| PRIN DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OM   |                |  |      |   |  |             |                            |  |
|--|----------------|--|------|---|--|-------------|----------------------------|--|
| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840   |                | X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                                  |      |   | (X3) DATE SURVEY COMPLETED 03/11/2024  |             |                            |  |
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC.  |                |  |      | STREET ADDRESS, CITY, STATE, ZIP COD  1532 CALUMET AVENUE  DYER, IN 46311 |  |             |                            |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION |      | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  |             | (X5)<br>COMPLETION<br>DATE |  |
| F 0000  Bldg. 00  This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00424703, IN00424731, IN00426055, IN00426751, IN00427100, IN00427561, and IN00429885. This visit included a State Residential Licensure Survey.  Complaint IN00424703 - Federal/State deficiencies |                |  | F 00 | 000   | Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. | an<br>y the |                            |  |

related to the allegations are cited at F677.

Complaint IN00426055 - No deficiencies related to the allegations are cited.

desk review for the given citations in this survey. Please see all attached documentation for your consideration.

Complaint IN00427100 - No deficiencies related to the allegations are cited.

Complaint IN00426751 - Federal/State deficiencies

related to the allegations are cited at F554.

Complaint IN00424731 - Federal/State deficiencies

Complaint IN00427561 - No deficiencies related to

Complaint IN00429885 - Federal/State deficiencies related to the allegations are cited at F677.

Survey dates: March 4, 5, 6, 7, 8, and 11, 2024.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Facility number: 013462 Provider number: 155840 AIM number: 201330210

the allegations are cited.

Census Bed Type: SNF/NF: 7 SNF: 91

TITLE

This facility respectfully requests a

(X6) DATE

Megan Matula Administrator 04/18/2024

Any defiency statement 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 disclodays 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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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY   |   |             | SURVEY   |                |                 |
|--|--|---|---|-------------|--|----------------|-----------------|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER   | A. BUILDING <u>00</u> COMPLETED   |             |  | ETED           |                 |
|  |  | 155840  | B. WI   | WING 03/11. |  |                | 2024            |
|  | ROVIDER OR SUPPLIER  |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |             |  |                |                 |
| (X4) ID  | SUMMARY S  | STATEMENT OF DEFICIENCIE  |   | ID          | PROVIDER'S PLAN OF CORRECTION  |                | (X5)            |
| PREFIX   | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL   |   | PREFIX      | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT  | ΓE             | COMPLETION      |
| TAG  |  | LSC IDENTIFYING INFORMATION   |   | TAG         | DEFICIENCY)  |                | DATE            |
| F 0554<br>SS=E<br>Bldg. 00                           | Residential: 28 Total: 126  Census Payor Type: Medicare: 36 Medicaid: 7 Other: 55 Total: 98  These deficiencies r accordance with 410 Quality review com 483.10(c)(7) Resident Self-Adm §483.10(c)(7) The medications if the defined by §483.2 that this practice is Based on observation interview, the facility had Physician's Ord medications, orders medications, and a semedication assessment residents reviewed for medication. (Residential of Nasobserved on the win room.  During random observed on the win room.  During random observed on the win room. | effect State Findings cited in DIAC 16.2-3.1.  pleted on 3/19/24.  pleted on 3/19/24. | F 05  |             | POC for F554 – Resident Self-Admin Meds-Clinically Appropriate What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No residents were affecte by this alleged deficient practic All medication in resident rooms J, L, H, M, and K have been removed.  How will you identify other residents having the potentia | l<br>ed<br>ce. | DATE 04/05/2024 |
|  | resident's window le   | edge.   |   |             | to be affected by the same deficient practice and what   |                |                 |

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|   |                                   | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                 |   |   |   |           |           |
|---|-----------------------------------|--|---|---|---|-----------|-----------|
| AND PLAN  | OF CORRECTION                     | IDENTIFICATION NUMBER                                      |   | A. BUILDING 00 COMPLETED  B. WING 03/11/2024                        |   |           |           |
|   |                                   | 155840   | B. W  | ING   |   | 03/11/202 | 24        |
|   | PROVIDER OR SUPPLIER              |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |   |           |           |
| (X4) ID   | SUMMARY                           | STATEMENT OF DEFICIENCIE                                   |   | ID  |   |           | (X5)      |
| PREFIX  |                                   | ICY MUST BE PRECEDED BY FULL                               |   | PREFIX  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | cc        | OMPLETION |
| TAG   | REGULATORY OR                     | R LSC IDENTIFYING INFORMATION                              |   | TAG   | DEFICIENCY)   | 16        | DATE      |
|   | The record for Resi               | dent J was reviewed on 3/5/24                              |   |   | corrective action will be take  | n?        |           |
|   |                                   | oses included, but were not                                |   |   |   |           |           |
|   |                                   | abetes and acute respiratory                               |   |   | All residents have the  |           |           |
|   |                                   | a (low levels of oxygen in the                             |   |   | potential to be affected by this  |           |           |
|   | body tissue).                     |  |   |   | alleged deficient practice.   |           |           |
|   | The Admission Mir                 | nimum Data Set (MDS)                                       |   |   | House audit was comple  | ted       |           |
|   |                                   | /15/24, indicated the resident                             |   |   | of all residents rooms to ensur   |           |           |
|   | was cognitively inta              |  |   |   | medications are in residents re   |           |           |
|   |                                   |  |   |   | that do not have a  |           |           |
|   |                                   | nysician's Order Summary                                   |   |   | self-administration of medicati   | on        |           |
|   | , ,                               | e resident had no order for the                            |   |   | assessment, Physicians order  | ,         |           |
| Nasal Relief nasal spray and they did not have an |                                   |  |   | and an updated careplan to re                                       | flect   |           |           |
|   | order to self admini              | ster their medications.                                    |   |   | self-administration.  |           |           |
|   | The resident did not              | t have a Self-Administration of                            |   |   | WhWhat measures will be put   | into      |           |
|   | Medication assessm                | nent.  |   | place or what systemic changes                                      |   |           |           |
|   |                                   |  |   |   | you will make to ensure that the  |           |           |
|   | _                                 | v on 3/6/24 at 3:49 p.m., the                              |   |   | deficient practice does not rec   | ur?       |           |
|   |                                   | nager indicated the nasal                                  |   |   |   |           |           |
|   |                                   | from the resident's room on                                |   |   | Nursing staff was educat  |           |           |
|   | 3/5/24.                           |  |   |   | on ensuring medications are r   |           |           |
|   | 2.5.                              | 1 2/4/24 2.55  |   |   | left at bedside unless there is   |           |           |
|   |                                   | observations on 3/4/24 at 2:55<br>an Albuterol inhaler was |   | self-administration assessment, a                                   |   |           |           |
|   |                                   | nt L's over bed table.                                     |   | physician order, and an updated careplan for self-administration of |   |           |           |
|   | obberved on Reside                | II. 25 over oca more.                                      |   |   | medications.  | 1 01      |           |
|   | During a random ob                | oservation on 3/5/24 at 8:45                               |   |   |   |           |           |
|   | _                                 | nained on the resident's over                              |   |   | DOH was educated to no  | tify      |           |
|   | bed table.                        |  |   |   | nursing staff if any medication   | s         |           |
|   |                                   |  |   |   | accompany guest while   |           |           |
|   |                                   | dent L was reviewed on 3/6/24                              |   |   | completing inventory of belone  |           |           |
|   | _                                 | noses included, but were not                               |   |   | upon admission to the facility.   |           |           |
|   | · ·                               | obstructive pulmonary disease                              |   |   | All ( 66 )  |           |           |
|   | (COPD), oxygen de                 | ependent, and asthma.                                      |   |   | All staff educated to notif   | y         |           |
|   | The 3/6/21 Dwinf In-              | terview for Mental Status                                  |   |   | nursing staff if they notice medications in rooms while   |           |           |
|   |                                   | ed the resident was cognitively                            |   |   | completing daily rounds and/o   | r         |           |
|   |                                   |  |   |   | answering call lights.  | '         |           |
|   | intact for daily decision making. |  |   |   | answering can lights.   |           |           |

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| STATEMENT OF DEFICIENCIES |   | X1) PROVIDER/SUPPLIER/CLIA                                   | (X2) M            | (X2) MULTIPLE CONSTRUCTION |  | (X3) DATE SURVEY |            |  |
|---------------------------|---|--|-------------------|----------------------------|--|------------------|------------|--|
| AND PLAN                  | OF CORRECTION   | IDENTIFICATION NUMBER  | A. BU             | A. BUILDING <u>00</u>      |  |                  | COMPLETED  |  |
|                           |   | 155840   | B. WING 03/11/202 |                            | 024  |                  |            |  |
|                           |   | <u> </u>   |                   | STREET A                   | ADDRESS, CITY, STATE, ZIP COD  | <u> </u>         |            |  |
| NAME OF I                 | PROVIDER OR SUPPLIER  | R  |                   |                            | ALUMET AVENUE  |                  |            |  |
| IGNITE I                  | MEDICAL RESORT  | DYER LLC.  |                   |                            | IN 46311   |                  |            |  |
| (X4) ID                   | SUMMARY STATEMENT OF DEFICIENCIE  |  |                   | ID                         | PROVIDER'S PLAN OF CORRECTION  |                  | (X5)       |  |
| PREFIX                    | (EACH DEFICIEN  | ICY MUST BE PRECEDED BY FULL                                 |                   | PREFIX                     | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | ATE (            | COMPLETION |  |
| TAG                       |   | R LSC IDENTIFYING INFORMATION                                |                   | TAG                        | DEFICIENCY)  |                  | DATE       |  |
|                           |   | nysician's Order Summary                                     |                   |                            | HwHow will the corrective  |                  |            |  |
|                           |   | e resident did not have an                                   |                   |                            | actions(s) be monitored to en  | sure             |            |  |
|                           | order to self admini  | ister their medications.                                     |                   |                            | the deficient practice will not  |                  |            |  |
|                           |   |  |                   |                            | recur, i.e., what quality assura                                       | I                |            |  |
|                           |   | t have a Self-Administration of                              |                   |                            | program will be put into place   | ?                |            |  |
|                           | Medication assessn  | nent.  |                   |                            | 0110/5 : 31 31   |                  |            |  |
|                           | Duning and internet   | or 2/6/24 at 2:40 41 -                                       |                   |                            | CNO/Designee will audit  | I                |            |  |
|                           | _   | v on 3/6/24 at 2:49 p.m., the                                |                   |                            | residents weekly on alternating  | -                |            |  |
|                           |   | g indicated the inhaler should at the resident's bedside. 3. |                   |                            | shifts to ensure no medication are left at resident's bedside          | is               |            |  |
|                           |   | servations on 3/4/24 at 2:15                                 |                   |                            | are left at resident's bedside unless there is a                       |                  |            |  |
|                           | 1   |  |                   |                            | self-administration assessmen  | nt a             |            |  |
|                           | p.m.,and 3:34 p.m., and on 3/5/24 at 8:40 a.m., there was a Breo Ellipta inhaler on top of Resident H's |  |                   |                            | physician order, and updated   |                  |            |  |
|                           | night stand.  |  |                   |                            | plan for the self-administration                                       |                  |            |  |
|                           | night stand.  |  |                   |                            | medications.   | 101              |            |  |
|                           | During random obs   | servations on 3/5/24 at 2:37 p.m.                            |                   |                            | modications.   |                  |            |  |
|                           | _   | 38 a.m., the Breo Ellipta inhaler                            |                   |                            | CNO/Designee will prese  | ent              |            |  |
|                           |   | night stand drawer.  |                   |                            | summaries of the audit to the  |                  |            |  |
|                           |   |  |                   |                            | Quality Assurance Committee  | ,                |            |  |
|                           | The record for Resi   | ident H was reviewed on 3/5/24                               |                   |                            | monthly for six months.  |                  |            |  |
|                           | at 3:03 p.m. Diagno   | oses included, but were not                                  |                   |                            | Thereafter, if determined by   |                  |            |  |
|                           | limited to, COPD a  | nd shortness of breath.                                      |                   |                            | Quality Assurance Committee  | that             |            |  |
|                           |   |  |                   |                            | further monitoring is needed,  |                  |            |  |
|                           | The 2/21/24 Modifi  | ication of the 5 day Medicare                                |                   |                            | audits will continue.  |                  |            |  |
|                           |   | (MDS) assessment, indicated                                  |                   |                            |  |                  |            |  |
|                           |   | oderately impaired for decision                              |                   |                            | Date of compliance: 4/5/202  | 4                |            |  |
|                           | making.   |  |                   |                            |  |                  |            |  |
|                           | Physician's Orders  | dated 2/28/24, indicated                                     |                   |                            |  |                  |            |  |
|                           | I -   | e-Vilanterol Inhalation Aerosol                              |                   |                            |  |                  |            |  |
|                           |   | ivated (Breo Ellipta inhaler)                                |                   |                            |  |                  |            |  |
|                           |   | s, inhale 1 puff orally one time a                           |                   |                            |  |                  |            |  |
|                           | day for shortness of  | -  |                   |                            |  |                  |            |  |
|                           | any 101 bilotuioss of   | <del></del>  |                   |                            |  |                  |            |  |
|                           | There was no order  | for the resident to  |                   |                            |  |                  |            |  |
|                           | self-administer thei  | r own medications or a                                       |                   |                            |  |                  |            |  |
|                           | Self-Administration   | n of Medication Assessment                                   |                   |                            |  |                  |            |  |
|                           | completed.  |  |                   |                            |  |                  |            |  |
|                           |   |  |                   |                            |  |                  |            |  |
|                           | During an interview   | v on 3/6/24 at 10:50 a.m., the                               |                   |                            |  |                  |            |  |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                        | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                    |                          |              |   |        |                    |
|--|------------------------|---|--------------------------|--------------|---|--------|--------------------|
| AND PLAN   | OF CORRECTION          | IDENTIFICATION NUMBER   | A. BUILDING 00 COMPLETED |              |   |        |                    |
|  |                        | 155840  | B. WIN                   | G            |   | 03/11/ | /2024              |
| NAME OF P  | PROVIDER OR SUPPLIER   | ·   |                          |              | DDRESS, CITY, STATE, ZIP COD  |        |                    |
|  |                        |   | l                        |              | ALUMET AVENUE   |        |                    |
| IGNITE   | MEDICAL RESORT         | DYER LLC.   |                          | υγΕΚ, Ι      | N 46311   |        |                    |
| (X4) ID  |                        | STATEMENT OF DEFICIENCIE                                      |                          | ID           | PROVIDER'S PLAN OF CORRECTION   |        | (X5)               |
| PREFIX<br>TAG  | ,                      | ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION    | Ρ.                       | REFIX<br>TAG | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE     | COMPLETION<br>DATE |
| TAG  |                        | of Nursing indicated the                                      |                          | IAU          |   |        | DATE               |
|  |                        | ers or an assessment to                                       |                          |              |   |        |                    |
|  | self-administer their  |   |                          |              |   |        |                    |
|  |                        |   |                          |              |   |        |                    |
|  | _                      | observations on 3/4/24 at 1:50                                |                          |              |   |        |                    |
|  |                        | , on 3/5/24 at 8:43 a.m., and at                              |                          |              |   |        |                    |
|  | • •                    | /6/24 at 9:38 a.m., there was an and held inhaler on Resident |                          |              |   |        |                    |
|  | M's over bed table i   |   |                          |              |   |        |                    |
|  | ivi s over bed table i | morae a vasket.   |                          |              |   |        |                    |
|  | The record for Resi    | dent M was reviewed on 3/6/24                                 |                          |              |   |        |                    |
|  | at 10:34 a.m. Diagn    | oses included, but were not                                   |                          |              |   |        |                    |
| limited to, brain and lung cancer, COPD,             |                        |   |                          |              |   |        |                    |
|  | respiratory failure,   | and high blood pressure.                                      |                          |              |   |        |                    |
|  | The 1/22/24 Admis      | sion Minimum Data Set (MDS)                                   |                          |              |   |        |                    |
|  | assessment, indicate   |   |                          |              |   |        |                    |
|  | · ·                    | d for daily decision making.                                  |                          |              |   |        |                    |
|  |                        | -   |                          |              |   |        |                    |
|  |                        | dated 1/15/24, indicated                                      |                          |              |   |        |                    |
|  |                        | FA Inhalation Aerosol   |                          |              |   |        |                    |
|  |                        | ase) micrograms, inhale 2 puffs                               |                          |              |   |        |                    |
|  | orally every 6 hours   | s as needed for wheezing.                                     |                          |              |   |        |                    |
|  | There was no Physi     | cian's Order or a   |                          |              |   |        |                    |
|  | -                      | n of Medication Assessment                                    |                          |              |   |        |                    |
|  | for the resident to a  | dminister the inhaler herself.                                |                          |              |   |        |                    |
|  | Duning or inter-       | or on 2/6/24 at 10.50 41                                      |                          |              |   |        |                    |
|  | -                      | or on 3/6/24 at 10:50 a.m., the of Nursing indicated the      |                          |              |   |        |                    |
|  |                        | ers or an assessment to                                       |                          |              |   |        |                    |
|  |                        | own medication.5. On 3/4/24 at                                |                          |              |   |        |                    |
|  |                        | at K was observed lying in bed                                |                          |              |   |        |                    |
|  | · ·                    | side table were a bottle of                                   |                          |              |   |        |                    |
|  | Tums and a bottle of   |   |                          |              |   |        |                    |
|  | 0.04/04                |   |                          |              |   |        |                    |
|  |                        | a.m., the resident was observed                               |                          |              |   |        |                    |
|  | remained on the bes    | pottle of Tums and eye drops                                  |                          |              |   |        |                    |
|  | remained on the bes    | Side table.   |                          |              |   |        |                    |
|  | i                      |   | 1                        |              |   |        | 1                  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING   | ONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 03/11/2024                      |               |
|--|---|--|--|--|---------------|
|  | PROVIDER OR SUPPLIER  |  | 1532 C   | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311 |               |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  | ID PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPLICATION SHOULD CROSS-REFERENCED TO THE APPLICATION CROSS-REFERENCED TO THE APPLICATIO |  | BE COMPLETION |
| ING  | On 3/5/24 at 9:25 a eating breakfast. Th  | m., the resident was observed<br>the bottle of Tums and eye<br>d in a wash basin on the  | Mo   |  | DATE          |
|  | getting ready for ph  | m., the resident was observed<br>ysical therapy. On the bedside<br>ottle of Tums, eye drops, and a<br>iever.   |  |  |               |
|  | at 9:56 a.m. Diagno<br>limited to, heart fail<br>obstruction (abnorn<br>esophagus), gastroe | dent K was reviewed on 3/6/24 sees included, but were not ture, weakness, esophageal nal narrowing of the sophageal reflux disease (acid ain, and a muscle disorder. |  |  |               |
|  | assessment, indicate  | sion Minimum Data Set (MDS)<br>ed the resident was<br>or daily decision making   |  |  |               |
|  | There was no Care medications.  | Plan to self-administer his  |  |  |               |
|  | There was no Self-Assessment comple   | Administer of Medication ted for the resident.   |  |  |               |
|  | There were no Phys  | sician's Orders for the Tums,<br>ain reliever.   |  |  |               |
|  | Director of Nursing   | on 3/06/24 at 1:54 p.m., the (DON) indicated he I no additional information to   |  |  |               |
|  | a.m., titled "Self Ac<br>and Treatments", in<br>the ability to self-ac                      | by the DON on 5/11/24 at 9:30 Ilministration of Medications dicated"1. Assessment of Ilminister medications will be ng the tool "Assessment for                      |  |  |               |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE C A. BUILDING B. WING   | onstruction<br><u>00</u>  | (X3) DATE SURVEY COMPLETED 03/11/2024   |                      |  |  |
|--|--|---|---|---|----------------------|--|--|
|  | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | (X5) COMPLETION DATE |  |  |
| F 0602<br>SS=D<br>Bldg. 00   | assessment will revicapable, able with a assessment criteria. resident who self addocumentation shownotes of teaching remedications or treat. This citation relates IN00426751.  3.1-11(a)  483.12 Free from Misappr §483.12 The resident has tabuse, neglect, miproperty, and explosubpart. This inclufreedom from corpinvoluntary seclus chemical restraint resident's medical Based on record reviailed to implement misappropriation of no documentation of the facility's emedical fresident (Resident Q)  Finding includes:  During an interview Resident Q indicate more than once they narcotic medication | ropriation/Exploitation the right to be free from sappropriation of resident oitation as defined in this udes but is not limited to roral punishment, ion and any physical or not required to treat the symptoms. iew and interview, the facility | F 0602  | POC for F602 – Free from Misappropriation/Exploitation What corrective action(s) wis be accomplished for those residents found to have been affected by the deficient practice?  No residents were affect by this alleged deficient practice that the practice is alleged deficient practice. Resident Q still resides if facility. | ted<br>iice.         |  |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                       | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |                    |                               | (X3) DATE SURVEY  |            |
|--|---------------------------------------|---|--------------------|-------------------------------|---|------------|
| AND PLAN   | OF CORRECTION                         | IDENTIFICATION NUMBER                       | A. B               | A. BUILDING 00 COMPLETED      |   |            |
|  |                                       | 155840                                      | B. WING 03/11/2024 |                               |   | 03/11/2024 |
|  |                                       | <u> </u>                                    |                    | STREET                        | ADDRESS, CITY, STATE, ZIP COD   | 1          |
| NAME OF F  | PROVIDER OR SUPPLIER                  | S.  |                    |                               | ALUMET AVENUE   |            |
| IGNITE N   | MEDICAL RESORT                        | DYER LLC.                                   |                    |                               | IN 46311  |            |
| (X4) ID  | SHMMADV                               | STATEMENT OF DEFICIENCIE                    |                    | ID                            |   | (X5)       |
| PREFIX   |                                       | CY MUST BE PRECEDED BY FULL                 |                    | PROVIDER'S PLAN OF CORRECTION |   |            |
| TAG  | `                                     | LISC IDENTIFYING INFORMATION                |                    | TAG                           | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | DATE       |
|  |                                       | here would be no Norco                      |                    |                               | residents having the potenti  |            |
|  |                                       | ext day, and that was at 3:00               |                    |                               | to be affected by the same  | "          |
|  | p.m.                                  |   |                    |                               | deficient practice and what   |            |
|  | 1                                     |   |                    |                               | corrective action will be take  | en?        |
|  | The record for Resi                   | dent Q was reviewed on 3/6/24               |                    |                               |   |            |
|  | at 12:08 p.m. The re                  | esident was admitted to the                 |                    |                               | All residents have the  |            |
|  | facility on 2/12/24.                  | Diagnoses included, but were                |                    |                               | potential to be affected by this  | ;          |
|  | not limited to, perip                 | heral vascular disease,                     |                    |                               | alleged deficient practice.   |            |
|  |                                       | m, osteomyelitis, high blood                |                    |                               |   |            |
|  | 1 -                                   | f the left toes, and adult failure          |                    |                               | MAR to cart audit was   |            |
|  | to thrive.                            |   |                    |                               | completed to ensure all ordere  |            |
|  |                                       |   |                    |                               | medications were available fo   | r all      |
| The 2/18/24 Admission Minimum Data Set (MDS)         |                                       |   |                    | residents.                    |   |            |
|  | assessment, indicate                  |   |                    |                               |   |            |
|  |                                       | nd required as needed (prn)                 |                    |                               | CNO/Pharmacy complete   | ed         |
|  | 1 ~                                   | e had frequent and moderate                 |                    | audit of RX Now machine to    |   |            |
|  | 1 -                                   | ys that occasionally affected               |                    | ensure most commonly used     |   |            |
|  | his sleep.                            |   |                    |                               | medications are on hand and   | par        |
|  | A Cara Plan dated                     | 3/4/24, indicated the resident              |                    |                               | level is appropriate.   |            |
|  | was receiving opioi                   |   |                    |                               | Nursing staff audit comp  | leted      |
|  | was receiving opion                   | d medications.                              |                    |                               | to ensure all nurses/QMAs ha  | <b>I</b>   |
|  | A Care Plan, dated                    | 2/22/24, indicated the resident             |                    |                               | access to our RX now machin   |            |
|  | · · · · · · · · · · · · · · · · · · · | in. The approaches were to                  |                    |                               | and educated on appropriate   |            |
|  |                                       | ons as ordered, anticipate the              |                    |                               | usage.  |            |
|  |                                       | pain relief and respond                     |                    |                               | Ĭ   |            |
|  |                                       | complaints of pain, and                     |                    |                               | What measures will be put   |            |
|  | identify and record                   | previous pain history and                   |                    |                               | into place or what systemic   |            |
|  | management of that                    | pain and impact on function.                |                    |                               | changes you will make to  |            |
|  |                                       |   |                    |                               | ensure that the deficient   |            |
|  |                                       | dated 2/12/24, indicated                    |                    |                               | practice does not recur?  |            |
|  | 1 -                                   | aminophen oral tablet 5-325                 |                    |                               |   |            |
|  |                                       | ve 1 tablet by mouth every 4                |                    |                               | Nursing staff was educat  | <b>I</b>   |
|  | hours as needed for                   | pain.                                       |                    |                               | on what medications are avail   |            |
|  |                                       |   |                    |                               | in RX Now (EDK), how to acc   | <b>I</b>   |
|  |                                       | ministration Record (MAR),                  |                    |                               | medications from RX Now (EI   | OK),       |
|  |                                       | ated the resident received 1                |                    |                               | and notification to   |            |
|  | l -                                   | on 2/12-2/15/24. He received                |                    |                               | CNO/MD/Pharmacy when a  | IX) :-     |
|  |                                       | and then 1 tablet on                        |                    |                               | medication from RX Now (ED  | K) IS      |
|  | 2/1/-2/20/24. He di                   | d not receive any Hydrocodone               |                    |                               | unavailable.  |            |

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE C A. BUILDING B. WING  | OO OOSTRUCTION      | (X3) DATE SURVEY COMPLETED 03/11/2024   |   |
|--|---|--|---------------------|---|---|
|  | PROVIDER OR SUPPLIER  |  | 1532 (              | ADDRESS, CITY, STATE, ZIP COD<br>CALUMET AVENUE<br>, IN 46311   |   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OF   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPR<br>DEFICIENCY)  | TION (X5)  COMPLETION OPRIATE  DATE   |
|  | Hydrocodone was a after the resident w  The 2/2024 MAR is Hydrocodone were consistently asked a 3 times a day for the During an interview Pharmacy Account order they received 2/21/24. The medic on 2/22/24 and show on that day. The see Hydrocodone was a the facility as well, medication machine were not available a received from the p Manager verified the in the RX Now made at the facility on 2/medications. On the Hydrocodone 5-32 dispense. The Pharmable to look in the I see what days the F Resident Q. He indivas no documentat Resident Q during a During an interview Director of Nursing 2 of the nurses who being administered both indicated they | ndicated after the 30 tablets of received the resident for the pain medication at least the rest of the month.  If on 3/7/24 at 9:30 a.m., the Manager indicated the first for the Hydrocodone was on ation would have been sent out all have arrived at the facility cond request for the on 3/2/24 and that was sent to The facility had a RX Now the to dispense medications that for that they had not yet the harmacy. The Account the Hydrocodone 5-325 mg was beline. He indicated he was just 13/24 and did an audit of all the fact day, there were 17 to mg tablets available to macy Account Manager was RX Now medication records to flydrocodone was pulled for icitated from 2/12-2/20/24 there ion the Norco was pulled for |                     | How will the corrective actions(s) be monitored ensure the deficient practice will not recur, i.e., what cassurance program will into place?  CNO/Designee will a new admissions daily to emedications including but limited to pain managememedications are available  CNO/Designee will psummaries of the audit to Quality Assurance Commmonthly for six months. Thereafter, if determined Quality Assurance Commfurther monitoring is need audits will continue.  Date of compliance: 4/56 | etice quality be put  audit all ansure all anot ent  aresent the ittee  by ittee that ed, |
| ĺ  | I   |  | 1                   | 1   |   |

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Event ID:

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING   | 00  | (X3) DATE SURVEY COMPLETED 03/11/2024   |                      |  |  |
|--|---|--|---|---|----------------------|--|--|
|  | ROVIDER OR SUPPLIER   |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION  |  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'<br>DEFICIENCY) | (X5) COMPLETION DATE |  |  |
| E 0637   | unaware and did not<br>Hydrocodone was n<br>after the resident wa<br>additional informati<br>3.1-28(a)  | DON indicated he was<br>t know why the script for the<br>ot sent to pharmacy right<br>as admitted. He had no<br>on to review.  |   |   |                      |  |  |
| F 0637<br>SS=A<br>Bldg. 00   | Chg §483.20(b)(2)(ii) Variable facility determines determined, that the change in the residence condition. (For pur "significant change or improvement in will not normally reintervention by state standard disease-interventions, that than one area of the and requires intervention of the care Based on record reversion of the care failed to ensure a Si | nere has been a significant dent's physical or mental pose of this section, a be means a major decline the resident's status that esolve itself without further ff or by implementing related clinical has an impact on more ne resident's health status, disciplinary review or be plan, or both.) iew and interview, the facility gnificant Change Minimum | F 0637  | Education was completed to ensure MDS aware of new hos  | 04/05/2024<br>spice  |  |  |
|  |   | essment was completed after re initiated, for 1 of 27 MDS ed. (Resident 11)  |   | orders.   |                      |  |  |
|  |   | dent 11 was reviewed on 3/7/24 oses included, but were not   |   |   |                      |  |  |
|  | A Quarterly Minimu  | 2/10/23, indicated the resident  |   |   |                      |  |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | onstruction<br>00   | (X3) DATE SURVEY COMPLETED 03/11/2024   |                      |  |  |
|--|--|---|---|---|----------------------|--|--|
|  | PROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | (X5) COMPLETION DATE |  |  |
| F 0677<br>SS=E<br>Bldg. 00   | in progress.  A Physician's Order resident was admitted.  A Significant Changbeen initiated.  During an interview MDS Coordinator in a Significant Change 3.1-33(d)(1)  483.24(a)(2)  ADL Care Provide §483.24(a)(2) A recarry out activities necessary service nutrition, grooming hygiene;  Based on observation interview, the facility (activities of daily livesidents, related to showers, nail care, and washing, and oral careviewed for ADL cand N)  Findings include:  1. During an interview Resident P indicated the shower room for the record for Resident P indicated the record for Resident P | d for Dependent Residents esident who is unable to of daily living receives the sto maintain good g, and personal and oral on, record review, and ty failed to provide ADL tiving) assistance to dependant completing scheduled removing facial hair, hair are, for 5 of 6 residents eare. (Residents P, Q, M, C, itew on 3/4/24 at 2:41 p.m., it they had not been taken to r at least a month and a half. | F 0677  | POC for F677 ADL Care Provided for Dependent Residents What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice?  No harm came to any residents related to this allege deficient practice.  Resident P and Q still resides in facility.  Resident P shower | n                    |  |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | onstruction<br><u>00</u>  | (X3) DATE SURVEY  COMPLETED  03/11/2024   |                           |  |  |
|---|---|---|---|---|---------------------------|--|--|
|   | ROVIDER OR SUPPLIER   |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |                           |  |  |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)  | (X5) COMPLETION DATE      |  |  |
|   | limited to, type 2 di with personal care.  The Quarterly Mini assessment, dated 1 was moderately impand the resident was themselves.  A Care Plan, dated had an ADL self-calimitation in physic included, but were assistance with shown the Shower Sheet findicated the resided 2/12, 2/26, and 2/29. The Shower Sheet findicated the resided 3/7/24.  The resident had not February and March During an interview Northwest Unit Maroom was not in use indicated the shower thoroughly complet 3/4/24 at 11:15 a.m. had not been washed.  The record for Resident 12:08 p.m. The refacility on 2/12/24. | abetes and need for assistance  mum Data Set (MDS) /8/24, indicated the resident paired for daily decision making and not able to bathe  1/5/24, indicated the resident re performance deficit and all mobility. Interventions not limited to, maximum wering and bathing.  For the month of February 2024, ant received a sponge bath on 1/24.  For the month of March 2024, ant received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24.  For the month of March 2024, and received a sponge bath on 1/24. |   | preferences reviewed with resident/family and ADL care/shower was offered and provided.  Resident Q shower preferences reviewed with resand ADL care/hair washing woffered and provided.  Resident M was immediately offered to have facial hair shat and fingernails cut.  Resident N was provided new toothbrush and assistant with oral care immediately.  Resident C, M, and N not longer reside in facility.  How will you identify other residents having the potentiat to be affected by the same deficient practice and what corrective action will be taken All residents have the potential to be affected by this alleged deficient practice.  Full house audit was completed to ensure showers/baths are being proving as scheduled.  Full house audit of nails | sident as ately ved date. |  |  |
|   | pulmonary embolis   | heral vascular disease,<br>m, osteomyelitis, high blood<br>f the left toes, and adult failure   |   | completed to ensure resident nails are trimmed and clean.   |                           |  |  |

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| STATEMENT OF DEFICIENCIES X1 |                       | X1) PROVIDER/SUPPLIER/CLIA        | (X2) MULTIPLE CONSTRUCTION (X3) DATE SUI |  | SURVEY   |         |            |
|------------------------------|-----------------------|-----------------------------------|--|--|--|---------|------------|
| AND PLAN                     | OF CORRECTION         | IDENTIFICATION NUMBER             | A. BU                                    | JILDING  | 00   | COMPL   | ETED       |
|                              |                       | 155840                            | B. W                                     | ING  |  | 03/11/  | 2024       |
| NAMEOU                       | DDOVIDED OF GUIDN TEX |                                   |  | STREET A   | ADDRESS, CITY, STATE, ZIP COD                  | •       |            |
| NAME OF I                    | PROVIDER OR SUPPLIEF  | C                                 |  | 1532 C   | ALUMET AVENUE                                  |         |            |
| IGNITE N                     | MEDICAL RESORT        | DYER LLC.                         | •  | DYER, IN 46311   |  |         |            |
| (X4) ID                      |                       |                                   |  | ID   | PROVIDER'S PLAN OF CORRECTION                  |         | (X5)       |
| PREFIX                       |                       | ICY MUST BE PRECEDED BY FULL      |  | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) |  | TE      | COMPLETION |
| TAG                          | to thrive.            | R LSC IDENTIFYING INFORMATION     |  | TAG DEFICIENCY)  Full house audit of facial hair   |  | la a ta | DATE       |
|                              | to thrive.            |                                   |  |  | was completed to ensure share                  |         |            |
|                              | The 2/18/24 Admis     | sion Minimum Data Set (MDS)       |  |  | were completed as                              | ves     |            |
|                              | assessment, indicate  |                                   |  |  | needed/requested.                              |         |            |
|                              | · ·                   | and it was very important for     |  |  | niedada/requestida:                            |         |            |
|                              |                       | een a shower or bath. He          |  |  | Full house audit was                           |         |            |
|                              |                       | oderate assistance with           |  |  | completed to ensure all reside                 | ents    |            |
|                              | bathing.              |                                   |  |  | have a toothbrush and oral ca                  |         |            |
|                              |                       |                                   |  |  | being completed as                             |         |            |
|                              |                       | 2/12/24, indicated the resident   |  |  | needed/requested.                              |         |            |
|                              |                       | performance deficits and          |  |  |  |         |            |
|                              | limitations in physi  | cal mobility related to surgical  |  |  | What measures will be put                      |         |            |
|                              | amputation.           |                                   |  |  | into place or what systemic                    |         |            |
|                              |                       |                                   |  |  | changes you will make to                       |         |            |
|                              |                       | indicated the resident received   |  |  | ensure that the deficient                      |         |            |
|                              |                       | 15, 2/19, and on 3/4/24. He       |  |  | practice does not recur?                       |         |            |
|                              |                       | /22 and 2/26/24. There was no     |  |  |  |         |            |
|                              |                       | cating the resident's hair was    |  |  | Nursing staff was educat                       |         |            |
|                              | washed.               |                                   |  |  | on the importance of providing                 |         |            |
|                              | Duning on interview   | y on 2/7/24 at 11.20 a m tha      |  |  | ADL care as scheduled/reque                    | sted    |            |
|                              | Unit Manager indic    | on 3/7/24 at 11:30 a.m., the      |  |  | including but not limited to                   | din a   |            |
|                              | _                     | resident had his hair washed      |  |  | showers/baths, nail care, shave and oral care. | virig,  |            |
|                              | since admission.      | resident had his hall washed      |  |  | and traite.                                    |         |            |
|                              |                       |                                   |  |  | Shower record has been                         |         |            |
|                              | During an interview   | on 3/7/24 at 2:30 p.m., the       |  |  | updated to include documenta                   | ation   |            |
|                              |                       | indicated there was no            |  |  | for hair washing, nail, shaving                |         |            |
|                              | documentation the     | resident's hair was washed.       |  |  | oral care.                                     |         |            |
|                              | 3. During an intervi  | new on 3/4/24 at 1:50 p.m.,       |  |  | How will the corrective                        |         |            |
|                              | -                     | ed she had not received a bath    |  |  | actions(s) be monitored to                     |         |            |
|                              | in 2 weeks. She had   | l a large amount of facial hair   |  |  | ensure the deficient practice                  | ,       |            |
|                              |                       | per lip and chin, as well as      |  |  | will not recur, i.e., what qual                |         |            |
|                              |                       | ne resident indicated at that     |  |  | assurance program will be p                    | -       |            |
|                              | time, she wanted he   | er nails trimmed and would like   |  |  | into place?                                    |         |            |
|                              | the facial hair remo  | ved, she would have never let     |  |  |  |         |            |
|                              | it grow that long.    |                                   |  |  | CNO/Designee will audit                        | 10      |            |
|                              |                       |                                   |  |  | dependent residents weekly o                   |         |            |
|                              |                       | .m., and 2:34 p.m., and on 3/6/24 |  |  | alternating shifts to ensure AD                | )L      |            |
|                              | I at 0.38 am the rec  | ident was still observed with     | ı  |  | care has been provided inclu                   | dina    | 1          |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 03/11/2024   |                                       |
|--|--|---|---------------------|---|---------------------------------------|
|  | ROVIDER OR SUPPLIER  |   | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |                                       |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | DATE                                  |
|  | long fingernails.  | dent M was reviewed on 3/6/24   |                     | but not limited to showers/bat<br>hair washed, nail care, and or<br>care.   | , , , , , , , , , , , , , , , , , , , |
|  | at 10:34 a.m. Diagn limited to, brain and respiratory failure, at The 1/22/24 Admiss assessment, indicate moderately impaire was very important between a bath or a substantial to maxim partial to moderate hygiene.  A Care Plan, dated had ADL self-care plimitations in physical The Shower Sheets resident received sp 1/26, and 1/30/24. The Shower Sheets resident received as 2/18 and 2/20/24. Self-care plank and not the Shower Sheets resident received as 2/18 and 2/20/24. Self-care plank and a shaw and care and a shaw and care and a shaw the shower sheets resident received as 2/18 and 2/20/24. Self-care plank and 2/20/24. Self-care plank and a shaw and a shaw are also shaw as a shaw and a shaw as a shaw as a shaw and a shaw as a s | d for daily decision making. It for the resident to choose shower. The resident needed nal assistance for bathing, and assistance with personal  1/16/24, indicated the resident performance deficits and cal mobility.  for 1/2024 indicated the onge baths on 1/16, 1/19, 1/23, The nail care and shave areas checked as being done.  for 2/2024 indicated the shower on 2/2, 2/6, 2/9, 2/13, the received a sponge bath on and there was documentation to was completed. |                     | CNO/Designee will prese summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee further monitoring is needed, audits will continue.  Date of compliance: 4/5/202 | e that                                |
|  | indicated the reside 3/1 and 3/5/24. Bott completed, indicatin on those days.  During an interview   | for the month of 3/2024, and was to receive a shower on a days were blank and not any she did not receive a bath of a on 3/6/24 at 10:55 a.m., the  |                     |   |                                       |
|  | Unit Manager indic   | ated the 3/2024 showers were  |                     |   |                                       |

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION   | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840  | l í | ILDING              | nstruction<br><u>00</u>   | (X3) DATE :<br>COMPL<br>03/11/ | ETED                       |
|--------------------------|---|--|-----|---------------------|---|--------------------------------|----------------------------|
|                          | ROVIDER OR SUPPLIER   |  | •   | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |                                |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>R LSC IDENTIFYING INFORMATION   |     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE                             | (X5)<br>COMPLETION<br>DATE |
|                          | _   | eleted, and there was no resident had a shave or that leted.   |     |                     |   |                                |                            |
|                          | on 3/7/24 at 8:33 a.:<br>the facility on 12/5/<br>12/22/23. Diagnose<br>to, fracture of the ri<br>disorder, Parkinson   | d for Resident C was reviewed<br>m. The resident was admitted to<br>23 and left the facility on<br>s included, but were not limited<br>ght wrist, major depressive<br>'s disease, seizures,<br>dementia without behaviors.   |     |                     |   |                                |                            |
|                          | assessment, dated 1 was moderately imp making. The resider of motion to both loneeded partial to me   | nimum Data Set (MDS) 2/12/23, indicated the resident paired for daily decision In that no impairment in range ower and upper extremities and oderate assistance with eating, mygiene, and was dependent and toileting.   |     |                     |   |                                |                            |
|                          |   | 12/5/23, indicated the resident performance deficits and cal mobility.   |     |                     |   |                                |                            |
|                          | received from the U<br>The sheets indicated<br>was checked on 12/<br>however, there was<br>to indicate they wer<br>checked for 12/18 a<br>Manager and CNA.<br>for 12/25/23, and a<br>12/28/23, both signs | for the month of 12/2023 were Unit Manager from her office. d a shower or sponge bath 7, 12/11, 12/14, and 12/21/23, no nurse or CNA signatures re all completed. A shower was and signed by the Unit A sponge bath was checked shower was checked for ed by the Unit Manager and resident was discharged from 2/23. |     |                     |   |                                |                            |
|                          |   | on 3/7/23 at 11:30 a.m., the ated she had signed that the  |     |                     |   |                                |                            |

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|                          | IT OF DEFICIENCIES OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br>00   | COM                                  | e survey<br>pleted<br>1/2024 |
|--------------------------|---|---|--|---|--------------------------------------|------------------------------|
|                          | PROVIDER OR SUPPLIER  |   | 1532 C                                     | ADDRESS, CITY, STATE, ZIP (<br>ALUMET AVENUE<br>IN 46311                                      | COD                                  |                              |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OF   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF COI<br>(EACH CORRECTIVE ACTION S<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | RRECTION<br>SHOULD BE<br>APPROPRIATE | (X5)<br>COMPLETION<br>DATE   |
|                          | 12/28/23, and did n<br>discharged. She cla<br>resident's name and<br>for another resident                               | er or sponge on 12/25 and ot know that he was already imed she did not look at the she had probably signed off .  |  |   |                                      |                              |
|                          | Director of Nursing<br>CNA were suppose<br>after they had been<br>supposed to receive                                   | indicated both the nurse and d to sign the shower sheets completed. Residents were 2 showers a week.  |  |   |                                      |                              |
|                          | Resident N indicate<br>toothbrush when sh<br>facility. She finally<br>Friday. She also ned                              | ew on 3/5/24 at 10:48 a.m., d she did not receive a e was first admitted to the received a toothbrush last eded help getting her e set up so she could for herself.   |  |   |                                      |                              |
|                          | -   | on 3/6/24 at 1:30 p.m., the he was not provided anything hus far today.   |  |   |                                      |                              |
|                          | at 3:30 p.m. The rest<br>facility on 2/22/24.<br>not limited to, COP  | dent N was reviewed on 3/5/24 sident was admitted to the Diagnoses included, but were D, severe obesity, repeated depression, and pain in the left  |  |   |                                      |                              |
|                          | assessment, dated 2 was cognitively into was very important she wanted. The remotion to both upper supervision or touch | nimum Data Set (MDS) /27/24, indicated the resident act daily decision making and it to choose what kind of bath sident had a limited range of er extremities and needed ning assistance with oral ntial/max assistance for |  |   |                                      |                              |

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|                          | NT OF DEFICIENCIES OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00   | COM      | TE SURVEY<br>MPLETED<br>11/2024 |
|--------------------------|---|---|--|---|----------|---------------------------------|
|                          | PROVIDER OR SUPPLIEF<br>MEDICAL RESORT  |   | 1532 C                                     | ADDRESS, CITY, STATE, ZIP C<br>ALUMET AVENUE<br>IN 46311  | OD       |                                 |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORI<br>(EACH CORRECTIVE ACTION SE<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE            |
|                          |   | 2/24/24, indicated the resident re performance deficit and cal mobility.  |  |   |          |                                 |
|                          | hygiene was not do on 3/1, 3/2, and 3/3   | Cask responses indicated oral cumented as being completed 8/4. There was only 1 time tiene on 2/23, 2/25, 2/27, 2/28,   |  |   |          |                                 |
|                          | shower on 2/29/24 and 3/2/24. The residen room on 3/4/24, and that time as well. So shower on Monday                      | indicated the resident had a and refused a shower on t was moved to a different d her shower days changed at ne was supposed to get a s and Thursdays in her new Sheet, dated 3/4/24, was blank                                 |  |   |          |                                 |
|                          | Unit Manger indica<br>rooms before shift  | on 3/6/24 at 10:55 a.m., the ted the resident transferred change during the day on er could have been offered to  |  |   |          |                                 |
|                          | Director of Nursing given a toothbrush admission. Her siste on the sink by the tenew one. Staff migl getting her a new to | on 3/7/24 at 2:30 p.m., the indicated the resident was in her welcome packet on er had observed the bed pan pothbrush and requested a not have taken some time in bothbrush. Nursing staff were or the resident to perform oral |  |   |          |                                 |
|                          | This citation relates and IN00429885.   | to Complaints IN00424731  |  |   |          |                                 |
|                          | 3.1-38(a)(2)(A)   |   |  |   |          |                                 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 03/11/2024   |      |                     | ETED   |         |                            |
|--|--|---|------|---------------------|--|---------|----------------------------|
|  | PROVIDER OR SUPPLIER   |   |      | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311   |         |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OF  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  |      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | TE      | (X5)<br>COMPLETION<br>DATE |
| F 0679<br>SS=D<br>Bldg. 00   | §483.24(c) Activiti<br>§483.24(c)(1) The<br>on the compreher   | facility must provide, based sive assessment and care   |      |                     |  |         |                            |
|  | ongoing program choice of activities group and individu independent activ interests of and su and psychosocial encouraging both interaction in the or Based on observation interview, the faciliactivity program was | ities, designed to meet the apport the physical, mental, well-being of each resident, independence and community.  on, record review, and ty failed to ensure an ongoing as implemented for cognitively residents, for 1 of 2 residents | F 06 | 679                 | POC for F679 – Activities Me<br>Interest/Needs Each Residen<br>What corrective action(s) wil<br>be accomplished for those<br>residents found to have been<br>affected by the deficient<br>practice?  | it<br>I | 04/05/2024                 |
|  | a.m. and 1:56 p.m., broda chair and pos Northwest Lounge and the television w  During a random of a.m., the resident w chair and positioned Lounge area. His ey television was turned                                | osservation on 3/5/24 at 9:30 as again seated in a broda d at the table in the Northwest wes were closed and the  |      |                     | No harm came to any residents by this alleged defici practice.  Resident 26 activity preferences were reviewed wi resident/family and care plans updated.  How will you identify other residents having the potentiato be affected by the same deficient practice and what | th      |                            |

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| AND PLAN OF CORRECTION    DENTIFICATION NUMBER   158400   | STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY |      |        | SURVEY                            |          |            |
|--|--|--|---|------|--------|-----------------------------------|----------|------------|
| STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 48311  SUMMARY STATEMENT OF DEFICIENCE (INCITE DEFICULTION OF THE PRICE OF DEFICIENCE (INCITE DEFICULTION OF THE PRICE OF DEFICIENCE (INCITE DEFICULTION OF THE PRICE OF DEFICIENCE (INCITE DEFICIENCY MIST IN EPRICEDED BY PRIL ATA)  a.m., 11-26 a.m., and 12:18 pm., the resident was again seated in a broad chair and positioned at the table in the Northwest Lounge area, His eyes were closed and the television was turned on. At 2:00 pm., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely important for the resident to listen to music, dutings with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident sactivity groups daily, enjoy observing his peers play a variety of tabley games, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident of sensor participation in rate of the same time maintaining saff social distance as much as possible. The resident currently engaged in the following leisure recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, marks and the was deducted on appropriate documentation including but not limited to activity assessments, are plans, activity notes, and 1:1 documentation for cognitively impaired for cognitively impaired residents.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-ascial with family during visits.  | AND PLAN   | OF CORRECTION                                      | IDENTIFICATION NUMBER                       | A. B |        |                                   |          | ETED       |
| IGNITE MEDICAL RESORT DYER LLC.  SUMMARY STATEMENT OF DEPICIENCE  BERTY TAG  REGILATORY OR LSC DINTETYING INFORMATION  a.m., 11-20 a.m., and 12-18 p.m., the resident was again seated in a broade chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident tudy, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisur-fecreation prusuits attend activity groups daily, erips observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psychos-social well being and quality of life through meaningful activities until the next review. Interventists included to the work of a calcilyt assessments, and care plan in place.  DEPARTIX  1.532 CALUMET AVENUE  PREFIX TAG  DD DEPARTIX TAG  DD DEPARTIX TAG  DD PREFIX TAG  All residents have the potential to be affected by this alleged deficient practice.  House audit was completed for all residents to ensure patients to ensure patients of a calcilytic |  |  | 155840                                      | B. W | ING    |                                   | 03/11/2  | 2024       |
| IGNITE MEDICAL RESORT DYER LLC.  SUMMARY STATEMENT OF DEPICIENCE  BERTY TAG  REGILATORY OR LSC DINTETYING INFORMATION  a.m., 11-20 a.m., and 12-18 p.m., the resident was again seated in a broade chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident tudy, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisur-fecreation prusuits attend activity groups daily, erips observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psychos-social well being and quality of life through meaningful activities until the next review. Interventists included to the work of a calcilyt assessments, and care plan in place.  DEPARTIX  1.532 CALUMET AVENUE  PREFIX TAG  DD DEPARTIX TAG  DD DEPARTIX TAG  DD PREFIX TAG  All residents have the potential to be affected by this alleged deficient practice.  House audit was completed for all residents to ensure patients to ensure patients of a calcilytic |  |  |   |      | CTREET | ADDRESS CITY STATE ZID COD        | <u> </u> |            |
| IGNITE MEDICAL RESORT DYER LLC.  DYER, IN 46311  DYER, IN 4641  A Corporation of LAPPROPHER  All residents have the potention of DR. Propher action of Completed for all residents were being | NAME OF P  | ROVIDER OR SUPPLIER                                | L   |      |        |                                   |          |            |
| SUMMARY STATEMENT OF DEFICIENCE   TAG   CACH DEFICIENCY MUST BE PRECEDED BY FULL   TAG   REGILATORY OR LES CENTERING BY FULL   TAG   COMPLETION   DATE      a.m., 11:26 a.m., and 12:18 p.m., the resident was again scated in a broda clair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on, At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main diming room.    The record was reviewed on 3:5/24 at 3:09 p.m.   Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.    The 2:23/24 Annual Minimum Data Set (MDS)   assessment, indicated the resident bad short and long term memory problems and he was severely important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.    A Care Plan, dated 2:20/23 and reviewed on 3:4/24, indicated the resident wal, while at the same time ministings afe social distance as much as possible. The resident currently engaged in the following leture-reviewed on 3:4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Intervenibins included, but were not the following leture-reviewed on 3:4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Intervenibins included, but were not to the following leture in religious activities until the next review. Intervenibins included, but were not to the following leture-review of page and previewed on 3:4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful a   | IONUTE N   | AEDIOAL DECODE                                     | DVED II O                                   |      |        |                                   |          |            |
| PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION  A .m., 11:26 a.m., and 12:18 p.m., the resident was again seated in a broad chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping.  A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MIDS) assessment, indicated the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 34/24, indicated the resident care and focus on abilities the resident day, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, cajoy observing his peers play a variety of lable games, watch a variety of television programs, movies and the news daily, is social with family during visits.  PREFIX TAG  REGULATORY OR LAB INTERMORDOM TO ADATE  TAG  COMPETION DORSON TO ACTION TO ADATE  All residents have the potential to be affected by this alleged deficient practice.  House audit was completed for all cognitively impaired residents to ensure their activities including but not limited to group and independent activities.  House audit was completed for all cognitively impaired residents to ensure their activity interests/needs are being met including but not limited to group and independent activities.  House audit was completed for all residents to ensure their activity interests/needs are being met including but not limited to to 1:1 activities.  House audit was completed for all residents to ensure the resident was ensure their activity assessment, participation in and documentation of appropriate to ensure all guests  | IGNITEN  | IEDICAL RESORT                                     | DYER LLC.                                   |      | DYEK,  | IN 46311                          |          |            |
| TAG REGULATORY OF ISE DESCRIPTION FORMATION  a.m., 11:26 a.m., and 12:18 p.m., the resident was again seated in a broad chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely impaired for daily decision making. It was very important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 34/24, indicated the resident sactivity involvement during the COVID-19 pandemic would be reflective of personal preferences and focus on abilities the resident had, while at the same time maintaining safe social distance as much as possible. The residence currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 34/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not   | (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE                    |      | ID     | PROVIDER'S PLAN OF CORRECTION     |          | (X5)       |
| A gain scated in a broda chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely impariared for daily decision making. It was very important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident had, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  Tag  Corrective action will be taken?  All residents have the potential to be affected by this alleged deficient practice.  House audit was completed for all cognitively interests/needs are being met including but not limited to group and independent activities.  House audit was completed for all cognitively interests/need are being met including but not limited to group and independent activities.  House audit was completed for all cognitively proprieta activities including but not limited to ensure all guests have a current activity assessment, participation notes, and care plan in place.  What measures will be put Into place or what systemic changes you will make to ensure their activity assessments, care plans, activity poles, and 1:1 documentation for cognitively impaired/dependent residents.   | PREFIX   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL          |   |      | PREFIX | (EACH CORRECTIVE ACTION SHOULD BE | TE       | COMPLETION |
| again seated in a broda chair and positioned at the table in the Northwest Lounge area. His eyes were closed and the television was turned on. At 2:00 p.m., the resident was in his room in bed sleeping. A music activity was taking place in the main dining room.  The record was reviewed on 3/5/24 at 3:09 p.m. Diagnoses included, but were not limited to, intellectual disabilities, bipolar, and intermittent explosive disorder.  The 2/23/24 Annual Minimum Data Set (MDS) assessment, indicated the resident had short and long term memory problems and he was severely impaired for daily decision making. It was very important for the resident to listen to music, do things with groups of people, do his favorite activities, and participate in religious activities.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident sactivity involvement during the COVID-19 pandemic would be reflective of personal preferences and focus on abilities the resident maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  | TAG  | REGULATORY OR LSC IDENTIFYING INFORMATION          |   |      | TAG    | DEFICIENCY)                       | .12      | DATE       |
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| involvement during the COVID-19 pandemic would be reflective of personal preferences and focus on abilities the resident had, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity   |  | 3/4/24, indicated the                              | e resident's activity                       |      |        |                                   |          |            |
| focus on abilities the resident had, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  into place or what systemic changes you will make to ensure that the deficient practice does not recur?  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity  |  | involvement during                                 | the COVID-19 pandemic                       |      |        |                                   |          |            |
| focus on abilities the resident had, while at the same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  into place or what systemic changes you will make to ensure that the deficient practice does not recur?  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity  |  | would be reflective                                | of personal preferences and                 |      |        | What measures will be put         |          |            |
| same time maintaining safe social distance as much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  changes you will make to ensure that the deficient practice does not recur?  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity  |  | focus on abilities th                              | e resident had, while at the                |      |        | -                                 |          |            |
| much as possible. The resident currently engaged in the following leisure/recreation pursuits: attend activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  ensure that the deficient practice does not recur?  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.   |  | same time maintain                                 | ing safe social distance as                 |      |        | _                                 |          |            |
| activity groups daily, enjoy observing his peers play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity   |  | much as possible. T                                | he resident currently engaged               |      |        |                                   |          |            |
| play a variety of table games, watch a variety of television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  DOE/Activity Department was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  |  | in the following leis                              | sure/recreation pursuits: attend            |      |        | practice does not recur?          |          |            |
| television programs, movies and the news daily, is social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  was educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on appropriate documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  |  | activity groups daily                              | y, enjoy observing his peers                |      |        |                                   |          |            |
| social with family during visits.  A Care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not documentation including but not limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  |  | play a variety of tab                              | ole games, watch a variety of               |      |        | DOE/Activity Department           | t        |            |
| limited to activity assessments, care Plan, dated 2/20/23 and reviewed on 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity   |  | television programs                                | , movies and the news daily, is             |      |        | was educated on appropriate       |          |            |
| limited to activity assessments, care plans, activity notes, and 1:1 3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  limited to activity assessments, care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity  |  | social with family d                               | luring visits.                              |      |        | 1                                 | iot      |            |
| A Care Plan, dated 2/20/23 and reviewed on  3/4/24, indicated the resident would maintain psycho-social well being and quality of life through meaningful activities until the next review. Interventions included, but were not  care plans, activity notes, and 1:1 documentation for cognitively impaired/dependent residents.  DOE educated on activity  |  |  |   |      |        | _                                 |          |            |
| psycho-social well being and quality of life impaired/dependent residents. through meaningful activities until the next review. Interventions included, but were not DOE educated on activity  |  | A Care Plan, dated                                 | 2/20/23 and reviewed on                     |      |        | <u> </u>                          |          |            |
| through meaningful activities until the next review. Interventions included, but were not DOE educated on activity   |  |  |   |      |        | documentation for cognitively     |          |            |
| through meaningful activities until the next review. Interventions included, but were not DOE educated on activity   |  | psycho-social well                                 | being and quality of life                   |      |        |                                   |          |            |
| review. Interventions included, but were not DOE educated on activity  |  | through meaningful                                 | activities until the next                   |      |        |                                   |          |            |
|  |  |  |   |      |        | DOE educated on activity          | y I      |            |
|  |  | limited to, Provide                                | activity programming                        |      |        | <u> </u>                          |          |            |

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|                          | IT OF DEFICIENCIES OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br><u>00</u>   | (X3) DATE SURVEY COMPLETED 03/11/2024  |
|--------------------------|---|--|--|--|--|
|                          | PROVIDER OR SUPPLIER  |  | 1532 C                                     | ADDRESS, CITY, STATE, ZIP COD<br>CALUMET AVENUE<br>IN 46311  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)   | (X5) COMPLETION DATE   |
| TAG                      | consistent with phy abilities. Help the relevel and recognize under-activity.  There was no Care attend activities.  The resident had no activity assessment.  The 1:1 program an indicated there was documentation for to the February 2024 resident had 1 to 1 vincluded giving him activities were attended to the control of the March 2024. The resided 2/29/24.  The March 2024 Add group activities were attempted on a was asleep.  During an interview Activity Director in this role for 3 week hiring more activity however, currently entire building, including and dependent need were not going to p | sical and psychosocial esident monitor his energy over-activity, as well as  Plan indicating he refused to  current activity notes nor an  d group documentation no participation he last 30 days.  Activity Calendar indicated the visits for the month, which a daily chronicles. No group aded.  ere received on 2/6, 2/15, and ent was asleep on 2/6 and  ctivity Calendar indicated no re attended. One to one visits 8/4 and 3/7/24 but the resident  or on 3/11/24 at 10:00 a.m., the dicated she had only been in s. She was in the process of a aides to help her out, she was responsible for the uding assisted living. She was who were cognitively impaired led 1 to 1 activities if they articipate in group sessions. It attended any group | TAG  | updated copy.  Activity Assistant has be hired and trained to assist we both group and 1:1 activities.  How will the corrective actions(s) be monitored to ensure the deficient practic will not recur, i.e., what quassurance program will be into place?  General Manager/Design will audit 10 dependent residness weekly to ensure residents a participating in group activities and/or 1:1 sessions.  General Manager/Design will audit 10 charts weekly to ensure activity assessment, plans, activity participation, a 1:1 participation are in placed guests.  General Manager/Design will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is need audits will continue.  Date of compliance: 4/5/20 | een ith  ce ality put  gnee dents are es  gnee o care and/or for all  gnee e ce mined nittee eded, |
|                          | activities duffing 2/2  | una 5/2021.  | - 1  | 1  | ĺ  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | onstruction<br><u>00</u> | (X3) DATE SURVEY COMPLETED 03/11/2024  |                      |
|--|--|---|--------------------------|--|----------------------|
|  | ROVIDER OR SUPPLIER  |   | 1532 C                   | ADDRESS, CITY, STATE, ZIP COD<br>CALUMET AVENUE<br>IN 46311  |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE |
| F 0684<br>SS=D<br>Bldg. 00   | applies to all treatifacility residents. Ecomprehensive as facility must ensur treatment and care professional stand comprehensive per and the residents. Based on observation interview, the facility bruising were assess residents reviewed in non-pressure related ensure treatment or excessive diarrheaft constipation and transurgical appointment reviewed for change Q, and 5)  Findings include:  1. On 3/4/23 at 3:1: observed with areas to his left forearm a interview at that timbruises were from late.  The record for Residut 2:13 p.m. Diagnothers. | a fundamental principle that ment and care provided to Based on the seessment of a resident, the e that residents receive e in accordance with lards of practice, the erson-centered care plan, choices.  In record review, and ty failed to ensure areas of sed and monitored for 1 of 2 for skin conditions  If the facility also failed to ders were obtained for for 1 of 1 residents reviewed for insportation was arranged for instance in condition. (Residents 13, e in condition. (Residents 13, e in condition. The facility also failed to ders were obtained for the for 1 of 1 residents e in condition. (Residents 13, e in condition. (Residents 14, e in condition. (Residents 15, e in condition. (Residents 16, e in condition. (Residents 16, e in condition. (Residents 16, e in condition. (Residents 17, e in condition. (Residents 18, e in condition.) | F 0684                   | POC for F684 – Quality of Ca What corrective action(s) wil be accomplished for those residents found to have been affected by the deficient practice?  No harm came to any residents related to this allege deficient practice.  Orders obtained for Resi 13 to monitor bruising until resolved.  Resident 13 has dischard to his Assisted Living Apartment Resident Q attended his wound care appointment.  Resident 5 receiving antidiarrheal medication per orders. | n<br>ed<br>dent      |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE C A. BUILDING B. WING  | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 03/11/2024  |                              |
|--|---|--|---------------------|--|------------------------------|
|  | PROVIDER OR SUPPLIER  |  | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>CALUMET AVENUE<br>, IN 46311  |                              |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE         |
|  | assessment, dated 2   | imum Data Set (MDS)<br>/10/24, indicated the resident<br>act for daily decision making.  |                     | Resident Q and Residen still reside in facility.   | t 5                          |
|  | A Care Plan, dated was receiving anticol Interventions included document and report reactions of anticoal such as bruising.  Physician's Orders, resident was to receive thinner) injection, 0 for DVT (deep vein skin checks weekly)  The Daily Skilled Na/5/24, indicated the related to bruising.          | dated 2/5/24, indicated the resident pagulant therapy.  led, but were not limited to, as needed (PRN) adverse gulant (blood thinner) therapy  dated 2/5/24, indicated the ive a Lovenox (a blood .4 milliliters (ml) one time a day thrombosis) prophylaxis and  |                     | How will you identify other residents having the potenti to be affected by the same deficient practice and what corrective action will be take.  All residents have the potential to be affected by this alleged deficient practice.  House audit was comple for all residents in house to enall bruises are documented with treatment orders in place.  House audit was comple for all residents to ensure all guests with diarrhea have appropriate orders in place ar receiving medications as order. | en?  Sted  issure  ith  sted |
|  | Northwest Unit Mar<br>have been obtained  Nurses' Notes, dated<br>the resident was not<br>the right and left up<br>indicated the bruisin<br>draws. Orders were<br>bruising every shift<br>2. During an intervi<br>Resident Q indicate<br>wound clinic to hav<br>treatment to his left<br>the last 2 weeks, an | on 3/6/24 at 3:49 p.m., the mager indicated orders should to monitor the bruising.  13/6/24 at 4:05 p.m., indicated ed with scattered bruising to per extremities. The resident me happened after blood e received to monitor the until resolved.  ew, on 3/4/24 at 11:17 a.m., d he could not go to the e a surgeon complete the foot. He had been going for d then on 2/29/24, the facility of go due to insurance |                     | House audit was completed for all residents with scheduled appointments to ensure transportation has been arranted.  What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?  Nursing staff educated to ensure all bruises are docume with orders in place to monito every shift until bruising is resolved.   | ed<br>aged.<br>Dented        |

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|                          | IT OF DEFICIENCIES OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840  | (X2) MULTIPLE C A. BUILDING B. WING | ONSTRUCTION  00   | (X3) DATE SURVEY COMPLETED 03/11/2024            |
|--------------------------|---|--|-------------------------------------|---|--|
|                          | PROVIDER OR SUPPLIER  |  | 1532 C                              | ADDRESS, CITY, STATE, ZIP COD<br>CALUMET AVENUE<br>, IN 46311   |  |
|                          |   |  |                                     | , 114 100 11  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                 | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BI<br>CROSS-REFERENCED TO THE APPROPE<br>DEFICIENCY)  | (X5) E COMPLETION DATE                           |
| TAG                      | reasons. The facility so their wound Nursover and provide we refused, as he wanted wound care.  The record for Resi at 12:08 p.m. The refacility on 2/12/24. not limited to, perippulmonary embolist pressure, absence of to thrive.  The 2/18/24 Admiss assessment, indicate cognitively intact, a him to choose betweeded substantial a received scheduled medication. He had the last 5 days that a sleep. The resident antiplatelet medication. | wanted him to sign a paper see Practitioner (NP) could take bund care. He indicated he ed a Physician to complete the ed a P | TAG                                 | Interdisciplinary team members and floor staff/ all departments educated on reporting areas of bruising to nurse to ensure appropriate documentation and orders a place.  HIM educated on ensure guests with scheduled appointments have transport arranged.  All staff educated on residents rights to choose physician/follow up appointment and ensure HIM is notified of transportation needing scheduled on reporting episodes of loose sto nurse immediately.  Nursing staff educated | o floor re in ring all tation nents f any duled. |
|                          | A Care Plan, dated had arterial ulcer to  | 2/29/24, indicated the resident the left dorsal foot.  |                                     | assess all guests with loose stools and administer antidia medication as ordered.   | arrheal  |
|                          | on 2/15 and 2/22/24   | Insported to the wound clinic<br>I. The last visit indicated a<br>ent was scheduled for 2/29/24  |                                     | How will the corrective actions(s) be monitored to ensure the deficient practic will not recur, i.e., what qua  |  |
|                          | indicated the reside<br>for a follow up appo  | ed 2/22/24 at 1:13 p.m.,<br>nt went to a Wound Doctor<br>pintment. The next<br>heduled for 2/29/24 at 9:00   |                                     | assurance program will be into place?  CNO/Designee will aud  | put  |
|                          | a.m.  During an interview   | r, on 3/7/24 at 11:30 a.m., the  |                                     | residents weekly to ensure a bruises are documented with monitoring orders in place.  |  |

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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|                          | OF CORRECTION  OF CORRECTION  155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00  | (X3) DATE SURVEY COMPLETED 03/11/2024 |
|--------------------------|--|--|--|---------------------------------------|
|                          | PROVIDER OR SUPPLIER MEDICAL RESORT DYER LLC.  | 1532 C                                     | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311   |                                       |
| (X4) ID<br>PREFIX<br>TAG | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE                  |
|                          | Assistant Director of Nursing and the Unit Manager both indicated they had heard the resident was not going out to see his physician for wound care because the facility had its own wound care and Wound NP.  During an interview, on 3/7/24 at 11:45 a.m., the Wound Nurse indicated she performed the bandage changes and did the treatments, however, he had refused to see the facility's own Wound NP. She thought they were waiting on a surgical consult because the wound was not healing, and the resident had decided on another amputation. She was not sure why he did not go to his wound clinic appointment on 2/29/24.  During an interview, on 3/7/24 at 12:18 p.m., the Administrator indicated the resident missed his appointment on 2/29/24 and did not go to the wound clinic. She was unsure why he missed it, but thought staff probably told the resident he could not go to his appointment because his insurance wound not pay to be treated at both places. The Administrator indicated that was not true, and the resident had the right to choose his own wound care. The resident did go to the wound clinic today for treatment the wound on his left foot. 3. On 3/4/24 at 11:18 a.m., Resident 5 was observed in bed watching television. At that time, she indicated she has had diarrhea every morning for over a month.  On 3/5/24 at 2:36 p.m. the resident was sitting in bed watching television. The resident indicated she had diarrhea again that morning.  On 3/6/24 at 9:47 a.m., the resident was observed eating breakfast. She indicated she was starting to have diarrhea at that moment. |  | CNO/Designee will audit residents weekly to assess for loose stools and ensure order in place and being administere as needed.  General Manager/Design will audit 10 residents weekly ensure residents are able to attend all scheduled appointments.  General Manager/Design will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determ by Quality Assurance Commit that further monitoring is need audits will continue.  Date of compliance: 4/5/2026 | s are ed nee to nee ined tee ed,      |

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| ) ´           |  | X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  |                    |                        |   |    |            |
|---------------|--|---|--------------------|------------------------|---|----|------------|
| AND PLAN      | OF CORRECTION  | IDENTIFICATION NUMBER   |                    | A. BUILDING 00 COMPLET |   |    |            |
|               |  | 155840  | B. WING 03/11/2024 |                        |   |    |            |
| NAME OF I     | PROVIDER OR SUPPLIEF   |   |                    |                        | ADDRESS, CITY, STATE, ZIP COD   |    |            |
| ICNITE &      | AEDICAL DESCRI   | DVEDILC   |                    |                        | ALUMET AVENUE   |    |            |
| IGNITE        | MEDICAL RESORT   | DIEK LLG.   |                    | EK, I                  | IN 46311  |    |            |
| (X4) ID       |  | STATEMENT OF DEFICIENCIE  | ID                 |                        | PROVIDER'S PLAN OF CORRECTION   |    | (X5)       |
| PREFIX<br>TAG | `  | ICY MUST BE PRECEDED BY FULL  | PREF               |                        | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE | COMPLETION |
| TAG           |  | R LSC IDENTIFYING INFORMATION  ) a.m., the resident was   | TA                 | G                      | Dia reliate 17  |    | DATE       |
|               |  | television. She indicated she   |                    |                        |   |    |            |
|               | _  | and had diarrhea again.   |                    |                        |   |    |            |
|               |  | The record for Resident 5 was reviewed on 3/6/24 at 11:04 a.m. Diagnoses included, but were not limited to, hemiplegia, diabetes, chronic obstructive pulmonary disease (respiratory disease), dementia, hypertension (high blood |                    |                        |   |    |            |
|               |  |   |                    |                        |   |    |            |
|               |  |   |                    |                        |   |    |            |
|               |  |   |                    |                        |   |    |            |
|               | _  |   |                    |                        |   |    |            |
|               |  | te and chronic respiratory  |                    |                        |   |    |            |
|               |  | failure.  The 2/22/24 Quarterly Minimum Data Set (MDS)  |                    |                        |   |    |            |
|               |  |   |                    |                        |   |    |            |
|               | ,  |   |                    |                        |   |    |            |
|               | assessment, indicated the resident was severely  |   |                    |                        |   |    |            |
|               | impaired with daily  | decision making.  |                    |                        |   |    |            |
|               | Δ Physicians' Order  | r, dated 2/29/24, indicated to  |                    |                        |   |    |            |
|               | administer Imodiun   |   |                    |                        |   |    |            |
|               |  | nd to give 1 tablet by mouth  |                    |                        |   |    |            |
|               | every 4 hours as ne  | eded (prn) for an antidiarrheal.  |                    |                        |   |    |            |
|               |  |   |                    |                        |   |    |            |
|               |  | ministration Record (MAR)   |                    |                        |   |    |            |
|               | _  | r date of 2/29/24 through 3/6/24.   |                    |                        |   |    |            |
|               | at an from the order   | date of 2/2//24 through 3/0/24.   |                    |                        |   |    |            |
|               | Bowel movements  | were documented as  |                    |                        |   |    |            |
|               |  | ne following dates: 2/12/24,  |                    |                        |   |    |            |
|               |  | /17/24, 2/18/24, 2/19/24, 2/21/24,  |                    |                        |   |    |            |
|               |  | /29/24, 3/1/24, 3/2/24, and   |                    |                        |   |    |            |
|               | 3/5//24.   |   |                    |                        |   |    |            |
|               | During an interview  | v, on 3/6/24 at 11:32 a.m., CNA   |                    |                        |   |    |            |
|               | _  | dent had diarrhea this morning  |                    |                        |   |    |            |
|               |  | the resident had a bowel  |                    |                        |   |    |            |
|               | movement she has l   | had diarrhea.   |                    |                        |   |    |            |
|               | Description of the transfer of |   |                    |                        |   |    |            |
|               | _  | y on 3/6/24 at 1:54 p.m., the g (DON) indicated he  |                    |                        |   |    |            |
|               |  | dent had not received   |                    |                        |   |    |            |
|               |  | ation despite multiple, ongoing   |                    |                        |   |    |            |

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|  | XI) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER 155840  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION  00   | (x3) date survey<br>completed<br>03/11/2024 |
|--|---|--|---|---|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT D  | OYER LLC.   | 1532 C                                     | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |   |
| PREFIX (EACH DEFICIENCY TAG REGULATORY OR I  | FATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | (X5) COMPLETION DATE                        |
| episodes of diarrhea, information to provid 3.1-37(a)  | and had no additional<br>le.  |  |   |   |
| The facility must en needs respiratory of tracheostomy care is provided such ca professional standar comprehensive per the residents' goals 483.65 of this subpart and the subpart of the residents' goals 483.65 of this subpart of the residents' goals 483.65 of this subpart of the resident of the subpart of the resident of the subpart of the subpart of the respirator of the subpart of the respirator of the respirator of the record for Resident of the respirator of the respirato | tory care, including and tracheal suctioning. sure that a resident who are, including and tracheal suctioning, re, consistent with ards of practice, the son-centered care plan, and preferences, and art.  In, record review, and ratiled to ensure oxygen was rate for 3 of 4 residents ory care (Residents M, 5 and servations on 3/4/24 at 1:50 as a.m. and 2:34 p.m., and on Resident M was observed asal cannula. The oxygen 3.5 liters per minute.  Lent M was reviewed on 3/6/24 sees included, but were not lung cancer, COPD, and high blood pressure.  Lent M minimum Data Set (MDS) | F 0695                                     | POC for F695 – Respiratory/Tracheostomy Cand Suctioning  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?  No harm came to any residents related to this alleged deficient practice.  Residents M no longer resides in facility.  Residents 5 still resides in facility and is receiving oxygen ordered flow rate. | d<br>d                                      |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  |      |         | (X3) DATE SURVEY  |            |  |
|--|--|--|------|---------|---|------------|--|
| AND PLAN   | OF CORRECTION  | IDENTIFICATION NUMBER                        | A. B | UILDING | 00  | COMPLETED  |  |
|  |  | 155840                                       | B. W | ING     |   | 03/11/2024 |  |
|  |  |  |      | CTREET  | ADDRESS, CITY, STATE, ZIP COD                                       |            |  |
| NAME OF I  | PROVIDER OR SUPPLIER   | 8  |      |         | ALUMET AVENUE   |            |  |
| ICNUTE A   | AEDICAL DECODE   | DVEDILO                                      |      |         |   |            |  |
| IGNITE   | MEDICAL RESORT   | DYER LLC.                                    |      | DIEK,   | IN 46311  |            |  |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE                     |      | ID      | PROVIDER'S PLAN OF CORRECTION                                       | (X5)       |  |
| PREFIX   | (EACH DEFICIEN   | CY MUST BE PRECEDED BY FULL                  |      | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |  |
| TAG  |  | LSC IDENTIFYING INFORMATION                  |      | TAG     | DEFICIENCY)   | DATE       |  |
|  | The resident used of   | xygen while a resident.                      |      |         |   |            |  |
|  |  |  |      |         | Resident 45's orders  |            |  |
|  | The Care Plan, dated 1/16/24, indicated the resident required oxygen therapy related to lung cancer and COPD. The approaches were to administer oxygen per Physician's Orders. |  |      |         | updated to include oxygen   |            |  |
|  |  |  |      |         | administration with flow rate.                                      |            |  |
|  |  |  |      |         |   |            |  |
|  |  |  |      |         |   |            |  |
|  | Physician's Orders   | Physician's Orders, dated 1/15/24, indicated |      |         | How will you identify other   |            |  |
|  |  | oxygen at 2 liters per minute.               |      |         | residents having the potenti  | al         |  |
|  | provide continuous   | oxygen at 2 incrs per inimate.               |      |         | to be affected by the same  | ai         |  |
|  | During an interview  | y on 3/6/24 at 10:50 a m the                 |      |         | deficient practice and what   |            |  |
|  | During an interview on 3/6/24 at 10:50 a.m., the Assistant Director of Nursing indicated the   |  |      |         | corrective action will be take                                      | an l       |  |
|  | resident's oxygen should be on per Physician's   |  |      |         | corrective action win be take                                       | ,····      |  |
|  | Orders. 2. On 3/4/24 at 11:18 a.m., Resident 5 was   |  |      |         |   |            |  |
|  |  | aring oxygen via nasal                       |      |         |   |            |  |
|  |  | ate was set at 3.5 liters.                   |      |         | All residents have the  |            |  |
|  | Cumulatur The Hew I  | ate was set at 3.3 mers.                     |      |         | potential to be affected by this                                    |            |  |
|  | On 3/5/24 at 2:36 p  | .m., the resident was sitting in             |      |         | alleged deficient practice.   | ´          |  |
|  | _  | sion. She was wearing oxygen                 |      |         | aneged denoient practice.   |            |  |
|  | via nasal cannula at   |  |      |         | Full house audit of all   |            |  |
|  |  |  |      |         | residents completed to ensure                                       | e          |  |
|  | On 3/6/24 at 9:47 a.   | m., the resident was observed                |      |         | oxygen orders entered for any                                       |            |  |
|  |  | e resident was wearing her                   |      |         | residents on oxygen, and that                                       | •          |  |
|  | _  | v rate was on at 4 liters.                   |      |         | oxygen is being administered  |            |  |
|  |  |  |      |         | ordered flow rate.  |            |  |
|  | The record for Resi  | dent 5 was reviewed on 3/6/24                |      |         |   |            |  |
|  | at 11:04 a.m. Diagn  | oses included, but were not                  |      |         |   |            |  |
|  | limited to, hemiples   | gia, diabetes, chronic                       |      |         |   |            |  |
|  | obstructive pulmon   | ary disease (respiratory                     |      |         | What measures will be put   |            |  |
|  | disease), dementia,  | hypertension (high blood                     |      |         | into place or what systemic   |            |  |
|  | pressure), gout, acu   | te and chronic respiratory                   |      |         | changes you will make to  |            |  |
|  | failure.   |  |      |         | ensure that the deficient   |            |  |
|  |  |  |      |         | practice does not recur?  |            |  |
|  | `  | rly Minimum Data Set (MDS)                   |      |         |   |            |  |
|  |  | ed the resident was severely                 |      |         |   |            |  |
|  | impaired with daily  | decision making.                             |      |         |   |            |  |
|  |  |  |      |         | Nursing staff was educat  | ted        |  |
|  | · ·  | 2/22/24, indicated the resident              |      |         | on ensuring that residents on                                       |            |  |
|  |  | ntions included, but were not                |      |         | oxygen therapy have orders in                                       |            |  |
|  | limited to, giving or  | xygen therapy as ordered by                  |      |         | place and are receiving oxyge                                       | en at      |  |

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840   |   | JILDING             | onstruction  00  | (X3) DATE SURVEY COMPLETED 03/11/2024 |                            |
|--------------------------|--|---|---|---------------------|--|---------------------------------------|----------------------------|
|                          | PROVIDER OR SUPPLIEF   |   | STREET ADDRESS, CITY, STATE, ZIP COD  1532 CALUMET AVENUE  DYER, IN 46311 |                     |  |                                       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OF  | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | TE                                    | (X5)<br>COMPLETION<br>DATE |
|                          | the physician and n<br>any side effects and                                      | nonitoring and documenting leffectiveness   |   |                     | the ordered flow rate.   |                                       |                            |
|                          | received oxygen the<br>failure. Intervention<br>limited to, giving or            | 2/22/24, indicated the resident erapy related to respiratory as included, but were not exygen therapy as ordered by bserving and documenting leffectiveness.        |   |                     | How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place?  | ty                                    |                            |
|                          | administer oxygen 3 liters per minute.  The Medication Ad                        | r, dated 8/21/23, indicated to via nasal cannula every shift at ministration Record (MAR) as signed out at 3 liters every 3/6/24.                                   |   |                     | DON/designee will monit<br>20 residents weekly to ensure<br>residents wearing oxygen hav<br>orders in place and are receiv<br>oxygen at ordered flow rate.   | that<br>e<br>ing                      |                            |
|                          | Director of Nursing understood the residincorrect flow rate, information to prov | y, on 3/6/24 at 1:54 p.m., the g (DON) indicated he dent had oxygen on at the and had no additional ide.  13 a.m., and 11:44 a.m., Resident earing oxygen via nasal |   |                     | DON/Designee will prese<br>the summaries of the audits to<br>Quality Assurance committee<br>monthly for six months.<br>Thereafter, if determined by th<br>Quality Assurance committee<br>further monitoring is needed, a<br>will continue. | the<br>e<br>that                      |                            |
|                          | cannula at a flow ra On 3/5/24 at 9:26 a   | .m., the resident was observed breakfast. She had oxygen on   |   |                     | Date of compliance: 04/05/24   | 4                                     |                            |
|                          |  | .m., the resident was observed<br>ng television. She had oxygen<br>sal cannula.   |   |                     |  |                                       |                            |
|                          | at 10:22 a.m. Diagralimited to, stroke, re                                       | dent 45 was reviewed on 3/6/24 tosses included, but were not espiratory failure, anxiety, y and hypertension (high  |   |                     |  |                                       |                            |

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|                            | NT OF DEFICIENCIES<br>OF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULTIPLE C<br>A. BUILDING  | onstruction<br>00  | (X3) DATE SURVEY<br>COMPLETED |
|----------------------------|--|--|---|--|-------------------------------|
|                            |  | 155840   | B. WING   |  | 03/11/2024                    |
|                            | PROVIDER OR SUPPLIE  |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |  |                               |
| (X4) ID<br>PREFIX          |  | STATEMENT OF DEFICIENCIE   | ID  | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE | (X5)                          |
| TAG                        | ` `  | NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION   | PREFIX<br>TAG   | CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                   | ATE COMPLETION DATE           |
| 1110                       | blood pressure).   | R LOC IDENTIFY THAT IN GRAMMITTEN  | 1716  |  | DATE                          |
|                            | The 2/7/24 Admiss assessment, indicate cognitively intact was a Care Plan, dated received oxygen the failure with hypoxis were not limited to ordered by the physide effects and eff signs of respiratory physician. | sion Minimum Data Set (MDS) and the resident was with daily decision making.  2/7/24, indicated the resident erapy related to respiratory and Interventions included, but a giving oxygen therapy as siscian, observe and document fectiveness, and observe for a distress and report to |   |  |                               |
|                            | oxygen.  A Nurses' Note, da  | ted 2/1/24, indicated the ring oxygen at 3 liters via nasal  |   |  |                               |
|                            | Director of Nursing<br>understood the resi<br>without a Physician<br>information to prov   | w, on 3/06/24 at 1:54 p.m., the g (DON) indicated he dent was wearing oxygen n's order, and had no additional vide.  |   |  |                               |
| F 0697<br>SS=D<br>Bldg. 00 | require such serve professional stan comprehensive pend the residents  | Management. ensure that pain rovided to residents who ices, consistent with dards of practice, the erson-centered care plan, ' goals and preferences.  |   |  |                               |
|                            | Dasca on record re   | view and interview, the facility   | F 0697  | POC for F697 – Pain  | 04/05/2024                    |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |  | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE               |                                  |                             |   |            |      |
|--|--|--|----------------------------------|-----------------------------|---|------------|------|
| AND PLAN   | OF CORRECTION                                    | IDENTIFICATION NUMBER                                    | A. BUILDING 00 COMPLETED         |                             |   |            |      |
|  |  | 155840   | B. WING 03/11/2024               |                             |   |            |      |
| NAME OF F  | PROVIDER OR SUPPLIER                             |  | _                                | 1                           | ADDRESS, CITY, STATE, ZIP COD                                       |            |      |
|  |  |  | 1532 CALUMET AVENUE              |                             |   |            |      |
| IGNITE N   | MEDICAL RESORT                                   | DYER LLC.  | DYER, IN 46311                   |                             |   |            |      |
| (X4) ID  |  | STATEMENT OF DEFICIENCIE                                 |                                  | ID                          | PROVIDER'S PLAN OF CORRECTION                                       |            | (X5) |
| PREFIX   | `  | CY MUST BE PRECEDED BY FULL                              |                                  | PREFIX                      | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA | COMPLETION |      |
| TAG  |  | LISC IDENTIFYING INFORMATION                             |                                  | TAG                         | DEFICIENCY)   |            | DATE |
|  |  | pain relief medication as                                |                                  |                             | Management  |            |      |
|  | ordered by the Phys                              | arcotic medication, for 1 of 1                           |                                  |                             |   |            |      |
|  |  | for pain management.                                     |                                  |                             | What corrective action(s) w   |            |      |
|  | (Resident Q)                                     | tor pain management.                                     |                                  |                             | be accomplished for those   | "          |      |
|  | (resident Q)                                     |  |                                  |                             | residents found to have been  | n          |      |
|  | Finding includes:                                |  |                                  |                             | affected by the deficient   |            |      |
|  |  |  |                                  |                             | practice?   |            |      |
|  | During an interview                              | y, on 3/4/24 at 11:28 a.m.,                              |                                  |                             |   |            |      |
|  |  | d nursing staff had told him                             |                                  |                             |   |            |      |
|  | more than once they                              |  |                                  | Resident Q still resides in | n   |            |      |
|  | (Hydrocodone) medication, and he was in a lot of |  |                                  |                             | facility. No harm came to resid                                     | dent       |      |
|  | pain. He indicated one day, the nurse told him   |  |                                  |                             | Q from this alleged deficient                                       |            |      |
|  | there would be no Norco available until the next |  |                                  |                             | practice.   |            |      |
|  | day, and that was at                             | 3:00 p.m.  |                                  |                             |   |            |      |
|  | The record for Resi                              | dent Q was reviewed on 3/6/24                            |                                  |                             |   |            |      |
|  |  | esident was admitted to the                              |                                  |                             | How will you identify other   |            |      |
|  | _  | Diagnoses included, but were                             |                                  |                             | residents having the potenti  | al         |      |
|  | 1  | heral vascular disease,                                  |                                  |                             | to be affected by the same  |            |      |
|  |  | m, osteomyelitis, high blood                             | deficient practice and what      |                             |   |            |      |
|  |  | f the left toes, and adult failure                       | corrective action will be taken. |                             |   |            |      |
|  | to thrive.                                       |  |                                  |                             |   |            |      |
|  |  |  |                                  |                             |   |            |      |
|  |  | sion Minimum Data Set (MDS)                              |                                  |                             | All markets (C. 20)   |            |      |
|  | assessment, indicate                             |  |                                  |                             | All residents with pain   |            |      |
|  |  | nd received scheduled and as nedication. He had frequent |                                  |                             | medication orders have the  |            |      |
|  |  | n the last 5 days that                                   |                                  |                             | potential to be affected by this alleged deficient practice.        | '          |      |
|  | occasionally affecte                             |  |                                  |                             | alleged delicient practice.   |            |      |
|  | occusionary arrecte                              | a ins sieep.   |                                  |                             | Full house audit was  |            |      |
|  | A Care Plan, dated                               | 3/4/24, indicated the resident                           |                                  |                             | completed to ensure residents                                       | ,          |      |
|  | was receiving opioi                              |  |                                  |                             | received appropriate pain   |            |      |
|  |  |  |                                  |                             | medication per orders.  |            |      |
|  | A Care Plan, dated                               | 2/22/24, indicated the resident                          |                                  |                             |   |            |      |
|  | had potential for pa                             | in. The approaches were to                               |                                  |                             | Full house audit was  |            |      |
|  | administer medicati                              | ons as ordered, anticipate the                           |                                  |                             | completed to ensure that all p                                      | ain        |      |
|  | _  | pain relief and respond                                  |                                  |                             | medications were received fro                                       | om         |      |
|  |  | complaints of pain, identify                             |                                  |                             | pharmacy and available for  |            |      |
|  | and record previous                              | pain history and management                              |                                  |                             | administration.   |            |      |

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|           |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY   |      |  |   |            |  |  |
|-----------|---|---|------|--|---|------------|--|--|
| AND PLAN  | OF CORRECTION   | IDENTIFICATION NUMBER   |      | A. BUILDING 00 COMPLETED  B. WING 03/11/2024 |   |            |  |  |
|           |   | 155840  | B. W | ING  |   | 03/11/2024 |  |  |
| NAME OF P | ROVIDER OR SUPPLIER   |   |      |  | ADDRESS, CITY, STATE, ZIP COD   |            |  |  |
|           |   |   |      |  | ALUMET AVENUE   |            |  |  |
| IGNITE    | MEDICAL RESORT  | DYER LLC.   |      | DYER, IN 46311                               |   |            |  |  |
| (X4) ID   |   | STATEMENT OF DEFICIENCIE  |      | ID   | PROVIDER'S PLAN OF CORRECTION   | (X5)       |  |  |
| PREFIX    | `   | CY MUST BE PRECEDED BY FULL   |      | PREFIX                                       | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | COMPLETION |  |  |
| TAG       |   | LSC IDENTIFYING INFORMATION   | -    | TAG  | DEFICIENCI)   | DATE       |  |  |
|           |   | impact on function, and   |      |  |   |            |  |  |
|           | • •   | identify previous response to analgesia including pain relief, side effects and its impact on function. |      |  |   |            |  |  |
|           | pain rener, side effe   | and its impact on function.   |      |  | What measures will be put   |            |  |  |
|           | Physician's Orders.   | dated 2/12/24, indicated  |      |  | into place or what systemic   |            |  |  |
|           | -   | aminophen oral tablet 5-325   |      |  | changes you will make to  |            |  |  |
|           | -   | ve 1 tablet by mouth every 4  |      |  | ensure that the deficient   |            |  |  |
|           | hours as needed for   | -   |      |  | practice does not recur?  |            |  |  |
|           |   | •   |      |  |   |            |  |  |
|           | The Medication Ad   | The Medication Administration Record (MAR),   |      |  |   |            |  |  |
|           | dated 2/2024, indicated the resident received 1<br>Hydrocodone tablet on 2/12-2/15/24. He received<br>2 tablets on 2/16/24 and then 1 tablet on |   |      |  |   |            |  |  |
|           |   |   |      |  | Nursing staff educated o  | n          |  |  |
|           |   |   |      |  | ensuring that residents with  |            |  |  |
|           | 2/17-2/20/24. He did not receive any Hydrocodone  |   |      |  | complaints of pain receive the  | •          |  |  |
|           | on 2/21/24.   |   |      |  | proper pain medication per  |            |  |  |
|           |   |   |      |  | physician orders.   |            |  |  |
|           |   | indicated 30 tablets of the   |      |  |   |            |  |  |
|           | -   | eceived 2/22/24 (10 days after  |      |  | Nursing staff educated th   |            |  |  |
|           | the resident was adı  | mitted).  |      |  | medications not on hand shou  | ıld        |  |  |
|           | The 2/2024 MAP:   | adjusted after the 20 tologo  |      |  | be pulled from the RxNow machine and administered pe                                  | _          |  |  |
|           |   | ndicated after the 30 tablets of received, the resident   |      |  | ſ   |            |  |  |
|           | -   | For the pain medication at least  |      |  | orders.   |            |  |  |
|           | 3 times a day for the   |   |      |  |   |            |  |  |
|           | 2 minos a day for the   | - 155 of the month.   |      |  | How will the corrective   |            |  |  |
|           | The facility had a R  | X Now medication machine to   |      |  | actions(s) be monitored to  |            |  |  |
|           | -   | ns that were currently unfilled,  |      |  | ensure the deficient practice   | ,          |  |  |
|           | _   | -325 mg was available.  |      |  | will not recur, i.e., what qual   |            |  |  |
|           | •   |   |      |  | assurance program will be p   | =          |  |  |
|           | During an interview   | y, on 3/7/24 at 10:00 a.m., the   |      |  | into place?   |            |  |  |
|           | Director of Nursing   | indicated he was unaware and  |      |  |   |            |  |  |
|           | -   | he script was not sent to the   |      |  |   |            |  |  |
|           |   | r the resident was admitted. He   |      |  | CNO/designee will monit   | or         |  |  |
|           | had no additional in  | formation to review.  |      |  | 15 residents with orders for page 15  | ain        |  |  |
|           |   |   |      |  | medications to ensure that  |            |  |  |
|           | 3.1-37(a)   |   |      |  | medications are available and   | l          |  |  |
|           |   |   |      |  | administered per orders.  |            |  |  |
|           |   |   |      |  | ONO/D-: ""  | 4          |  |  |
|           |   |   |      |  | CNO/Designee will prese   |            |  |  |
|           |   |   | 1    |  | the summaries of the audits to  | o tne      |  |  |

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/24/2024 FORM APPROVED OMB NO. 0938-039

|                            |   | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER  | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING                        |              |  | (X3) DATE SURVEY  COMPLETED  03/11/2024 |                    |
|----------------------------|---|--|---|--------------|--|---|--------------------|
|                            |   | 155840   | B. WI   | NG           | _  | 03/11/                                  | 2024               |
|                            | PROVIDER OR SUPPLIER                            |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |              |  |   |                    |
| (X4) ID<br>PREFIX          |   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL  |   | ID<br>PREFIX | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA'   | TE                                      | (X5)<br>COMPLETION |
| TAG                        | REGULATORY OR                                   | LSC IDENTIFYING INFORMATION  |   | TAG          | Quality Assurance committee monthly for six months. Thereafter, if determined by th Quality Assurance committee further monitoring is needed, a will continue. | e<br>that                               | DATE               |
|                            |   |  |   |              | Date of compliance: 4/5/24   |   |                    |
| F 0757<br>SS=D<br>Bldg. 00 | Drugs<br>§483.45(d) Unnec<br>Each resident's dr | Free from Unnecessary ressary Drugs-General. regimen must be free drugs. An unnecessary rhen used- |   |              |  |   |                    |
|                            | §483.45(d)(1) In e. duplicate drug the          | xcessive dose (including rapy); or   |   |              |  |   |                    |
|                            | §483.45(d)(2) For                               | excessive duration; or   |   |              |  |   |                    |
|                            | §483.45(d)(3) With<br>or                        | nout adequate monitoring;  |   |              |  |   |                    |
|                            | §483.45(d)(4) With for its use; or              | hout adequate indications  |   |              |  |   |                    |
|                            | consequences wh                                 | ne presence of adverse<br>ich indicate the dose<br>d or discontinued; or                           |   |              |  |   |                    |
|                            | reasons stated in (5) of this section.          | combinations of the paragraphs (d)(1) through view and interview, the facility                     | F 07  | <i>1</i> 57  | POC for F757 – Drug Regime   | n                                       | 04/05/2024         |

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|                          | T OF DEFICIENCIES<br>OF CORRECTION  | XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction<br><u>00</u>   | (X3) DATE SURVEY COMPLETED 03/11/2024 |  |
|--------------------------|---|---|--|--|---------------------------------------|--|
|                          | ROVIDER OR SUPPLIER   |   | 1532 C                                     | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311  |                                       |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE                           |                                       |  |
|                          | failed to ensure medications were managed appropriately, related to missed doses of an anticoagulant medication, for 1 of 5 residents reviewed for unnecessary medications (Resident Q)  Finding includes:  |   |  | is Free from Unnecessary D  What corrective action(s) w  |                                       |  |
|                          |   |   |  | be accomplished for those residents found to have bee affected by the deficient practice?                                    |                                       |  |
|                          | Resident Q indicate (anticoagulant) inje  | r, on 3/4/24 at 11:22 a.m.,<br>d he had missed his Lovenox<br>ctions many times. Some days<br>hot, and on other days he did<br>nem. |  | No harm came to reside from this alleged deficient practice.   | nt Q                                  |  |
|                          | not receive any of them.  The record for Resident Q was reviewed on 3/6/24 at 12:08 p.m. The resident was admitted to the facility on 2/12/24. Diagnoses included, but were not limited to, peripheral vascular disease, pulmonary embolism, osteomyelitis, high blood pressure, absence of the left toes, and adult failure to thrive.  The 2/18/24 Admission Minimum Data Set (MDS) |   |  | Resident Q still resides i facility.   | n                                     |  |
|                          |   |   |  | How will you identify other residents having the potenti to be affected by the same deficient practice and what              | ial                                   |  |
|                          |   | ed the resident was and received an anticoagulant lication while a resident.  |  | corrective action will be take   | en.                                   |  |
|                          | received an anticoa   | 2/12/24, indicated the resident gulant medication. The administer the medication as   |  | All residents have the potential to be affected by this alleged deficient practice.  | s                                     |  |
|                          | Enoxaparin (Lovene<br>Prefilled Syringe 10  | dated 2/13/24, indicated ox) Sodium Injection Solution 00 milligrams/milliliters (mg)/(ml) cutaneously two times a day for          |  | Full house audit was completed to ensure resident receiving anticoagulation medication were receiving medication per orders. | s                                     |  |
|                          |   | tion Administration Record<br>ne Enoxaparin was signed out  |  | What measures will be put  |                                       |  |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                               | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY                   |                     |          | JRVEY   |               |            |
|--|-------------------------------|---|---------------------|----------|---|---------------|------------|
| AND PLAN   | OF CORRECTION                 | IDENTIFICATION NUMBER   | A. BU               | JILDING  | 00  | COMPLE        | ΓED        |
|  |                               | 155840  | B. W                | ING      |   | 03/11/2       | 024        |
|  |                               | <u> </u>  |                     | STREET A | ADDRESS, CITY, STATE, ZIP COD   |               |            |
| NAME OF P  | PROVIDER OR SUPPLIER          | t .   | 1532 CALUMET AVENUE |          |   |               |            |
| IGNITE N   | MEDICAL RESORT                | DYER LLC.   | DYER, IN 46311      |          |   |               |            |
|  |                               |   | 1                   |          |   |               |            |
| (X4) ID  |                               | STATEMENT OF DEFICIENCIE                                      |                     | ID       | PROVIDER'S PLAN OF CORRECTION   |               | (X5)       |
| PREFIX   | · ·                           | CY MUST BE PRECEDED BY FULL                                   |                     | PREFIX   | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY) | TE            | COMPLETION |
| TAG  |                               | R LSC IDENTIFYING INFORMATION                                 |                     | TAG      |   |               | DATE       |
|  | -                             | ed on 2/12-2/20/24 two times a                                |                     |          | into place or what systemic   |               |            |
|  | -                             | 9" was coded for both the 9:00                                |                     |          | changes you will make to  |               |            |
|  |                               | doses, indicating to see nurses' are month, 2/22-2/29/24, the |                     |          | ensure that the deficient   |               |            |
|  |                               |   |                     |          | practice does not recur?  |               |            |
|  |                               | ned out as being administered                                 |                     |          |   |               |            |
|  | for 2 times a day.            |   |                     |          |   |               |            |
|  | Nurses' Notes date            | Jurses' Notes, dated 2/21/24, indicated the                   |                     |          | Nursing staff educated or   | n             |            |
|  | Enoxaparin was not available. |   |                     |          | ensuring that residents are   | ''            |            |
|  | Znozupurni was not            | arandore.   |                     |          | receiving medications as orde   | red           |            |
|  | The 3/2024 MAR in             | ndicated the Enoxaparin was                                   |                     |          | including but not limited to  | 104           |            |
|  |                               | administered 3/1-3/4/24 twice                                 |                     |          | anticoagulation medications.  |               |            |
|  | -                             | "9" was coded for 5 p.m. dose,                                |                     |          | aooagaiation modioations.   |               |            |
|  |                               | ' was coded for 9 a.m. dose.                                  |                     |          | Nursing staff was educat  | <sub>ed</sub> |            |
|  |                               |   |                     |          | on what medications are avail   |               |            |
|  | Nurses' Notes, dated          | d 3/5/24 at 5:46 p.m., indicated                              |                     |          | in RX Now (EDK), how to acco  |               |            |
|  | the Enoxaparin was            |   |                     |          | medications from RX Now (ED   |               |            |
|  | 1                             |   |                     |          | and notification to   | -17           |            |
|  | Nurses' Notes, date           | d 3/6/24 at 8:01 a.m., indicated                              |                     |          | CNO/ACNO/MD/Pharmacy wh   | nen           |            |
|  |                               | lication was unavailable and                                  |                     |          | a medication from RX Now (E   |               |            |
|  | was reordered with            |   |                     |          | is unavailable.   |               |            |
|  |                               |   |                     |          |   |               |            |
|  | During an interview           | y, on 3/7/24 at 9:30 a.m., the                                |                     |          | How will the corrective   |               |            |
|  |                               | Manager indicated they sent                                   |                     |          | actions(s) be monitored to  |               |            |
|  | · ·                           | igh for 5 days) of the  |                     |          | ensure the deficient practice   |               |            |
|  | -                             | /24. They sent another 10                                     |                     |          | will not recur, i.e., what quali  | ity           |            |
|  |                               | days) on 2/27/24. They  |                     |          | assurance program will be p   | ut            |            |
|  |                               | or more, however, the   |                     |          | into place?   |               |            |
|  |                               | backorder and they had not                                    |                     |          |   |               |            |
|  | •                             | 24. The Account Manager                                       |                     |          |   |               |            |
|  |                               | ation was available in the RX                                 |                     |          | CNO/designee will monit   | or            |            |
|  |                               | aff could have used that                                      |                     |          | 15 residents with orders for  |               |            |
|  |                               | esident would not go without,                                 |                     |          | anticoagulation medications to  |               |            |
|  | · ·                           | d there was no documentation                                  |                     |          | ensure that medications are   |               |            |
|  | _                             | signed out for the resident                                   |                     |          | available and administered pe   | r             |            |
|  | from the RX Now n             | nedication machine.   |                     |          | orders.   |               |            |
|  | A 1 . COO 1                   | ( 16.101  |                     |          | ONO/5 : "   |               |            |
|  |                               | (enough for 10 days) were                                     |                     |          | CNO/Designee will prese   |               |            |
|  | -                             | harmacy and the resident had                                  |                     |          | the summaries of the audits to  | tne           |            |
|  | aiready been residir          | ng in the facility for 24 days.                               |                     |          | Quality Assurance committee   |               |            |

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|                            | TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | onstruction 00  | (X3) DATE SURVEY COMPLETED 03/11/2024 |
|----------------------------|--|--|---|---------------------------------------|
|                            | PROVIDER OR SUPPLIER MEDICAL RESORT DYER LLC.  | 1532 C                                     | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |                                       |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)                        | (X5) COMPLETION DATE                  |
|                            | On 3/7/24 at 10:00 a.m., the Director of Nursing entered the medication room where the RX Now machine was located. At that time, he used his fingerprint and was able to open the machine to remove the 100 mg of Enoxaparin prefilled syringes. There were a total of 8 syringes available for use.   |  | monthly for six months. Thereafter, if determined by th Quality Assurance committee further monitoring is needed, a will continue.            | that                                  |
|                            | During an interview at that time, the DON indicated he was unaware the Enoxaparin medication was even available in the RX Now machine.   |  | Date of compliance: 4/5/24  |                                       |
|                            | During an interview, on 3/7/24 at 10:30 a.m., the DON had informed RN 1 about the Lovenox being available in the RX Now machine. She indicated at that time, she was unaware it was in there.  |  |   |                                       |
| F 0759<br>SS=D<br>Bldg. 00 | 3.1-48(a)  483.45(f)(1)  Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors.  The facility must ensure that its-  |  |   |                                       |
|                            | §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 3 of 6 residents observed during medication pass. Three errors were observed during 29 opportunities for errors during medication administration. This resulted in a medication error rate of 10.34%. (Residents 49, 41, and J) | F 0759                                     | POC for F759 – Free of Medication Error Rts 5 Prcnt More  What corrective action(s) wi be accomplished for those residents found to have beer | II                                    |
|                            | Findings include:  |  | affected by the deficient practice?   |                                       |
|                            | 1. On 3/6/24 at 9:41 a.m., LPN 1 was observed  |  |   |                                       |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |   | (X2) M  | ULTIPLE CO | (X3) DATE SURVEY | ) DATE SURVEY   |               |   |
|--|---|---|------------|------------------|---|---------------|---|
| AND PLAN   | OF CORRECTION                                   | IDENTIFICATION NUMBER   |            | UILDING          | 00  | COMPLETED     |   |
|  |   | 155840  | B. W       | ING              |   | 03/11/2024    |   |
| NAME OF I  | DOWNER OF CURRINE                               |   |            | STREET A         | ADDRESS, CITY, STATE, ZIP COD   |               |   |
|  | PROVIDER OR SUPPLIER                            |   |            | 1532 C           | ALUMET AVENUE   |               |   |
| IGNITE N   | MEDICAL RESORT                                  | DYER LLC.   |            | DYER,            | IN 46311  |               |   |
| (X4) ID  | SUMMARY   | STATEMENT OF DEFICIENCIE  |            | ID               | PROVIDER'S PLAN OF CORRECTION   | (X5)          |   |
| PREFIX   | · ·   | CY MUST BE PRECEDED BY FULL   |            | PREFIX           | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE COMPLETION | 1 |
| TAG  |   | LISC IDENTIFYING INFORMATION  |            | TAG              |   | DATE          |   |
|  | 1 1 0   | 49's medications. She crushed rations at one time, including  |            |                  | No harm came to any   |               |   |
|  |   |   |            |                  | residents related to this alleged   | a             |   |
|  |   | one Isosorbide Mononitrate ER Tablet Extended<br>Release 24 hour 30 milligrams (mg) tablet. A total<br>of 13 crushed pills were observed in the |            |                  | deficient practice.   |               |   |
|  |   |   |            |                  | LPN 1 was immediately   |               |   |
|  | medication cup.                                 |   |            |                  | educated on not crushing  |               |   |
|  |   |   |            |                  | extended release medications  |               |   |
|  | The record for Resi                             | e record for Resident 49 was reviewed on 3/6/24<br>9:28 a.m. There was no physician's order to  |            |                  | S. C. Toronto Toronto Trical California   |               |   |
|  |   |   |            |                  | LPN 2 educated on waiti   | na            |   |
|  | crush medications.                              | 1 2   |            |                  | appropriate time between  |               |   |
|  |   |   |            |                  | inhalations of medications and  | 1             |   |
|  | LPN 1 contacted the                             | e pharmacy to verify if the   |            |                  | priming of insulin pens prior to  | )             |   |
|  | Isosorbide ER tablet could be crushed. The      |   |            |                  | administration.   |               |   |
|  | pharmacy indicated the medication should not be |   |            |                  |   |               |   |
|  | crushed.  |   |            |                  |   |               |   |
|  | During an interview                             | y, on 3/6/24 at 9:19 a.m., LPN 1  |            |                  | How will you identify other   |               |   |
|  | _   | led release medications should  |            |                  | residents having the potentia   | al            |   |
|  | not be crushed.                                 |   |            |                  | to be affected by the same  |               |   |
|  |   |   |            |                  | deficient practice and what   |               |   |
|  | 2. On 3/6/24 at 10:                             | 23 a.m., LPN 2 was observed   |            |                  | corrective action will be take  | n.            |   |
|  | administering Incru                             | se Ellipta 62.5   |            |                  |   |               |   |
|  | milligrams/microgr                              | ams (mg/mcg) inhaler to   |            |                  |   |               |   |
|  |   | inded the inhaler to the  |            |                  |   |               |   |
|  | · ·   | cted the resident to take two   |            |                  | All residents have the  |               |   |
|  | -   | medication. Resident 41 took  |            |                  | potential to be affected by this  | 1             |   |
|  |   | he inhaler and closed the   |            |                  | alleged deficient practice.   |               |   |
|  |   | PN 2 continued to administer  |            |                  |   |               |   |
|  | the rest of the medic                           | cations to the resident.  |            |                  | All nurses/QMAs receive   |               |   |
|  | Duning on intermi                               | y, on 3/6/24 at 10:37 a.m., LPN 2   |            |                  | competency check on medica administration via all routes.   | tion          |   |
|  | _   | t to instruct the resident to   |            |                  | aummistration via all roules.   |               |   |
|  | wait two minutes be                             |   |            |                  |   |               |   |
|  | two minutes of                                  | ormeen puns.  |            |                  |   |               |   |
|  |   | 51 a.m., LPN 2 was preparing  |            |                  | What measures will be put   |               |   |
|  |   | injection. The resident was to  |            |                  | into place or what systemic   |               |   |
|  |   | umalog 100 unit/Insulin Lispro  |            |                  | changes you will make to  |               |   |
|  |   | d Resident J's insulin pen  |            |                  | ensure that the deficient   |               |   |
|  |   | iming the insulin pen. LPN 2  |            |                  | practice does not recur?  |               |   |
|  | entered the resident                            | 's room, cleaned her hands,   |            |                  |   |               |   |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |                                 | i '   | LDING | instruction<br>00   | (X3) DATE :<br>COMPL<br>03/11/  | ETED                |                            |
|--|---------------------------------|---|-------|---------------------|---|---------------------|----------------------------|
| NAME OF P  | PROVIDER OR SUPPLIER            |   |       |                     | ADDRESS, CITY, STATE, ZIP COD   |                     |                            |
| IGNITE N   | MEDICAL RESORT                  | DYER LLC.   |       | DYER, I             | IN 46311  |                     |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ]     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)   | \TE                 | (X5)<br>COMPLETION<br>DATE |
|  | insulin without prin            | administered Resident J's ning the insulin pen.  y on 3/6/24 at 12:33 p.m., LPN 2 know she had to prime the ne insulin. |       |                     | Nursing staff educated of proper medication administrate technique including, but not limited to, not crushing extending extending each telease tablets, waiting the appropriate amount of time between the inhalation of medications, and priming insurpen needles prior to administration of insulin. | ion<br>led<br>Ilin  |                            |
|  |                                 |   |       |                     | How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what qual assurance program will be p into place?  | ity                 |                            |
|  |                                 |   |       |                     | CNO/designee will monit 10 medication administrations weekly on alternating shifts to ensure proper technique is be used, with a focus on crushed medications, inhaled medicati and insulin administration.   | eing<br>I           |                            |
|  |                                 |   |       |                     | CNO/Designee will prese<br>the summaries of the audits to<br>Quality Assurance committee<br>monthly for six months.<br>Thereafter, if determined by th<br>Quality Assurance committee<br>further monitoring is needed, a<br>will continue.  | o the<br>ne<br>that |                            |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER |  | · ′  | ILDING | onstruction<br>00   | (X3) DATE SURVEY  COMPLETED  03/11/2024  |     |                            |
|--|--|--|--------|---------------------|--|-----|----------------------------|
|  | PROVIDER OR SUPPLIE  |  | •      | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311   |     |                            |
| (X4) ID<br>PREFIX<br>TAG                     | (EACH DEFICIE)   | STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  | 1      | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                        | ATE | (X5)<br>COMPLETION<br>DATE |
|  |  |  |        |                     | Date of compliance: 4/5/24   |     |                            |
| F 0761<br>SS=D<br>Bldg. 00                   | Drugs and biolog must be labeled i accepted profess the appropriate a instructions, and applicable.  §483.45(h) Storage §483.45(h)(1) In a Federal laws, the and biologicals in under proper tempermit only authoraccess to the key §483.45(h)(2) The separately locked compartments for listed in Scheduled Drug Abuse Prev 1976 and other dexcept when the package drug disting the quantity stores. | ing of Drugs and Biologicals icals used in the facility in accordance with currently ional principles, and include occessory and cautionary the expiration date when ge of Drugs and Biologicals accordance with State and facility must store all drugs locked compartments perature controls, and rized personnel to have is.  The facility must provide a facility must pro |        |                     |  |     |                            |
|  | interview, the facil<br>were properly store<br>insulin vial and loc  | on, record review, and ity failed to ensure medications ed, related to one unlabeled ose pills inside the medication medication carts observed.  | F 07   | 61                  | POC for F761 – Label/Store<br>Drugs and Biologicals  What corrective action(s) w<br>be accomplished for those<br>residents found to have bee |     | 04/05/2024                 |

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| STATEME  | NT OF DEFICIENCIES   | X1) PROVIDER/SUPPLIER/CLIA  | (X2) M | ULTIPLE CO   | ONSTRUCTION   | (X3) DATE                | SURVEY     |
|----------|--|---|--------|--|---|--------------------------|------------|
| AND PLAN | OF CORRECTION  | IDENTIFICATION NUMBER   | A. BU  | ЛLDING   | 00  | COMPL                    | ETED       |
|          |  | 155840  | B. W   | ING  |   | 03/11/                   | /2024      |
|          |  |   | -      | STREET A   | ADDRESS, CITY, STATE, ZIP COD   |                          |            |
| NAME OF  | PROVIDER OR SUPPLIEI   | R   |        |  | ALUMET AVENUE   |                          |            |
| IGNITE I | MEDICAL RESORT   | DYER LLC.   |        |  | IN 46311  |                          | <u> </u>   |
| (X4) ID  | SUMMARY  | STATEMENT OF DEFICIENCIE  |        | ID PROVIDER'S PLAN OF CORRECTION   |   |                          | (X5)       |
| PREFIX   | •  | NCY MUST BE PRECEDED BY FULL  |        | PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |   | TE.                      | COMPLETION |
| TAG      |  | R LSC IDENTIFYING INFORMATION   |        | TAG DEFICIENCY)  |   |                          | DATE       |
|          | Findings include:  |   |        |  | affected by the deficient   |                          |            |
|          | 3/6/24 at 11:51 a.m cart was observed vunlabeled and unda medication cart.  During an interview indicated the insuli properly discarded.  2. During a medica | tion storage observation, on  |        |  | No harm came to any resident from this alleged defipractice.  LPN 2 immediately eduction proper labeling of medication including, but not limited to, insulin vials.  LPN 3 immediately eduction.   | ated<br>ons<br>ated      |            |
|          | 3/7/24 at 5:59 p.m.  | , the North East Hall medication  |        |  | on cart cleanliness and on pro  |                          |            |
|          | cart was observed v  | with LPN 3. At that time, there   |        |  | disposal of loose pills inside o  | -                        |            |
|          | -  | inside the drawer of the  |        |  | medication cart.  |                          |            |
|          | medication cart. Th  | ne pills ranged in size and color.  |        |  |   |                          |            |
|          | indicated she shoul<br>and properly dispose<br>A facility policy, ti<br>Storage", provided<br>current, indicated,  | w, on 3/7/24 at 5:59 p.m., LPN 3 d have cleaned her cart out sed of the loose medications.  tled, "Medication Labeling and by the Director of Nursing as " "Medication are labeled in cility requirements and state |        |  | How will you identify other residents having the potentiato be affected by the same deficient practice and what corrective action will be take  |                          |            |
|          | 3.1-25(j)  |   |        |  | All residents have the potential to be affected by this alleged deficient practice.  Full house audit complet of all medication carts to ensu all medications, including, but limited to, insulin vials are laborappropriately.  Full house audit complet of all medication carts to ensu | ed<br>ire<br>not<br>eled |            |

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|                          | OF CORRECTION       | IDENTIFICATION NUMBER  155840   | A. BUILDING B. WING | 00   | COMPLETED 03/11/2024               |
|--------------------------|---------------------|---|---------------------|--|------------------------------------|
|                          | ROVIDER OR SUPPLIER |   | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311   |                                    |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN      | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LISC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE               |
|                          |                     |   |                     | that no loose pills are present<br>any loose pills are disposed o<br>appropriately.  | l l                                |
|                          |                     |   |                     | What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?  |                                    |
|                          |                     |   |                     | Nursing staff educated o proper labeling of all medication.  Nursing staff educated of cart cleanliness, ensuring no loose pills are present in cart, proper disposal of any loose pills are present i | ons.  n and oills.                 |
|                          |                     |   |                     | CNO/Designee will audit medication carts weekly to en all medications are appropriat labeled and that no loose pills present in medication carts.  CNO/Designee will prese the summaries of the audits to Quality Assurance committee monthly for six months.  | sure<br>ely<br>are<br>ent<br>o the |

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|                            | OF CORRECTION  | IDENTIFICATION NUMBER  155840   | A. BUILDING B. WING | 00   | COMPLETED 03/11/2024 |
|----------------------------|--|---|---------------------|--|----------------------|
|                            | PROVIDER OR SUPPLIER   |   | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311   |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)                        | (X5) COMPLETION DATE |
|                            |  |   |                     | Thereafter, if determined by t<br>Quality Assurance committee<br>further monitoring is needed,<br>will continue.  Date of compliance: 4/5/24 | that                 |
| F 0842<br>SS=E<br>Bldg. 00 | §483.20(f)(5) Resi (i) A facility may no is resident-identifia (ii) The facility may resident-identifiable accordance with a agent agrees not to information except itself is permitted to §483.70(i) Medica §483.70(i)(1) In according to the grofessional stand facility must mainte each resident that (i) Complete; (ii) Accurately docu (iii) Readily access (iv) Systematically §483.70(i)(2) The confidential all information and infor | - Identifiable Information dent-identifiable information. of release information that able to the public.  I release information that is a to an agent only in contract under which the o use or disclose the ato the extent the facility o do so.  I records.  I records.  I records with accepted ards and practices, the ain medical records on are-  umented; sible; and organized  facility must keep ormation contained in the orm or storage method of the when release is- all, or their resident are permitted by applicable |                     |  |                      |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 03/11/2024   |               |
|--|--|---|---------------------|---|---------------|
|  | PROVIDER OR SUPPLIER   |   | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |               |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD I<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | BE COMPLETION |
|  | operations, as per compliance with 4 (iv) For public hear abuse, neglect, or oversight activities proceedings, law organ donation pure or to coroners, and to a health or safety as compliance with 4 §483.70(i)(3) The medical record infection destruction, or unated with the same of the contained for (ii) The period of tine (ii) Five years from when there is no remarked the contained for (iii) For a minor, 3 reaches legal age §483.70(i)(5) The contained in the comprehense of the contained for the comprehense for the | 5 CFR 164.506; alth activities, reporting of a domestic violence, health is, judicial and administrative enforcement purposes, irposes, research purposes, edical examiners, funeral evert a serious threat to is permitted by and in 5 CFR 164.512.  facility must safeguard formation against loss, authorized use.  ical records must be  me required by State law; or in the date of discharge requirement in State law; or years after a resident under State law.  medical record must  mation to identify the  resident's assessments; ensive plan of care and inducted by the State; urse's, and other licensed | F 0842              | POC for F842 Resident   | 04/05/2024    |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |                       | (X2) MULTIPLE C A. BUILDING B. WING                      | onstruction<br><u>00</u> | (X3) DATE SURVEY COMPLETED 03/11/2024                              |                |
|--|-----------------------|--|--------------------------|--|----------------|
| NAME OF P  | ROVIDER OR SUPPLIER   |  |                          | ADDRESS, CITY, STATE, ZIP COD                                      |                |
| IGNITE N   | MEDICAL RESORT        | DYER LLC.  |                          | CALUMET AVENUE<br>, IN 46311                                       |                |
| (X4) ID  | SUMMARY               | STATEMENT OF DEFICIENCIE                                 | ID                       | PROVIDER'S PLAN OF CORRECTION                                      | (X5)           |
| PREFIX   | `                     | CY MUST BE PRECEDED BY FULL                              | PREFIX                   | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI | ATE COMPLETION |
| TAG  |                       | LSC IDENTIFYING INFORMATION                              | TAG                      | DEFICIENCY)  | DATE           |
|  |                       | ical records were complete,                              |                          | Records-Identifiable   |                |
|  |                       | sumption intake, for 4 of 6                              |                          | Information  |                |
|  | and N)                | for food. (Residents Q, M, E,                            |                          | What corrective action(s) w  | 'III           |
|  | and N)                |  |                          | be accomplished for those residents found to have bee              | .n             |
|  | Findings include:     |  |                          | affected by the deficient  |                |
|  | i manigs metade.      |  |                          | practice?  |                |
|  | 1. The record for Re  | esident Q was reviewed on                                |                          | No harm came to any  |                |
|  |                       | . The resident was admitted to                           |                          | resident from this alleged def                                     | icient         |
|  | the facility on 2/12/ | 24. Diagnoses included, but                              |                          | practice. Residents M, E   |                |
|  | were not limited to,  | peripheral vascular disease,                             |                          | and N no longer reside in fac                                      | ility.         |
|  | -                     | m, osteomyelitis, high blood                             |                          | How will you identify other  |                |
|  | _                     | f the left toes, and adult failure                       |                          | residents having the potent  | ial            |
|  | to thrive.            |  |                          | to be affected by the same   |                |
|  |                       |  |                          | deficient practice and what  |                |
|  |                       | sion Minimum Data Set (MDS)                              |                          | corrective action will be  |                |
|  | assessment, indicate  | ed the resident was                                      |                          | taken. All residents have  |                |
|  | cognitively intact.   |  |                          | potential to be affected by this                                   | S              |
|  | Physician's Order     | lated 2/15/24, indicated a no                            |                          | alleged deficient practice.  House audit of all residents          |                |
|  | -                     | texture and consistency diet.                            |                          | completed to ensure that clini                                     | ical           |
|  | san packet, regular   | texture and consistency diet.                            |                          | records were complete relate                                       | <b>I</b>       |
|  | The Meal Consump      | tion Logs for February &                                 |                          | meal consumption intake.   | a to           |
|  |                       | ted all three meals were blank                           |                          | What measures will be pu   | ıt             |
|  | and not documented    | d on 2/13, 2/15, 2/19, 2/22, 2/24,                       |                          | into place or what systemic  |                |
|  | 2/29, and 3/5/24. T   | here was no breakfast meal                               |                          | changes you will make to   |                |
|  |                       | 4/24 and no lunch meal                                   |                          | ensure that the deficient  |                |
|  |                       | 7/24. The dinner meal was not                            |                          | practice does not recur?   |                |
|  |                       | 4, 2/16, 2/18, 2/20, 2/21, 2/23,                         |                          | All clinical staff educated  | d to           |
|  | 2/25, 2/27, 3/2, and  | 3/3/24.  |                          | properly document meal   |                |
|  | Daning a ' ' '        | 2/7/24 - 42:20   |                          | consumption intake within  |                |
|  | _                     | on 3/7/24 at 2:30 p.m., the                              |                          | POC. How will the corrective                                       | re             |
|  | _                     | indicated meals were to be lay for all 3 meals consumed. |                          | actions(s) be monitored to ensure the deficient practice           |                |
|  | documented every (    | iay 101 an 3 meais consumed.                             |                          | will not recur, i.e., what qua                                     |                |
|  | 2. The record for Re  | esident M was reviewed on                                |                          | assurance program will be  | -              |
|  |                       | . Diagnoses included, but were                           |                          | into place?  | , u.           |
|  |                       | and lung cancer, COPD,                                   |                          | CNO/designee will revie  | ew 5           |
|  |                       | and high blood pressure.                                 |                          | resident charts daily 5x a wee                                     |                |
|  |                       |  |                          | ensure food consumption is   |                |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING  | ONSTRUCTION  00     | (X3) DATE SURVEY COMPLETED 03/11/2024  |                                 |
|--|---|---|---------------------|--|---------------------------------|
|  | ROVIDER OR SUPPLIER   |   | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311   |                                 |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN<br>REGULATORY OR   | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE            |
| TAG  | The 1/22/24 Admiss assessment, indicate moderately impaire  The resident was to  The Meal Consump March 2024, indicated documentation of an 2/19, 2/28, and 2/29 documentation of b. 2/23, 2/26, 3/2, 3/3 documentation of th 2/13, 2/14, 2/17, 2/10  During an interview Director of Nursing documented every of the company of | sion Minimum Data Set (MDS) and the resident was defor daily decision making.  receive a regular diet.  tion Logs for February & ted there was no may meal on 2/9, 2/10, 2/11, 2/15, 2/24. There was no reakfast on 2/6, 2/16, 2/20, and 3/5/24 and no reakfast on 2/6, 2/14, and 2/25/24.  To no 3/7/24 at 2:30 p.m., the indicated meals were to be day for all 3 meals consumed.  In Diagnoses included, but dementia, type 2 diabetes, essive disorder, high blood fibrillation.  The diagnose of the resident brained for daily decision making and clean up assist for eating.  To Logs for December 2023 andicated there was no may meal on 12/2, 12/3, 12/5, 2/13, 12/16, 12/17, 12/19, 12/21, 12/29, 12/31, 1/2, 1/8, 1/10, 1/17, 11/31/24.  To on 3/7/24 at 2:30 p.m., the indicated meals were to be | TAG                 | documented appropriately. CNO/Designee will present summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee further monitoring is needed, will continue.  Date of compliance: 4/5/24 | the<br>e<br>ne<br>that<br>audit |
|  | accumented every (  | lay for all 3 meals consumed.   |                     |  |                                 |

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| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |  | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING   | ONSTRUCTION  00     | (X3) DATE SURVEY  COMPLETED  03/11/2024   |                      |
|--|--|--|---------------------|---|----------------------|
|  | PROVIDER OR SUPPLIER   |  | 1532 C              | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |                      |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | (X5) COMPLETION DATE |
|  | 3/5/24 at 3:30 p.m. the facility on 2/22/were not limited to, repeated falls, oster in the left knee.  The Admission Min assessment, dated 2 was cognitively into Physician's Orders, resident was to recessweets, regular text  The Meal Consump March 2024, indicated and not documented and 3/3/24 and not 2/23, 2/24, 2/25, 2/2  During an interview Director of Nursing be documented ever consumed  The current 5/2023 provided by the DO a.m., indicated each | otion Logs for February & ted all three meals were blank d on 2/28, 2/29, and 3/5/24. Ifast meal documented on 3/2 linner meal documented on |                     |   |                      |
| F 0880   | 3.1-50(a)(1)<br>483.80(a)(1)(2)(4)   | o(e)(f)  |                     |   |                      |
| SS=D<br>Bldg. 00   | Infection Prevention §483.80 Infection   | on & Control   |                     |   |                      |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER  155840  A. BUILDING  B. WING |  |   | COMPL<br>03/11/     | ETED   |    |                            |
|--|--|---|---------------------|--|----|----------------------------|
| NAME OF P  | ROVIDER OR SUPPLIER  |   |                     | ADDRESS, CITY, STATE, ZIP COD  |    |                            |
| IGNITE N   | MEDICAL RESORT   | DYER LLC.   |                     | IN 46311   |    |                            |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY) | TE | (X5)<br>COMPLETION<br>DATE |
|  | designed to provide comfortable environment at   | n and control program<br>le a safe, sanitary and<br>onment and to help prevent<br>and transmission of<br>eases and infections.  |                     |  |    |                            |
|  | program. The facility must e prevention and co   | on prevention and control stablish an infection ntrol program (IPCP) that minimum, the following  |                     |  |    |                            |
|  | identifying, reporting controlling infection diseases for all revisitors, and other services under a conducted according to the services and the factorial diseases and the services and the services and the services and the services are services are services and the services are services and the services are se | vstem for preventing, and, investigating, and and communicable sidents, staff, volunteers, individuals providing contractual arrangement cility assessment ng to §483.70(e) and I national standards; |                     |  |    |                            |
|  | and procedures for include, but are not include, but are not (i) A system of sur identify possible or infections before the persons in the fact (ii) When and to we communicable distinguished be reported; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; include).  | veillance designed to<br>ommunicable diseases or<br>ney can spread to other   |                     |  |    |                            |

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| STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 |   | (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 00 COMPLETED  B. WING 03/11/2024   |   |  |                      |  |
|--|---|---|---|--|----------------------|--|
|  | PROVIDER OR SUPPLIEF  |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |  |                      |  |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)  | (X5) COMPLETION DATE |  |
|  | the least restrictive under the circums (v) The circumstant must prohibit emp communicable dis lesions from direct their food, if direct disease; and (vi)The hand hygic followed by staff in contact.  §483.80(a)(4) A sincidents identified and the corrective facility.  §483.80(e) Linens Personnel must he transport linens so of infection.  §483.80(f) Annual The facility will contain the facility will contain the garbage of the facility of the facility will control guidelines were related to improper placed in the garbage observed for glucor.  Finding includes:  On 3/6/24 at 10:23 | that the isolation should be a possible for the resident tances. Incest under which the facility loyees with a lease or infected skin to contact with residents or contact will transmit the lene procedures to be involved in direct resident lystem for recording diffunder the facility's IPCP actions taken by the lend of as to prevent the spread | F 0880  | POC for F880 – Infection<br>Prevention & Control  What corrective action(s) was be accomplished for those residents found to have been affected by the deficient practice? |                      |  |
|  | removed the glucon  | neter, lancet, alcohol swabs,   |   | Resident 41 suffered no  | ill                  |  |

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|                          | IT OF DEFICIENCIES<br>OF CORRECTION                                  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING | ONSTRUCTION <u>00</u>   | (X3) DATE SURVEY COMPLETED 03/11/2024 |
|--------------------------|--|---|--|---|---------------------------------------|
|                          | PROVIDER OR SUPPLIER   |   | 1532 C                                     | ADDRESS, CITY, STATE, ZIP COD<br>ALUMET AVENUE<br>IN 46311  |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIEN<br>REGULATORY OR                                      | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG                        | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)                                   | DATE                                  |
|                          | performed hand hyg<br>both hands and prod                            | om the medication cart. She giene and donned gloves to reeded to walk into the that time, she checked the   |  | effects from this alleged defici practice.  | ent                                   |
|                          | resident's blood sug   | ar and threw all of her ident's garbage can when she  |  | Resident 41 no longer resides in facility.  LPN 2 educated that all   |                                       |
|                          | During and intervie<br>2 indicated she was<br>tossed everything in   | w on 3/6/24 at 10:26 a.m., LPN rushing and accidentally the garbage can. She was s to be disposed of into a   |  | sharps, including but not limite glucometer lancets, have to be properly disposed of in an approved sharps container immediately after use.     |                                       |
|                          | Injury Protection Pl<br>current on 3/8/24 at<br>disposable needles/s | jection Safety and Sharps<br>an", presented by the DON as<br>3:00 p.m., indicated,"Used<br>sharps shall be discarded<br>se without recapping into an<br>intainer" |  | How will you identify other residents having the potentia to be affected by the same deficient practice and what corrective action will be take |                                       |
|                          |  |   |  | All residents have the potential to be affected by this alleged deficient practice.   | ;                                     |
|                          |  |   |  | All medication carts audito ensure that each had an approved functional sharps container attached.  | ted                                   |
|                          |  |   |  | What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?               |                                       |

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|   | OF CORRECTION  | IDENTIFICATION NUMBER  155840  | A. BUILDING  B. WING  | 00   | COMPLETED 03/11/2024 |  |  |
|---|----------------|--|---|--|----------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC. |                |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |  |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIEN | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)  | (X5) COMPLETION DATE |  |  |
|   |                |  |   | Nurses educated that all sharps, including but not limite glucometer lancets, need to be immediately disposed of in an approved sharps container.  | e                    |  |  |
|   |                |  |   | How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place?  | ty                   |  |  |
|   |                |  |   | CNO/designee will audit insulin administrations a week ensure that all sharps, includir but not limited to glucometer lancets, are immediately disport of in an approved sharps container.   | to<br>ng             |  |  |
|   |                |  |   | CNO/Designee will prese<br>the summaries of the audits to<br>Quality Assurance committee<br>monthly for six months.<br>Thereafter, if determined by th<br>Quality Assurance committee<br>further monitoring is needed, a<br>will continue. | e the<br>that        |  |  |
|   |                |  |   | Date of compliance: 04/05/24   | 4                    |  |  |

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|   |   | IDENTIFICATION NUMBER  155840  | <br>JILDING   | 00  | COMPL<br>03/11/ | ETED                       |  |
|---|---|--|---|---|-----------------|----------------------------|--|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC. |   |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |                 |                            |  |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIEN  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION   | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | TE              | (X5)<br>COMPLETION<br>DATE |  |
| F 0887<br>SS=E<br>Bldg. 00                                    | LTC facility must of policies and proces following:  (i) When COVID-1 facility, each residing is offered the COV immunization is must be en immunized;  (ii) Before offering members are provided effects associve (iii) Before offering resident or the resident represent provided with curresident | ization VID-19 immunizations. The levelop and implement dures to ensure all the  9 vaccine is available to the ent and staff member VID-19 vaccine unless the edically contraindicated or ff member has already  COVID-19 vaccine, all staff ided with education efits and risks and potential lated with the vaccine; COVID-19 vaccine, each ident representative in regarding the benefits and side effects associated effects associated effects associated evaccine; here COVID-19 vaccination loses, the resident, ative, or staff member is ent information regarding lated with the COVID-19 questing consent for any additional doses; esident representative, or the opportunity to accept or 9 vaccine, and change their medical record includes at indicates, at a minimum, |   |   |                 |                            |  |

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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/S |  | (X2) MULTIPLE A. BUILDING B. WING   |                     |   |                      |  |  |  |
|--|--|---|---------------------|---|----------------------|--|--|--|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC.  |  |   | 1532                | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311   |                      |  |  |  |
| (X4) ID<br>PREFIX<br>TAG   | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)   | (X5) COMPLETION DATE |  |  |  |
|  | COVID-19 vaccine (B) Each dose of administered to the (C) If the resident COVID-19 vaccine contraindications (vii) The facility management of the covider of | COVID-19 vaccine e resident; or did not receive the e due to medical or refusal; and aintains documentation oVID-19 vaccination that mum, the following: e provided education efits and potential risks | F 0887              | POC for F887 – COVID-19 Immunization  What corrective action(s) who be accomplished for those residents found to have been affected by the deficient practice?  No residents suffered are effects from this alleged deficient practice.  Residents 41, 77, 198, and 247 no longer reside in facility. | ny ill<br>sient      |  |  |  |

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|   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840   | (X2) MULTIPLE CO<br>A. BUILDING<br>B. WING                              | onstruction<br><u>00</u>  | (X3) DATE SURVEY COMPLETED 03/11/2024 |  |  |
|---|---|---|---|---|---------------------------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC. |   |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |   |                                       |  |  |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIEN<br>REGULATORY OR   | STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRI<br>DEFICIENCY)   | (X5) COMPLETION DATE                  |  |  |
|   | provided.  c. Resident 198 was admitted on 2/22/24. There was no documentation of a signed consent or refusal of the COVID vaccine or of education being provided.            |   |   | How will you identify other residents having the potent to be affected by the same deficient practice and what corrective action will be take   |                                       |  |  |
|   | no documentation o  | s admitted on 3/3/24. There was f a signed consent or refusal ine or of education being   |   | All residents have the potential to be affected by this alleged deficient practice.   | s                                     |  |  |
|   | Infection Prevention had not been offering their new pharmacy. The pharmacy would vaccinations to be a the pharmacy staff I clinics for the COV have requested constitutions. | on 3/8/24 at 10:46 a.m., the in (IP) manager indicated they ing COVID vaccinations since it transitioned in January 2024. Id not send the vials for the indinistered by staff, however, have come and provided ID-19 vaccine previously. Staff sent forms for COVID inve not yet received them. |   | House audit of all reside completed to ensure that all residents have been offered to Covid-19 vaccine, education provided, consent/declination obtained, and resident provid with vaccine if consent was obtained.                             | the                                   |  |  |
|   | Director of Nursing   | y, on 3/8/24 at 12:56 p.m., the (DON) indicated he was ifications of offering the   |   | What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?   |                                       |  |  |
|   |   |   |   | Nurses educated that<br>Covid-19 vaccination needs to<br>offered to all residents on<br>admission, education provide<br>consent/declination obtained<br>documented, and IP nurse/Clinotified of any consents so<br>vaccine can be administered. | and<br>NO                             |  |  |

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|   | T OF DEFICIENCIES  OF CORRECTION | IDENTIFICATION NUMBER  155840  | A. BUILDING  B. WING  | 00   | COMPLETED 03/11/2024 |  |  |
|---|----------------------------------|--|---|--|----------------------|--|--|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC. |                                  |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |  |                      |  |  |
| (X4) ID<br>PREFIX<br>TAG                                      | (EACH DEFICIENC                  | STATEMENT OF DEFICIENCIE<br>CY MUST BE PRECEDED BY FULL<br>LSC IDENTIFYING INFORMATION | ID<br>PREFIX<br>TAG   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE |  |  |
|   |                                  |  |   | Covid-19 Vaccination Consent/Declination Evaluation added to PCC and set to trigg on all new admissions to ensu vaccine is offered to all reside   | er<br>re             |  |  |
|   |                                  |  |   | How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quali assurance program will be p into place?  | ty                   |  |  |
|   |                                  |  |   | CNO/Designee will audit new admissions to ensure tha Covid-19 vaccine was offered education provided, consent/declination obtained, vaccine administered if consent  | t<br>,<br>and        |  |  |
|   |                                  |  |   | CNO/Designee will prese<br>the summaries of the audits to<br>Quality Assurance committee<br>monthly for six months.<br>Thereafter, if determined by th<br>Quality Assurance committee<br>further monitoring is needed, a<br>will continue. | o the<br>ne<br>that  |  |  |
|   |                                  |  |   | Date of compliance: 04/05/24   | 4                    |  |  |
| R 0000  |                                  |  |   |  |                      |  |  |

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| AND PLAN OF CORRECTION  |  | IDENTIFICATION NUMBER  155840   |   | JILDING             | 00  | COMPL<br>03/11/     | ETED                       |
|---|--|---|---|---------------------|---|---------------------|----------------------------|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC. |  |   | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |                     |   |                     |                            |
| (X4) ID<br>PREFIX<br>TAG<br>Bldg. 00                          | SUMMARY STATEMENT OF DEFICIENCIE  (EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION   |   |   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)  | ΓE                  | (X5)<br>COMPLETION<br>DATE |
| Diug. 00  | Survey. This visit in State Licensure Survey. Complaints IN0042. IN00426751, IN004 IN00429885.  Complaint IN00424 related to the allegated to the allegations are complaint IN00427 the allegations are complaint IN00427 the allegations are complaint IN00429 related to the allegated to the allegat | 751 - Federal/State deficiencies tions are cited at F554.  100 - No deficiencies related to ited.  561 - No deficiencies related to ited.  885 - Federal/State deficiencies tions are cited at F677.  h 4, 5, 6, 7, 8, and 11, 2024.  3462  28  ort Dyer Llc was found to be in 0 IAC 16.2-5 in regard to the censure Survey. | R 00  | 000                 | Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.  This facility respectfully request desk review for the given citati in this survey. Please see all attached documentation for yo consideration. | the<br>sts a<br>ons |                            |

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|   |                | XI) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER<br>155840 | (X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING |   | (X3) DATE SURVEY  COMPLETED  03/11/2024                                |    |            |
|---|----------------|---|--|---|--|----|------------|
| NAME OF PROVIDER OR SUPPLIER  IGNITE MEDICAL RESORT DYER LLC. |                |   |  | STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 |  |    |            |
| (X4) ID   | SUMMARY        | STATEMENT OF DEFICIENCIE                                      |  | ID  | PROVIDER'S PLAN OF CORRECTION  |    | (X5)       |
| PREFIX  | (EACH DEFICIEN | CY MUST BE PRECEDED BY FULL                                   |  | PREFIX  | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA | TE | COMPLETION |
| TAG   | REGULATORY OR  | LSC IDENTIFYING INFORMATION                                   |  | TAG   | DEFICIENCY)  |    | DATE       |
|   |                |   |  |   |  |    |            |

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