STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Crown Point LLC	1555 S Main Street Crown Point, IN 46307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. 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 flushing orders and flushing of the catheter, medications administered as ordered, documentation of the insertion and discontinuation of the catheter, assessments of the catheter line with dressing changes and after discontinuing the catheter, for 3 of 3 residents reviewed for midline/PICC (peripherally inserted central catheter) care. (Residents B, C, and F)Findings include:1. Resident B's closed record was reviewed on 9/8/25 at 9:56 a.m. The diagnoses included, but were not limited to, urinary tract infection and bladder cancer. A Care Plan, dated 6/2/25, indicated IV medication was being administered. The interventions included, the dressing for the site was to be changed daily and the observations of the site were to be recorded and the IV line was to be flushed per the Physician's Orders.A Physician's Order, dated 6/2/25, indicated the dressing on the midline was to be changed every seven days for midline maintenance per the midline maintenance protocol.The Medication Administration Record (MAR), dated 6/2025, had initials as completed on June 2, 10, 26, and 24, 2025. There was no assessment of site and length of the IV line documented.A Physician's Order, dated 6/2/25, indicated piperacillin-tazobactam (antibiotic) 3-0.375 grams was to be administered per the IV in 100 milliliters (ml) of normal saline every eight hoursThe Medication Administration Record (MAR), dated 6/2025, indicated the last dose of the antibiotic had been administered on 6/10/25 at 2:00 p.m. A Physician's Order, dated 6/2/25 and discontinued on 6/30/25, indicated a normal saline flush solution, 10 mls was to be used to flush the midline before and after the medication was infused. The MAR, dated 6/2025, indicated the flush was scheduled as needed and had not been administered from 6/2/25 to 6/30/25.A Nurse Practitioner's (NP) Progress Note, dated 6/3/25 at 2:37 p.m., indicated the IV antibiotic was to be discontinued on 6/9/25. An admission Minimum Data Set (MDS) assessment, dated 6/7/25, indicated a moderately impaired cognitive status, and indwelling urinary catheter was present, had a urinary tract infection in the last 30 days, and an IV was present.There was no documentation on the MAR or the Nurses' Progress Notes that indicated the IV line had been flushed before and after the medication and after the IV antibiotics had been discontinued.A Nurse's Progress Note, dated 6/25/25 at 7:07 p.m., indicated the midline in the right upper arm had been removed per the NP orders. There was no bleeding or signs of infection. The resident had tolerated the procedure well.There was documentation in the Nurse's Progress Note that indicated the length of the IV line and the condition of the tip of the catheter.During an interview on 9/8/25 at 12:05 p.m., the Director of Nursing (DON), indicated the midlines/PICC lines were usually discontinued when it was determined there would be no further treatment. When the line was no longer in use, it was to be flushed with 10 ml normal saline twice a day.During an interview on 9/8/25 at 1:25 p.m., the DON indicated she was trying to find the flush orders for before and after the antibiotic was administered and assumed it had been done per the as needed order when the medication had been (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Crown Point LLC	1555 S Main Street Crown Point, IN 46307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	administered. She acknowledged there was no assessment of the length of the line and the tip condition with dressing changes and when the line had been discontinued. 2. During an observation on 9/8/25 at 8:25 a.m., Resident C was lying in bed and had an IV line in her upper left arm. The dressing that covered the insertion site had a date of 9/5/25.Resident C's record was reviewed on 9/8/25 at 1:37 p.m. The diagnoses included, but were not limited to urinary tract infection.A Physician's Order, dated 9/4/25, indicated meropenem (antibiotic) one gram was to be administered per the IV every 12 hours for seven days due to a urinary tract infection.A Physician's order, dated 9/5/25, indicated a midline IV was to be inserted for the antibiotic treatment.The MAR, dated 9/2025, indicated the meropenem had not been administered as ordered on 9/5/25 at 9:00 a.m., 9/6/25 at 9:00 p.m. and 9/7/25 at 9:00 p.m.There were no Physician's Orders for the weekly dressing change, assessment of the site, or the normal saline flushes before and after the antibiotic until 9/8/25 at 8:53 a.m.An NP Progress Note, dated 9/4/25 at 3:25 p.m., indicated, a urinary tract infection was present secondary to the urinary catheter. Cipro (antibiotic) had been initiated for seven days, pending the final sensitivity report.A MAR Note, dated 9/5/25 at 9:00 a.m., indicated the meropenem had not arrived from the pharmacy and had not been administered.An NP Progress Note, dated 9/5/25 at 4:21 p.m. and written on 9/6/25 at 12:22 p.m., indicated meropenem per IV had been ordered due to the sensitivity indicating the organism was resistant to the Cipro. A heperin lock (IV insertion) had been placed in the antecubital for IV access and a midline catheter had been ordered.A MAR Note, dated 9/6/25 at 8:57 p.m., indicated the meropenem had not been administered. No reason was documented.A MAR Note, dated 9/7/25 at 10:07 p.m., indicated the meropenem had not been administered. No reason was documented.There was no documentation who had inserted the heparin lock and when the midline had been inserted.During an interview on 9/8/25 at 2:22 p.m., the DON indicated the NP had inserted the heparin lock. There was no documentation who had placed the heparin lock and no documentation when the midline had been administered.During an interview on 9/8/25 at 3:19 p.m., the DON indicated the nurses had attempted to place the heparin lock and were unable to place, so the NP had placed the lock. The meropenem had not arrived from the pharmacy. The facility did have the medication available in the EDK 9emergency frug kit). The nurse had not looked in the EDK for the medication. The physician had not been notified. The flush orders and care of the mid-line had not been written at the time of the insertion. The first dose of the meropenem had been administered through the heparin lock on 9/5/25 at 10:00 a.m.3. Resident F's record was reviewed on 9/8/25 at 3:03 p.m. The diagnoses included, but were not limited to, rhabdomyolysis and peripheral vascular disease.A Care Plan, dated 5/20/25 and revised on 8/11/25, indicated IV medication was being received. The interventions included, the dressing would be changed weekly and the observation of the IV site was to be recorded. The IV would be flushed as ordered.A Physician's Order, dated 7/23/25 and discontinued on 8/13/25, indicated the IV midline dressing change was to be completed every seven days per midline protocol.A Physician's Order, dated 7/23/25 and discontinued on 8/13/25, indicated a flush of normal saline, 10 ml was to be completed before and after the IV medication was given.A Physician's Order, dated 7/23/25 and discontinued on 8/6/25, indicated meropenem one gram was to be administered every 8 hours for a urinary tract infection for 14 days. (42 doses)The MAR, dated 7/2025, indicated the meropenem had not been administered on 7/23/25 at 10:00 p.m. and 7/24/25 at 6:00 a.m. and was marked as refused.A Physician's Order, dated 7/23/24, indicated daptomycin (antibiotic) 476 milligrams as to be administered every 24 hours for 14 day, for the urinary tract infection.The MAR, dated 7/2025, indicated the daptomycin dose on 7/24/25 had not been given at 11:22 a.m.The MAR's, dated 7/2025 and 8/2025, indicated the dressing change had been completed on 7/26/25, 8/2/25, 8/10/25, 8/16/25, and 8/24/25. There was no documentation of the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155835	A. Building B. Wing	09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Crown Point LLC	1555 S Main Street Crown Point, IN 46307

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mid-line's length.A Physician's Order, dated 8/14/25, indicated the midline IV was to be discontinued.There was no documentation the mid-line had been discontinued, the length of the line or the status of the line's tip.During an interview on 9/9/25 at 10 a.m., the DON indicated the full dosages of the antibiotics were not administered and there was no documentation of the mid-line being discontinued and the assessment of the site and line had not been completed.The facility's central line care policy, dated 12/2024 and received from the DON as current, indicated general instructions after insertion of all PICC line treatments and dressings required a physician's order. A physician's order was required for flushing the line prior to and post administration of the medication, maintenance of the lines and routine line care. The removal of the line was to be documented in the record. The measurement of the line will be obtained by measuring the entire length of the line and was to be recorded. The measurement was to be compared to the insertion measurement. Assessment of the insertion site was to be completed every shift for seventy-two hours.This citation relates to Intake 1839939.3.1-47(a)(2)