STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155844	A. BUILDING _____ B. WING _____	C 07/02/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00437236. Complaint IN00437236 - Federal/state deficiencies related to the allegations are cited at F757. Survey dates: July 2, 2024. Facility number: 013688 Provider number: 1550844 AIM number: 201352370 Census Bed Type: SNF/NF: 15 SNF: 53 Residential: 25 Total: 93 Census Payor Type: Medicare: 28 Medicaid: 13 Other: 27 Total: 68 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/8/24.	F 000		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-	F 757		

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

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F 757	Continued From page 1 §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure each resident's medication regimen was managed and monitored to promote or maintain the resident's highest practicable mental, physical, and psychosocial well-being, related to a resident receiving an anti-anxiety medication due to a transcription error for 1 of 3 residents reviewed for unnecessary medications. (Resident C) The deficient practice was corrected on 6/21/24, prior to the start of the survey, and was therefore past noncompliance. The facility identified the concern, completed audits of new admission medication orders, required two nurses to verify admission medications, and completed an inservice for staff on confirmation of admission medications. Finding includes:	F 757	Past noncompliance: no plan of correction required.	

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F 757	Continued From page 2	F 757		

Resident C's closed record was reviewed on 7/2/24 at 9:05 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and anxiety disorder. The resident was readmitted to the facility on 6/14/24.

The Admission Minimum Data Set (MDS) assessment, dated 6/18/24, indicated the resident was cognitively impaired and had received anti-anxiety medications.

A care plan, updated 6/6/24, indicated the resident had an anxiety disorder and used anti-anxiety medications. The interventions included, to give the anti-anxiety medication as ordered by the Physician and monitor for side effects and effectiveness.

The Hospital Discharge Medication List, dated 6/14/24, indicated an order for alprazolam (Xanax, an anti-anxiety medication) 0.5 milligrams (mg) three times a day as needed for anxiety.

A Physician's Order, dated 6/15/24, indicated to give alprazolam 0.5 mg three times a day for anxiety. The medication order was put in as scheduled, not PRN (as needed).

The Medication Administration Record (MAR), dated 6/2024, indicated the resident received the alprazolam medication scheduled on the following dates:
6/16/24 at 8:00 p.m.
6/17/24 at 8:00 a.m., 2:00 p.m., and 8:00 p.m.

There was a lack of any documentation the resident had experienced any anxiety or any

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F 757	Continued From page 3	F 757		

behaviors to require the use of the alprazolam PRN (as needed).

A Progress Note, dated 6/18/24 at 3:51 p.m., indicated the resident had been sleeping on and off all day. The nurse had updated the resident's family on the resident's status and informed the family the resident had been receiving alprazolam. The resident's family requested the medication be put on hold.

A Skilled Nursing Evaluation, dated 6/18/24, indicated the resident was very lethargic and slept all day.

A Bed Hold Policy/Ombudsman Notification Form, dated 6/18/24, indicated the resident was lethargic, had a low heart rate, and altered mental status.

An Indiana Department of Health (IDOH) reportable incident, dated 6/21/24, indicated the facility was made aware of a concern with the resident's medication by the resident's family. The facility's investigation indicated the resident had experienced a change in condition and was sent out to the hospital on 6/18/24 due to lethargy and the family's request. The resident's medications had been reviewed and she had received four scheduled doses of alprazolam 0.5 mg since she had been readmitted to the facility.

During an interview on 7/2/24 at 11:23 a.m., the Chief Nursing Officer (CNO) and the Vice President of Clinical Operations indicated the resident was sent to the hospital on 6/18/24 due to lethargy and per the family's request. The family reported a concern with the resident's medications and upon review, the facility noted

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F 757	Continued From page 4	F 757		

the alprazolam order had been put in as a scheduled order instead of a PRN order. The resident had received four scheduled doses of alprazolam 0.5 mg. She had not received over the intended Physician's ordered dosage of 0.5 mg three times a day. They were unable to provide any further documentation that the resident had experienced any anxiety or behaviors to warrant administering any PRN alprazolam. Once they had identified the concern, they completed audits of all new admission medication orders, required two nurses to verify admission medications, and completed an inservice for staff on confirmation of admission medications. A Nurse Manager was also to review all admission medications within 24 hours of admission.

This citation relates to Complaint IN00437236.

3.1-48(a)(6)