STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETED			ETED	
		155840	B. WI	NG		04/29	/2025
			<u> </u>	_			
NAME OF F	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
IONUTE A	AEDIOAL DECORT	- DVED II O			ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYERLLC		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0000							
Bldg. 00							
	This visit was for a	a Recertification and State	F 00	000	Ignite Medical Resorts Please		
	Licensure Survey a	and Investigation of Complaints			accept the following as the		
	IN00455936, IN00	456419, IN00456626, IN00456640,			facility's credible allegation of		
	IN00457582, and I	N00458078. This visit included a			compliance. This plan of		
	State Residential L	icensure Survey.			correction does not constitute	an	
					admission of guilt or liability by	/ the	
		5936 - No deficiencies related to			facility and is submitted only ir	1	
	the allegations are	cited.			response to the regulatory		
					requirement.		
	Complaint IN00456419 - No deficiencies related to the allegations are cited.						
					This facility respectfully reques		
					desk review for the given citat	ions	
		6626 - No deficiencies related to			in this survey. Please see all		
	the allegations are	cited.	attached documentation for your		our		
					consideration.		
		6640 - No deficiencies related to					
	the allegations are	cited.					
	G 1 ' . D10045	7500 N 1 C					
		7582 - No deficiencies related to					
	the allegations are	cited.					
	G 1 ' 4 D 100 45	0070 N 1 C ' ' 1 . 1 .					
	the allegations are	8078 - No deficiencies related to					
	the anegations are	cited.					
	Survey dotes Ann	il 21, 22, 23, 24, 25, 28, and 29,					
	2025	11 21, 22, 23, 24, 23, 26, and 29,					
	2023						
	Facility number: 0	013462					
	Provider number:						
	Trovider number.	133010					
	Census Bed Type:						
	SNF: 86						
	Residential: 26						
	Total: 112						
	Census Payor Type	e:					
	Medicare: 41						
	ī				i e e e e e e e e e e e e e e e e e e e		1

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

(X6) DATE

TITLE

Megan Matula General Manager 05/18/2025

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 AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A. BUILDING 00 COMPLETED B. WING 04/29/2025			
	ROVIDER 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 0554	accordance with 410 Quality review com 483.10(c)(7)	pleted on 5/5/25.			
SS=D Bldg. 00	Based on observation interview, the facility who were left to consider independently had be self-administration for respiratory service. Finding includes: During a random of a.m., Resident 29 wroom. A nebulizer face mask. He remote the drawer of his nigresident indicated throom while he received throught it was done and put it in his draw. The resident's record 2:57 p.m. Diagnose limited to, COPD (edisease), chronic resident (low oxygen levels). The 4/10/25 Quarter	oservation on 4/21/25 at 11:40 as observed sitting alone in his treatment was in progress via a coved the face mask and put it in ghtstand. At that time, the ne staff did not stay in the ved the nebulizer treatments. the treatment, and when he he, he would remove the mask wer. d was reviewed on 4/23/25 at es included, but were not chronic obstructive pulmonary spiratory failure with hypoxia h, and dementia. rly MDS (Minimum Data Set) at the resident had moderate	F 0554	POC F554 Resident Self-Adr Meds – Clinically Approp IGNITE MEDICAL RESORT I LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Place Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submed this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allegate contained herein. Please note the facility may contest the merit or form of any of the alleged deficient findings and may take reasonable steps to appeal the This Plan of Correction constil IGNITE MEDICAL RESORT I LLC's written credible allegatic compliance for the deficiencies noted. It is the facility's policy that residents have the right to self-administer medications if interdisciplinary team has	DYER erate and an of aitting are to ations enthat erits are em. tutes DYER on of es

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MUGE11 Facility ID: 013462

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPLETED				
		155840	B. WING 04/29/2025				25
),,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	DROLUBER OF STATE		'	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	t .	1532 CALUMET 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		REFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	OMPLETION
TAG		LISC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	*	sistance with activities of daily			determined that this practice is		
	living and transfers.				clinically appropriate through a	a	
	The 1/27/25 Self A	dministration Assessment did			comprehensive assessment		
	not indicate the resi				process. Corrective Action for Affecte	.	
	self-administer neb				Residents: A comprehensive	ч	
	Self definitister neo	unzer treatments.			self-administration assessmer	nt	
	There was no physic	cian's order for the resident to			was completed by the IDT tea		
	self-administer neb				for Resident 29. The resident's		
					physician was notified, and ne		
	During an interview	on 4/24/25 at 11:57 a.m., the			orders were obtained for		
	_	Nursing) indicated the resident			self-administration of nebulize	r	
	· ·	ated for self-administration of			treatments. The care plan was		
	nebulizers.				updated to reflect these chang		
					Identifying other Residents		
	A policy titled "Sel	f Administration of			having the Potential to be		
	Medications and Tr	eatments", received as current			Affected: CNO and Unit		
	from the DON on 4	/28/25 at 3:31 p.m. indicated, "			Managers conducted a		
	Self administration	of medications and treatments			facility-wide audit of residents		
	is determined by ph	ysician order after determining			receiving nebulizer treatments	to	
	that the resident is a	able to self administer".			identify any other residents wh	10	
					may be self-administering		
	3.1-11(a)				treatments without proper		
					assessment and physician ord		
					All residents receiving nebulize	er	
					treatments were reviewed for		
					appropriate self-administration	1	
					assessments and physician		
					orders.		
					Measures put into place or	.	
					Systemic Changes: The DON		
					provided in-service education	io	
					licensed nurses regarding: Policy and procedure for		
					self-administration of medicati		
					and treatments	0113	
					Requirements for IDT		
					assessment prior to allowing		
					self-administration		
					Proper documentation		

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	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING	00 00	COMPLETED 04/29/2025
	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
				requirements including physical orders Supervision requirements of nebulizer treatments Process for ongoing monitor of residents who self-administration assessment tool has been updated to specifically include evaluation criteria for nebulize treatments. The IDT will review new admissions and quarterly assessments for potential self-administration capabilities. Plan to Monitor Performance DON/Designee will conduct weekly audits of 10 residents on nebulizer treatments to ensure residents who are able to self-administer have appropriated documentation in place, include but not limited to self-administration assessment and physician order, and that in nurse stays in room for entire duration of nebulizer treatment residents who are not able to self-administer. The Director of Nursing will read undit results and report finding the Quality Assurance and Performance Improvement (Quamittee will monitor compliated until substantial compliance is achieved and maintained for 60 consecutive months. Date of Compliance: 05/23/28	uring ring er n r v all

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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 <u>00</u>	(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIEI		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY O	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(i Notify of Changes	ɪv)(15) s (Injury/Decline/Room, etc.)			
Bldg. 00	failed to ensure the elevated blood sugar medications and in medication refusals for notification of ce 264) Findings include: 1. The record for F4/24/25 at 3:03 p.m. not limited to, type disease. The Admission Mirassessment, dated 3 was cognitively int A Physician's Orderesident was to reconsubcutaneously (injugate fatty tissue layer be The Physician was blood sugar level was 400. The March 2025 M. Record (MAR) individuals was 425 on 3/20/25 at 9 p.m., the resident's There was no docuphysician and/or the	Resident 52 was reviewed on Diagnoses included, but were 2 diabetes and end stage renal	F 0580	POC for F580 – Notify of Changes (Injury/Decline/Rootetc.) IGNITE MEDICAL RESORT ELLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Placorrection is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submit this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allegate contained herein. Please note the facility may contest the meror form of any of the alleged deficient findings and may tak reasonable steps to appeal the This Plan of Correction constitus IGNITE MEDICAL RESORT ELC's written credible allegatic compliance for the deficiencies noted. It is the facility's policy to immediately inform the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the resident's physician, and notify the residence consult with the residence consult with the residence consult with the residence consult with the residence cons	e to titing e to titions that erits e e em. tutes DYER on of s mt, ent e but od ons,

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Event ID:

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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. WING		04/29/2025
			STREE	ET ADDRESS, CITY, STATE, ZIP COD	1
NAME OF I	PROVIDER OR SUPPLIEF	R		CALUMET AVENUE	
IGNITE N	MEDICAL RESORT	DYER LLC		R, IN 46311	
(V4) ID	CLIMANA DAY	CTATEMENT OF DEFICIENCIE			(7/5)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI	(X5) COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE DATE
1710	During an interview on 4/29/25 at 2:09 p.m., the		ind	Residents:	DATE
	_	; indicated the physician and/or		·No harm came to any residents.	lente
	_	tified of the resident's blood		related to this alleged deficier	
		n 3/20/25 and 3/21/25.		practice.	
				Residents 52 and 154 no l	onger
				reside in facility.	
	2. The record for R	desident 154 was reviewed on		Identifying other Residents	
	4/23/25 at 11:34 a.r	n. Diagnoses included, but		having the Potential to be	
	were not limited to,	dementia with mood		Affected: The Director of Nur	sing
		diabetes, hypertension, and		(DON) and Unit Managers	
	acute kidney failure	e.		completed an audit of current	
				residents with physician orde	rs for
	The Admission Minimum Data Set (MDS)			insulin, blood pressure	
		/14/25, indicated the resident		medications, and other	
		paired for daily decision		medications with specific	
	making.			parameters to ensure proper	
	A DI COLO	1 4 1 4/10/05 : 1: 4 141		physician notification occurre	
		r, dated 4/12/25, indicated the every Midodrine HCl (a		any held or refused doses with	nin
		treat low blood pressure) 5		the past 7 days.	
		mouth three times a day for		Measures put into place or Systemic Changes:	
		lood pressure). There were no		1.The DON provided in-ser	vice
		meters indicating when the		education to licensed nurses	VICC
	medication should l	_		regarding:	
				·Physician notification	
	The April 2025 Me	dication Administration Record		requirements for out-of-range	blood
	(MAR), indicated the	he resident's blood pressure		sugar readings	
	was 132/79 on 4/19	/25 at 9:00 a.m. and 145/69 at		·Protocol for notification	
	5:00 p.m. The Mid	odrine was not given at 9:00		when medications are held or	
	a.m. and 5:00 p.m.			refused	
				·Documentation	
		nentation indicating the		requirements for physician	
		e nurse practitioner (NP) were		notifications	
	notified of the med	ication being held.		Plan to Monitor Performanc	
	D	4/04/05 + 10.00		1.DON/Designee will condu	ct
		v on 4/24/25 at 12:00 p.m., the		daily reviews of medication	
		indicated the physician and/or		administration records 5 time	
		been notified that the		week to ensure proper physic	an
	Midodrine was held			notification for:	
	3. Resident 264's record was reviewed on 4/23/25		1	·Blood sugar readings	

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 04/29/2025		
	PROVIDER 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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PREFIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE A CATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
	limited to, CHF (condiabetes. The 4/12/25 Admission assessment indicate cognitive impairment activities of daily live. A Physician's Order Insulin Lispro (a fast before meals. There holding the insulin. The April 2025 Met (MAR) indicated the dose of insulin on 4 4/16/25 evening insulin blood sugar was 70. There was no documphysician was inforgiven. During an interview Director of Nursing	dication Administration Record e resident refused the morning /14/25. The nurse held the ulin dose when the resident's mentation indicating the med of the insulin doses not		outside parameters	Il be y ee for until	
F 0623 SS=A Bldg. 00	failed to ensure the was notified in writ	nts Before e view and interview, the facility resident's Responsible Party ing related to a transfer to the esidents reviewed for	F 0623	Education completed with Resident Care Transitions to ensure notification of transfers hospitals were mailed to famil in writing.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		l í	ILDING	nstruction 00	(X3) DATE : COMPL 04/29/	ETED	
NAME OF PROV	VIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD		
IGNITE MED	DICAL RESORT	DYER LLC			ALUMET AVENUE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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)	ΓE	(X5) COMPLETION DATE
Fi TI 4/ no di TI ass w m A in ho ho ho TI tra re D D m no	the record for Reside (28/25 at 9:28 a.m. of limited to, deme isturbance, anemia, the Medicare 5 day assessment, dated 4/as cognitively imputating. Nurse's Note, date dicated the resider cospital due to having ematocrit level. The ospital and returned to the facility on 3/2. Nurse's Note, date dicated the resider cospital based on abording the facility on 3/2. Nurse's Note, date dicated the resider cospital related to a dicated the resider cospi	dent 79 was reviewed on Diagnoses included, but were ntia without psychotic and chronic kidney disease. Minimum Data Set (MDS) Minimum D		TAG	DEFICIENCY)		DATE

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CENTERSTON	MEDICAKE & MEDIC				ONID 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 <u>00</u>		COMPLETED	
		155840	B. WING		04/29/2025	
		<u> </u>	CTREET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
ICNITE A	MEDICAL DESCRI	DVEBILC				
	MEDICAL RESORT	DIEK LLG	DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	(X5)		
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	3.1-12(a)(6)(ii)					
	3.1-12(a)(6)(iii)					
F 0641	483.20(g)					
SS=D	Accuracy of Asse	ssments				
Bldg. 00						
	Based on record rev	view and interview, the facility	F 0641	POC F641 Accuracy of	05/23/2025	
	failed to ensure the	Minimum Data Set (MDS)		Assessments		
	assessment was acc	curately completed related to		IGNITE MEDICAL RESORT D	YER	
	terminal prognosis	and hospice care for 1 of 27		LLC makes every effort to ope	rate	
	MDS assessments i	reviewed. (Resident 44)		in substantial compliance with		
				Federal and State laws and		
	Finding includes:			regulations. Nothing in this Pla	n of	
				Correction is an admission		
	Resident 44's record	d was reviewed on 4/28/25 at		otherwise. IGNITE MEDICAL		
	10:05 a.m. Diagnos	ses included, but were not		RESORT DYER LLC is submit	ttina	
	_	nsion, atrial fibrillation, and		this Plan of Correction in	3	
	Alzheimer's disease			compliance with its regulatory		
				obligations and does not waive		
	The Quarterly MDS	S assessment, dated 4/9/25,		any objections it may have as		
	I	ent had not received hospice		the merit or form of any allega		
		ve a condition or chronic		contained herein. Please note		
	disease that may re-	sult in a life expectancy of less		the facility may contest the me	rits	
	than six months.	1 3		or form of any of the alleged		
				deficient findings and may take	e	
	A Physician's Orde	er, dated 10/4/24, indicated the		reasonable steps to appeal the		
	1	ted to hospice services.		This Plan of Correction constit		
		•		IGNITE MEDICAL RESORT D		
	A Care Plan, dated	2/21/25, indicated the resident		LLC's written credible allegation	l l	
	had a terminal end	stage prognosis and was		compliance for the deficiencies		
	receiving hospice s			noted.		
	_ ^			It is the facility's policy that all		
	The Hospice Certif	fication, dated 2/26/25, indicated		Minimum Data Set (MDS)		
	_	rminally ill with a life		assessments accurately reflect	t l	
	expectancy of six n	-		each resident's status, includir		
	• •			terminal prognosis and hospic	·	
	During an interviev	w on 4/28/25 at 3:14 p.m., MDS		services.		
	1	Nurse 2 indicated the resident		Corrective Action for Affecte	d	
		ice care and had a terminal		Residents: MDS Nurse 1 and		
		ould modify the MDS		MDS Nurse 2 completed a		

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		A. BUILDING B. WING	00	COMPLETED 04/29/2025			
	PROVIDER OR SUPPLIER		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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	assessment. 3.1-31(i)			modification of the Quarterly Massessment immediately to accurately reflect the resident' hospice status and terminal prognosis. The modified MDS completed, validated, and submitted to CMS. Identifying other Residents having the Potential to be Affected: Director of Nursing (DON) and MDS Coordinator conducted an audit of current residents receiving hospice services to ensure their most recent MDS assessments accurately reflect their hospice status and terminal prognosis. Any discrepancies identified was corrected through MDS modification. Measures put into place or Systemic Changes: The DON completed in-servicing with MI nurses on Accurate coding of Section (Health Conditions) and Section (Special Treatments) of the Minary Review of clinical documentation including physic orders, care plans, and hospice certifications prior to MDS completion Importance of accurately reflecting hospice services and terminal prognosis on the MDS Plan to Monitor Performance: The GM/Design will audit MDS assessments for residents receiving hospice services weekly to ensure	s was was erere Jos Jon O DS dcian de d S ee		

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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 <u>00</u>	(X3) DATE SURVEY COMPLETED 04/29/2025		
	PROVIDER OR SUPPLIE		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	N (X5) SEE COMPLETION RIATE DATE	N
F 0656 SS=D	483.21(b)(1)(3) Develop/Impleme	ent Comprehensive Care Plan		accurate coding of hospice services and terminal progn Results of these audits will be documented on a quality monitoring tool. The General Manager will remonitoring results to the Question Assurance and Performance Improvement (QAPI) commitmentally for 6 months. The Committee will evaluate the effectiveness of the plan and recommendations for continuation modification, or discontinual monitoring based on complisacores. Date of Compliance: 05/236	eport eality e ittee QAPI d make suation, tion of ance	
Bldg. 00	interview, the facil comprehensive car place for edema, co oxygen for 1 of 27 (Resident 60) Finding includes: On 4/22/25 at 9:18 with oxygen in plarate was set at 1.5 I slightly swollen an glove on her bedsic indicated she used liters. She wore th right hand, but only	on, record review, and ity failed to ensure a e plan was developed and in ompression glove use, and resident care plans reviewed. a.m., Resident 60 was observed the via nasal cannula. The flow iters. Her right hand was defined there was a compression detable. The resident oxygen and it was usually at 2 e compression glove on her year night. Resident 60 was completed on	F 0656	POC F656 - Develop-Implet Comprehensive Care Plan IGNITE MEDICAL RESORT LLC makes every effort to o in substantial compliance will Federal and State laws and regulations. Nothing in this F Correction is an admission otherwise. IGNITE MEDICA RESORT DYER LLC is subthis Plan of Correction in compliance with its regulato obligations and does not war any objections it may have a the merit or form of any allegations and designations and the facility may contest the ror form of any of the alleged deficient findings and may to	T DYER perate ith Plan of L mitting ry sive as to gations ote that merits	25

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

Event ID:

MUGE11 Facility ID: 013462

If continuation sheet Page 11 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155840	B. W	ING		04/29/	/2025
		<u>l</u>	I	STREET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	₹			ALUMET AVENUE		
ICNITE A	MEDICAL RESORT	DYERLIC		DYER, IN 46311			
IGNITE	MEDICAL RESORT	DILIVELO		DIEN,	114		
(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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
		n. Diagnoses included, but			reasonable steps to appeal the		
		hypertension, end stage renal			This Plan of Correction constit		
	disease, and type 2	diabetes mellitus.			IGNITE MEDICAL RESORT D		
					LLC's written credible allegation		
		nimum Data Set (MDS)			compliance for the deficiencie	s	
		2/23/25, indicated the resident			noted.		
	' '	gnitively impaired and did not			It is the facility's policy to deve	-	
	receive oxygen then	rapy.			and implement comprehensive		
					person-centered care plans fo	r	
		3/10/25, indicated the resident			each resident that includes		
		ncy. The interventions			measurable objectives and		
		feet to help prevent dependent			timeframes to meet residents'		
		tor for signs of hypervolemia			medical, nursing, mental and		
		ch as dependent edema. There			psychosocial needs identified	in	
	_	e plan or interventions related			their comprehensive		
	to the right hand ed	ema or the compression glove			assessments.		
	use.				Corrective Action for Affecte		
					Residents: the Director of Nu	_	
	There was no curre	nt care plan related to oxygen			reviewed and updated Reside	nt	
	use.				60's care plan to include		
					interventions for right hand ed	ema,	
	_	v on 4/24/25 at 1:53 p.m., the			compression glove use, and		
		g was made aware of the lack of			oxygen therapy.	_	
	_	cated he would put in care			Resident 60 no longer resides	in	
	1 -	dema, and compression glove			facility.		
	use.				Identifying other Residents		
	2.1.25()				having the Potential to be		
	3.1-35(a)				Affected: Facility-wide audit of		
					current residents completed to		
					identify those receiving oxyger	n	
					therapy, using compression		
					garments, or experiencing ede		
					to ensure comprehensive care	;	
					plans are in place.		
					Measures put into place or		
					Systemic Changes:		
					1.In-services completed with	1	
					nursing staff on:		
					Care plan development	and	
			1		implementation requirements		1

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIE		1532 (CADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE 1, IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R 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
				Process for initiating new care plans when new condition interventions arise Documentation requirements for oxygen there compression garments, and edema monitoring 1. The MDS Coordinator will review all new admission assessments and significant change assessments during morning clinical meeting to encare plans are developed for a identified needs. Plan to Monitor Performance DON/Designee will audit 10 resident care plans weekly to ensure residents receiving oxytherapy, wearing compression garments, or experiencing edenave corresponding care plans with interventions in place. Resof these audits will be reviewed the Director of Nursing. The Director of Nursing will reaudit findings to the Quality Assurance Performance Improvement (QAPI) Committed monthly for 6 months. The QAR committee will evaluate the effectiveness of the plan and changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 05/23/26	ns or apy, sure all e: ygen nema s esults ed by port ee API make
F 0658 SS=D Bldg. 00	Standards	d Meet Professional on, record review, and	F 0658	POC F658 – Services Provide	ed 05/23/2025

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Event ID:

MUGE11 Facility ID: 013462

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ILDING	00	COMPL	ETED
		155840	B. WI	NG		04/29/	/2025
			<u> </u>	CTREET A	ADDRESS CITY STATE ZID COD		
NAME OF P	ROVIDER OR SUPPLIER	L			ADDRESS, CITY, STATE, ZIP COD		
IONUTE N	AEDIOAL DECODE	DVEDILO			ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYER LLC		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 CROSS-REFERENCED TO THE APPROPRIA'	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
	interview, the facili	ty failed to ensure professional			Meet Professional Standards	;	
	standards of quality were maintained related to a				IGNITE MEDICAL RESORT D	YER	
	CNA placing a tube feeding pump on hold for 1 of				LLC makes every effort to ope	rate	
	2 residents reviewed for tube feeding. (Resident				in substantial compliance with		
	73)				Federal and State laws and		
	,				regulations. Nothing in this Pla	n of	
	Finding includes:				Correction is an admission		
	8				otherwise. IGNITE MEDICAL		
	During a random ob	oservation on 4/23/25 at 3:34			RESORT DYER LLC is submi	ttina	
	-	vas observed in her room in			this Plan of Correction in	···9	
	*	e bed was elevated and the			compliance with its regulatory		
		ing was infusing at 50 cubic			obligations and does not waive	<u> </u>	
	centimeters (cc's). CNA 1 proceeded to enter the				any objections it may have as		
		erform incontinence care.			the merit or form of any allega		
	_	e head of the bed, the CNA			contained herein. Please note		
	placed the tube feed				the facility may contest the me		
	1				or form of any of the alleged		
	After incontinence	care was completed, the CNA			deficient findings and may take	e	
	had a nurse resume	-			reasonable steps to appeal the		
		C			This Plan of Correction constit		
	The record for Resi	dent 73 was reviewed on			IGNITE MEDICAL RESORT D		
	4/25/25 at 2:10 p.m	. Diagnoses included, but were			LLC's written credible allegation		
	-	ostomy (a feeding tube placed			compliance for the deficiencies		
	_	en and into the stomach to			noted.		
	-	ids, or medications), adult			It is the facility's policy that all		
		d dysphagia (difficulty			services provided or arranged	bv	
	swallowing).				the facility, as outlined by the	,	
					comprehensive care plan, mus	st	
	The Admission Mir	nimum Data Set (MDS)			meet professional standards o		
	assessment, dated 2	/24/25, indicated the resident			quality, including ensuring that		
	had short and long t	erm memory problems and			staff members operate within t		
	was severely impair	red for daily decision making.			scope of practice regarding tul		
	The resident was re-	ceiving the majority of her			feeding management.		
	nutrition through a				Corrective Action for Affecte	d	
		-			Residents: Resident 73's tube		
	The Indiana State D	epartment of Health Nurse			feeding was immediately resu	med	
	Aide Curriculum states, " The resident with a				by licensed nursing staff. The		
		ould not lie flat If the bed			Director of Nursing counseled		
		eek the nurse 's assistance to			CNA 1 regarding scope of pra	ctice	
	· ·	rior to the procedure and turn			limitations related to tube feed		
ı			1			-	Ī

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/29/2025
	PROVIDER OR SUPPLIER MEDICAL RESORT DYER LLC	1532 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE 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 BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE
	the pump back on after the procedure" During an interview on 4/23/25 at 4:08 p.m., the Nurse Consultant indicated it was not within the CNA's scope of practice to put the tube feeding pump on hold and education would be provided. 3.1-35(g)(1)		pump operation. Resident 73 no longer resider facility. Identifying other Residents having the Potential to be Affected: Director of Nursing conducted an audit of all curresidents with tube feedings ensure proper management tube feeding pumps by approstaff. Measures put into place or Systemic Changes: The Director of Nursing will provide in-sereducation to CNAs regarding scope of practice and proper protocol for tube feeding carreducation will emphasize that licensed nurses may operate feeding pumps, including plapumps on hold or restarting Plan to Monitor Performant DON/Designee will conduct observation of tube feeding of 5 random residents on altern shifts to ensure compliance of professional standards regare tube feeding management. To Director of Nursing will review results weekly. The Director of Nursing will review results weekly. The Director of Nursing will review results weekly. The Director of Nursing will review the effectiveness of interventions make changes as needed unsubstantial compliance is achieved and maintained.	rent to of opriate ector vice g e. The at only e tube cing them. ce: direct care for nating with ding The w audit eport ality etee (API

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Event ID:

MUGE11 Facility ID: 013462

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING 00 COMPLETE B. WING 04/29/202			LETED		
	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)	ATE	(X5) COMPLETION DATE
F 0684 SS=E Bldg. 00	483.25 Quality of Care	.83.25			Date of Compliance: 05/23/2	5	
	interview, the facility assessed and monitor reviewed for non-prosigns and symptoms monitored for 1 of 1 constipation, edema for 1 of 3 residents medications were he parameters for 1 of unnecessary medications were he parameters for 1 of unnecessary medications include: 1. During a random 10:14 a.m., an area was noticed on Resident and the record for Resident and	ty failed to ensure bruises were pred for 2 of 2 residents ressure related skin conditions, as of constipation were a resident reviewed for a was monitored and assessed reviewed for edema and eld per blood pressure 5 residents reviewed for ations. (Residents 91, 255, 60, an observation on 4/22/25 at of reddish/purple discoloration ident 91's left forearm. Ident 91 was reviewed on an Diagnoses included, but type 2 diabetes, severe sepsis and atherosclerotic heart thimum Data Set (MDS) /28/25, indicated the resident and he was receiving an dithinner).	F 00	584	POC F684 – Quality of Care IGNITE MEDICAL RESORT I LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Pla Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submithis Plan of Correction in compliance with its regulatory obligations and does not waiv any objections it may have as the merit or form of any allegat contained herein. Please note the facility may contest the mo or form of any of the alleged deficient findings and may tak reasonable steps to appeal th This Plan of Correction consti IGNITE MEDICAL RESORT I LLC's written credible allegatic compliance for the deficiencie noted. It is the facility's policy to ensuresidents receive treatment at care in accordance with professional standards of prac comprehensive person-center care plans, and residents' choices, including proper assessment and monitoring of bruises, constipation, edema, medication administration. Corrective Action for Affects Corrective Action for Affects	erate an of itting re at to ations e that erits tutes DYER on of es ure and ctice, red f and	05/23/2025

AND PLAN OF CORRECTION INDESTIFICATION NUMBER 155840 NAME OF PROVIDER OR SUPPLIER INSERT ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 DYER, IN 46311 SUMMARY STATEMENT OF DEFICIENCIE PREPIX TAG SEGULATORY OR LSC IDENTIFYING INFORMATION as bruising. Physician's Orders, dated 3/21/25, indicated the resident was receiving Plavis (an antiplatelet) 75 milligrams (mg) by mouth at beldime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Enoxaparin Sodium Solution (a blood thinner) 40 mg/0 4 milliliters (ml), inject 40 mg subcutaneously one time a day to prevent blood elotting for 30 days. The Daily Skilled Nursing E-valuation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2.04 p.m., the Embers Unit Manager was informed of the discoloration. She indicated documentation should have been completed related to the discoloration and ostcomyelitis (a hone infection) of the left ankle and foot. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/16/25, and indicated the resident was to receive Hydrocodone-Acetaminophen Tablet (an opioid pain medication) 5-325 milligrams (ng), give 1	STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
STREET ADDRESS, CITY, STATE, JP COT 1532 CALUMETT AVENUE DYER. IN 46311 STREET ADDRESS, CITY, STATE, JP COT 1532 CALUMETT AVENUE DYER. IN 46311	AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
ISSUMARY STATEMENT OF DEFICIENCE (PACH DEPICIENCY MUST BE PRECEDED BY FULL TAG. SUMMARY STATEMENT OF DEFICIENCE (PACH DEPICIENCY MUST BE PRECEDED BY FULL TAG. PREFIX TAG. Physician'S Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth aspirin 91 mg by mouth at bedtime and Aspirin 10 particuous aspirint and			155840	B. W	NG		04/29/	/2025
ISSUMARY STATEMENT OF DEFICIENCE (PACH DEPICIENCY MUST BE PRECEDED BY FULL TAG. SUMMARY STATEMENT OF DEFICIENCE (PACH DEPICIENCY MUST BE PRECEDED BY FULL TAG. PREFIX TAG. Physician'S Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth aspirin 91 mg by mouth at bedtime and Aspirin 10 particuous aspirint and				<u> </u>	STREET 4	ADDRESS CITY STATE ZIP COD		
IGNITE MEDICAL RESORT DYER LLC IXMARY STATEMENT OF DEFICIENCE PROPERTY TAG REGULATORY OR LSC IDENTIFYING INFORMATION as bruising. A physician's Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Floxsaparin Sodium Solution (a blood thinner) 40 mg 0.4 milliliters (ml), inject 40 mg subtraneously one time a day to prevent blood clotting for 30 days. The Daily Skilled Nursing Evaluation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2:04 p.m., the Embers Unit Manager was informed of the discoloration. She indicated documentation should have been completed related to the discoloration. 2. The record for Resident 255 was reviewed on 4/23/25 at 10:21 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following a surgical amputation and osteomyellis (a bone infection) of the left ankle and foot. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/16/25, indicated the resident was cognitively intect. A Physician's Order, dated 4/16/25, indicated the resident was receive Hydrocodone-Acetaminophen Tablet (an opioid pain medication) - 3:255 milligrams (mg), give 1	NAME OF P	PROVIDER OR SUPPLIEF	R					
CX3 ID PREFIX CEAT DEFICIENCY MUST BE PRECEDED BY FULL TAG SECONDERISTICATION SHOOLDING COMPLETION COMPLETION DATE	IGNITE M	MEDICAL RESORT	DYFRIIC					
PREFIX TAG REGILATORY OR LSC IDENTIFYING INFORMATION BUILDING PROSMETTION PAGE PAGE PROSMETTION PAGE PAGE PROSMETTION PAGE PAGE PROSMETTION PAGE PAGE PAGE PAGE PAGE PAGE PAGE PAGE				ı				1
as bruising. Physician's Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Enoxaparin Sodium Solution (a blood thinary) 40 mg/0.4 millilitiers (ml), inject 40 mg subcutaneously one time a day to prevent blood clotting for 30 days. The Daily Skilled Nursing Evaluation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2:04 p.m., the Embers Unit Manager was informed of the discoloration. Be indicated documentation should have been completed related to the discoloration. Passident S94 bruises were assessed and documented with monitoring orders added to the EMR. Resident 264's bruises were reviewed and parameters for holding blood pressure medications were reinforced. Resident 264's bruises were assessed and adocumented with monitoring orders added to the EMR. Resident 264's bruises were assessed and documented with monitoring order was clarified on 4/24/25 to include specific wear times and documentation requirements. Resident 264's bruises were assessed and documented with monitoring orders added to temps. Resident 264's bruises were reviewed and parameters for holding blood pressure medications were reinforced. Resident 264's bruises were assessed and documented with monitoring orders added to the EMR. Resident 264's bruises were assessed and documented with monitoring orders added to the EMR. Resident 264's bruises were reviewed and parameters for holding blood pressure medications were reinforced. Resident 264's bruises were assessed and documented with monitoring orders added to the EMR. Resident 264's bruises were assessed and documented with monitoring orders added to the EMR. Resident 264's bruises were assessed and added to the feet and to the discoloration. Resident 264's bruises and documented with monitoring orders added to th		SUMMARY	STATEMENT OF DEFICIENCIE					
as bruising. Physician's Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth at bedtime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Enoxaparin Sodium Solution (a blood thinner) 40 mg/0.4 millitiers (ml), inject 40 mg subcutaneously one time a day to prevent blood clotting for 30 days. The Daily Skilled Nursing Evaluation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2.04 p.m., the Embers Unit Manager was informed of the discoloration. During an interview on 4/24/25 at 2.04 p.m., the Embers Unit Manager was informed of the discoloration. 2. The record for Resident 255 was reviewed on 4/23/25 at 10:21 a.m. Diagnoses included, but were not limited to, orthopedic affercare following a surgical amputation and ostcomyelitis (a bone infection) of the left ankle and foot. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/16/25, was in progress and indicated the resident was cognitively intact. A Physician's Order, dated 4/16/25, indicated the resident was to receive Hydrocodone-Acetaminophen Tablet (an opioid pain medication) 5-325 milligrams (mg), give 1		· ·				CROSS-REFERENCED TO THE APPROPRIA	TE	
Physician's Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Enoxaparin Sodium Solution (a blood thinner) 40 mg/0.4 milliliters (ml), inject 40 mg subcutaneously one time a day to prevent blood clotting for 30 days. The Daily Skilled Nursing Evaluation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2.04 p.m., the Embers Unit Manager was informed of the discoloration. She indicated documentation should have been completed related to the discoloration. The Position of the left ankle and foot. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/16/25, was in progress and indicated the resident was to receive Hydrocodone-Acetaminophen Tablet (an opioid pain medication) 5-325 milligrams (mg), give 1	TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
Physician's Orders, dated 3/21/25, indicated the resident was receiving Plavix (an antiplatelet) 75 milligrams (mg) by mouth at bedtime and Aspirin 81 mg by mouth daily. A Physician's Order, dated 3/24/25, indicated the resident was receiving Enoxaparin Sodium Solution (a blood thinner) 40 mg/04 milliliters (ml), inject 40 mg subcutaneously one time a day to prevent blood clotting for 30 days. The Daily Skilled Nursing Evaluation, dated 4/23/25, indicated there was no documentation related to new and/or existing skin conditions. During an interview on 4/24/25 at 2:04 p.m., the Embers Unit Manager was informed of the discoloration. During an interview on 4/24/25 at 2:04 p.m., the Embers Unit Manager was informed of the discoloration. Should have been completed related to the discoloration of the left ankle and foot. 2. The record for Resident 255 was reviewed on 4/23/25 at 10:21 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following a surgical amputation and osteomyelitis (a bone infection) of the left ankle and foot. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/16/25, indicated the resident was to receive Hydrocodone-Acetaminophen Tablet (an opioid pain medication) 5-325 milligrams (mg), give 1		as bruising.						
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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155840	B. W	NG		04/29/	2025
		<u> </u>		CTDEET	ADDRESS CITY STATE ZIR COD		
NAME OF P	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE		
IONUTE A	AEDICAL DECORT	DVEDILO					
IGNITE N	MEDICAL RESORT	DIEK LLC		DYEK,	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	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		dication Administration Record			requiring monitoring		
	, ,	e resident received the			Measures put into place or		
	1 -	aminophen on 4/16/25 at 5:44			Systemic Changes:		
	1 -	34 p.m., 4/19/25 at 6:03 p.m., and			·The DON will in-service		
	4/20/25 at 3:22 a.m	-			licensed nurses on:		
					·Bruise assessment,		
		tion Flow Sheet located in the			documentation, and monitoring	g	
		e electronic medical record			requirements		
		nt did not have a bowel			·Bowel movement monito	oring	
	movement on 4/17/25, 4/18/25, and 4/19/25. There				and constipation protocol		
	was no documentation on 4/20/25.				implementation		
					·Proper documentation o	f	
	A Nurse's Note, dated 4/20/25 at 9:07 p.m.,				compression device usage an	d	
	indicated during shift report the oncoming nurse				monitoring		
		at had vomited twice. The			·Medication administratio	n	
	I -	ain right after shift change and			related to blood pressure		
		ner (NP) was notified. An order			parameters		
		ofran (a medication to prevent			·Proper documentation ir	the	
		g) 4 mg every 6 hours as			electronic health record		
		ose was given at 8:00 p.m.			Plan to Monitor Performance	:	
		was given, the resident			·DON/Designee will conduct		
	continued to vomit	and the NP was notified.			weekly audits of residents with	ו	
					bruises, on anticoagulation		
		r, dated 4/20/25, indicated the			therapy, receiving opioids, usi	-	
		e a KUB (kidney, ureter, and			compression devices, and tho		
	bladder x-ray).				with blood pressure medicatio		
					parameters to ensure appropr	iate	
	l -	dated 4/21/25, indicated the			assessment, monitoring, and		
		eive Docusate Sodium (a stool			documentation are in place.		
		capsule two times a day for			·The DON will review audit		
		days, Lactulose (a laxative)			results weekly and address ar	ıy	
		ms/30 ml, give 30 ml every 24			identified issues immediately.		
		constipation for 30 days, and			Results of audits will be		
		a laxative) 17 gram scoop, give			reported to the Quality Assura		
	1 -	for constipation for 30 days,			Performance Improvement (Q	•	
	give 17 grams mixed with 8 ounces of fluid twice				Committee monthly for 6 month		
	daily as needed.				and until substantial compliand	ce is	
					achieved and maintained.		
	_	AR indicated the resident			·The QAPI Committee will m		
	received the Docus	ate Sodium on 4/21/25 at 5:00			recommendations for addition	al	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIER		1532 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	received the Lactule	9:00 a.m. The resident had not ose or the Glycolax Powder. tiated on 4/21/25 related to the pioid medications.		monitoring or changes in monitoring frequency based of audit results. Date of Compliance: 05/23/2	
		tion Flow Sheet indicated the bowel movement on 4/21/25.			
	indicated the reside adynamic ileus (a comovement is slowed coordinated muscle abdomen with no be continued with naus	ed 4/22/25 at 2:08 p.m., nt's KUB showed a mild ondition where the bowel's d or stopped due to a lack of activity) in the right mid owel obstruction. The resident sea and vomiting and he resident would be sent to a for evaluation.			
	Director of Nursing	on 4/25/25 at 11:00 a.m., the and the Nurse Consultant d follow up on the issue with pation.			
	Wing Unit Manager	on 4/25/25 at 11:15 a.m., the C rindicated the resident did ment on 4/20/25 but it was not			
	provided by the Dir 4:25 p.m. The polic regimen would be e constipating medica protocol, if the resid or only small docum days outside of the determine if additio were warranted. 3.	"Bowel Protocol" policy was ector of Nursing on 4/29/25 at ey indicated the resident's drug valuated to identify possible utions and per the bowel dent had no bowel movement mented bowel movements for baseline, the provider would nal testing and/or medications On 4/22/25 at 9:18 a.m., nand was observed to be			

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	l í	UILDING	nstruction <u>00</u>	(X3) DATE COMPL 04/29 /	ETED
	PROVIDER OR SUPPLIER			1532 CA	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	glove on her bedsid indicated she wore right hand, but only On 4/22/25 at 2:26	I there was a compression te table. The resident the compression glove on her at night. p.m., Resident 60 was observed on glove in place to her right					
	4/23/25 at 11:33 a.r	Resident 60 was completed on n. Diagnoses included, but hypertension, end stage renal diabetes mellitus.					
		nimum Data Set (MDS) /23/25, indicated the resident entitively impaired.					
	had renal insufficient included to elevate edema and to monit (fluid overload) suc was no specific care	3/10/25, indicated the resident ney. The interventions feet to help prevent dependent for for signs of hypervolemia h as dependent edema. There is plan or interventions related ema or the compression glove					
	remove the right hat every morning for s document any abnot were no directions of	r, dated 3/21/25, indicated to nd glove to assess the skin kin breakdown and to rmalities or skin issues. There on when to apply the or how long the resident was ach day.					
	Treatment Adminis 4/2025, indicated the removed daily at 9 at	ministration (MAR) and tration (TAR) Records, dated the compression glove had been a.m. The skin was monitored tign was documented. A - sign					

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CC A. BUILDING B. WING	onstruction 00	COM	E SURVEY PLETED 9/2025	
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	4/13, 4/14, 4/15, 4/1 A + sign was docum 4/12, 4/18, 4/21, and definition or key to meant. During an interview Director of Nursing	4/1, 4/3, 4/5, 4/6, 4/7, 4/8, 4/11, 16, 4/17, 4/19, 4/20, and 4/22/25. nented on 4/2, 4/4, 4/9, 4/10, d 4/23/25. There was no indicate what the + or - sign or on 4/24/25 at 1:53 p.m., the indicated he had clarified the order so it would be less					
	4:29 p.m. Diagnose	cord was reviewed on 4/23/25 at s included, but were not limited nellitus, hypertension, and					
		nimum Data Set (MDS) /16/25, indicated the resident act.					
	had an altered cardi atrial fibrillation, co	2/11/25, indicated the resident ovascular status related to bronary artery disease, heart n, and hyperlipidemia.					
	hydralazine (a medi pressure) 100 mg (r hold if systolic bloc	r, dated 2/15/25, indicated cation used to lower blood milligrams) three times a day, and pressure (top number of ing) is less than 120.					
	Entresto (sacubitril- to treat heart failure pressure) 97-103 m	r, dated 2/15/25, indicated evalsartan, a medication used that can lower blood g every morning and at tolic blood pressure is less					

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	NT OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COM	e survey pleted 9/2025
	PROVIDER OR SUPPLIEF		1532 C	ADDRESS, CITY, STATE, ZIP C ALUMET AVENUE IN 46311	COD	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	The Medication Addated 4/2025, indicated 4/2025, indicated 4/2025, indicated and times: - 4/1/25 at 2:00 p.m. 10:00 p.m., blood p.m., blood p.m., blood p.m., blood p.m., 4/3/25 at 2:00 p.m 4/3/25 at 2:00 p.m 4/16/25 at 2:00 p.m 4/16/25 at 2:00 p.m 4/18/25 at 2:00 p.m 4/19/25 at 2:00 p.m. The MAR, dated 4/was not held per the following dates and - 4/1/25 at 8:00 a.m. 8:00 p.m., blood pr 4/3/25 at 8:00 a.m. 8:00 p.m., blood pr 4/3/25 at 8:00 a.m 4/16/25 at 8:00 a.m 4/16/25 at 8:00 a.m 4/19/25 a	ministration Record (MAR), ated the hydralazine was not ian's Order on the following a., blood pressure 112/63 and pressure 112/69 a., blood pressure 112/68 a., blood pressure 115/64 a., blood pressure 118/72 a., blood pressure 118/72 a., blood pressure 118/72 a., blood pressure 118/72 a., blood pressure 118/58 a., blood pressure 118/58 a., blood pressure 118/65 a., blood pressure 112/61 and a limes: a., blood pressure 112/61 and a lessure 112/69 a., blood pressure 116/63 and a lessure 116/63 a., blood pressure 113/61 and a limes a., blood pressure 113/61 and a limes a., blood pressure 113/61 and a limes a., blood pressure 113/62 a., blood pressure 113/65 a.,				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CO A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/29/2025		
	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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	assessment, indicate	sion MDS (Minimum Data Set) ed the resident had mild nt and was dependent in ving and transfers.			
	was at risk for adve anticoagulant (bloo	led monitoring, documenting,			
	There was no documentation of an assessment of the bruises.				
	indicated the bruise The left hand bruise last hospitalization, indicated the bruisi	on 4/24/25 at 10:05 a.m., LPN 3 s were from lab blood draws. had been present since his but it was improving. She ng should have been umented in the record.			
	-Indiana", received Nursing on 4/24/25 staff nurse will obta the new bruise daily monitoring will be	uise Identification Monitoring- as current from the Director of at 11:19 a.m., indicated " The ain a physician order to monitor a until resolved. This recorded on the MAR stration record] or TAR ration record]".			
	3.1-37(a)				
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Device	s to Maintain Hearing/Vision			
-	failed to assist a res	view and interview, the facility ident to see an eye doctor for ewed for vision. (Resident 29)	F 0685	POC F685 – Treatment/Devicto Maintain Hearing/Vision IGNITE MEDICAL RESORT LLC makes every effort to opin substantial compliance with	DYER erate

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Event ID:

MUGE11 Facility ID: 013462

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AND PLAN OF CORRECTION 155840 NAME OF PROVIDER OR SUPPLIER GNITE MEDICAL RESORT DYER LLC (X4) ID SUMMARY STATEMENT OF DEFICIENCIE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG) TAG PROULATORY OR LSC DENTIFYING INFORMATION During an interview on 4/21/25 at 11:33 a.m., Resident 29 indicated he could not see with the glasses he had and he had not been evaluated by an eye doctor since before his admission to the facility on 7/8/24. During an interview on 4/23/25 at 2:00 p.m., the resident's daughter indicated she had asked Social Worker I about setting up an eye doctor since before his admission to the facility and they could not make arrangements for him. The resident's record was reviewed on 4/23/25 at 2:57 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic respiratory failure with hypoxia (low oxygen levels), and dementia. The 4/10/25 Quarterly Minimum Data Set (MDS) assessment indicated the resident and moderate cognitive impairment, and required partial/moderate assistance with activities of daily living and transfers. A BULLDING BY TRATE ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311 PREFIX TAG SEARCH OF CRESCRIT DYER LC SCALUMET AVENUE DYER, IN 46311 PREFIX TAG SEARCH OF CRESCRIT DYER LC SCALUMET AVENUE DYER, IN 46311 Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submitting this Plan of Correction in compliance on to waive any objections it may have as to the merit or form of any of the allegations on the merit or form of any of the allegation of contained herein. Please note that the facility may contest the merits or form of any of the allegation of compliance for the deficiencies noted. It is the facilities by assisting residents in making appointments and arranging transportation to vision and heari	STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY
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living and transfers. making appointments and arranging transportation to vision			-			maintain vision and hearing		
arranging transportation to vision		•	•	abilities by assisting residents in			in	
		living and transfer	S.			making appointments and		
There was no documentation of vision/eye care						arranging transportation to vis	ion	
and he documentation of vision eye care and literating specialists as		There was no docu	amentation of vision/eye care			and hearing specialists as		
for the resident. needed.		for the resident.				needed.		
Corrective Action for Affected						Corrective Action for Affecte	d	
During an interview on 4/24/25 at 11:08 a.m., the Residents: An appointment was		During an intervie	w on 4/24/25 at 11:08 a.m., the			Residents: An appointment w	as	
Director of Social Services indicated the resident scheduled for Resident 29 with an		Director of Social	Services indicated the resident			scheduled for Resident 29 with	h an	
should be able to see an eye doctor if needed and optometrist. Transportation		should be able to s	see an eye doctor if needed and			optometrist. Transportation		
they would help make those arrangements. arrangements have been made						arrangements have been mad	е	
through facility-approved						_		
3.1-39(a)(1) transportation services. The Social		3.1-39(a)(1)					ocial	
3.1-39(a)(2) Services Director has documented						1		
these arrangements in the						these arrangements in the		
resident's medical record.						-		
Identifying other Residents								

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING	00	COMP	E SURVEY PLETED 9/2025
	ROVIDER OR SUPPLIEF		1532 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	ION D BE OPRIATE	(X5) COMPLETION DATE
				having the Potential to be Affected: The Social Serve Director initiated a facility-audit of all current residen identify those requiring vis services. The audit include of medical records, most in MDS assessments, and resident/family interviews identify any unmet vision of needs. Measures put into place Systemic Changes: 1. The Director of Nursing/General Manager in-service all Social Service and Licensed Nurses on: Facility policy regard vision and hearing care seed. Process for scheduli appointments and arranging transportation Documentation requirements for vision/he care needs and services Plan to Monitor Performation. The GM/Designee will weekly audits of 10 reside records to ensure: Vision/hearing needs properly assessed Appointments are scheduled as needed Transportation is arr Services are documented and services are documented and services. The General Manager review audit results weekly 2. The Social Services Desired will report monitoring results well results well report monitoring results well report monitoring results well results well results well results well results results well results results well results results well report monitoring results r	vices wide ts to ts to sion care es review recent to care or will tes staff ding ervices ing ng aring ance: conduct ents' s are ranged ented in will y irector	

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

Event ID:

MUGE11 Facility ID: 013462

If continuation sheet Page 25 of 53

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 04/29/2025	
NAME OF F	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE	
IGNITE N	MEDICAL RESORT	DYER LLC	DYER,	, IN 46311	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
me	REGELITORI GA	A SEC IDENTIFY THE THE ORIGINATION	n.o	Quality Assurance and Performance Improvement (Committee monthly for 6 m	API) hs. uate ons
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mg	mt/Restore Eating Skills			
	interview, the facilii (gastrostomy tube, a the stomach) flushe 1 of 6 residents obse administration. (Reference of Finding includes: On 4/24/25 at 1:04 preparing Resident crushed each pill and She entered the resifeeding on hold, and (cc) of water into a the G-tube syringe in drew up the 30 cc of G-tube and placed to tube and pushed the using the plunger. So medications in 5 cc medications and reribusing an interview.	p.m., LPN 2 was observed 202's medications. She d placed it in a separate cup. dent's room, put the tube d poured 30 cubic centimeters medication cup. She inserted nto the medication cup and f water. She opened the he syringe directly into the 30 cc of water down the tube She diluted each of the of water and administered the naining flushes by gravity.	F 0693	POC F693 – Tube Feedings Mgmt/Restore Eating Skills IGNITE MEDICAL RESORT I LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Pla Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is subm this Plan of Correction in compliance with its regulatory obligations and does not waiv any objections it may have as the merit or form of any allega contained herein. Please note the facility may contest the mo or form of any of the alleged deficient findings and may tak reasonable steps to appeal th This Plan of Correction consti IGNITE MEDICAL RESORT I LLC's written credible allegati compliance for the deficiencie noted. It is the facility's policy to ensu that residents who receive en	erate an of an of itting e to otions e that erits ee em. tutes DYER on of es

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Event ID:

MUGE11 Facility ID: 013462

If continuation sheet Page 26 of 53

PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/29/2025
	PROVIDER OR SUPPLIER		1532 (ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE , IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	N (X5) SE COMPLETION DATE
	Director of Nursing flush had not been a G-tube medication requested. A current facility por Administration Entra Remove plunger from tubing. 10. Fl	on 4/24/25 at 1:53 p.m., the was made aware the G-tube administered by gravity. The administration policy was blicy, titled "Medication eral Tubes," indicated, "9. om syringe and insert syringe ush with waterb. Allow down tube via gravity"		nutrition receive appropriate treatment and services to p complications, including proadministration of G-tube fluxia gravity method as outlin our "Medication Administrate Enteral Tubes" policy. Corrective Action for Affect Residents: LPN 2 was immediately re-educated by Director of Nursing on propicative flush administration gravity method. No adverse noted. Resident 202 no longer resident having the Potential to be Affected: Director of Nursing conducted an audit of all curesidents with G-tubes to id those potentially affected by practice and to ensure that medications/flushes are bei administered via gravity method proper G-medication administration affush procedures, emphasiz gravity method requirement 2. The facility's "Medication Administration Enteral Tube policy was reviewed and recurrent with no revisions ne Plan to Monitor Performant.	revent oper shes ed in ion cted the er via effects des in s g rrent entify this ng thod. r h return ed tube nd ing the . n es" mains eded. ice:

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Event ID:

MUGE11 Facility ID: 013462

If continuation sheet

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PRINTED: 05/21/2025 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING	00	COMPLETED 04/29/2025
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT DYER LLC			1532 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311	į.
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				direct observation audits of G- medication administration for 8 random observations on alternating shifts weekly to ens proper G-tube medication administration and flush procedures are followed. 2.Any identified deficiencies result in immediate re-educatic and additional monitoring of th involved staff member. 3.The Director of Nursing wil analyze audit results and repo findings to the Quality Assurar and Performance Improvemer (QAPI) committee monthly for months. The QAPI committee evaluate the effectiveness of ti plan and make changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 05/23/25	sure will on ee Il ort nce ot 6 will he
F 0695 SS=D Bldg. 00	Suctioning Based on observation interview, the facility received the necessary to oxygen administrative for respiration of the facility reviewed for respiration of the facility reviewed for respiration of the facility for the facility facility for the facility	eostomy Care and on, record review and ty failed to ensure residents ary care and treatment related ration for 1 of 4 residents atory care. (Resident 60)	F 0695	POC F695 – Respiratory/Tracheostomy C and Suctioning IGNITE MEDICAL RESORT D LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Pla Correction is an admission	oYER erate
	rate was set at 1.5 li	e via nasal cannula. The flow ters. The resident indicated d it was usually set at 2 liters.		otherwise. IGNITE MEDICAL RESORT DYER LLC is submithis Plan of Correction in compliance with its regulatory	tting

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 04/29/2025 155840 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **1532 CALUMET AVENUE** IGNITE MEDICAL RESORT DYER LLC DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE On 4/22/25 at 2:26 p.m., Resident 60 was observed obligations and does not waive with oxygen in place via nasal cannula. The flow any objections it may have as to rate was set at 1.5 liters. the merit or form of any allegations contained herein. Please note that Record review for Resident 60 was completed on the facility may contest the merits 4/23/25 at 11:33 a.m. Diagnoses included, but or form of any of the alleged were not limited to, hypertension, end stage renal deficient findings and may take disease, and type 2 diabetes mellitus. reasonable steps to appeal them. This Plan of Correction constitutes The Admission Minimum Data Set (MDS) IGNITE MEDICAL RESORT DYER assessment, dated 2/23/25, indicated the resident LLC's written credible allegation of was moderately cognitively impaired and did not compliance for the deficiencies receive oxygen therapy. noted. It is the facility's policy to ensure There was no current care plan related to oxygen that residents who need respiratory care, including oxygen therapy, receive such care The Physician's Order Summary, dated 4/2025, consistent with professional lacked any orders for oxygen. standards of practice, the comprehensive person-centered During an interview on 4/24/25 at 11:58 a.m., the care plan, and the residents' goals Director of Nursing indicated he was unable to and preferences. find any current orders for oxygen. **Corrective Action for Affected** Residents: Resident 60's A facility policy, titled "Oxygen," indicated, "1. physician was notified and orders Residents who are admitted on oxygen or were obtained for oxygen at 2 isolation precautions will have orders recorded in liters per nasal cannula. A care the resident's chart. The oxygen will be plan was developed addressing administered by the route and liter flow ordered oxygen therapy needs. The by the physician..." resident's oxygen flow rate was adjusted to 2 liters as ordered. 3.1-47(a)(6) Identifying other Residents having the Potential to be Affected: Director of Nursing conducted an audit of all current residents receiving oxygen therapy to ensure proper physician orders, care plans, and flow rates were in place. Measures put into place or

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	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING	00	COMPLETED 04/29/2025
	ROVIDER OR SUPPLIER IEDICAL RESORT		1532 C	ADDRESS, CITY, STATE, ZIP COD FALUMET AVENUE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
				Systemic Changes: The Dir of Nursing in-serviced all Lic nurses on: Proper documentation requirements for oxygen the Verification of physician oprior to oxygen administration Development and implementation of care plans residents receiving oxygen the Monitoring and document of oxygen flow rates Protocol for obtaining and documenting oxygen orders admission and as needed The Director of Reservations add oxygen orders to admission and as needed The Unit Managers will verify oxygen orders and care planduring daily clinical meeting. Plan to Monitor Performance DON/Designee will audit 10 residents receiving oxygen tweekly for 6 months to ensue Physician orders are in plander of the Director of Nursing implemented Documentation is completed accurate The Unit Manager will conducted all residents receiving oxygen to the Director of Nursing immediately. The Director of Nursing will read the Director of Nursing immediately. The Director of Nursing will resudit findings to the Quality Assurance and Performance Improvement (QAPI) commit	erapy orders on s for therapy tation d upon s will sion fy ns . ce: therapy ire: ace d and te and uct as on en ncies

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Event ID:

MUGE11 Facility ID: 013462

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING 00 COMPI				
		155840	B. WING 04/29/202			/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	DROVIDED'S DI AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	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
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG			DATE
					monthly for 6 months. The QA committee will review the resuland make recommendations for additional interventions if need until substantial compliance is achieved and maintained. Date of Compliance: 05/23/25	ilts or ded	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication	n Error Rts 5 Pront or More					
nag. 00	interview, the facility error rate of less that observed during me medication errors we opportunities for erradministration. This rate of 7.69%. (Rest Finding includes: On 4/24/25 at 9:30 a preparing Resident of included Lantus (insignature). LPN 1 rentered the insulin pen with needle on the pen. Spen to 20 units and the resident's left about the insulin pen prior She then removed her hands, and disposal record for Resident.	a.m., LPN 1 was observed 66's medications, which sulin glargine, long-acting noved the resident's insulin pen a cart and donned a gown and I the room, cleaned the top of an alcohol swab, and put the She dialed the Lantus insulin administered the injection to domen. She had not primed to administering the injection. er gown and gloves, washed osed of the needle in the	F 07	759	POC F759 – Free of Medication Error Rts 5 Prcnt or More IGNITE MEDICAL RESORT D LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Plat Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submit this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allegat contained herein. Please note the facility may contest the me or form of any of the alleged deficient findings and may tak reasonable steps to appeal the This Plan of Correction constit IGNITE MEDICAL RESORT D LLC's written credible allegation compliance for the deficiencies noted. It is the facility's policy to ensure	DYER erate an of titing e to tions that erits e em. tutes DYER on of s	05/23/2025
		. Diagnoses included, but were			medication error rates are not percent or greater and that ins is administered according to		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER				COMPLETED
		155840	B. W	ING	_	04/29/2025
)	NOT THE OF STATE			STREET .	ADDRESS, CITY, STATE, ZIP COD	
NAME OF F	PROVIDER OR SUPPLIER	t			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	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
					physician orders and facility	
	1	der Summary, dated 4/2025,			protocols, including proper pri	ming
		units subcutaneously in the			of insulin pens.	
	morning.				Corrective Action for Affecte	
	Duning on interview	. on 4/24/25 at 0.55 a m. I DN 1			Residents: Resident 66 asses	ssea
	_	on 4/24/25 at 9:55 a.m., LPN 1 ot primed the insulin pen prior			for any adverse effects from	
		e injection. The insulin pen prior			receiving 20 units instead of 1 units of Lantus insulin. The	0
	_	they were new and first				
		lministered 20 units of insulin,			physician was notified of the medication error and provided	new
	_	s supposed to receive 18			orders as needed.	IICAA
	units.	s supposed to receive 18			Identifying other Residents	
	units.				having the Potential to be	
	During an interview	on 4/24/25 at 10:44 a.m., the			Affected: Director of Nursing	
	_	was made aware of the			initiated an audit of all residen	ts
	_	The insulin administration			receiving insulin via insulin pe	
	policy was requeste		ensure proper administration			
					technique and correct dosing.	
	A facility policy, tit	led "Insulin Administration			Measures put into place or	
		ed, "Insulin Pens:8. Turn			Systemic Changes: Director	of
		2 units. Hold the pen with the			Nursing completed in-serviced	
		and tap the cartridge gently a			education to Licensed nurses	
	few times. This mo	oves the air bubbles to the top.			regarding:	
	9. Press the push by	utton all the way in until the			·Proper insulin pen priming	
	dose selector is bac	k to a 0. A drop of insulin			technique	
		e tip of the needle. This will			Verification of insulin doses	
		g and avoid injecting air onto			prior to administration	
	1 -	rn the dose selector to the			·Review of facility's Insulin	
		eded to inject. The pointer			Administration Procedure	
	should line up with	the correct dose"			·Importance of following	
					physician orders exactly as	
	3.1-48(c)(1)				written	
					·Documentation requiremen	ts for
					insulin administration	
					Plan to Monitor Performance	
					DON/Designee will conduct di	l l
					observation audits of insulin p	
					administration for 5 random in	sulin
					administrations on alternating	
	l		1		shifts per week. Any identified	1

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE		SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLET			ETED	
		155840	B. WING 04/29/2025			/2025	
			- 	STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIER	-			ALUMET AVENUE		
IGNITE N	MEDICAL RESORT	DYER LLC			IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	F	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					deficiencies will result in immediate re-education and additional monitoring. The Director of Nursing will retall audit results and present findings to the Quality Assurar and Performance Improvement (QAPI) committee monthly for months and quarterly thereafted. The QAPI committee will evaluate effectiveness of the plan a make changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 05/23/25	nce nt 6 er. uate nd	
F 0761 SS=D Bldg. 00	failed to ensure medication cart at a observed during medication (Resident 66) Finding includes: On 4/24/25 at 9:30 a preparing medication a pill card of multive card of ferrous sulfamedication cart. She containing the resident top of the medication indicated she needed the Nurse's Station a away from the medication of medications and	and Biologicals on and interview, the facility dications were kept in a locked ll times for 1 of 6 residents dication administration. a.m., LPN 1 was observed ons for Resident 66. She placed itamin medication and a pill the medication on top of the the placed the medication cup ent's morning medications on on cart. At 9:37 a.m. she d to go "get something" from and walked down the hallway the cation cart. The two pill cards the medication cup with the medications remained on top of	F 07	61	POC F761 Label/Store Drugs and Biologicals MEDICAL RESORT DYER LL makes every effort to operate substantial compliance with Federal and State laws and regulations. Nothing in this Pla Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submithis Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allega contained herein. Please note the facility may contest the meror form of any of the alleged deficient findings and may take reasonable steps to appeal the This Plan of Correction constit	C in an of tting e to tions that erits e e em.	05/23/2025

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CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
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. WING		04/29/2025	
NAME OF 1	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD			
IGNITE I	MEDICAL RESORT	DYER LLC		ALUMET AVENUE IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	DROVIDED'S DI AN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	On 4/24/25 at 9:40 medication cart. Do LPN 1 indicated she medications unatter During an interview Director of Nursing medications had be medication cart. A	a.m., LPN 1 returned to the uring an interview, at that time, e should not have left the ided. y on 4/24/25 at 10:44 a.m., the gwas made aware the		PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) IGNITE MEDICAL RESORT D LLC's written credible allegatic compliance for the deficiencies noted. It is the facility's policy that all medications must be stored in locked compartments under proper temperature controls, w access limited to authorized personnel only. Medications m not be left unattended on medication carts or other unsecured areas. Corrective Action for Affecte Residents: LPN 1 was immediately re-educated by the Director of Nursing regarding proper medication security procedure Resident 66's medications we secured immediately in the medication cart. Identifying other Residents having the Potential to be Affected: All residents who receive medications have the potential to be affected by this practice. Director of Nursing conducted an audit of all medication carts to ensure pro-	DYER on of s with must ed	
				medication security was being maintained. Measures put into place or Systemic Changes: 1 The Director of Nursing was being maintained.		
				licensed nurses regarding: Proper medication security		

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Requirements for maintaining

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u> COMPLETE			ETED	
		155840	B. WING 04/29/2025			2025	
				CTREET	ADDRESS SITY STATE TIP SOD		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
ICNUTE A	AEDICAL DECODE	DVEDILIC			ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYER LLC		DYEK,	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	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					locked medication carts at all		
					times		
					Protocol for never leaving		
					medications unattended		
					Procedure for securing		
					medications before leaving		
					medication cart area		
					Plan to Monitor Performance	:	
					1 DON/Designee will condu	ıct	
					random medication security a	udits	
					5 times per week on alternatin	g	
					shifts to ensure:		
					Nurses are following medica	tion	
					administration practices		
					Medications are locked and		
					secured		
					3334.34		
					2 Results of these audits w	ill	
					be reported to the Quality		
					Assurance and Performance		
					Improvement (QAPI) committe		
					review and recommendations	until	
					substantial compliance is		
					achieved and maintained for 6	i	
					consecutive months.		
					Date of Compliance: 05/23/25	5	
E 0700	100 55()(1) (5)						
F 0790 SS=D	483.55(a)(1)-(5)	ou Dontel Omice in ONE-					
	Routine/Emergend	cy Dental Srvcs in SNFs					
Bldg. 00	Rosed on magaind mar	riany and interview the facility	E 05	700	DOC E700 Bouting/Emarca		05/22/2025
		riew and interview, the facility ident to obtain dental care for	F 07	/90	POC F790 Routine/Emergend	у	05/23/2025
		ewed for dental services.			Dental Srvcs	VED	
	(Resident 29)	wed for dental services.			IGNITE MEDICAL RESORT D		
	(Nesident 29)				LLC makes every effort to ope in substantial compliance with		
	Finding includes:				Federal and State laws and		
	1 maing metades.				regulations. Nothing in this Pla	an of	

During an interview on 4/21/25 at 11:33 a.m.,

Correction is an admission

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	·			ETED
		155840	B. W	ING		04/29/	2025
		<u> </u>		STREET /	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			ALUMET AVENUE		
IGNITE N	MEDICAL RESORT	DYER LLC			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 APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE
		ed his dentures did not fit well,			otherwise. IGNITE MEDICAL		
	-	o chew, and he had not been			RESORT DYER LLC is submi	itting	
	_	ist since before his admission			this Plan of Correction in		
	to the facility on 7/8	8/24.			compliance with its regulatory		
		4/22/25 2.00			obligations and does not waiv		
	-	v on 4/23/25 at 2:00 p.m., the			any objections it may have as		
	_	indicated she asked Social			the merit or form of any allega		
		ting up a dentist appointment			contained herein. Please note		
		he indicated dental care was			the facility may contest the me	erits	
	•	at the facility and they could			or form of any of the alleged		
	not make arrangeme	ents for him.			deficient findings and may tak		
	and the state of	1 1 1/02/05			reasonable steps to appeal th		
		d was reviewed on 4/23/25 at			This Plan of Correction consti		
		es included, but were not			IGNITE MEDICAL RESORT D		
	· ·	chronic obstructive pulmonary			LLC's written credible allegation		
	· ·	spiratory failure with hypoxia			compliance for the deficiencie	S	
	(low oxygen levels)), and dementia.			noted.		
	FT 4/10/05 0	1.1F2(0f) D G)			It is the facility's policy to assis		
		rly MDS (Minimum Data Set)			residents in obtaining routine		
		d the resident had moderate			emergency dental care, includ	ling	
	cognitive impairme				making appointments and		
		sistance with activities of daily			arranging transportation as		
	living and transfers.	•			needed, in accordance with F	790	
	Tri 1				requirements.		
		mentation of dental care for the			Corrective Action for Affecte		
	resident.				Residents: Resident 29 state	u ne	
	Duning on intermi	v on 4/24/25 at 11:08 a.m., the			will notify Social Services	ot o d	
	_	Services indicated the resident			Department once he has sele	cied	
					his dentist of choice. An	no	
	would help make th	e a dentist if needed and they			appointment and transportation will be scheduled once decision		
	would help make th	iose arrangements.				ווע	
	3 1-24(a)(1)				has been made. The facility's	ıı	
	3.1-24(a)(1) 3.1-24(b)				social services department will document all dental care	II	
	J.1-27(U)				coordination in the resident's		
					medical record.		
					Identifying other Residents		
					having the Potential to be		
					Affected: The Social Services		
					Director initiated a facility-wide		
					T DUSCIOL HUMAIEU A IACIUM-WICE	-	•

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	COMP	E SURVEY PLETED 9/2025
	ROVIDER OR SUPPLIE		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE IN 46311	•	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)	TION ILD BE ROPRIATE	(X5) COMPLETION DATE
				audit of all current resider identify those requiring do services, including those dentures. The audit inclure review of medical records recent MDS assessments resident/family interviews identify any unmet dental needs. Measures put into place Systemic Changes: 1 The Director of Nursing/General Manage in-service all social service and licensed nurses on: Facility policy regarding services coordination Process for scheduling appointments Documentation required dental care coordination Transportation arrange procedures Plan to Monitor Perform 1 The GM/Designee we conduct weekly audits of residents' records to ensure Dental needs are being and addressed Appointments are being and addressed Appointments are being scheduled as needed Transportation is being appropriately Services documented in records The General Manage review audit results weekly audit results weekly audit report monitoring results will report monitoring results.	ental with des s, most s, and s to l care e or er will des staff g dental dental ments for ment lance: will 10 ure: g identified g arranged n medical der will sly Director	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	00	COMPLETED	
		155840	B. W	ING		04/29/	2025
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	BROWINEDIS DI ANI OE CORDECTIONI		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PROVIDERS PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store Based on observation interview, the facility clean and in good re labeled and dated for potential to affect 86	e/Prepare/Serve-Sanitary on, record review, and ty failed to keep the kitchen epair related to food not or 1 of 1 kitchen. This had the 6 residents who resided in the d food from the kitchen. (The	F 08		Quality Assurance and Performance improvement (Quality Assurance improvement) The QAPI committee will evaluate the effectiveness of intervention and make changes as needed until substantial compliance is achieved and maintained. Date of Compliance: 05/23/25 POC F812 Food Procurement Store/Prepare/Serve – Sanital IGNITE MEDICAL RESORT DELIC Makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Plate	t, by t, by Erate	05/23/2025
	4/21/25 at 9:17 a.m. following was obser 1. In the dry storage unlabeled storage bi and an unlabeled co yellow liquid. 2. In the walk-in counlabeled squeeze be substance. There we with cut-up potatoes	e room, there was a large in containing a white powder intainer partially filled with coler, there was a partially full, bottle containing a red/brown as an uncovered bucket filled is and water. There were trays			Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submithis Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allega contained herein. Please note the facility may contest the merit or form of any of the alleged deficient findings and may take reasonable steps to appeal the This Plan of Correction constitution.	etting to tions that erits e em. cutes DYER on of	
	of desserts in a rack unlabeled.	that were uncovered and			compliance for the deficiencies noted. It is the facility's policy to store		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/29/2025 155840 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **1532 CALUMET AVENUE** IGNITE MEDICAL RESORT DYER LLC DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 3. In the walk-in freezer, there was an open, prepare, distribute and serve food unlabeled bag of fish patties and an open, in accordance with professional unlabeled bag of corn. standards for food service safety, including proper labeling and 4. In the food prep area, there was a large plastic covering of all food items. bin and a smaller plastic container filled with a **Corrective Action for Affected** white powder. Both were unlabeled. **Residents:** The Kitchen Manager immediately discarded all During an interview on 4/21/25 at 9:20 a.m., the unlabeled food items in the dry Kitchen Manager indicated all food items should storage room, walk-in cooler, have been labeled and dated when opened and walk-in freezer, and food prep the uncovered items should have had lids on area. All remaining food items them. were properly labeled with contents and dates. The A policy titled "Labeling and Dating Foods", uncovered bucket of cut-up received as current from the Kitchen Manager on potatoes and uncovered dessert 4/24/25 at 8:28 a.m. indicated, " ... Packaged or trays were immediately covered containerized bulk food may be removed from the with appropriate lids. original package and stored in an ingredient bin **Identifying other Residents** labeled with the common name of the food, the having the Potential to be date the item was opened and the date by which **Affected:** The Dietary Manager the item should be discarded or used by ..." conducted a complete inventory inspection of all food storage A policy titled "Storage of Dry Goods/Foods", areas including dry storage, received as current from the Kitchen Manager on walk-in cooler, walk-in freezer, and 4/24/25 at 8:28 a.m. indicated, " ... Opened food prep areas to identify any products are labeled, dated with the use by date other unlabeled or uncovered food and tightly covered to protect against items. All food items were contamination including from insects and rodents evaluated for proper labeling and covering. Measures put into place or A policy titled "Labeling and Dating Foods-**Systemic Changes:** -Refrigerated Food", received as current from the 1.The Dietary Manager provided Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, in-service education to all dietary " ... If opened, the cold food item is labeled with staff regarding proper food the date opened and the date by which to discard labeling, dating, and storage or use by ..." requirements. 2. The facility's policies on 3.1-21(i)(3)"Labeling and Dating Foods" were reviewed and reinforced with all

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	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING	00	COMPLETED 04/29/2025	
	ROVIDER OR SUPPLIER		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 APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				dietary staff. 3."Label and Cover" reminder signs were posted in all food storage areas. Plan to Monitor Performance 1.The Dietary Manager/Designee will conducted daily audits of all food storage areas to ensure compliance with proper food labeling and cover requirements. 2.Any identified issues will be corrected immediately and additional staff education proves needed. 3.The Dietary Manager will report monitoring results to the Quality Assurance and Performance improvement (Quality Assurance and Performance improvement (Quality Assurance and Performance improvement in QAPI committee will evaluate effectiveness of intervention and make changes as needed until substantial compliance is achieved and maintained.	e ided API) ns. uate	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.7 Resident Records	'0(i)(1)-(5) - Identifiable Information				
	failed to ensure the and accurately docu administration docu orders for 1 of 27 re Finding includes:	iew and interview, the facility medical record was complete mented related to medication mentation and medication cords reviewed. (Resident 42)	F 0842	POC F842 Resident Records Identifiable Information IGNITE MEDICAL RESORT D LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Pla Correction is an admission otherwise. IGNITE MEDICAL	oyer oyer oyer oyer oyer oyer oyer oyer	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 04/29/2025 155840 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **1532 CALUMET AVENUE** IGNITE MEDICAL RESORT DYER LLC DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE 8:26 a.m. Diagnoses included, but were not limited RESORT DYER LLC is submitting to, diabetes and heart failure. this Plan of Correction in compliance with its regulatory A Physician's Order, dated 2/25/25, indicated obligations and does not waive Droxidopa (a medication to treat the symptoms of any objections it may have as to low blood pressure) every 8 hours. the merit or form of any allegations contained herein. Please note that The boxes for documenting administration of the the facility may contest the merits medication on the April 2025 Medication or form of any of the alleged Administration Record (MAR) were blank for the deficient findings and may take following doses: 4/6/25 at 10:00 p.m., 4/7/25 at reasonable steps to appeal them. 6:00 a.m., and 4/12/25 at 6:00 a.m. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER A Physician's Order, dated 4/13/25, indicated LLC's written credible allegation of compliance for the deficiencies Midodrine (a medication to treat low blood pressure)every 8 hours as needed for noted. hypotension (low blood pressure). There were no It is the facility's policy to maintain orders for blood pressure parameters for complete and accurate medical administration. records for each resident, including proper documentation of During an interview on 4/24/25 at 3:45 p.m., the medication administration and Assistant Director of Nursing indicated the nurse physician orders with specific parameters for PRN medications. administered the Droxidopa at the times that were blank on the MAR, but she forgot to document it. **Corrective Action for Affected** Residents: Resident 42's During an interview on 4/24/25 at 12:01 p.m., the midodrine medication was Director of Nursing indicated there should be discontinued. specific blood pressure parameters for Identifying other Residents administering the Midodrine, but he could not having the Potential to be find any. Affected: The Director of Nursing initiated an audit of all current 3.1-50(a)(1)residents receiving PRN blood 3.1-50(a)(2)pressure medications to ensure specific parameters are documented. Additionally, the DON conducted a facility-wide audit of medication administration documentation for the past 7 days to identify any other documentation gaps.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
	MEDICAL RESORT SUMMARY (EACH DEFICIEN					N will on: Inting In	(X5) COMPLETION DATE
R 0000 Bldg. 00					until substantial compliance is achieved and maintained. Date of Compliance: 05/23/25		

State Form Event ID: MUGE11 Facility ID: 013462 If continuation sheet Page 42 of 53

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 04/29/2025		
	ROVIDER OR SUPPLIER			1532 C	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311		
IGNITE M (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OR This visit was for a Survey. This visit is State Licensure Sur Nursing Home Corr IN00456419, IN004 and IN00458078. Complaint IN00455 the allegations are corr Complaint IN00456 the allegations are corr Complaint IN00457 the allegations are corr Complaint IN00458 the allegations are corr Complaint IN00458 the allegations are corr Complaint IN00458	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION State Residential Licensure included a Recertification and vey and the Investigation of inplaints IN00455936, 456626, IN00456640, IN00457582, 4936 - No deficiencies related to ited. 419 - No deficiencies related to ited. 4626 - No deficiencies related to ited. 4640 - No deficiencies related to ited. 4582 - No deficiencies related to ited. 4582 - No deficiencies related to ited. 4593 - No deficiencies related to ited. 4594 - No deficiencies related to ited. 4595 - No deficiencies related to ited. 4597 - No deficiencies related to ited.	R 00	DYER, ID PREFIX TAG		an the sts a ons	(X5) COMPLETION DATE
	These State Resider accordance with 410 Quality review com						
R 0217 Bldg. 00	410 IAC 16.2-5-2(Evaluation - Defici						'

State Form Event ID: MUGE11 Facility ID: 013462 If continuation sheet Page 43 of 53

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2025	
	PROVIDER 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 LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
IAU	Based on record reversal failed to ensure service completed and/or up records reviewed. (In Finding includes: Record review for February for Februa	riew and interview, the facility rice plans were signed and polated with changes for 1 of 7 Resident 7) Resident 7 was completed on m. Diagnoses included, but hypertension, atrial fibrillation, order. The resident was cility on 9/1/24. Atted 9/3/24 at 4:05 p.m., mt was admitted to hospice is lack of documentation the en updated with this change. Aluation/Interim Service Plan, ed indication the resident rvices. The outside rvices section was blank. It the resident or responsible A on 4/29/25 at 3:12 p.m., the rector indicated she had gone in with the resident's daughter April and she had signed it,	RO	217	R-217 Evaluations IGNITE MEDICAL RESORT D LLC makes every effort to ope in substantial compliance with Federal and State laws and regulations. Nothing in this Pla Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submit this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allegal contained herein. Please note the facility may contest the me or form of any of the alleged deficient findings and may tak reasonable steps to appeal the This Plan of Correction constit IGNITE MEDICAL RESORT D LLC's written credible allegatic compliance for the deficiencie noted. It is the facility's policy to ensu- that service plans are complet signed, dated, and updated w there are changes in resident services, including the addition hospice services. Corrective Action for Affecte Residents: The Assisted Livir Director reviewed and updated Resident 7's service plan to include hospice services. The service plan was reviewed wit resident and responsible party and signatures were obtained Identifying other Residents having the Potential to be	erate an of titing e to tions that erits e em. tutes DYER on of s ered, then on of the desired o	05/23/2025

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	OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING	00 00	COMPLETED 04/29/2025		
	ROVIDER OR SUPPLIER		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 APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
				Affected: The Assisted Living Director conducted an audit of current resident service plans ensure they were complete, signed, dated, and accurately reflected current services, including outside agency servi Any identified discrepancies w corrected immediately. Measures put into place or Systemic Changes: The Assis Living Director will in-service a licensed nurse on: requirements for service plan completion, including signatures and dating process for updating ser plans when changes occur in resident services documentation requirem for outside agency services a timeline for service pla updates. Plan to Monitor Performance 1 Assisted Living Director/Designee will audit 5 resident service plans weekly ensure compliance with completion, signatures, dating and accurate reflection of curr services. Results of these aud will be documented on a Servi Plan Audit Tool. 2 The Assisted Living Direc will report monitoring results to Quality Assurance and Performance Improvement (Quentity Assurance and	ces. ere sted ill vice ents an : to , ent its ce ctor o the API) hs.		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 04/29/2025	
IGNITE N	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 APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. 3 Date of Compliance: 5/23/	/25
R 0243	410 IAC 16.2-5-4(
Bldg. 00	Health Services - Based on record rev	Deficiency riew and interview, the facility	R 0243	R243 – Health Services	05/23/2025
	with a PRN (as need	e blood pressure of a resident ded) blood pressure medication ords reviewed. (Resident 2)		IGNITE MEDICAL RESORT D' LLC makes every effort to oper in substantial compliance with Federal and State laws and	
	Finding includes:			regulations. Nothing in this Plan Correction is an admission	n of
	at 2:45 p.m. Diagno	dent 2 was reviewed on 4/28/25 oses included, but were not neer and hypertension.		otherwise. IGNITE MEDICAL RESORT DYER LLC is submitt this Plan of Correction in compliance with its regulatory	ting
	resident was alert as	Care Evaluation indicated the and oriented but required the age his medications.		obligations and does not waive any objections it may have as t the merit or form of any allegati contained herein. Please note to	ions
	hydralazine hcl (a b every 8 hours as neo	r, dated 4/4/25, indicated lood pressure medication) eded, give for systolic (the top pressure reading) greater than		the facility may contest the mer or form of any of the alleged deficient findings and may take reasonable steps to appeal the This Plan of Correction constitu- IGNITE MEDICAL RESORT D	m. utes
	The record lacked d	ocumentation of the resident's g monitored.		LLC's written credible allegation compliance for the deficiencies noted.	n of
		on 4/29/25 at 11:20 a.m., the aff did not monitor his blood		It is the facility's policy that nursing staff will monitor and document blood pressure read for all residents with PRN blood	_
		on 4/29/25 at 12:16 p.m., LPN es did not have to check the ssure.		pressure medication orders according to the parameters specified in the physician's order	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155840	B. W	ING		04/29/2025	
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	R			ALUMET AVENUE		
IGNITE N	MEDICAL RESORT	DYFRIIC			IN 46311		
1011111111	TEDIONE NEOGNI	D TER LEG		D I E I K,			1
(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 CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		4/20/27			Corrective Action for Affecte		
	_	v on 4/29/25 at 2:10 p.m. the			Residents: The Assisted Livin	•	
	_	g indicated the parameter order			Director reviewed and discont		
	should not have stayed in the resident's record when they moved to assisted living.				the PRN hydralazine order for		
	when they moved to	o assisted living.			Resident 2 as the resident had		
					transferred to assisted living.		
					resident's physician was notific		
					of the order discontinuation or 4/29/25.	1	
					Identifying other Residents		
					having the Potential to be		
					Affected: The Assisted Living		
					Director conducted an audit of		
					current residents with PRN blo		
					pressure medication orders to		
					ensure proper blood pressure		
					monitoring and documentation		
					was in place. Any identified is:		
					were immediately corrected.		
					Measures put into place or		
					Systemic Changes: The Assi	sted	
					Living Director will in-service a	all	
					Licensed Nurses on:		
					Proper monitoring and		
					documentation requirements f	or	
					PRN blood pressure medication	ons	
					Review of medication		
					administration documentation		
					requirements including vital si	gn	
					parameters		
					Process for order review		
					during level of care transitions		
					Plan to Monitor Performance		
					The Assisted Living Director w	/111	
					conduct weekly audits of:	ام	
					1 Residents with PRN bloo		
			1		pressure medication orders to		
					ensure proper blood pressure		
					monitoring and documentation	1.	
			1				1

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 04/29/2025
	PROVIDER OR SUPPLIEI MEDICAL RESORT		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R 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
R 0273	410 IAC 16.2-5-5	1(f)		2 The Assisted Living Direct will report monitoring plan resist to the Quality Assurance and Performance Improvement (Quality Assurance of Improvement (Quality Assurance of Improvement (Quality Assurance of Improvement (Quality Assurance of Improvement (Assurance of Impro	API) hs . API)
Bldg. 00	Food and Nutritio	on, record review, and	R 0273	R273 – Food and	05/23/2025
	interview, the facilic clean and in good relabeled and dated, is potential to affect 2 facility and received. Findings include: During the Initial Ke 4/21/25 at 9:17 a.m. following was obseted. In the dry storage unlabeled storage be and an unlabeled storage be and an unlabeled concept of the walk-in concept of the w	ity failed to keep the kitchen epair related to food not for 1 of 1 kitchen. This had the for residents who resided in the d food from the kitchen. Citchen Sanitation Tour on with the Kitchen Manager, the		Nutritional Service IGNITE MEDICAL RESORT DELC makes every effort to open in substantial compliance with Federal and State laws and regulations. Nothing in this Plate Correction is an admission otherwise. IGNITE MEDICAL RESORT DYER LLC is submit this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as the merit or form of any allegate contained herein. Please note the facility may contest the merit or form of any of the alleged deficient findings and may tak reasonable steps to appeal the This Plan of Correction constitution.	SOYER crate an of tting e to tions that crits e em. tutes

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	ЛLDING	00	COMPL	ETED
		155840	B. W	ING		04/29/	2025
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	ROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP COD		
IONUTE A	AEDIOAL DECODE	DVEDILO			ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYER LLC		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	DDOVIDED'S DI AN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		rc	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	I C	DATE
	unlabeled.				LLC's written credible allegation	n of	
					compliance for the deficiencies		
	3. In the walk-in fre	eezer, there was an open,			noted.		
		sh patties and an open,			It is the facility's policy that all		
	unlabeled bag of co				food preparation and serving a	reas	
	8				are maintained in accordance		
	4. In the food prep a	area, there was a large plastic			state and local sanitation and		
		astic container filled with a			food handling standards, inclu		
	white powder. Botl				proper labeling and dating of fo	-	
	F 2011				items and covering of stored		
	During an interview	on 4/21/25 at 9:20 a.m., the			foods.		
	Kitchen Manager indicated all food items should				Corrective Action for Affecte	Ч	
	have been labeled and dated when opened and				Residents: The Kitchen Mana		
	the uncovered items should have had lids on				immediately labeled all unlabe	-	
	them.				items in the kitchen including t		
	them.				storage bin containing white	i i C	
	A policy titled "I ab	peling and Dating Foods",			powder, container with yellow		
		from the Kitchen Manager on			1 -		
		. indicated, " Packaged or	liquid, squeeze bottle with red/brown substance, fish patties,				
		food may be removed from the			and corn. All uncovered items	163,	
		d stored in an ingredient bin			including the bucket of cut-up		
		nmon name of the food, the			potatoes and dessert trays we	ro	
		pened and the date by which			properly covered. All items we		
		discarded or used by"			inspected for quality and	16	
	the item should be t	inscarded of dised by			appropriately dated.		
	A policy titled "Sto	rage of Dry Goods/Foods",			Identifying other Residents		
		from the Kitchen Manager on			having the Potential to be		
		. indicated, " Opened			Affected: All residents have the		
		d, dated with the use by date					
	and tightly covered				potential to be affected by this		
		iding from insects and rodents			practice. The Dietary Manager		
		iding from insects and rodents			conducted a complete invento	-	
	"				all food storage areas including	•	
	A maliary 4:41 - 1 11T 1	soling and Dating E d-			dry storage, walk-in cooler, an		
		beling and Dating Foods-			freezer to ensure all items wer	е	
	-	', received as current from the			properly labeled, dated, and		
	_	n 4/24/25 at 8:28 a.m. indicated,			covered.		
		old food item is labeled with			Measures put into place or		
	•	I the date by which to discard			Systemic Changes		
	or use by"				1 The Dietary Manager		
					provided in-service education	to all	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 04/29/2025		
	PROVIDER OR SUPPLIER		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 LISC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) dietary staff regarding proper	DATE		
				labeling, dating, and storage requirements. 1. The facility's policies on "Labeling and Dating Foods" or reviewed and reinforced with dietary staff. 2. "Label and Cover" reminds signs were posted in all food storages areas. Plan to Monitor Performance 1 The Dietary Manager/Designee will conducted daily audits of all food storages areas tomensure compliance proper food labeling and coverequirements. 1. Any identified issues will be corrected immediately and stawill be re-educated as needed. The Dietary Manager will report monitoring results to the Qual Assurance and Performance Improvement (QAPI) committed monthly for 6 months. The Qual Assurance and Performance Improvement (QAPI) committed will monitor on an ongoing base until substantial compliance of set-forth protocol is achieved. Date of Compliance: 05/23/25	all er ct with ring ee aff d. ort ity ee ality ee sis f the		
R 0354 Bldg. 00	410 IAC 16.2-5-8. Clinical Records -	,					
2.25. 00	failed to ensure a tra	riew and interview, the facility ansfer/discharge form was 7 records reviewed. (Resident	R 0354	R-354 Clinical records IGNITE MEDICAL RESORT I LLC makes every effort to ope			

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155840	A. BUILDING 00 B. WING		COMPLETED 04/29/2025			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE				
IGNITE N	MEDICAL RESORT	DYER LLC		IN 46311				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE			
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION Finding includes:		TAG	in substantial compliance with	5.112			
	I mang meraacs.	I maing includes.		Federal and State laws and	'			
	Record review for Resident 7 was completed on			regulations. Nothing in this Pla	an of			
	4/29/25 at 10:49 a.m. Diagnoses included, but			Correction is an admission				
	were not limited to, hypertension, atrial fibrillation,			otherwise. IGNITE MEDICAL				
	and adjustment disc	order.		RESORT DYER LLC is subm	itting			
				this Plan of Correction in				
	A Progress Note, dated 6/5/24 at 10:59 a.m.,			compliance with its regulatory				
		nt had an unwitnessed fall.		obligations and does not waiv				
	She had low blood pressure, altered mental status,			any objections it may have as				
	and was complaining of pain to her right arm and			the merit or form of any allega				
	ribs. The nurse practitioner was notified and the			contained herein. Please note				
	resident was sent to the emergency room for			the facility may contest the merits				
	evaluation.			or form of any of the alleged				
	1.5			deficient findings and may tak				
		ated 9/2/24 at 11:36 a.m.,		reasonable steps to appeal them.				
	indicated the resident was lethargic, drooling,			This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER				
	clammy, and slurring words. The nurse			LLC's written credible allegation of				
	practitioner was notified and the resident was sent to the emergency room for evaluation.			compliance for the deficiencies				
	to the emergency to	on for evaluation.		noted.				
	There was a lack of	documentation to indicate a		It is the facility's policy to ensu	ıre			
		ompleted and sent to the		a complete transfer form is				
		or 9/2/24 that included the name		completed for all residents be	ina			
	of the receiving institution and date of transfer,			transferred to another healtho	_			
	nursing notes related to the resident, functional			facility, including all required				
	abilities and physical limitations, nursing care,			elements as specified in 410 l	AC			
	medications, treatments, current diet, or resident			16.2-5-8.1(g)(1-7).				
	condition upon transfer.			Corrective Action for Affects	ed			
				Residents: The Director of				
	_	on 4/29/25 at 3:20 p.m., the		Nursing reviewed Resident 7's				
	Director of Nursing indicated he was unable to			medical record and confirmed				
	find any transfer forms or transfer paperwork for			transfer forms were not completed				
	the resident.			for transfers on 6/5/24 and 9/2	2/24.			
				Identifying other Residents				
				having the Potential to be	istad			
				Affected: The Director of Ass				
				Living conducted an audit of a residents transferred to acute				
				facilities in the past 30 days to				
				lacilities in the past 30 days to	'			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 04/29/2025	
	ROVIDER OR SUPPLIE IEDICAL RESORT		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE 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 APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
				identify any other instances of missing or incomplete transfe forms. Any identified deficient were immediately corrected. Measures put into place or Systemic Changes: The Assiliving Director will in-service Licensed nurses on: The requirement to complete transfer forms for a resident transfers All required elements of transfer documentation Location and proper use transfer forms Documentation requirements in the electronic health record Plan to Monitor Performanc The Assisted Living Director of audit: Resident transfers daily during clinical meeting to ensity transfer forms were completed appropriately and documentatis in place in Health Record. Any identified deficiencies will be corrected immediately additional education will be provided to the responsible simember. The Assisted Living Director will report monitoring plan resident transfer forms were completed appropriately and documentation in place in Health Record. Any identified deficiencies will be corrected immediately additional education will be provided to the responsible simember. The Assisted Living Director will report monitoring plan resident to the Quality Assurance and Performance Improvement (Ocommittee monthly for 6 mont	of er cies sisted all II f e of e: will sure ed ed etion es e, and etaff ector sults QAPI) ths.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155840	B. WING			04/29/2025	
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT DYER LLC				STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311			
(X4) ID	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 APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					compliance of the set-forth protocol is achieved. Date of Compliance: 05/23/25		

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