STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	04/29/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and Investigation of Complaints IN00455936, IN00456419, IN00456626, IN00456640, IN00457582, and IN00458078. This visit included a State Residential Licensure Survey. Complaint IN00455936 - No deficiencies related to the allegations are cited. Complaint IN00456419 - No deficiencies related to the allegations are cited. Complaint IN00456626 - No deficiencies related to the allegations are cited. Complaint IN00456640 - No deficiencies related to the allegations are cited. Complaint IN00457582 - No deficiencies related to the allegations are cited. Complaint IN00458078 - No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, 25, 28, and 29, 2025 Facility number: 013462 Provider number: 155840 Census Bed Type: SNF: 86 Residential: 26 Total: 112 Census Payor Type: Medicare: 41	F 0000	Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Matula	General Manager	05/18/2025

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

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	Other: 45 Total: 86 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/5/25.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp Based on observation, record review and interview, the facility failed to ensure residents who were left to complete nebulizer treatments independently had been assessed for safe self-administration for 1 of 4 residents reviewed for respiratory services. (Resident 29) Finding includes: During a random observation on 4/21/25 at 11:40 a.m., Resident 29 was observed sitting alone in his room. A nebulizer treatment was in progress via a face mask. He removed the face mask and put it in the drawer of his nightstand. At that time, the resident indicated the staff did not stay in the room while he received the nebulizer treatments. They would initiate the treatment, and when he thought it was done, he would remove the mask and put it in his drawer. 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 MDS (Minimum Data Set) assessment, indicated the resident had moderate cognitive impairment, and required	F 0554	**POC F554 Resident Self-Admin Meds – Clinically Approp** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that residents have the right to self-administer medications if the interdisciplinary team has	05/23/2025

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	partial/moderate assistance with activities of daily living and transfers. The 1/27/25 Self Administration Assessment did not indicate the resident was safe to self-administer nebulizer treatments. There was no physician's order for the resident to self-administer nebulizer treatments. During an interview on 4/24/25 at 11:57 a.m., the DON (Director of Nursing) indicated the resident had not been evaluated for self-administration of nebulizers. A policy titled "Self Administration of Medications and Treatments", received as current from the DON on 4/28/25 at 3:31 p.m. indicated, "... Self administration of medications and treatments is determined by physician order after determining that the resident is able to self administer...". 3.1-11(a)		determined that this practice is clinically appropriate through a comprehensive assessment process. **Corrective Action for Affected Residents**: A comprehensive self-administration assessment was completed by the IDT team for Resident 29. The resident's physician was notified, and new orders were obtained for self-administration of nebulizer treatments. The care plan was updated to reflect these changes. **Identifying other Residents having the Potential to be Affected**: CNO and Unit Managers conducted a facility-wide audit of residents receiving nebulizer treatments to identify any other residents who may be self-administering treatments without proper assessment and physician orders. All residents receiving nebulizer treatments were reviewed for appropriate self-administration assessments and physician orders. **Measures put into place or Systemic Changes**: The DON provided in-service education to licensed nurses regarding: Policy and procedure for self-administration of medications and treatments ·Requirements for IDT assessment prior to allowing self-administration ·Proper documentation	

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			requirements including physician orders ·Supervision requirements during nebulizer treatments ·Process for ongoing monitoring of residents who self-administer medications/treatments The facility's self-administration assessment tool has been updated to specifically include evaluation criteria for nebulizer treatments. The IDT will review all 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 appropriate documentation in place, including but not limited to self-administration assessment and physician order, and that the nurse stays in room for entire duration of nebulizer treatment for residents who are not able to self-administer. The Director of Nursing will review audit results and report findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly. The QAPI committee will monitor compliance until substantial compliance is achieved and maintained for 6 consecutive months. **Date of Compliance: 05/23/25**	

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F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) Based on record review and interview, the facility failed to ensure the physician was notified of elevated blood sugars, blood pressure medications and insulin being held, and medication refusals for 3 of 3 residents reviewed for notification of change. (Residents 52, 154, and 264) Findings include: 1. The record for Resident 52 was reviewed on 4/24/25 at 3:03 p.m. Diagnoses included, but were not limited to, type 2 diabetes and end stage renal disease. The Admission Minimum Data Set (MDS) assessment, dated 3/2/25, indicated the resident was cognitively intact. A Physician's Order, dated 3/20/25, indicated the resident was to receive Lantus insulin, 25 units subcutaneously (injecting a medication into the fatty tissue layer beneath the skin) at bedtime. The Physician was to be notified if the resident's blood sugar level was less than 60 or greater than 400. The March 2025 Medication Administration Record (MAR) indicated the resident's blood sugar was 425 on 3/20/25 at 9:00 p.m. On 3/21/25 at 9:00 p.m., the resident's blood sugar was 433. There was no documentation indicating the physician and/or the nurse practitioner (NP) were notified of the blood sugars greater than 400.	F 0580	**POC for F580 – Notify of Changes (Injury/Decline/Room, etc.)** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to immediately inform the resident, consult with the resident's physician, and notify the resident representative when there are significant changes in the resident's condition, including but not limited to out-of-range blood sugar readings, held medications, and medication refusals. **Corrective Action for Affected**	05/23/2025

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	During an interview on 4/29/25 at 2:09 p.m., the Director of Nursing indicated the physician and/or the NP were not notified of the resident's blood sugars above 400 on 3/20/25 and 3/21/25. 2. The record for Resident 154 was reviewed on 4/23/25 at 11:34 a.m. Diagnoses included, but were not limited to, dementia with mood disturbance, type 2 diabetes, hypertension, and acute kidney failure. The Admission Minimum Data Set (MDS) assessment, dated 4/14/25, indicated the resident was moderately impaired for daily decision making. A Physician's Order, dated 4/12/25, indicated the resident was to receive Midodrine HCl (a medication used to treat low blood pressure) 5 milligrams (mg) by mouth three times a day for hypotension (low blood pressure). There were no blood pressure parameters indicating when the medication should be held. The April 2025 Medication Administration Record (MAR), indicated the resident's blood pressure was 132/79 on 4/19/25 at 9:00 a.m. and 145/69 at 5:00 p.m. The Midodrine was not given at 9:00 a.m. and 5:00 p.m. There was no documentation indicating the physician and/or the nurse practitioner (NP) were notified of the medication being held. During an interview on 4/24/25 at 12:00 p.m., the Director of Nursing indicated the physician and/or the NP should have been notified that the Midodrine was held. 3. Resident 264's record was reviewed on 4/23/25		**Residents:** ·No harm came to any residents related to this alleged deficient practice. ·Residents 52 and 154 no longer reside in facility. **Identifying other Residents having the Potential to be Affected:** The Director of Nursing (DON) and Unit Managers completed an audit of current residents with physician orders for insulin, blood pressure medications, and other medications with specific parameters to ensure proper physician notification occurred for any held or refused doses within the past 7 days. **Measures put into place or Systemic Changes:** 1.The DON provided in-service education to licensed nurses regarding: ·Physician notification requirements for out-of-range blood sugar readings ·Protocol for notification when medications are held or refused ·Documentation requirements for physician notifications **Plan to Monitor Performance:** 1.DON/Designee will conduct daily reviews of medication administration records 5 times a week to ensure proper physician notification for: ·Blood sugar readings	

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	at 10:58 a.m. Diagnoses included, but were not limited to, CHF (congestive heart failure) and diabetes. The 4/12/25 Admission Minimum Data Set (MDS) assessment indicated the resident had mild cognitive impairment and was dependent for activities of daily living and transfers. A Physician's Order, dated 4/6/25, indicated Insulin Lispro (a fast-acting insulin) 18 units before meals. There were no parameters for holding the insulin. The April 2025 Medication Administration Record (MAR) indicated the resident refused the morning dose of insulin on 4/14/25. The nurse held the 4/16/25 evening insulin dose when the resident's blood sugar was 70. There was no documentation indicating the physician was informed of the insulin doses not given. During an interview on 4/25/25 at 1:00 p.m., the Director of Nursing indicated the staff should have informed the physician of the refused and held doses of insulin. 3.1-5(a)(3)		outside parameters ·Held medications, including but not limited to, insulin and blood pressure medications ·Medication refusals 1.Results of these audits will be reported monthly to the Quality Assurance and Performance Improvement (QAPI) committee for review and recommendations until substantial compliance is achieved and maintained for 6 consecutive months. **Date of Compliance: 05/23/25**	
F 0623 SS=A Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge Based on record review and interview, the facility failed to ensure the resident's Responsible Party was notified in writing related to a transfer to the hospital for 1 of 3 residents reviewed for hospitalization. (Resident 79)	F 0623	Education completed with Resident Care Transitions to ensure notification of transfers to hospitals were mailed to families in writing.	05/23/2025

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	Finding includes: The record for Resident 79 was reviewed on 4/28/25 at 9:28 a.m. Diagnoses included, but were not limited to, dementia without psychotic disturbance, anemia, and chronic kidney disease. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 4/12/25, indicated the resident was cognitively impaired for daily decision making. A Nurse's Note, dated 2/20/25 at 3:30 p.m., indicated the resident was transferred to the hospital due to having a low hemoglobin and hematocrit level. The resident was admitted to the hospital and returned to the facility on 2/23/25. A Nurse's Note, dated 3/18/25 at 4:18 p.m., indicated the resident was transferred to the hospital based on abnormal lab results. The resident was admitted to the hospital and returned to the facility on 3/21/25. A Nurse's Note, dated 4/4/25 at 8:32 p.m., indicated the resident was being transferred to the hospital related to a low hemoglobin level. The resident was admitted to the hospital and returned to the facility on 4/8/25. There was no documentation indicating the State transfer form was mailed to the resident's responsible party for all three hospitalizations. During an interview on 4/29/25 at 3:30 p.m., the Director of Nursing indicated the front desk staff mailed out copies of the transfer notices and from now on it would be documented when the notice was sent.			

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	3.1-12(a)(6)(ii) 3.1-12(a)(6)(iii)			
F 0641 SS=D Bldg. 00	483.20(g) Accuracy of Assessments Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately completed related to terminal prognosis and hospice care for 1 of 27 MDS assessments reviewed. (Resident 44) Finding includes: Resident 44's record was reviewed on 4/28/25 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and Alzheimer's disease. The Quarterly MDS assessment, dated 4/9/25, indicated the resident had not received hospice care and did not have a condition or chronic disease that may result in a life expectancy of less than six months. A Physician's Order, dated 10/4/24, indicated the resident was admitted to hospice services. A Care Plan, dated 2/21/25, indicated the resident had a terminal end stage prognosis and was receiving hospice services. The Hospice Certification, dated 2/26/25, indicated the resident was terminally ill with a life expectancy of six months or less. During an interview on 4/28/25 at 3:14 p.m., MDS Nurse 1 and MDS Nurse 2 indicated the resident was receiving hospice care and had a terminal prognosis. They would modify the MDS	F 0641	**POC F641 Accuracy of Assessments** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that all Minimum Data Set (MDS) assessments accurately reflect each resident's status, including terminal prognosis and hospice services. **Corrective Action for Affected Residents:** MDS Nurse 1 and MDS Nurse 2 completed a	05/23/2025

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	assessment. 3.1-31(i)		modification of the Quarterly MDS assessment immediately to accurately reflect the resident's hospice status and terminal prognosis. The modified MDS was 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 were corrected through MDS modification. **Measures put into place or Systemic Changes:** The DON completed in-servicing with MDS nurses on… ·Accurate coding of Section J (Health Conditions) and Section O (Special Treatments) of the MDS ·Review of clinical documentation including physician 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/Designee will audit MDS assessments for residents receiving hospice services weekly to ensure	

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			accurate coding of hospice services and terminal prognosis. Results of these audits will be documented on a quality monitoring tool. The General Manager will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of the plan and make recommendations for continuation, modification, or discontinuation of monitoring based on compliance scores. **Date of Compliance: 05/23/25**	
F 0656 SS=D Bldg. 00	483.21(b)(1)(3) Develop/Implement Comprehensive Care Plan Based on observation, record review, and interview, the facility failed to ensure a comprehensive care plan was developed and in place for edema, compression glove use, and oxygen for 1 of 27 resident care plans reviewed. (Resident 60) Finding includes: On 4/22/25 at 9:18 a.m., Resident 60 was observed with oxygen in place via nasal cannula. The flow rate was set at 1.5 liters. Her right hand was slightly swollen and there was a compression glove on her bedside table. The resident indicated she used oxygen and it was usually at 2 liters. She wore the compression glove on her right hand, but only at night. Record review for Resident 60 was completed on	F 0656	**POC F656 - Develop-Implement Comprehensive Care Plan** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take	05/23/2025

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	4/23/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/23/25, indicated the resident was moderately cognitively impaired and did not receive oxygen therapy. A Care Plan, dated 3/10/25, indicated the resident had renal insufficiency. The interventions included to elevate feet to help prevent dependent edema and to monitor for signs of hypervolemia (fluid overload) such as dependent edema. There was no specific care plan or interventions related to the right hand edema or the compression glove use. There was no current care plan related to oxygen use. During an interview on 4/24/25 at 1:53 p.m., the Director of Nursing was made aware of the lack of care plans. He indicated he would put in care plans for oxygen, edema, and compression glove use. 3.1-35(a)		reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to develop and implement comprehensive person-centered care plans for each resident that includes measurable objectives and timeframes to meet residents' medical, nursing, mental and psychosocial needs identified in their comprehensive assessments. **Corrective Action for Affected Residents:** the Director of Nursing reviewed and updated Resident 60's care plan to include interventions for right hand edema, compression glove use, and oxygen therapy. Resident 60 no longer resides in facility. **Identifying other Residents having the Potential to be Affected:** Facility-wide audit of all current residents completed to identify those receiving oxygen therapy, using compression garments, or experiencing edema to ensure comprehensive care plans are in place. **Measures put into place or Systemic Changes:** 1.In-services completed with nursing staff on: Care plan development and implementation requirements	

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			Process for initiating new care plans when new conditions or interventions arise Documentation requirements for oxygen therapy, compression garments, and edema monitoring 1.The MDS Coordinator will review all new admission assessments and significant change assessments during morning clinical meeting to ensure care plans are developed for all identified needs. **Plan to Monitor Performance:** DON/Designee will audit 10 resident care plans weekly to ensure residents receiving oxygen therapy, wearing compression garments, or experiencing edema have corresponding care plans with interventions in place. Results of these audits will be reviewed by the Director of Nursing. The Director of Nursing will report audit findings to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of the plan and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0658 SS=D Bldg. 00	483.21(b)(3)(i) Services Provided Meet Professional Standards Based on observation, record review, and	F 0658	**POC F658 – Services Provided**	05/23/2025

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	155840	A. BUILDING 00 B. WING	04/29/2025

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	interview, the facility failed to ensure professional standards of quality were maintained related to a CNA placing a tube feeding pump on hold for 1 of 2 residents reviewed for tube feeding. (Resident 73) Finding includes: During a random observation on 4/23/25 at 3:34 p.m., Resident 73 was observed in her room in bed. The head of the bed was elevated and the resident's tube feeding was infusing at 50 cubic centimeters (cc's). CNA 1 proceeded to enter the resident's room to perform incontinence care. Prior to lowering the head of the bed, the CNA placed the tube feeding pump on hold. After incontinence care was completed, the CNA had a nurse resume the tube feeding. The record for Resident 73 was reviewed on 4/25/25 at 2:10 p.m. Diagnoses included, but were not limited to, gastrostomy (a feeding tube placed through the abdomen and into the stomach to deliver nutrition, fluids, or medications), adult failure to thrive, and dysphagia (difficulty swallowing). The Admission Minimum Data Set (MDS) assessment, dated 2/24/25, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was receiving the majority of her nutrition through a feeding tube. The Indiana State Department of Health Nurse Aide Curriculum states, " ... The resident with a feeding infusing should not lie flat ... If the bed must be flattened, seek the nurse ' s assistance to turn off the pump prior to the procedure and turn		**Meet Professional Standards** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that all services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality, including ensuring that staff members operate within their scope of practice regarding tube feeding management. **Corrective Action for Affected Residents:** Resident 73's tube feeding was immediately resumed by licensed nursing staff. The Director of Nursing counseled CNA 1 regarding scope of practice limitations related to tube feeding	

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	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 resides in facility. **Identifying other Residents having the Potential to be Affected:** Director of Nursing conducted an audit of all current residents with tube feedings to ensure proper management of tube feeding pumps by appropriate staff. **Measures put into place or Systemic Changes:** The Director of Nursing will provide in-service education to CNAs regarding scope of practice and proper protocol for tube feeding care. The education will emphasize that only licensed nurses may operate tube feeding pumps, including placing pumps on hold or restarting them. **Plan to Monitor Performance:** DON/Designee will conduct direct observation of tube feeding care for 5 random residents on alternating shifts to ensure compliance with professional standards regarding tube feeding management. The Director of Nursing will review audit results weekly. The Director of Nursing will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The QAPI committee will review the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained.	

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			Date of Compliance: 05/23/25	
F 0684 SS=E Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure bruises were assessed and monitored for 2 of 2 residents reviewed for non-pressure related skin conditions, signs and symptoms of constipation were monitored for 1 of 1 resident reviewed for constipation, edema was monitored and assessed for 1 of 3 residents reviewed for edema and medications were held per blood pressure parameters for 1 of 5 residents reviewed for unnecessary medications. (Residents 91, 255, 60, 27, and 264) Findings include: 1. During a random observation on 4/22/25 at 10:14 a.m., an area of reddish/purple discoloration was noticed on Resident 91's left forearm. The record for Resident 91 was reviewed on 4/23/25 at 12:17 p.m. Diagnoses included, but were not limited to, type 2 diabetes, severe sepsis with septic shock, and atherosclerotic heart disease. The Admission Minimum Data Set (MDS) assessment, dated 3/28/25, indicated the resident was cognitively intact and he was receiving an anticoagulant (blood thinner). A Care Plan, dated 3/21/25, indicated the resident was receiving anticoagulant therapy. Interventions included, but were not limited to, monitor/document/report as needed (PRN) adverse reactions of anticoagulant therapy such	F 0684	**POC F684 – Quality of Care** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure residents receive treatment and care in accordance with professional standards of practice, comprehensive person-centered care plans, and residents' choices, including proper assessment and monitoring of bruises, constipation, edema, and medication administration. **Corrective Action for Affected**	05/23/2025

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	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 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. 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, 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 tablet every 6 hours as needed for pain.		**Residents:** ·Resident 91's bruise was assessed and documented immediately and a physician order for monitoring was obtained and added to EMR. ·Resident 60's compression glove order was clarified on 4/24/25 to include specific wear times and documentation requirements. ·Resident 27's medication orders 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. ·Residents 91, 60, and 27 no longer reside in facility. **Identifying other Residents having the Potential to be Affected:** The Director of Nursing (DON) and Unit Managers will conduct an audit of 10 current residents by to ensure appropriate assessment, monitoring, and documentation are in place: ·Residents on anticoagulation therapy requiring bruise monitoring ·Residents receiving opioid medications requiring bowel monitoring and interventions ·Residents with compression devices/garments ·Residents on medications with blood pressure parameters ·Residents with existing bruises	

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	The April 2025 Medication Administration Record (MAR) indicated the resident received the Hydrocodone-Acetaminophen on 4/16/25 at 5:44 p.m., 4/17/25 at 12:34 p.m., 4/19/25 at 6:03 p.m., and 4/20/25 at 3:22 a.m. The Bowel Elimination Flow Sheet located in the "Task" section of the electronic medical record indicated the resident did not have a bowel movement on 4/17/25, 4/18/25, and 4/19/25. There was no documentation on 4/20/25. A Nurse's Note, dated 4/20/25 at 9:07 p.m., indicated during shift report the oncoming nurse was told the resident had vomited twice. The resident vomited again right after shift change and the Nurse Practitioner (NP) was notified. An order was received for Zofran (a medication to prevent nausea and vomiting) 4 mg every 6 hours as needed. The first dose was given at 8:00 p.m. Since the first dose was given, the resident continued to vomit and the NP was notified. A Physician's Order, dated 4/20/25, indicated the resident was to have a KUB (kidney, ureter, and bladder x-ray). Physician's Orders, dated 4/21/25, indicated the resident was to receive Docusate Sodium (a stool softener) 100 mg, 1 capsule two times a day for constipation for 30 days, Lactulose (a laxative) oral solution 20 grams/30 ml, give 30 ml every 24 hours as needed for constipation for 30 days, and Glycolax Powder (a laxative) 17 gram scoop, give 17 grams as needed for constipation for 30 days, give 17 grams mixed with 8 ounces of fluid twice daily as needed. The April 2025 MAR indicated the resident received the Docusate Sodium on 4/21/25 at 5:00		requiring monitoring **Measures put into place or Systemic Changes:** ·The DON will in-service licensed nurses on: ·Bruise assessment, documentation, and monitoring requirements ·Bowel movement monitoring and constipation protocol implementation ·Proper documentation of compression device usage and monitoring ·Medication administration related to blood pressure parameters ·Proper documentation in the electronic health record **Plan to Monitor Performance:** ·DON/Designee will conduct weekly audits of residents with bruises, on anticoagulation therapy, receiving opioids, using compression devices, and those with blood pressure medication parameters to ensure appropriate assessment, monitoring, and documentation are in place. ·The DON will review audit results weekly and address any identified issues immediately. ·Results of audits will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for 6 months and until substantial compliance is achieved and maintained. ·The QAPI Committee will make recommendations for additional	

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	p.m. and 4/22/25 at 9:00 a.m. The resident had not received the Lactulose or the Glycolax Powder. A Care Plan was initiated on 4/21/25 related to the resident receiving opioid medications. The Bowel Elimination Flow Sheet indicated the resident had a large bowel movement on 4/21/25. A Nurse's Note, dated 4/22/25 at 2:08 p.m., indicated the resident's KUB showed a mild adynamic ileus (a condition where the bowel's movement is slowed or stopped due to a lack of coordinated muscle activity) in the right mid abdomen with no bowel obstruction. The resident continued with nausea and vomiting and abdominal pain. The resident would be sent to the emergency room for evaluation. During an interview on 4/25/25 at 11:00 a.m., the Director of Nursing and the Nurse Consultant indicated they would follow up on the issue with the resident's constipation. During an interview on 4/25/25 at 11:15 a.m., the C Wing Unit Manager indicated the resident did have a bowel movement on 4/20/25 but it was not documented. The current facility "Bowel Protocol" policy was provided by the Director of Nursing on 4/29/25 at 4:25 p.m. The policy indicated the resident's drug regimen would be evaluated to identify possible constipating medications and per the bowel protocol, if the resident had no bowel movement or only small documented bowel movements for days outside of the baseline, the provider would determine if additional testing and/or medications were warranted. 3. On 4/22/25 at 9:18 a.m., Resident 60's right hand was observed to be		monitoring or changes in monitoring frequency based on audit results. **Date of Compliance: 05/23/25**	

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	slightly swollen and there was a compression glove on her bedside table. The resident indicated she wore the compression glove on her right hand, but only at night. On 4/22/25 at 2:26 p.m., Resident 60 was observed with the compression glove in place to her right hand. Record review for Resident 60 was completed on 4/23/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/23/25, indicated the resident was moderately cognitively impaired. A Care Plan, dated 3/10/25, indicated the resident had renal insufficiency. The interventions included to elevate feet to help prevent dependent edema and to monitor for signs of hypervolemia (fluid overload) such as dependent edema. There was no specific care plan or interventions related to the right hand edema or the compression glove use. A Physician's Order, dated 3/21/25, indicated to remove the right hand glove to assess the skin every morning for skin breakdown and to document any abnormalities or skin issues. There were no directions on when to apply the compression glove or how long the resident was to wear the glove each day. The Medication Administration (MAR) and Treatment Administration (TAR) Records, dated 4/2025, indicated the compression glove had been removed daily at 9 a.m. The skin was monitored and either a + or - sign was documented. A - sign			

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	was documented on 4/1, 4/3, 4/5, 4/6, 4/7, 4/8, 4/11, 4/13, 4/14, 4/15, 4/16, 4/17, 4/19, 4/20, and 4/22/25. A + sign was documented on 4/2, 4/4, 4/9, 4/10, 4/12, 4/18, 4/21, and 4/23/25. There was no definition or key to indicate what the + or - sign meant. During an interview on 4/24/25 at 1:53 p.m., the Director of Nursing indicated he had clarified the compression glove order so it would be less confusing. 4. Resident 27's record was reviewed on 4/23/25 at 4:29 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus, hypertension, and atrial fibrillation. The Admission Minimum Data Set (MDS) assessment, dated 2/16/25, indicated the resident was cognitively intact. A Care Plan, dated 2/11/25, indicated the resident had an altered cardiovascular status related to atrial fibrillation, coronary artery disease, heart failure, hypertension, and hyperlipidemia. A Physician's Order, dated 2/15/25, indicated hydralazine (a medication used to lower blood pressure) 100 mg (milligrams) three times a day, hold if systolic blood pressure (top number of blood pressure reading) is less than 120. A Physician's Order, dated 2/15/25, indicated Entresto (sacubitril-valsartan, a medication used to treat heart failure that can lower blood pressure) 97-103 mg every morning and at bedtime, hold if systolic blood pressure is less than 120.			

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	The Medication Administration Record (MAR), dated 4/2025, indicated the hydralazine was not held per the Physician's Order on the following dates and times: - 4/1/25 at 2:00 p.m., blood pressure 112/63 and 10:00 p.m., blood pressure 112/69 - 4/2/25 at 2:00 p.m., blood pressure 116/63 - 4/3/25 at 6:00 a.m., blood pressure 112/68 - 4/10/25 at 2:00 p.m., blood pressure 115/64 - 4/16/25 at 2:00 p.m., blood pressure 117/63 - 4/17/25 at 2:00 p.m., blood pressure 118/72 - 4/18/25 at 2:00 p.m., blood pressure 118/58 - 4/19/25 at 2:00 p.m., blood pressure 113/65 The MAR, dated 4/2025, indicated the Entresto was not held per the Physician's Order on the following dates and times: - 4/1/25 at 8:00 a.m., blood pressure 112/61 and 8:00 p.m., blood pressure 112/69 - 4/2/25 at 8:00 a.m., blood pressure 116/63 and 8:00 p.m., blood pressure 116/63 - 4/3/25 at 8:00 a.m., blood pressure 113/61 - 4/16/25 at 8:00 a.m., blood pressure 117/63 - 4/18/25 at 8:00 a.m., blood pressure 115/62 - 4/19/25 at 8:00 a.m., blood pressure 113/65 During an interview on 4/25/25 at 12:44 p.m., the Director of Nursing indicated the medications had been given outside the blood pressure parameters. 5. During random observations on 4/22/25 at 9:31 a.m., 4/23/25 at 10:21 a.m., and 4/24/25 at 10:05 a.m., Resident 264 was observed resting in bed. There were purple bruises on the back of both of his hands, and on his right arm. The resident's record was reviewed on 4/23/25 at 10:58 a.m. Diagnoses included, but were not limited to, CHF (congestive heart failure) and diabetes.			

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	The 4/12/25 Admission MDS (Minimum Data Set) assessment, indicated the resident had mild cognitive impairment and was dependent in activities of daily living and transfers. A Care Plan, dated 3/24/25, indicated the resident was at risk for adverse reactions related to anticoagulant (blood thinner) therapy. Interventions included monitoring, documenting, and reporting bruising. There was no documentation of an assessment of the bruises. During an interview on 4/24/25 at 10:05 a.m., LPN 3 indicated the bruises were from lab blood draws. The left hand bruise had been present since his last hospitalization, but it was improving. She indicated the bruising should have been monitored and documented in the record. A policy titled, "Bruise Identification Monitoring--Indiana", received as current from the Director of Nursing on 4/24/25 at 11:19 a.m., indicated " ... The staff nurse will obtain a physician order to monitor the new bruise daily until resolved. This monitoring will be recorded on the MAR [medication administration record] or TAR [treatment administration record]...". 3.1-37(a)			
F 0685 SS=D Bldg. 00	483.25(a)(1)(2) Treatment/Devices to Maintain Hearing/Vision Based on record review and interview, the facility failed to assist a resident to see an eye doctor for 1 of 1 resident reviewed for vision. (Resident 29) Finding includes:	F 0685	**POC F685 – Treatment/Devices to Maintain Hearing/Vision** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with	05/23/2025

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	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 1 about setting up an eye doctor appointment for the resident, and he indicated seeing the eye doctor was not part of his care at 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 had moderate cognitive impairment, and required partial/moderate assistance with activities of daily living and transfers. There was no documentation of vision/eye care for the resident. During an interview on 4/24/25 at 11:08 a.m., the Director of Social Services indicated the resident should be able to see an eye doctor if needed and they would help make those arrangements. 3.1-39(a)(1) 3.1-39(a)(2)		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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities by assisting residents in making appointments and arranging transportation to vision and hearing specialists as needed. **Corrective Action for Affected Residents:** An appointment was scheduled for Resident 29 with an optometrist. Transportation arrangements have been made through facility-approved transportation services. The Social Services Director has documented these arrangements in the resident's medical record. **Identifying other Residents**	

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	155840	A. BUILDING 00 B. WING	04/29/2025

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			having the Potential to be Affected: The Social Services Director initiated a facility-wide audit of all current residents to identify those requiring vision care services. The audit includes review of medical records, most recent MDS assessments, and resident/family interviews to identify any unmet vision care needs. **Measures put into place or Systemic Changes:** 1.The Director of Nursing/General Manager will in-service all Social Services staff and Licensed Nurses on: ·Facility policy regarding vision and hearing care services ·Process for scheduling appointments and arranging transportation ·Documentation requirements for vision/hearing care needs and services **Plan to Monitor Performance:** 1.The GM/Designee will conduct weekly audits of 10 residents' records to ensure: ·Vision/hearing needs are properly assessed ·Appointments are scheduled as needed ·Transportation is arranged ·Services are documented in medical records 1.The General Manager will review audit results weekly 2.The Social Services Director will report monitoring results to the	

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			Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills Based on observation, record review and interview, the facility failed to ensure G-tube (gastrostomy tube, a tube inserted directly into the stomach) flushes were instilled via gravity for 1 of 6 residents observed for medication administration. (Resident 202) Finding includes: On 4/24/25 at 1:04 p.m., LPN 2 was observed preparing Resident 202's medications. She crushed each pill and placed it in a separate cup. She entered the resident's room, put the tube feeding on hold, and poured 30 cubic centimeters (cc) of water into a medication cup. She inserted the G-tube syringe into the medication cup and drew up the 30 cc of water. She opened the G-tube and placed the syringe directly into the tube and pushed the 30 cc of water down the tube using the plunger. She diluted each of the medications in 5 cc of water and administered the medications and remaining flushes by gravity. During an interview on 4/24/25 at 1:30 p.m., LPN 2 indicated she should have administered the G-tube flush by gravity.	F 0693	**POC F693 – Tube Feedings Mgmt/Restore Eating Skills** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure that residents who receive enteral	05/23/2025

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	During an interview on 4/24/25 at 1:53 p.m., the Director of Nursing was made aware the G-tube flush had not been administered by gravity. The G-tube medication administration policy was requested. A current facility policy, titled "Medication Administration Enteral Tubes," indicated, "...9. Remove plunger from syringe and insert syringe into tubing. 10. Flush with water...b. Allow medication to flow down tube via gravity..." 3.1-44(a)(2)		nutrition receive appropriate treatment and services to prevent complications, including proper administration of G-tube flushes via gravity method as outlined in our "Medication Administration Enteral Tubes" policy. **Corrective Action for Affected Residents:** LPN 2 was immediately re-educated by the Director of Nursing on proper G-tube flush administration via gravity method. No adverse effects noted. Resident 202 no longer resides in facility. **Identifying other Residents having the Potential to be Affected:** Director of Nursing conducted an audit of all current residents with G-tubes to identify those potentially affected by this practice and to ensure that medications/flushes are being administered via gravity method. **Measures put into place or Systemic Changes:** 1.The Director of Nursing conducted an in-service with return demonstration for all Licensed nurses regarding proper G-tube medication administration and flush procedures, emphasizing the gravity method requirement. 2.The facility's "Medication Administration Enteral Tubes" policy was reviewed and remains current with no revisions needed. **Plan to Monitor Performance:** 1.DON/Designee will conduct	

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			direct observation audits of G-tube medication administration for 5 random observations on alternating shifts weekly to ensure proper G-tube medication administration and flush procedures are followed. 2.Any identified deficiencies will result in immediate re-education and additional monitoring of the involved staff member. 3.The Director of Nursing will analyze audit results and report findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of the plan and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to oxygen administration for 1 of 4 residents reviewed for respiratory care. (Resident 60) Finding includes: On 4/22/25 at 9:18 a.m., Resident 60 was observed with oxygen in place via nasal cannula. The flow rate was set at 1.5 liters. The resident indicated she used oxygen and it was usually set at 2 liters.	F 0695	**POC F695 – Respiratory/Tracheostomy Care and Suctioning** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory	05/23/2025

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	On 4/22/25 at 2:26 p.m., Resident 60 was observed with oxygen in place via nasal cannula. The flow rate was set at 1.5 liters. Record review for Resident 60 was completed on 4/23/25 at 11:33 a.m. Diagnoses included, but were not limited to, hypertension, end stage renal disease, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 2/23/25, indicated the resident was moderately cognitively impaired and did not receive oxygen therapy. There was no current care plan related to oxygen use. The Physician's Order Summary, dated 4/2025, lacked any orders for oxygen. During an interview on 4/24/25 at 11:58 a.m., the Director of Nursing indicated he was unable to find any current orders for oxygen. A facility policy, titled "Oxygen," indicated, "1. Residents who are admitted on oxygen or isolation precautions will have orders recorded in the resident's chart. The oxygen will be administered by the route and liter flow ordered by the physician..." 3.1-47(a)(6)		obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure that residents who need respiratory care, including oxygen therapy, receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. **Corrective Action for Affected Residents:** Resident 60's physician was notified and orders were obtained for oxygen at 2 liters per nasal cannula. A care plan was developed addressing oxygen therapy needs. The resident's oxygen flow rate was adjusted to 2 liters as ordered. **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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			Systemic Changes: The Director of Nursing in-serviced all Licensed nurses on: ·Proper documentation requirements for oxygen therapy ·Verification of physician orders prior to oxygen administration ·Development and implementation of care plans for residents receiving oxygen therapy ·Monitoring and documentation of oxygen flow rates ·Protocol for obtaining and documenting oxygen orders upon admission and as needed The Director of Reservations will add oxygen orders to admission announcements. The Unit Managers will verify oxygen orders and care plans during daily clinical meeting. **Plan to Monitor Performance:** DON/Designee will audit 10 residents receiving oxygen therapy weekly for 6 months to ensure: ·Physician orders are in place ·Care plans are developed and implemented ·Documentation is complete and accurate The Unit Manager will conduct daily oxygen flow rate checks on all residents receiving oxygen therapy and report discrepancies to the Director of Nursing immediately. The Director of Nursing will report audit findings to the Quality Assurance and Performance Improvement (QAPI) committee	

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			monthly for 6 months. The QAPI committee will review the results and make recommendations for additional interventions if needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 1 of 6 residents observed during medication administration. Two medication errors were observed during 26 opportunities for error in medication administration. This resulted in a medication error rate of 7.69%. (Resident 66) Finding includes: On 4/24/25 at 9:30 a.m., LPN 1 was observed preparing Resident 66's medications, which included Lantus (insulin glargine, long-acting insulin). LPN 1 removed the resident's insulin pen from the medication cart and donned a gown and gloves. She entered the room, cleaned the top of the insulin pen with an alcohol swab, and put the needle on the pen. She dialed the Lantus insulin pen to 20 units and administered the injection to the resident's left abdomen. She had not primed the insulin pen prior to administering the injection. She then removed her gown and gloves, washed her hands, and disposed of the needle in the sharps container. The record for Resident 66 was reviewed on 4/23/25 at 2:33 p.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus.	F 0759	**POC F759 – Free of Medication Error Rts 5 Prcnt or More** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure medication error rates are not 5 percent or greater and that insulin is administered according to	05/23/2025

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	The Physician's Order Summary, dated 4/2025, indicated Lantus 18 units subcutaneously in the morning. During an interview on 4/24/25 at 9:55 a.m., LPN 1 indicated she had not primed the insulin pen prior to administering the injection. The insulin pens were primed when they were new and first opened. She had administered 20 units of insulin, and the resident was supposed to receive 18 units. During an interview on 4/24/25 at 10:44 a.m., the Director of Nursing was made aware of the medication errors. The insulin administration policy was requested. A facility policy, titled "Insulin Administration Procedure," indicated, "...Insulin Pens:...8. Turn the dose selector to 2 units. Hold the pen with the needle pointing up, and tap the cartridge gently a few times. This moves the air bubbles to the top. 9. Press the push button all the way in until the dose selector is back to a 0. A drop of insulin should appear at the tip of the needle. This will ensure proper dosing and avoid injecting air onto the patient...12. Turn the dose selector to the number of units needed to inject. The pointer should line up with the correct dose..." 3.1-48(c)(1)		physician orders and facility protocols, including proper priming of insulin pens. **Corrective Action for Affected Residents:** Resident 66 assessed for any adverse effects from receiving 20 units instead of 18 units of Lantus insulin. The physician was notified of the medication error and provided new orders as needed. **Identifying other Residents having the Potential to be Affected:** Director of Nursing initiated an audit of all residents receiving insulin via insulin pens to ensure proper administration technique and correct dosing. **Measures put into place or Systemic Changes:** Director of Nursing completed in-serviced education to Licensed nurses regarding: ·Proper insulin pen priming technique ·Verification of insulin doses prior to administration ·Review of facility's Insulin Administration Procedure ·Importance of following physician orders exactly as written ·Documentation requirements for insulin administration **Plan to Monitor Performance:** DON/Designee will conduct direct observation audits of insulin pen administration for 5 random insulin administrations on alternating shifts per week. Any identified	

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			deficiencies will result in immediate re-education and additional monitoring. The Director of Nursing will review all audit results and present findings to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months and quarterly thereafter. The QAPI committee will evaluate the effectiveness of the plan and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals Based on observation and interview, the facility failed to ensure medications were kept in a locked medication cart at all times for 1 of 6 residents observed during medication administration. (Resident 66) Finding includes: On 4/24/25 at 9:30 a.m., LPN 1 was observed preparing medications for Resident 66. She placed a pill card of multivitamin medication and a pill card of ferrous sulfate medication on top of the medication cart. She placed the medication cup containing the resident's morning medications on top of the medication cart. At 9:37 a.m. she indicated she needed to go "get something" from the Nurse's Station and walked down the hallway away from the medication cart. The two pill cards of medications and the medication cup with the resident's morning medications remained on top of the medication cart, out of her sight.	F 0761	**POC F761 Label/Store Drugs and Biologicals** MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes	05/23/2025

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	On 4/24/25 at 9:40 a.m., LPN 1 returned to the medication cart. During an interview, at that time, LPN 1 indicated she should not have left the medications unattended. During an interview on 4/24/25 at 10:44 a.m., the Director of Nursing was made aware the medications had been left on top of the medication cart. A medication storage policy was requested. No further information was provided. 3.1-25(m)		IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that all medications must be stored in locked compartments under proper temperature controls, with access limited to authorized personnel only. Medications must not be left unattended on medication carts or other unsecured areas. **Corrective Action for Affected Residents:** LPN 1 was immediately re-educated by the Director of Nursing regarding proper medication security procedures. Resident 66's medications were 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 proper medication security was being maintained. **Measures put into place or Systemic Changes:** **1** The Director of Nursing will conduct an in-service for all licensed nurses regarding: Proper medication security procedures Requirements for maintaining	

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			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 conduct random medication security audits 5 times per week on alternating shifts to ensure: Nurses are following medication administration practices Medications are locked and secured **2** Results of these audits will be reported to the Quality Assurance and Performance Improvement (QAPI) committee for review and recommendations until substantial compliance is achieved and maintained for 6 consecutive months. **Date of Compliance: 05/23/25**	
F 0790 SS=D Bldg. 00	483.55(a)(1)-(5) Routine/Emergency Dental Srvcs in SNFs Based on record review and interview, the facility failed to assist a resident to obtain dental care for 1 of 1 resident reviewed for dental services. (Resident 29) Finding includes: During an interview on 4/21/25 at 11:33 a.m.,	F 0790	**POC F790 Routine/Emergency Dental Srvcs** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission	05/23/2025

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	Resident 29 indicated his dentures did not fit well, making it difficult to chew, and he had not been evaluated by a dentist 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 asked Social Worker 1 about setting up a dentist appointment for the resident, and he indicated dental care was not part of his care at 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 MDS (Minimum Data Set) assessment indicated the resident had moderate cognitive impairment, and required partial/moderate assistance with activities of daily living and transfers. There was no documentation of dental care for the resident. During an interview on 4/24/25 at 11:08 a.m., the Director of Social Services indicated the resident should be able to see a dentist if needed and they would help make those arrangements. 3.1-24(a)(1) 3.1-24(b)		otherwise. IGNITE MEDICAL RESORT DYER LLC is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to assist residents in obtaining routine and emergency dental care, including making appointments and arranging transportation as needed, in accordance with F790 requirements. **Corrective Action for Affected Residents:** Resident 29 stated he will notify Social Services Department once he has selected his dentist of choice. An appointment and transportations will be scheduled once decision has been made. The facility's social services department will document all dental care coordination in the resident's medical record. **Identifying other Residents having the Potential to be Affected:** The Social Services Director initiated a facility-wide	

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	155840	A. BUILDING 00 B. WING	04/29/2025

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			audit of all current residents to identify those requiring dental services, including those with dentures. The audit includes review of medical records, most recent MDS assessments, and resident/family interviews to identify any unmet dental care needs. **Measures put into place or Systemic Changes:** **1** The Director of Nursing/General Manager will in-service all social services staff and licensed nurses on: Facility policy regarding dental services coordination Process for scheduling dental appointments Documentation requirements for dental care coordination Transportation arrangement procedures **Plan to Monitor Performance:** **1** The GM/Designee will conduct weekly audits of 10 residents' records to ensure: Dental needs are being identified and addressed Appointments are being scheduled as needed Transportation is being arranged appropriately Services documented in medical records **2** The General Manager will review audit results weekly **3** The Social Services Director will report monitoring results to the	

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			Quality Assurance and Performance improvement (QAPI) committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food not labeled and dated for 1 of 1 kitchen. This had the potential to affect 86 residents who resided in the facility and received food from the kitchen. (The Main Kitchen) Findings include: During the Initial Kitchen Sanitation Tour on 4/21/25 at 9:17 a.m. with the Kitchen Manager, the following was observed: 1. In the dry storage room, there was a large unlabeled storage bin containing a white powder and an unlabeled container partially filled with yellow liquid. 2. In the walk-in cooler, there was a partially full, unlabeled squeeze bottle containing a red/brown substance. There was an uncovered bucket filled with cut-up potatoes and water. There were trays of desserts in a rack that were uncovered and unlabeled.	F 0812	**POC F812 Food Procurement, Store/Prepare/Serve – Sanitary** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to store,	05/23/2025

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	155840	A. BUILDING 00 B. WING	04/29/2025

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	3. In the walk-in freezer, there was an open, unlabeled bag of fish patties and an open, unlabeled bag of corn. 4. In the food prep area, there was a large plastic bin and a smaller plastic container filled with a white powder. Both were unlabeled. During an interview on 4/21/25 at 9:20 a.m., the Kitchen Manager indicated all food items should have been labeled and dated when opened and the uncovered items should have had lids on them. A policy titled "Labeling and Dating Foods", received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, " ... Packaged or containerized bulk food may be removed from the original package and stored in an ingredient bin labeled with the common name of the food, the date the item was opened and the date by which the item should be discarded or used by ..." A policy titled "Storage of Dry Goods/Foods", received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, " ... Opened products are labeled, dated with the use by date and tightly covered to protect against contamination including from insects and rodents ..." A policy titled "Labeling and Dating Foods--Refrigerated Food", received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, " ... If opened, the cold food item is labeled with the date opened and the date by which to discard or use by ..." 3.1-21(i)(3)		prepare, distribute and serve food in accordance with professional standards for food service safety, including proper labeling and covering of all food items. **Corrective Action for Affected Residents:** The Kitchen Manager immediately discarded all unlabeled food items in the dry storage room, walk-in cooler, walk-in freezer, and food prep area. All remaining food items were properly labeled with contents and dates. The uncovered bucket of cut-up potatoes and uncovered dessert trays were immediately covered with appropriate lids. **Identifying other Residents having the Potential to be Affected:** The Dietary Manager conducted a complete inventory inspection of all food storage areas including dry storage, walk-in cooler, walk-in freezer, and food prep areas to identify any other unlabeled or uncovered food items. All food items were evaluated for proper labeling and covering. **Measures put into place or Systemic Changes:** 1.The Dietary Manager provided in-service education to all dietary staff regarding proper food labeling, dating, and storage requirements. 2.The facility's policies on "Labeling and Dating Foods" were reviewed and reinforced with all	

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			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 conduct daily audits of all food storage areas to ensure compliance with proper food labeling and covering requirements. 2.Any identified issues will be corrected immediately and additional staff education provided as needed. 3.The Dietary Manager will report monitoring results to the Quality Assurance and Performance improvement (QAPI) committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure the medical record was complete and accurately documented related to medication administration documentation and medication orders for 1 of 27 records reviewed. (Resident 42) Finding includes: Resident 42's record was reviewed on 4/24/25 at	F 0842	**POC F842 Resident Records – Identifiable Information** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with Federal and State laws and regulations. Nothing in this Plan of Correction is an admission otherwise. IGNITE MEDICAL	05/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	8:26 a.m. Diagnoses included, but were not limited to, diabetes and heart failure. A Physician's Order, dated 2/25/25, indicated Droxidopa (a medication to treat the symptoms of low blood pressure) every 8 hours. The boxes for documenting administration of the medication on the April 2025 Medication Administration Record (MAR) were blank for the following doses: 4/6/25 at 10:00 p.m., 4/7/25 at 6:00 a.m., and 4/12/25 at 6:00 a.m. A Physician's Order, dated 4/13/25, indicated Midodrine (a medication to treat low blood pressure)every 8 hours as needed for hypotension (low blood pressure). There were no orders for blood pressure parameters for administration. During an interview on 4/24/25 at 3:45 p.m., the Assistant Director of Nursing indicated the nurse administered the Droxidopa at the times that were blank on the MAR, but she forgot to document it. During an interview on 4/24/25 at 12:01 p.m., the Director of Nursing indicated there should be specific blood pressure parameters for administering the Midodrine, but he could not find any. 3.1-50(a)(1) 3.1-50(a)(2)		RESORT DYER LLC is submitting this Plan of Correction in compliance with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to maintain complete and accurate medical records for each resident, including proper documentation of medication administration and physician orders with specific parameters for PRN medications. **Corrective Action for Affected Residents:** Resident 42's midodrine medication was discontinued. **Identifying other Residents having the Potential to be Affected:** The Director of Nursing initiated an audit of all current residents receiving PRN blood 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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R 0000 Bldg. 00			**Measures put into place or Systemic Changes:** The DON will in-service all Licensed nurses on: ·Proper medication administration documentation requirements ·The importance of documenting medications at the time of administration ·Requirements for specific parameters for PRN medication orders ·Procedure for late entry documentation when needed **Plan to Monitor Performance:** **1** DON/Designee will conduct 10 medication administration documentation audits to ensure medications administered have been signed out. **2** DON/Designee will conduct 10 medication audits of all PRN blood pressure medication orders to ensure specific parameters are documented as needed. **3** The Director of Nursing will report monitoring results to the Quality Assurance and Performance improvement (QAPI) committee monthly for 6 months. The QAPI committee will evaluate the effectiveness of interventions and make changes as needed until substantial compliance is achieved and maintained. **Date of Compliance: 05/23/25**	

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	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Nursing Home Complaints IN00455936, IN00456419, IN00456626, IN00456640, IN00457582, and IN00458078. Complaint IN00455936 - No deficiencies related to the allegations are cited. Complaint IN00456419 - No deficiencies related to the allegations are cited. Complaint IN00456626 - No deficiencies related to the allegations are cited. Complaint IN00456640 - No deficiencies related to the allegations are cited. Complaint IN00457582 - No deficiencies related to the allegations are cited. Complaint IN00458078 - No deficiencies related to the allegations are cited. Survey dates: April 21, 22, 23, 24, 25, 28, and 29, 2025 Facility number: 013462 Residential Census: 26 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 5/5/25.	R 0000	Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency			

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	Based on record review and interview, the facility failed to ensure service plans were signed and completed and/or updated with changes for 1 of 7 records reviewed. (Resident 7) Finding includes: Record review for Resident 7 was completed on 4/29/25 at 10:49 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and adjustment disorder. The resident was readmitted to the facility on 9/1/24. A Progress Note, dated 9/3/24 at 4:05 p.m., indicated the resident was admitted to hospice services. There was lack of documentation the service plan had been updated with this change. A Senior Living Evaluation/Interim Service Plan, dated 2/14/25, lacked indication the resident received hospice services. The outside agencies/support services section was blank. It was not signed by the resident or responsible party. During an interview on 4/29/25 at 3:12 p.m., the Assisted Living Director indicated she had gone over the service plan with the resident's daughter at the beginning of April and she had signed it, but she was unable to provide any documentation.	R 0217	**R-217 Evaluations** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure that service plans are completed, signed, dated, and updated when there are changes in resident services, including the addition of hospice services. **Corrective Action for Affected Residents:** The Assisted Living Director reviewed and updated Resident 7's service plan to include hospice services. The service plan was reviewed with the resident and responsible party, and signatures were obtained. **Identifying other Residents having the Potential to be**	05/23/2025

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			Affected: The Assisted Living Director conducted an audit of current resident service plans to ensure they were complete, signed, dated, and accurately reflected current services, including outside agency services. Any identified discrepancies were corrected immediately. **Measures put into place or Systemic Changes:** The Assisted Living Director will in-service all licensed nurse on: requirements for service plan completion, including signatures and dating process for updating service plans when changes occur in resident services documentation requirements for outside agency services a timeline for service plan updates. **Plan to Monitor Performance:** 1 Assisted Living Director/Designee will audit 5 resident service plans weekly to ensure compliance with completion, signatures, dating, and accurate reflection of current services. Results of these audits will be documented on a Service Plan Audit Tool. 2 The Assisted Living Director will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The Quality Assurance and Performance Improvement (QAPI)	

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			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 Bldg. 00	410 IAC 16.2-5-4(e)(3) Health Services - Deficiency Based on record review and interview, the facility failed to monitor the blood pressure of a resident with a PRN (as needed) blood pressure medication order for 1 of 7 records reviewed. (Resident 2) Finding includes: The record for Resident 2 was reviewed on 4/28/25 at 2:45 p.m. Diagnoses included, but were not limited to, colon cancer and hypertension. The 4/3/25 Level of Care Evaluation indicated the resident was alert and oriented but required the facility staff to manage his medications. A Physician's Order, dated 4/4/25, indicated hydralazine hcl (a blood pressure medication) every 8 hours as needed, give for systolic (the top number of a blood pressure reading) greater than 150. The record lacked documentation of the resident's blood pressure being monitored. During an interview on 4/29/25 at 11:20 a.m., the resident indicated staff did not monitor his blood pressure. During an interview on 4/29/25 at 12:16 p.m., LPN 4 indicated the nurses did not have to check the resident's blood pressure.	R 0243	R243 – Health Services IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that nursing staff will monitor and document blood pressure readings for all residents with PRN blood pressure medication orders according to the parameters specified in the physician's orders.	05/23/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	04/29/2025

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	During an interview on 4/29/25 at 2:10 p.m. the Director of Nursing indicated the parameter order should not have stayed in the resident's record when they moved to assisted living.		**Corrective Action for Affected Residents:** The Assisted Living Director reviewed and discontinued the PRN hydralazine order for Resident 2 as the resident had transferred to assisted living. The resident's physician was notified of the order discontinuation on 4/29/25. **Identifying other Residents having the Potential to be Affected:** The Assisted Living Director conducted an audit of all current residents with PRN blood pressure medication orders to ensure proper blood pressure monitoring and documentation was in place. Any identified issues were immediately corrected. **Measures put into place or Systemic Changes:** The Assisted Living Director will in-service all Licensed Nurses on: Proper monitoring and documentation requirements for PRN blood pressure medications Review of medication administration documentation requirements including vital sign parameters Process for order review during level of care transitions **Plan to Monitor Performance:** The Assisted Living Director will conduct weekly audits of: 1 Residents with PRN blood pressure medication orders to ensure proper blood pressure monitoring and documentation.	

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			2 The Assisted Living Director will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months . The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. Date of Compliance: 5/23/25	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency Based on observation, record review, and interview, the facility failed to keep the kitchen clean and in good repair related to food not labeled and dated, for 1 of 1 kitchen. This had the potential to affect 26 residents who resided in the facility and received food from the kitchen. Findings include: During the Initial Kitchen Sanitation Tour on 4/21/25 at 9:17 a.m. with the Kitchen Manager, the following was observed: 1. In the dry storage room, there was a large unlabeled storage bin containing a white powder and an unlabeled container partially filled with yellow liquid. 2. In the walk-in cooler, there was a partially full, unlabeled squeeze bottle containing a red/brown substance. There was an uncovered bucket filled with cut-up potatoes and water. There were trays of desserts in a rack that were uncovered and	R 0273	**R273 – Food and Nutritional Services** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER	05/23/2025

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	unlabeled. 3. In the walk-in freezer, there was an open, unlabeled bag of fish patties and an open, unlabeled bag of corn. 4. In the food prep area, there was a large plastic bin and a smaller plastic container filled with a white powder. Both were unlabeled. During an interview on 4/21/25 at 9:20 a.m., the Kitchen Manager indicated all food items should have been labeled and dated when opened and the uncovered items should have had lids on them. A policy titled "Labeling and Dating Foods", received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, " ... Packaged or containerized bulk food may be removed from the original package and stored in an ingredient bin labeled with the common name of the food, the date the item was opened and the date by which the item should be discarded or used by ..." A policy titled "Storage of Dry Goods/Foods", received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, " ... Opened products are labeled, dated with the use by date and tightly covered to protect against contamination including from insects and rodents ..." A policy titled "Labeling and Dating Foods--Refrigerated Food", received as current from the Kitchen Manager on 4/24/25 at 8:28 a.m. indicated, " ... If opened, the cold food item is labeled with the date opened and the date by which to discard or use by ..."		LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy that all food preparation and serving areas are maintained in accordance with state and local sanitation and safe food handling standards, including proper labeling and dating of food items and covering of stored foods. **Corrective Action for Affected Residents:** The Kitchen Manager immediately labeled all unlabeled items in the kitchen including the storage bin containing white powder, container with yellow liquid, squeeze bottle with red/brown substance, fish patties, and corn. All uncovered items including the bucket of cut-up potatoes and dessert trays were properly covered. All items were inspected for quality and appropriately dated. **Identifying other Residents having the Potential to be Affected:** All residents have the potential to be affected by this practice. The Dietary Manager conducted a complete inventory of all food storage areas including dry storage, walk-in cooler, and freezer to ensure all items were properly labeled, dated, and covered. **Measures put into place or Systemic Changes** 1 The Dietary Manager provided in-service education to all	

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	155840	A. BUILDING 00 B. WING	04/29/2025

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			dietary staff regarding proper food labeling, dating, and storage requirements. 1.The facility's policies on "Labeling and Dating Foods" were reviewed and reinforced with all dietary staff. 2."Label and Cover" reminder signs were posted in all food storages areas. **Plan to Monitor Performance:** 1 The Dietary Manager/Designee will conduct daily audits of all food storage areas tom ensure compliance with proper food labeling and covering requirements. 1.Any identified issues will be corrected immediately and staff will be re-educated as needed. The Dietary Manager will report monitoring results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial compliance of the set-forth protocol is achieved. Date of Compliance: 05/23/25	
R 0354 Bldg. 00	410 IAC 16.2-5-8.1(g)(1-7) Clinical Records - Noncompliance Based on record review and interview, the facility failed to ensure a transfer/discharge form was completed for 1 of 7 records reviewed. (Resident 7)	R 0354	**R-354 Clinical records** IGNITE MEDICAL RESORT DYER LLC makes every effort to operate	05/23/2025

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	Finding includes: Record review for Resident 7 was completed on 4/29/25 at 10:49 a.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation, and adjustment disorder. A Progress Note, dated 6/5/24 at 10:59 a.m., indicated the resident had an unwitnessed fall. She had low blood pressure, altered mental status, and was complaining of pain to her right arm and ribs. The nurse practitioner was notified and the resident was sent to the emergency room for evaluation. A Progress Note, dated 9/2/24 at 11:36 a.m., indicated the resident was lethargic, drooling, clammy, and slurring words. The nurse practitioner was notified and the resident was sent to the emergency room for evaluation. There was a lack of documentation to indicate a transfer form was completed and sent to the hospital on 6/5/24 or 9/2/24 that included the name of the receiving institution and date of transfer, nursing notes related to the resident, functional abilities and physical limitations, nursing care, medications, treatments, current diet, or resident condition upon transfer. During an interview on 4/29/25 at 3:20 p.m., the Director of Nursing indicated he was unable to find any transfer forms or transfer paperwork for the resident.		in substantial compliance with 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 with its regulatory obligations and does not waive any objections it may have as to the merit or form of any allegations contained herein. Please note that the facility may contest the merits or form of any of the alleged deficient findings and may take reasonable steps to appeal them. This Plan of Correction constitutes IGNITE MEDICAL RESORT DYER LLC's written credible allegation of compliance for the deficiencies noted. It is the facility's policy to ensure a complete transfer form is completed for all residents being transferred to another healthcare facility, including all required elements as specified in 410 IAC 16.2-5-8.1(g)(1-7). **Corrective Action for Affected Residents:** The Director of Nursing reviewed Resident 7's medical record and confirmed transfer forms were not completed for transfers on 6/5/24 and 9/2/24. **Identifying other Residents having the Potential to be Affected:** The Director of Assisted Living conducted an audit of all residents transferred to acute care facilities in the past 30 days to	

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			identify any other instances of missing or incomplete transfer forms. Any identified deficiencies were immediately corrected. **Measures put into place or Systemic Changes:** The Assisted Living Director will in-service all Licensed nurses on: The requirement to complete transfer forms for all resident transfers All required elements of transfer documentation Location and proper use of transfer forms Documentation requirements in the electronic health record **Plan to Monitor Performance:** The Assisted Living Director will audit : 1 Resident transfers daily during clinical meeting to ensure transfer forms were completed appropriately and documentation is in place in Health Record. 2 Any identified deficiencies will be corrected immediately, and additional education will be provided to the responsible staff member. 3 The Assisted Living Director will report monitoring plan results to the Quality Assurance and Performance Improvement (QAPI) committee monthly for 6 months. The Quality Assurance and Performance Improvement (QAPI) committee will monitor on an ongoing basis until substantial	

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			compliance of the set-forth protocol is achieved. Date of Compliance: 05/23/25	