STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
IGNITE MEDICAL RESORT DYER LLC.	1532 CALUMET AVENUE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00438865, IN00439338, IN00439371, IN00439585, and IN00439697. Complaint IN00438865 - Federal/State deficiencies related to the allegations are cited at F624 and F684. Complaint IN00439338 - No deficiencies related to the allegations are cited. Complaint IN00439371 - Federal/State deficiencies related to the allegations are cited at F641 and F689. Complaint IN00439585 - Federal/State deficiencies related to the allegations are cited at F656, F684 and F732. Complaint IN00439697 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: August 5, 6, and 8, 2024 Facility number: 013462 Provider number: 155840 Census Bed Type: SNF: 96 Residential: 25 Total: 121 Census Payor Type: Medicare: 49 Other: 47	F 0000	Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Matula	General Manager	08/29/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Total: 96 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 8/14/24.			
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to provide and document sufficient information for a resident who was being transferred to the hospital Emergency Room (ER), related to the circumstances of a resident being transferred to the ER not documented in the resident's record and transfer information was not provided to the Emergency Medical Services (EMS) and hospital, for 1 of 3 residents reviewed for transfers and discharges. (Resident E) Finding includes: Resident E's record was reviewed on 8/6/24 at 10:25 a.m. The diagnoses included, but were not limited to, metabolic encephalopathy. The Census Form indicated the resident was discharged from the facility on 7/19/24. The discharge status was not listed on the Discharge, return not anticipated Minimum Data	F 0624	**POC for F624 Preparation for Safe/Orderly Transfer/Dschrg** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident E no longer resides in this facility so no corrective action can be accomplished. **How will you identify other residents having the potential 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.	09/06/2024

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	Set assessment, dated 7/19/24. There was no documentation in the Nurses' Progress Notes, dated 7/19/24, the resident had a change of condition, was transferred to the ER, and/or discharged from the facility. There was no Transfer Form or Discharge Form that indicated the resident had been transferred or discharged from the facility. The Hospital ER Notes, dated 7/19/24, indicated the resident had lost consciousness when he had been transferred from the bed to the chair. There was no prolonged loss of consciousness. During an interview on 8/6/24 at 11:41 a.m., the Director of Nursing (DON) indicated the family member had called 911 for the transfer. There was no documentation in the record that indicated the resident had a change of condition and no transfer sheet had been completed. The DON was unable to determine if any paperwork was sent with the resident or if the hospital ER was notified with information about the resident. He indicated the circumstances about the transfer should have been documented in the record. This citation relates to Complaint IN00438865. 3.1-12(a)(21)		House audit was completed for any residents transferred to the hospital to ensure E Interact form, progress note, bed hold policy, and report given to hospital are completed in EMR. **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 were educated to ensure E Interact form, progress notes, bed hold policy and report given to hospital are all completed in EMR for residents discharging to hospital including when 911 call is self or family initiated. IDT team educated to audit discharges/transfers to ensure proper documentation is in place during morning clinical meeting. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit transfers to the hospital 5xs a week to ensure E Interact form, progress note, bed hold policy and	

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			report to hospital are completed and documented. The CNO/Designee 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 needed, audits will continue. **Date of compliance: 9/6/24**	
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed related to falls, medications, and behaviors for 2 of 8 MDS assessments reviewed. (Residents G and J) Findings include: 1. Resident G's record was reviewed on 8/8/24 at 9:21 a.m. The diagnoses included, but were not limited to, dementia. An Admission MDS assessment was completed on 6/26/24. The MDS indicated there had been no	F 0641	**POC for F641 Accuracy of Assessments** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident G no longer resides in this facility so no corrective action can be accomplished. Resident J no longer resides in this facility so no	09/06/2024

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	behaviors, no falls, and the resident had not received an antipsychotic medication. The Nurses's Progress Notes indicated the resident had fallen on 6/22/24 at 11:06 a.m., 6/23/24 at 9:45 a.m., and 6/24/24 at 10:33 p.m. The Physician's Orders, dated 6/23/24, indicated olanzapine (antipsychotic) 10 milligrams daily was ordered for bipolar disorder with behaviors. The Medication Administration Record, dated 6/2024, indicated the resident had 4 episodes of behaviors on 6/24/24 on the evening shift. A Nurse's Progress Note, dated 6/24/24 at 11:33 p.m., indicated Resident G was in the Unit Dining Room with magazines and a cup of water in front of him. He stood from the wheelchair, lost his balance and fell. There were no injuries. A Nurse's Progress Note, dated 6/25/24 at 1:04 a.m., indicated the resident transferred himself out of bed and propelled himself to the bathroom in the wheelchair. A CNA attempted to assist him and he became agitated, yelling, cursing, and calling the staff names. Resident G attempted several times to hit the staff with his fist. Redirection, one on one care, and assistance with toileting was attempted and were unsuccessful. He continued to yell foul language and told the staff to leave. He was offered snacks and juice. The Psychiatric Nurse Practitioner was notified. During an interview on 8/8/24 at 11:49 a.m., MDS LPN 2, indicated the Admission MDS had not been coded correctly. 2. Resident J's record was reviewed on 8/8/24 at 2:11 p.m. The diagnoses included, but were not		corrective action can be accomplished. **How will you identify other residents having the potential 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. House audit was completed for residents with falls to ensure accuracy of MDS coding. House audit was completed for residents on anti-psychotic medications to ensure accuracy of MDS coding. House audit was completed for residents with documented behaviors to ensure accuracy of MDS coding. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** LPN 2/MDS department was educated on the importance of coding MDS accurately and per RAI guidelines. IDT team will review residents during clinical meeting	

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	limited to, diabetes mellitus. An Admission MDS assessment, dated 6/26/24, indicated there had been no falls since admission into the facility. A Nurse's Progress Note, dated 6/21/24 at 12 p.m., indicated the resident had an unwitnessed fall and was found on the floor in her room next to her bed. The Director of Nursing was informed of the incorrect MDS on 8/8/24 at 3:38 p.m., no further information was provided. This citation relates to Complaint IN00439371. 3.1-31(i)		to ensure the information including but not limited to falls, behaviors, and medications that pertains to MDS has been discussed for accurate coding. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** GM/Designee will audit 5 MDS weekly to ensure accuracy of assessments including but not limited to falls, behaviors, and medications has been coded accurately on residents MDS. The GM/Designee 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 needed, audits will continue. **Date of compliance: 9/6/24**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan §483.21(b) Comprehensive Care Plans			

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	§483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with			

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	the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. Based on observation, record review, and interview, the facility failed to ensure individualized Care Plans were developed and implemented related to a knee immobilizer and behaviors for 2 of 8 residents reviewed for care plans. (Resident J and G) See F744 for additional information regarding Resident G. Findings include: 1. During an observation on 8/5/24 at 10:53 a.m., Resident J was in the bathroom sitting in a wheelchair. There was a knee immobilizer on the left lower extremity. The resident indicated she had a pressure sore from the immobilizer that started out as a blister. During an observation on 8/6/24 at 11:04 a.m. with LPN Wound Nurse 3 and LPN Wound Nurse 4, LPN Wound Nurse 3 completed a treatment on the left heel wound and left posterior ankle wound. Both areas were dried. LPN Wound Nurse 3 indicated the immobilizer slid down and the staff continued to pull the immobilizer back up. There was a pad that went under the immobilizer to prevent pressure issues. The treatments were applied and the immobilizer was reapplied with the padding underneath to assist with pressure prevention.	F 0656	**POC for F656 Develop/Implement Comprehensive Care Plan** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident J no longer resides in this facility so no corrective action can be accomplished. Resident G no longer resides in this facility so no corrective action can be accomplished. **How will you identify other residents having the potential 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. House audit was completed for residents with orthotic devices, including but not limited to braces, immobilizers, slings, and surgical	09/06/2024

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	Resident J's record was reviewed on 8/8/24 at 2:11 p.m. The diagnoses included, but were not limited to, diabetes mellitus and left knee fracture. A Physician's Order, dated 6/20/24, indicated a left leg immobilizer was to remain on at all times. There was no care plan for the left knee immobilizer and care to assist with prevention of pressure ulcers. During an interview on 8/8/24 at 3:38 p.m., the Director of Nursing indicated there had been no care plan for the left leg immobilizer. 2. Resident G's record was reviewed on 8/8/24 at 9:21 a.m. The diagnoses included, but were not limited to, dementia. Cross Reference F744. The Medication Administration Record (MAR), dated 6/2024, indicated episodes of behaviors were documented on the following days: On 6/24/24, evening shift, there were four episodes of behaviors. He was redirected, one on one given and the provider was notified of the changes. The interventions were effective. On 6/28/24, evening shift, there were four episodes of behaviors. There were no interventions provided. On 6/29/24, evening shift, there were four episodes of behaviors. He was redirected and one on one care was given. The outcome of the interventions was not documented. On 6/30/24, day shift, there were 4 episodes of behaviors. He was redirected and one on one care		shoes, to ensure a care plan is in place and includes interventions for the prevention of pressure ulcers. House audit was completed for residents with behaviors to ensure personalized care plan identifying behaviors and interventions is in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** DOR educated to bring a list of residents with orthotic devices to clinical meeting daily to review with IDT team to ensure a care plan is in place and includes interventions for the prevention of pressure ulcers. Nursing staff educated to document behaviors in progress notes, including but not limited to behavior being displayed, interventions, and effectiveness. IDT team will discuss residents with documented behaviors during morning clinical meeting to ensure proper documentation is in place, including but not limited to effectiveness of interventions and personalized care plan in place.	

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	provided. The outcome of the interventions was not documented The Medication Administration Record (MAR), dated 7/2024, indicated episodes of behaviors were documented on the following days: On 7/1/24, day shift there was one episode. He was redirected and removed from his peers. The interventions were effective. On 7/1/24, evening shift, there were three episodes, he was redirected and the the intervention was effective. On 7/2/24, evening shift, there were three episodes, he was redirected and the intervention was effective. On 7/3/24, evening shift, there were two episodes, he was redirected and the intervention was effective. On 7/5/24, evening shift, there was one episode, he was removed from the environment and the intervention was not effective. On 7/6/24, day shift, there was one episode, no interventions documented. On 7/6/24, evening shift, there were two episodes, he was redirected and the intervention was effective. On 7/7/24, day shift, there were two episodes. There were no interventions documented. On 7/12/24, evening shift, there were three episodes. He was redirected and the intervention was effective.		**How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit residents with orthotic devices 5xs a week to ensure care plan is in place including interventions for prevention of pressure ulcers. CNO/Designee will audit documented behaviors 5xs a week to ensure personalized care plan is in place, including but not limited to interventions and effectiveness. The CNO/Designee 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 needed, audits will continue. **Date of compliance: 9/6/24**	

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	On 7/13/24, day shift, there was one episode, he was redirected and the intervention was effective. The resident had no care plan for behaviors. During an interview on 8/8/24 at 1:27 p.m., the Social Service Director indicated there was no care plan for the resident's behaviors. This citation relates to Complaint IN00439585. 3.1-25(a)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident received the necessary care and services related to antibiotics not administered, a blood sugar level not obtained, and physician notification of elevated blood sugar levels not completed as ordered for 1 of 8 residents reviewed for quality of care. (Resident B) Finding includes: Resident B's record was reviewed on 8/5/24 at 11:10 a.m. The diagnoses included, but were not limited to, diabetes mellitus and an abscess of the	F 0684	**POC for F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident B no longer resides in this facility so no corrective action can be accomplished. **How will you identify other residents having the potential to be affected by the same**	09/06/2024

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	abdominal wall. An Admission Minimum Data Set assessment, dated 6/14/24, indicated the resident received insulin, an antibiotic, and a hypoglycemic medication. A Care Plan, dated 6/17/24, indicated insulin was received. The interventions included the blood glucose would be monitored as ordered and hyperglycemia protocol would be followed as ordered by the physician. (a) A Physician's Order, dated 6/17/24, indicated ceftriaxone sodium (antibiotic), 1 gram was to be administered once a day for seven days for an abdominal wall abscess. The Medication Administration Record (MAR), dated 6/2024 indicated the ceftriaxone sodium was marked as not administered on 6/18/24. The antibiotic was administered on June 19, 20, 21, 22, 23, and 24, 2024 and was only administered for six days. A Physician's Order, dated 6/29/24, indicated cephalexin (antibiotic) 500 milligrams (mg), one capsule was to be administered three times a day for a urinary tract infection. The MAR, dated 6/2024, indicated the antibiotic had not been administered on 7/6/24 at 5 p.m. (b) A Physician's Order, dated 6/24/24, indicated the blood glucose was to be checked three times a day before meals and Novolog (regular insulin) was to be administered per the results of the blood glucose results (sliding scale). The dose of insulin was to be 10 units if the blood glucose result was 351 or more and the physician was to		**deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed for residents on anti-biotic therapy to ensure all doses have been administered as ordered. House audit was completed for residents to ensure blood glucose monitoring is completed, insulin administered as ordered and Physician notification is documented per order parameters. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing team educated on ensuring all doses of antibiotic therapy are administered as ordered and on the necessity to notify Physician of any missed doses and update orders per Physician order. Nursing team educated on ensuring blood glucose monitoring is completed, insulin administered as ordered and Physician is notified of any abnormal results based on order parameters.	

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	be notified. The MAR, dated 7/2024, indicated the blood glucose had not been monitored and insulin administration not received if needed at 4 p.m. on 7/6/24. The following blood glucose results were 351 or above. The physician had not been notified of the high blood glucose levels: On 6/24/24 at 4 p.m., the blood glucose was 484. On 6/25/24 at 4 p.m., the blood glucose was 351. On 6/26/24 at 11 a.m., the blood glucose was 400. On 6/27/24 at 6 a.m., the blood glucose was 391, at 11 a.m. it was 515, and at 4 p.m. it was 462. On 6/28/24 at 6 a.m., the blood glucose was 483 and at 4 p.m. it was 368. The MAR, dated 7/2024, indicated on 7/11/24 at 4 p.m., the blood glucose was 375 with no physician notification. During an interview on 8/5/24 at 2:06 p.m., the Director of Nursing indicated the the antibiotics had not been administered and the blood glucose had not been obtained as ordered. During an interview on 8/5/24 at 3:43 p.m., the Director of Nursing indicated there had been no documentation that indicated the physician had been notified of the blood glucose results of 351 and over. This citation relates to Complaints IN00438865 and IN00439585. 3.1-37		IDT team education to review antibiotic administrations to ensure correct amount of doses have been given pertaining to order, blood glucose monitoring is completed, and Physician notification is documented when required. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** IP Nurse/Designee will audit residents on anti-biotic therapy 5xs a week to ensure medication has been administered per order and Physician notified of any missed doses, and order was updated according to Physicians orders. CNO/Designee will audit residents on blood glucose monitoring 5xs a week to ensure monitoring has been completed, insulin was administered per orders, and Physician notification documented per order parameters. The CNO/Designee 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 needed,	

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			audits will continue. **Date of compliance: 09/06/24**	
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to ensure a thorough investigation of a fall was completed which included the root cause of the fall and failed to initiate an intervention related to the circumstances of the fall, for 1 of 3 residents reviewed for falls. (Resident D) Finding includes: Resident D's record was reviewed on 8/6/24 at 9:11 a.m. The diagnoses included, but were not limited to, dementia. An Admission Cognitive Assessment, completed on 7/18/24 by Social Service, indicated a severe cognitive impairment. An Admission Fall Risk Assessment, completed by nursing staff on 7/18/24, indicated a high risk	F 0689	**POC for F689 Free of Accident Hazards Supervision Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D no longer resides in this facility so no corrective action can be accomplished. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the	09/06/2024

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	for falls. A Care Plan, dated 7/18/24, indicated a risk for falls. The interventions included a possible root cause of the fall would be determined and the potential cause of the fall would be altered and/or removed. A Nurse's Progress Note, dated 7/22/24 at 10:38 p.m., indicated there resident was observed on the floor. The resident had indicated he "just wanted to see what the world looked like from the bottom up." He denied falling. He was assisted off the floor and back into the wheelchair by two staff members. He was educated to use the call light. The Fall Investigation, dated 7/22/24 at 8:45 p.m. and received from the Director of Nursing (DON), indicated the resident was found on the floor, was assessed for injuries and then placed back into the wheelchair prior to being assisted with changing and getting ready for bed. The predisposing situation factors included, the call light was in reach, a wheelchair had been in use, footwear was in place, and the wheelchair was unlocked. A note at the end of the investigation, dated 7/23/24, indicated a fall mat was placed at the bedside. A Nurse's Note, dated 7/23/24 at 8:55 a.m., indicated an un-witnessed fall occurred on 7/22/24 and the resident had been observed on the floor beside the bed. He was unable to describe the circumstances leading up to the fall and a fall mat had been placed immediately by the bedside. The investigation had not indicated when the resident had been observed prior to the fall nor the root cause of the fall. The intervention initiated immediately after the fall indicated he was		potential to be affected by this alleged deficient practice. House audit was completed for residents with a fall to ensure thorough investigation was completed, root cause identified, and intervention was in place and appropriate. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** CNO/IDT team educated on completion of thorough fall investigation including root cause analysis and appropriate intervention related to the circumstances of fall. Nursing team educated on documentation of falls to include completion of risk management, and thorough progress note including but not limited to the circumstances of fall and last time resident was seen. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** GM/Designee will audit falls 5xs a week during clinical meeting	

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	educated to use the call light. The resident was assessed with a severely impaired cognitive status. During an interview on 8/6/24 at 1:24 p.m., the DON indicated he thought the resident had rolled out of bed and the intervention post-fall was a mat was placed on the floor next to the bed. The investigation had not included the last time the resident had been observed prior to the fall or the root cause of the fall. During an interview on 8/6/24 at 1:50 p.m., the DON indicated staff discussed falls every morning and thought the resident had fallen from the bed. During an interview on 8/6/24 at 2:11 p.m., LPN 1 indicated she was the nurse on duty at the time of the fall. The resident had been sitting in his wheelchair before the fall but no prior observation time was documented. The facility's fall prevention policy, dated 5/2024 and received from the DON as current, did not include a post fall protocol. This citation refers to Complaint IN00439371. 3.1-45(a)		to ensure fall investigation is through, root cause identified, and intervention is appropriate based on circumstance of fall. The GM/Designee 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 needed, audits will continue. **Date of compliance: 09/06/24**	
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of			

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	licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information was current and included only the staff who were scheduled for Long Term Care. This had the potential to affect all residents who resided in the facility during July and August, 2024. Findings include:	F 0732	**POC for F732 Posted Nurse Staffing Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Staffing sheet was immediately placed at front desk.	09/06/2024

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	1. The facility was entered on 8/5/24 at 7:34 a.m. The Nurse Staffing Information was posted at the Receptionist Desk by the entry door to the facility. The date on the Nurse Staffing Information was 8/1/24. During an interview on 8/5/24 at 9:22 a.m., the Director of Nursing indicated he would leave the posting information in a binder for the Weekend Manager to post. 2. The schedules and Nurse Staffing Information Postings for July 1 through July 31, 2024 were reviewed on 8/5/24 at 5:00 p.m. During an interview on 8/6/24 at 7:49 a.m., the Administrator indicated the Nurse Staffing Information postings included the Assisted Living Staff also and just realized on 8/5/24 they were included on the postings. This citation relates to Complaint IN00439585.		**How will you identify other residents having the potential 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. Staffing sheets requested by surveyor were immediately corrected to reflect long term care staff only and provided to surveyor in building at the time survey. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** CNO/ACNO educated to ensure the posted Nurse Staffing Information was current and included only the staff who were scheduled for Long term care. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** GM/Designee will audit staffing sheets 5xs a week to ensure current day is posted and only includes long term care staff.	

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			The GM/Designee 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 needed, audits will continue. **Date of compliance: 09/06/24**	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based record review and interview, the facility failed to ensure a resident with dementia received appropriate treatment and services to meet his needs, related to ongoing behaviors without input from the Interdisciplinary Team (IDT) and Social Service, no identification of behavior type, no Care Plan with interventions for the behaviors, no updated nursing interventions for the behaviors, no interventions attempted, and no interventions attempted for the behaviors before medication was administered, for 1 of 1 resident reviewed for dementia/behaviors. (Resident G) Finding includes:	F 0744	**POC for F744 – Treatment/Services for Demetia** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident G no longer resides in facility so no corrective action can be accomplished. **How will you identify other residents having the potential to be affected by the same**	09/06/2024

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	Resident G's record was reviewed on 8/8/24 at 9:21 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 6/26/24, indicated a severely impaired cognitive status, no behaviors, no impairment of the bilateral upper extremities, impairment of the bilateral lower extremities, moderate assistance required with chair to bed transfers, supervision with wheelchair mobility, moderate assistance with ambulation of 10 feet, no falls, and received an anti-anxiety medication. There was no Care Plan for behaviors. A Physician's Order, dated 6/21/24, indicated, "resident specific targeted behavior/s: (specify)...", no behaviors were listed. The interventions were, #1 - redirect, #2 - remove from environment, #3 - remove objects of self harm, #4 - remove peers from area, #5 - provide 1 on 1 time/validation, #6 - notify providers of clinical changes. The outcome of the interventions and the number of episodes were to be documented. A Physician's Order, dated 6/21/24, indicated, "TARGETED BEHAVIOR: Resident specific targeted behavior/s (specify)..." The interventions were #1 - redirect, #2 - remove from environment, #3 - see notes, #4 - PRN (as needed) given. The outcome to the interventions and number of episodes were to be documented. A Physician's Order, dated 6/21/24, indicated prior to the administration of any PRN psychotropic medication (antidepressants, anti-anxiety, stimulants, antipsychotics, and mood stabilizers), non-pharmacological interventions were to be attempted and the response was to be		**deficient practice and what corrective action will be taken?** Residents with a diagnosis of dementia, and/or targeted behavior, have the potential to be affected by this alleged deficient practice. Full house audit of residents with a diagnosis of dementia and/or specific targeted behaviors was completed to ensure; IDT, including social services, has review, discussed, and implemented residents plan of care as a team. Targeted behaviors, if any, are identified with effective interventions. Careplans are resident centered related to behaviors and interventions. Full house audit of residents receiving PRN psychotropics for behaviors was completed with IDT and psych services to ensure the PRN medication is appropriate and effective **What measures will be put into place or what systemic changes you will make to ensure that the deficient**	

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	documented. A Psychiatry Consult, dated 6/22/24 at 7:03 a.m., indicated they would follow the resident for management of psychotropic medications. A Nurse's Behavior Progress Note, dated 6/23/24 at 6:51 a.m., indicated the resident was restless throughout the night shift. There were multiple exit seeking attempts made through the emergency exit doors. He was verbally abusive and at times was combative with attempts to redirect. He continued to stand from the wheelchair and walk around the the unit while he looked for an exit door and voiced he was going home. Scheduled medications to treat the restlessness were ineffective. One on one care was recommended. Physician's Orders, dated 6/23/24, indicated olanzapine (antipsychotic) 10 mg (milligrams) daily for behaviors and lorazepam (anti-anxiety) 0.5 mg every 12 hours for anxiety. A Nurse's Progress Note, dated 6/23/24 at 4:11 p.m., indicated the resident stood up from the wheelchair, attempted to walk and fell. There were no injuries. A Nurse's Progress Note, dated 6/24/24 at 11:33 p.m., indicated the resident was in the Unit Dining Room with magazines and a cup of water in front of him. He stood from the wheelchair, lost his balance and fell. There were no injuries. A Nurse's Progress Note, dated 6/25/24 at 1:04 a.m., indicated the resident transferred himself out of bed and propelled himself to the bathroom in the wheelchair. A CNA attempted to assist him and he became agitated, yelling, cursing, and		**practice does not recur?** Nursing staff was educated on; thoroughly documenting all resident specific behaviors with each episode thoroughly documenting all interventions attempted with effectiveness of intervention. attempting nonpharmacological interventions and documenting effectiveness prior to administration of any PRN psychotropic **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit progress notes 5xs a week to ensure residents with a diagnosis of dementia with behaviors, and/or residents who have had a behavior have appropriate documentation of targeted behaviors, documented non-pharmacological interventions with effectiveness, and all PRN psychotropic administrations have appropriate nonpharmacological interventions documented prior to administration and effectiveness of PRN medication documented.	

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	calling the staff names. He attempted several times to hit the staff with his fist. Redirection, one on one care, and assistance with toileting was attempted and were unsuccessful. He continued to yell foul language and told the staff to leave. He was offered snacks and juice. The Psychiatric Nurse Practitioner was notified. A Psychiatric Nurse Practitioner Progress Note, dated 6/28/24 at 4:30 p.m., indicated there were concerns with dementia with psychosis and adjustment anxiety disorder. The staff reported psychotic behaviors of agitation, yelling, cursing, and inappropriate language. He attempted several time to hit the nursing staff with his fist. Staff provided one on one care and toileting and they were unsuccessful. The resident had made several attempts to exit the facility. The olanzapine and lorazepam was to be continued. A Nurse's Behavior Note, dated 6/29/24 at 2:51 p.m., indicated the resident was not easily directed and required extensive monitoring from the staff. He was displaying exit seeking behavior and would stand from the wheelchair and had an unsteady gait. A Nurse's Progress Note, dated 6/29/24 at 10:39 p.m., indicated the resident was ambulating in his room. The nursing staff attempted to assist the resident and he began to yell obscenities towards the staff and told them to get out. The nursing staff continued to monitor and supervise the resident. He attempted to enter other residents' rooms. The nursing staff provided one on one redirection and food. He accepted the food. A Nurse's Behavior Note, dated 6/30/24 at 2:30 p.m., indicated the resident required frequent monitoring. He would stand up from his		CNO/Designee will audit progress notes 5xs a week to ensure any new residents with diagnosis of dementia and/or new targeted behaviors identified are reviewed by IDT with social services input to ensure target behavior and appropriate interventions are added to careplans. CNO/Designee 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 needed, audits will continue. **Date of compliance: 9/6/2024**	

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	wheelchair and has an unsteady gait. The staff assisted with toileting needs, meals, and fluids were given. He verbalized he wanted to get to his car and go home. He propelled himself to the exit doors and attempted to leave the facility. He became verbally hostile while staff attempted to redirect. He cursed at the staff and threatened to hit the staff. The Medication Administration Record (MAR), dated 6/2024, indicated episodes of behaviors were documented on the following days: - On 6/24/24, evening shift, there were four episodes of behaviors. He was redirected, one on one care was given and the provider was notified of the changes. The interventions were effective. - On 6/28/24, evening shift, there were four episodes of behaviors. There were no interventions provided. - On 6/29/24, evening shift, there were four episodes of behaviors. He was redirected and one on one care was given. The outcome of the interventions was not documented. - On 6/30/24, day shift, there were 4 episodes of behaviors. He was redirected and one on one care provided. The outcome of the interventions was not documented. There were no specific targeted behaviors listed. There were no times documented when the behavior occurred. The MAR, dated 6/2024, indicated, "TARGETED BEHAVIOR: Resident specific targeted behavior/s (specify)..." The interventions were #1 - redirect, #2 - remove from environment, #3 - see notes, #4 - PRN (as needed) given. The outcome to the interventions and number of episodes were to be documented. were monitored. Each day and shift was initialed with a check mark. There was no			

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	number of episodes, interventions attempted or outcomes documented. A Behavior Progress Note, dated 7/1/24 at 8:15 a.m., indicated the resident ambulated out of his room. He had urinated on the floor. The staff redirected him back to his room. He was yelling and cursing at the staff. The staff were unable to get his clothes and brief changed. He had hit a nurse three times. The nurse left the room. The other staff attempted to get his clothing changed and he drew a fist and stated to leave him alone and verbally threatened to hit the staff. Staff redirected the resident and after several attempts he allowed the staff to clean him and change his clothing. A Nurse's Progress Note, dated 7/3/24 at 1:10 a.m., indicated the resident was combative and verbally abusive toward the staff. He had grabbed and pulled a staff member's arm multiple times while being redirected to the wheelchair. He cursed throughout the shift. The Nurse Practitioner was notified and orders were obtained to transfer the resident to the Emergency Room for an evaluation. A Nurse's Progress Note, dated 7/3/24 at 2 a.m., indicated the resident returned to the facility from the Emergency Room with no new orders. A Social Service Note, dated 7/3/24 at 9:39 a.m., indicated referrals for long term care placement would be sent as requested from the resident's family. Physician's Orders, dated 7/3/24, indicated olanzapine 10 mg every 12 hours for dementia/psychotic disturbances, trazodone (anti-anxiety) 50 mg at bedtime, and lorazepam 0.5			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	mg every 12 hours as needed for adjustment disorder with anxiety for 14 days. A Medication Administration Note, dated 7/5/24 at 7:15 p.m., indicated the resident was very anxious and aggressive. The lorazepam 0.5 mg was administered. There was no documentation of any prior interventions attempted. The MAR, dated 7/2024, indicated the lorazepam 0.5 mg was administered on 7/5/24 at 7:15 p.m. and was ineffective. A Nurse's Behavior Note, dated 7/5/24 at 10:03 p.m., indicated the resident was voicing a strong desire to leave the facility and displayed aggressive behavior towards the staff. He was resistant to redirection and had not responded to the lorazepam 0.5 mg. A Nurse's Progress Note, dated 7/6/24 at 1:00 p.m., indicated the nurse attempted to assess the resident, he became combative and resistant. Care was stopped and would be re-attempted at a later time. A Medication Administration Note, dated 7/10/24 at 7:38 a.m., indicated lorazepam, 0.5 mg was administered. There was no reason documented and there were no interventions attempted prior to the administration of the lorazepam. The MAR, dated 7/2024, indicated the lorazepam 0.5 mg was administered on 7/10/24 at 7:38 a.m. and was effective. A Nurse's Progress Note, dated 7/12/24 at 1:47 a.m., indicated the resident had continuously attempted to get in and out of bed most of the shift when he fell. There were no injuries from the			

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	155840	A. BUILDING 00 B. WING	08/08/2024

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	fall. The Medication Administration Record (MAR), dated 7/2024, indicated episodes of behaviors were documented on the following days: - On 7/1/24, day shift there was one episode. He was redirected and removed from his peers. The interventions were effective. - On 7/1/24, evening shift, there were three episodes, he was redirected and the the intervention was effective. - On 7/2/24, evening shift, there were three episodes, he was redirected and the intervention was effective. - On 7/3/24, evening shift, there were two episodes, he was redirected and the intervention was effective. - On 7/5/24, evening shift, there was one episode, he was removed from the environment and the intervention was not effective. - On 7/6/24, day shift, there was one episode, no interventions documented. - On 7/6/24, evening shift, there were two episodes, he was redirected and the intervention was effective. - On 7/7/24, day shift, there were two episodes. There were no interventions documented. - On 7/12/24, evening shift, there were three episodes. He was redirected and the intervention was effective. - On 7/13/24, day shift, there was one episode, he was redirected and the intervention was effective. There were no specific targeted behaviors listed. There were no times documented when the behaviors occurred. The MAR, dated 7/2024, indicated, "TARGETED BEHAVIOR: Resident specific targeted behavior/s (specify)..." The interventions were #1 - redirect,			

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	#2 - remove from environment, #3 - see notes, #4 - PRN (as needed) given. The outcome to the interventions and number of episodes were to be documented. were monitored. Each day and shift was initialed with a check mark. There were no number of episodes, interventions attempted and outcomes documented. A Psychiatric Nurse Practitioner Progress Note, dated 7/14/24 at 9:15 a.m., indicated the resident was seen for a follow up visit for medication management evaluation due to concerns with dementia with psychotic disturbance and adjustment disorder with anxiety. The facility staff reported psychotic behaviors of agitation, yelling, cursing, and inappropriate language. The resident had attempted several time to hit the the nursing staff with his fist. His behaviors had improved with medication adjustments during the last visit. The frequency and intensity had decreased. (Last medication change was 7/3/24) During an interview on 8/8/24 at 1:27 p.m. with the Social Service Director (SSD), Director of Nursing (DON), and the Administrator, the SSD indicated there was no care plan with interventions for the resident's behaviors and there had been no social service involvement with behavior modification. There had been no updated interventions for the behaviors. The Administrator indicated the facility had spoken with the family and the conversation had not been documented. The DON indicated there was no specific behavior documented on the MAR to indicated what behaviors the resident was exhibiting. The SSD indicated social services should have been involved with the resident's behaviors and the CNA's were to document the behaviors on the Plan of Care in the computer, which would communicate to social service there was a behavior and the nurse was to document			

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	the behaviors. The DON acknowledged there were no interventions attempted prior to the PRN lorazepam administration. During an interview on 8/8/24 at 2 p.m., the DON indicated there CNA's were not to mark the behaviors on the Plan of Care in the computer and there was not a place for them to do that. They were to tell the nurse on duty, who was then supposed to document the behavior. The DON indicated not all the behaviors were documented. The behavioral management policy, dated 4/2023 and received from the DON as current, indicated all behaviors related to any/all types of dementia were to be monitored and documented for the purpose of tracking and trending the behaviors for the development of person-centered, individualized dementia care plan programming for each resident to identify triggers of behaviors and unmet needs, development of care plan interventions, and to evaluate current behavior management programming interventions. Direct care staff were to monitor and document behaviors and all behaviors were to be reported to the nurse. The nurse was to evaluate, assess and document the behaviors in the clinical record. 3.1-37			
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.			

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	§483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility			

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	must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (LPN Wound Nurse 3 and LPN Wound Nurse 4) when providing pressure ulcer treatments for 1 of 1 random observation (Resident J). This had the potential to affect 13 residents who required wound treatments. Finding includes: During an observation on 8/5/24 at 11:04 a.m., Resident J's room was entered with LPN Wound Nurse 3 and LPN Wound Nurse 4. There was no sign on the resident's door that indicated Enhanced Barrier Precautions (EBP) were to be	F 0880	**POC for F880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Enhanced Barrier Precaution Signage was immediately placed on residents door at the time of survey. Resident was seen by the Wound Physician with no adverse outcomes.	08/29/2024

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	used. The dressing had already been taken off the pressure sores on the left heel and the left posterior ankle. The Wound Nurses had applied gloves. LPN Wound Nurse 3 indicated Enhanced Barrier Precautions only had to be implemented if the wounds had drainage. LPN Wound Nurse 3 continued to complete the wound treatments on the left heel and left posterior ankle. A facility enhanced barrier precaution policy, dated 3/2024 and received as current from the Director of Nursing, indicated EBP was to be used for wounds, including any skin opening that required a dressing. 3.1-18(b)		**How will you identify other residents having the potential 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. House audit was completed for residents requiring isolation precautions to ensure proper signage was posted and PPE was available outside of residents room. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** LPN 3 and LPN 4 were educated on Enhanced Barrier Precaution Policy. Nursing team educated on Isolation Policies, including but not limited to Enhanced Barriers, and ensuring proper signage is posted upon admission with isolation cart outside room. IDT Team will review admissions in morning clinical meeting to ensure residents have proper signage posted and PPE is available.	

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			How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Infection Control Nurse/Designee will audit admissions 5xs a week in clinical meeting to ensure all guests needing isolation requirements, including but not limited to EBP, have proper signage posted and PPE available. The GM/Designee 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 needed, audits will continue. **Date of compliance: 9/6/24**	