PRINTED: 01/30/2025 FORM APPROVED

CENTERS FOR	MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039		
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155840	B. WING		01/09/2025		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
	, IDDIT OR BOTT BILL	-		ALUMET AVENUE			
IGNITE N	MEDICAL RESORT	DYER LLC.	DYER,	IN 46311			
(VA) ID	CIIMMAADV	STATEMENT OF DEFICIENCIE	ID.	I	(V5)		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)		
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE		
F 0000							
Bldg. 00							
			F 0000	Ignite Medical Resorts Please			
	This visit was for th	e Investigation of Complaints		accept the following as the			
	IN00447372, IN00450096, IN00450148, IN00450163, and IN00450726.			facility's credible allegation of			
				compliance. This plan of			
				correction does not constitute	an		
	Complaint IN00447	7372 - No deficiencies related to		admission of guilt or liability by			
	the allegations are c			facility and is submitted only in			
				response to the regulatory			
	Complaint IN00450	0096 - No deficiencies related to		requirement.			
	the allegations are c			requirement.			
	the anegations are c	nted.		This facility was a setfully we say	-1		
	G 1: D100450	0140 NT 16" 14 14		This facility respectfully reques			
	_	0148 - No deficiencies related to		desk review for the given citat	ions		
	the allegations are c	eited.		in this survey. Please see all			
				attached documentation for yo	our		
	_	1163 - No deficiencies related to		consideration.			
	the allegations are c	eited.					
	Complaint IN00450	9726 - Federal/State deficiencies					
	related to the allega	tions are cited at F686.					
	Unrelated deficience	ies are cited.					
	Survey dates: Janua	ry 8 and 9, 2025					
	,						
	Facility number: 01	3462					
	Provider number: 1:						
	AIM number: 2013						
	AIIVI IIUIIIUCI. 2013.	JUZ 1 U					
	C D 1T						
	Census Bed Type:						
	SNF: 98						
	Residential: 30						
	Total: 128						
	Census Payor Type:	:					
	Medicare: 51						
	Other: 47						

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

TITLE (X6) DATE

Megan Matula General Manager 01/22/2025

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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: L3GO11 Facility ID: 013462 If continuation sheet

Total: 98

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/09/2025	
	PROVIDER OR SUPPLIER		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0686 SS=D	accordance with 410 Quality review com 483.25(b)(1)(i)(ii)	pleted on 1/13/25.			
83-D Bldg. 00	Ulcer Based on observation interview, the facility with a pressure ulce treatment and service to interventions not not completed as or	on, record review, and ty failed to ensure a resident er received the necessary ees to promote healing, related in place and a treatment was dered and care planned for 1 wed for pressure ulcers.	F 0686	POC for F686 – Treatment/Sy to Prevent/Heal Pressure Ulco What corrective action(s) wi be accomplished for those residents found to have been affected by the deficient practice?	er II
	During an observati Resident G was lyir bed elevated. There observed lying on to resident's heels were mattress. There was floor in the entrywal During an observati 1 and LPN 2 entered incontinent care to to resident, a new brie cream had not been the incontinent care	son on 1/8/25 at 10:00 a.m., ag in bed with the head of the were heel protectors op of the dresser and the elying directly on a regular a low air mattress lying on the y of the room. Son on 1/8/25 at 10:18 a.m., LPN d the room and provided the resident. After washing the f was applied. The skin barrier applied. Upon completion of the heels remained resting on bed. The low air mattress or in the entryway of the room.		Resident G suffered no effects from this alleged deficie practice. Resident G's wound car plan was reviewed to ensure wound interventions were in p Wound Care Nurse 3 ar Wound Care Nurse 4 immedia educated on completing woun treatments as ordered and ensuring wound care plan interventions are in place.	ent re lace. nd utely
	Wound Nurse 4 ind	on 1/8/25 at 11:14 a.m., icated the resident had a DTI (underlying soft tissue		How will you identify other residents having the potentia to be affected by the same	al

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l '		, ,		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840			JILDING	00	COMPLETED	
155840			B. WING 01/09/2025				
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
ICNITE A	MEDICAL DESCRI	DVEDIIC		1	ALUMET AVENUE		
IGNITE I	MEDICAL RESORT	DIEK LLG.	-	DIEK,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
TAG		R LSC IDENTIFYING INFORMATION a discolored area of intact		TAG		DATE	_
	skin) on the right he				deficient practice and what corrective action will be take	n	
	skiii) on the right he				corrective action will be take		
	During an observati	ion on 1/8/25 at 11:14 a.m.,					
		d CNA 4 entered the room to					
	provide a pressure ulcer treatment to the DTI on the right heel. Wound Nurse 3 indicated she was unsure why the low air loss mattress was on the				All residents with wound	ds	
					have the potential to be affect	ed	
					by this alleged deficient practi	ce.	
floor in the entryway to the room and maybe the mattress needed to be placed on the resident's						,	
		be placed on the resident's d the resident to turn onto the			House audit completed	of	
					all residents with wound care		
	left side. There was no dressing on the DTI of the right heel and the resident's heels remained				plans to ensure all intervention were in place.	15	
	~	ress. Wound Nurse 3 indicated			were in place.		
	-	roximately the size of a dime			CNO rounded with wou	nd	
		ed fluid filled blister and a DTI.			care team to ensure schedule		
	She indicated the re	esident's heels were to be off			wound treatments were comp	eted	
	loaded off the mattr	ress (kept off the mattress to			according to physician orders.		
		the area). The DTI was purple					
		arse 3 then washed the DTI,					
	_	paked gauze over the area and					
	_	with two foam dressings. Two			What measures will be put		
	pillows were then placed under the resident's				into place or what systemic		
	the mattress.	e heels from directly lying on			changes you will make to ensure that the deficient		
	the mattress.				practice does not recur?		
	During an observati	ion on 1/8/25 at 2:35 p.m., the			practice does not recui :		
		tress remained on the floor in					
	the entryway of the						
					Nurses, including woun	d	
		was reviewed on 1/8/25 at			care team, were educated tha		
		gnoses included, but were not			wound treatments need to		
		mellitus, peripheral vascular			completed according to physic	cian	
	disease, and stroke.				orders.		
	An Admission Mini	imum Data Set assessment,			Nursee in alredia a	_	
		icated an intact cognitive			Nurses, including woun		
		sistance was required for bed			care team, educated that care plan interventions related to		
		ys incontinent of bowel and			wounds need to be in place.		
		unhealed pressure ulcers.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLI.		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI		MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED	
AND I LAN OF CORRECTION		155840		ING		01/09/	01/09/2025	
				CTREET	ADDRESS OF A STATE FOR SOR			
NAME OF I	PROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD			
	IGNITE MEDICAL RESORT DVER LLC				ALUMET AVENUE			
IGNITE	IGNITE MEDICAL RESORT DYER LLC.				IN 46311			
(X4) ID	SUMMARY		ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	ATE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	_	Note, dated 12/29/24 at 3:33						
	p.m., indicated the	resident was admitted into the			How will the corrective			
	hospital for hypoglycemia, chronic kidney disease, and vomiting.				actions(s) be monitored to			
					ensure the deficient practice	9		
	A Nurse's Progress Note, dated 1/6/25 at 10:03				will not recur, i.e., what qual	lity		
					assurance program will be p	out		
	-	resident was re-admitted into			into place?			
	the facility.							
	_	mission Evaluation, dated			CNO/designee will aud			
		DTI was present on the right			wound care treatments weekl	y to		
	heel and there was i	redness to the coccyx.			ensure that treatment is			
					completed as ordered.			
		e, dated 1/7/25 at 2:30 p.m.,						
		a DTI to the right heel. The			CNO/designee will aud	it 10		
	I	ned and treatment orders were			wound care plans weekly to			
	received.				ensure that documented			
		D 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			interventions are in place.			
		Progress Notes, dated 1/7/25,			0110/5			
		n the right heel was 1.2			CNO/Designee will pre			
	centimeters (cm) by	1 cm and the skin was intact.			the summaries of the audits to			
	A.C. DI 1.1	1/7/25 : 1: 4 1 DTI			Quality Assurance committee	;		
	· ·	1/7/25, indicated a DTI was			monthly for six months.			
		heel. The interventions ttress would be utilized and			Thereafter, if determined by t			
	· · · · · · · · · · · · · · · · · · ·				Quality Assurance committee			
	_	s would be considered with			further monitoring is needed,	audit		
	-	ther offloading devices.			will continue.			
	episode would be u							
	episode would be u	sea.						
	Δ Physician Order	dated 1/6/25, indicated barrier			Date of compliance: 01/31/2	0025		
	-	ed after incontinence care as			Date of compliance. 01/31/2			
	needed.	a monumente cure us						
	Physician's Orders.	dated 1/7/25, indicated a low						
		s to placed on the bed for						
		and the right heel DTI was to						
	_	ormal saline, patted dry,						
		ne and was to be covered with						

	PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00		(X3) DATE SURVEY COMPLETED 01/09/2025		
	ROVIDER OR SUPPLIER		1532 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0880 SS=D Bldg. 00	a dry dressing daily The Treatment Adm 1/2025, indicated th present as ordered of During an interview the Director of Nurs p.m., the DON indicated loss mattress we bed. A facility wound po 3/2020 and received indicated wounds we interventions impless resident's clinical re This citation relates 3.1-40(a) 483.80(a)(1)(2)(4) Infection Prevention Based on observation review, the facility of Personal Protective	ninistration Record, dated e low air loss mattress was in 1/7/25, night shift. Twith the Administrator and sing (DON) on 1/8/25 at 3:01 cated he would ensure the low uld be placed on the resident's licy and procedure, dated I from the DON as current, ould be assessed and mented and documented in the cord. To Complaint IN00450726.	F 0880		
	care to a resident (R Enhanced Barrier P	esident G) who was in recautions (EBP) for one for infection control.		What corrective action(s) we be accomplished for those residents found to have been affected by the deficient practice?	
	1 and LPN 2 entered incontinent care. The on each side of the l	on on 1/8/25 at 10:18 a.m., LPN d Resident G's room to provide e LPN's applied gloves, stood ped and assisted the resident to side. LPN 2 provided		Resident G suffered no effects from this alleged defici practice.	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840 R. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG Washing of the skin and a clean brief was applied. LPN 1 and LPN 2 had not donned a gown prior to providing the care. During an observation and interview on 1/8/25 at 10:32 a.m., there was a sign on the door and indicated PPE should have been used. LPN 1 was unsure why the resident required PPE And a cart was located inside the door to the room with the PPE. LPN 1 acknowledged the sign on the door and indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required EBP. LPN 2 indicated PPE for the EBP should have been used. LPN 1 was unsure why the resident required PPE for the EBP should have been used. LPN 1 was unsure why the resident required PPE for the EBP should have been used. LPN 1 was unsure wh	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE	(X3) DATE SURVEY	
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The Nursing Re-admission Evaluation, dated 1/6/25, indicated a Deep Tissue Injury (DTI) affected by this alleged deficient practice.						-	n or		
The Nursing Re-admission Evaluation, dated 1/6/25, indicated a Deep Tissue Injury (DTI) practice.		disease, and stroke.				· ·			
1/6/25, indicated a Deep Tissue Injury (DTI)						1	ent		
		_				practice.			
(underlying soft tissue damage resulting in a Residents reviewed to									
discolored area of intact skin) was present on the compile a current list of residents			,			1	nts		
right reel and there was redness to the coccyx. who require isolation or EBP.		right reel and there was redness to the coccyx.				who require isolation or EBP.			
A Clair /W d N d d 1/7/05 2-20		A C1.:/337 1.3.7	1-4-11/7/25 -4-2 20			Desident to the			
A Skin/Wound Note, dated 1/7/25 at 2:30 p.m., Residents in isolation,			•			· ·			
		indicated there was a DTI to the right heel. The							
Physician was notified and treatment orders were Enhanced Barrier Precautions,		'	ied and treatment orders were				,		
received. audited to ensure that proper		received.				1	_		
The Wound Round Progress Notes, dated 1/7/25, signage was in place and PPE was available.		The Wound Down	Progress Notes dated 1/7/25				<u>-</u>		
indicated the DTI on the right heel was 1.2			_			was available.			
centimeters (cm) by 1 cm and the skin was intact.			-						
centificters (citi) by 1 citi and the skill was intact.		centimeters (citi) by	1 cm and the skin was litaet.						
A Physician's Order, dated 1/8/25, indicated EBP What measures will be put		A Physician's Order	r dated 1/8/25 indicated FRP			What measures will be put			
precautions were to be utilized due to the wound into place or what systemic						-			
on the right heel. changes you will make to		1 -	55 Shinked and to the would						
ensure that the deficient		on the right heer.							
A facility EBP policy, dated 3/2024, indicated staff practice does not recur?		A facility EBP police	cv. dated 3/2024, indicated staff						
were to don a gown and gloves during			-			F. 404.00 4000 Hot 10041 i			

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

PRINTED: 01/30/2025 FORM APPROVED OMB NO. 0938-039

i i						(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUIL B. WING		00	COMPL 01/09/	
						01/09/	2020
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP COD		
IGNITE N	MEDICAL RESORT	DYER LLC.			IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		a LSC IDENTIFYING INFORMATION nt care. EBP PPE was to be		TAG	Dia teliate 17		DATE
	~	with wounds including any					
	skin opening that re	quired a dressing.			Facility staff educated to)	
					ensure staff understand mean	ing	
	3.1-18(b)				of each type of isolation sign,	_	
					when a resident meets criteria		
					EBP or other types of isolation and appropriate PPE to use w		
					entering a room and/or providi		
					care.	5	
					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	ut	
					into place?		
					CNO/Designee will audi	it 10	
					staff members weekly on rand		
					shifts to ensure appropriate PI	PE	
					is worn based on isolation stat	tus.	
					CNO/Designes will are a	ont	
					CNO/Designee will pres the summaries of the audits to		
					Quality Assurance committee		
					monthly for six months.		
					Thereafter, if determined by th	ie	
					Quality Assurance committee		
					further monitoring is needed, a	audit	
					will continue.		
					Date of compliance: 01/31/20	025	
			1				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

L3GO11 Facility ID: 013462

If continuation sheet Page 7 of 8

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/30/2025 FORM APPROVED OMB NO. 0938-039

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 01/09/2025	
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT DYER LLC.				STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL 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

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: L3GO11 Facility ID: 013462 If continuation sheet Page 8 of 8