She indicated the catheter was used because she had a sore they wanted to keep clean. Resident L's record was reviewed on 4/28/25 at 10:49 a.m. The diagnoses included, but were not limited to abscess of the groin. A Care Plan, dated 4/14/25, indicated a urinary catheter was present. The interventions included to monitor for signs and symptoms of a urinary tract infection, which included no urinary output.			

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	An Admission MDS assessment, dated 4/18/25, indicated an intact cognitive status and a urinary catheter was present. The urinary output monitoring indicated there were no urinary outputs documented on April 13, 15, 26, 17, 20, 21, 22, 26, and 27, 2025. There was only one urinary output documented on 4/18/25 at 3:21 p.m. with 650 cc's of urine, 4/19/25 at 3:11 a.m. with 600 cc's of urine, 4/23/25 at 4:27 p.m. with 500 cc's of urine, 4/24/25 at 1:28 a.m. with 800 cc's of urine, 4/24/25 at 1:28 a.m. with 800 cc's urine and 4/25/25 at 5:59 a.m. with 250 cc's of urine. A catheter care policy, dated 5/2024 and received from the DON as current, indicated the urinary drainage bag was to be emptied at the end of each shift or more often if needed and the total amount of urine was to be documented in the clinical record. This citation relates to Complaint IN00457659. 3.1-41(a)(2)			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by a staff members (CNA 2 and CNA 3) when providing care to a resident (Resident B) who was in Enhanced Barrier Precautions (EBP) for one random observation for infection control. Finding includes:	F 0880	IGNITE MEDICAL RESORT CHESTERTON makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. IGNITE MEDICAL RESORT CHESTERTON is submitting this	05/21/2025

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	During an interview and observation on 4/23/25 at 4:42 p.m., Resident B's call light had been activated. Upon entering the room, a magnetic sign was on the outside door frame that indicated EBP was required when providing care. At 4:55 p.m., CNA 2 and CNA 3 entered the room, donned gloves and began to assist the resident to the toilet. The CNA's were stopped and asked if the resident required EBP and both CNA's stated, "no" and continued to assist the resident to transfer to the toilet. The resident's incontinent brief was changed after incontinence care had been completed. She was then dressed in a clean pair of slacks and transferred back to the wheelchair. Resident B's record was reviewed on 4/24/25 at 9:24 a.m. The diagnoses included, but were not limited to right femur fracture, pressure wound, and falls. A Physician's Order, dated 4/7/25, indicated EBP was to be implemented due to wounds being present. A Care Plan, dated 4/7/25, indicated EBP was required related to a wound. The interventions included PPE of gowns and gloves were to be worn during high contact care activities. A facility EBP policy, dated 3/2024 and identified as current by the Executive Director, indicated staff were to don a gown and gloves during high-contact resident care. EBP PPE was to be used for residents with wounds. 3.1-18(b)		Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT CHESTERTON's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to maintain an infection prevention and control program designed to provide a safe, sanitary environment and prevent the development and transmission of communicable diseases and infections, including proper use of Personal Protective Equipment (PPE) for residents requiring Enhanced Barrier Precautions (EBP). **Corrective Action for Affected Residents**: Resident B was assessed for any adverse effects related to improper PPE usage during care. The Infection Preventionist reviewed Resident B's care plan and verified appropriate EBP signage and PPE supplies were in place. CNA 2 and CNA 3 received immediate one-on-one education from the CNO regarding proper PPE requirements for EBP, including the use of gowns and gloves	

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			during high-contact resident care activities. **Identifying other Residents having the Potential to be Affected**: A facility-wide audit of residents requiring EBP was completed to ensure proper signage was in place and adequate PPE supplies were available. The care plans were reviewed to identify those requiring EBP and verified that appropriate precautions were documented. **Measures put into place or Systemic Changes:** 1.The Director of Nursing and Infection Preventionist conducted mandatory in-service education for clinical staff regarding: ·Proper identification and interpretation of isolation signage ·EBP criteria and requirements ·Appropriate PPE selection and use during high-contact care activities ·Documentation requirements for residents requiring EBP 1.Specific examples of high-contact care activities requiring PPE use was reviewed with staff. 2.New visual aids were posted on resident door entryway illustrating proper PPE requirements for different types of precautions. **Plan to Monitor Performance:** 1.The CNO/designee will conduct direct observation audits	

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	04/28/2025

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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			of 10 staff members compliance with EBP requirements during high-contact care activities weekly for 6 months. 2.The CNO/designee will conduct competency validations for proper PPE use with clinical staff monthly x 6 months. The Director of Nursing will report monitoring results to the Quality Assurance Performance Improvement (QAPI) committee monthly for six months. The QAPI committee will analyze data for patterns/trends and make recommendations for continued monitoring based on compliance	
R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00456560. This visit included the Investigation of Nursing Home Complaints IN00457192 and IN00457659. Complaint IN00456560 - No deficiencies related to the allegations are cited. Complaint IN00457192 - Federal/State deficiencies related to the allegations are cited at F557. Complaint IN00457659 - Federal/State deficiencies related to the allegations are cited at F690. Unrelated deficiencies are cited. Survey dates: April 23, 24, and 28, 2025 Facility number: 013688	R 0000	We respectfully request a desk review and will be submitting all the documentation we have worked on and will continue to work on thru date of compliance to ensure compliance.	

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	Residential Census: 26 Ignite Medical Resort Chesterton was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Residential Complaint IN00456560. Quality review completed on 5/5/25.			