CENTERS FUI	K MEDICAKE & MEDIC		_		OMB NO. 0936-039		
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING		COMPLETED		
		155840	B. WING		05/15/2025		
		1	CTDEET	ADDRESS, CITY, STATE, ZIP COD	<u> </u>		
NAME OF I	PROVIDER OR SUPPLIEF	₹		CALUMET AVENUE			
ICNITE N	MEDICAL DESCRI	DVERILC	DYER, IN 46311				
IGNITE	MEDICAL RESORT	DIERLLC	DIEN, IN 40011				
(X4) ID	SUMMARY	SUMMARY STATEMENT OF DEFICIENCIE		PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
E 0000							
Bldg							
	An Emergency Pre	paredness Survey was	E 0000	Ignite Medical Resorts Please			
	conducted by the Ir	ndiana Department of Health in		accept the following as the			
	accordance with 42	-		facility's credible allegation of			
				compliance. This plan of			
	Survey Date: 05/15	7/2025		correction does not constitute	an		
	=====================================	- -		admission of guilt or liability by			
	Facility Number: 0	13462		facility and is submitted only in			
	Provider Number:			response to the regulatory	'		
	AIM Number: 2013			requirement.			
	7 HW Tumber: 2015	330210		requirement.			
	At this Emergency	Preparedness survey, Ignite		This facility respectfully reque	ete a		
		er LLC, was found not in		desk review for the given citat			
		mergency Preparedness		in this survey. Please see all	10113		
	-	Medicare and Medicaid		attached documentation for yo	NUT.		
	-	ders and Suppliers, 42 CFR		consideration.	Jui		
		has 100 certified beds. At the		consideration.			
	time of the survey,	the census was 93.					
	Quality Review con	mpleted on 05/19/25					
L 0004	400.740/1.1/02	0.54/5./5/440.440/1./					
E 0024		6.54(b)(5), 418.113(b)(
SS=F	Policies/Procedur	es-Volunteers and Staffing					
Bldg	Događ or manad	view and interview the facility	E 0024		06/06/2025		
		view and interview, the facility	E 0024	E-024	06/06/2025		
		ergency preparedness policies lude the use of volunteers in		Policies/Procedure	ne		
	_	her emergency staffing			,3		
		g the process and role for		Volunteers and			
	-	or Federally designated health		Staffing			
	_	o address surge needs during		_			
	^	cordance with 42 CFR		It is the facility's policy to com	-		
		COTUATION WITH 42 CFK		with all applicable federal and			
	483.73(b)(6).	ian apuld affact all maridants		state regulations regarding			
	_	cice could affect all residents,		emergency preparedness poli			
	staff and visitors.			and procedures, specifically 4			
	E' 1' ' 1 1			CFR 483.73(b)(6), concerning	the		
	Findings include:			use of volunteers and emerge	ncy		
				staffing strategies during			

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

TITLE (X6) DATE

Megan Matula General Manager 06/06/2025

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

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	N OF CORRECTION	IDENTIFICATION NUMBER 155840	A. BUILDING B. WING		INSTRUCTION	COMPLETED 05/15/2025	
NAME OF	PROVIDER OR SUPPLIER	<u>.</u>		1	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYER LLC			IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	Environmental Servi 05/15/2025, the face Policies and Proceed of volunteers in an estaffing strategies, or integration of State care professionals to an emergency. Based Director of Environ on 05/15/2025, he available to address staffing strategies, or integration of State care professionals. This finding was re Manager, Regional	riew with the Director of rices at 10:40 a.m. on ility's Emergency Preparedness ures did not address the use emergency, emergency or the process and role for or Federally designated health to address surge needs during ad on interview with the mental Services at 10:40 a.m. tecknowledged no policy was volunteers in and emergency, or the process and role for or Federally designated health wiewed with the General General Manager, and the mental Services at the exit			emergencies. Corrective Action Taken: The facility developed and implemented a comprehensive Emergency Preparedness Pol addressing the use of volunteer and emergency staffing strates. The policy includes: Volunteer Support, Policy Implementatio Establishing Volunteer Resour and Arrangements with other Facilities. The facility develope and implemented a policy to provide an understanding and guidance of typical Medical Su Capacity and Capability plan to can be implemented for a mass casualty incident, pandemic, of other large scale incident that requires beds, staffing, and other large scale incident that requires beds, staffing and call departments and evaluation of current emergen staffing protocols	e icy ers gies. n, rces, ed irge hat es r etor d eved	

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/15/2025		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
E 0030 SS=F Bldg	403.748(c)(1), 416 Names and Conta	5.54(c)(1), 418.113(c)(act Information		Systemic Changes and Measures Implemented: The following systemic changes in been implemented: Created a Volunteer Management Program (5/27/2025) Developed procedures emergency credentialing of healthcare professionals (5/27/2025) Monitoring and Quality Assurance: The Director of Environmental Services/Designates will conduct monthly audits of Volunteer Management Police Staffing and Surge Capacity is ensure no changes to policy/procedures/resources is changed or need updated. Results will be reported mont the Quality Assurance Performance Improvement (Committee. The QAPI Comm will review findings and make necessary adjustments to ensongoing compliance. Monitori will continue until substantial compliance is achieved and maintained for six consecutive months. Date of Completion: 6/6/2025	gnee fy and for have hly to QAPI) ittee sure ing		
Ü	failed to ensure the communication pla	riew and interview, the facility emergency preparedness in includes (1) Names and for the following: (i) Staff (ii)	E 0030	E-030 Names and Contact Information It is the facility's policy to com			

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 05/15/2025	
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)	
TAG	Entities providing s Residents' physiciar Volunteers in accor (1). This deficient p occupants. Findings include: Based on record rev Environmental Serv 05/15/2025, the fac- not include (1) Nam the following: (i) St services under arrar physicians (iv) Othe Based on interview Environmental Serv 05/15/2025, he was contact information This finding was re Manager, Regional	ervices under arrangement (iii) as (iv) Other LTC facilities (v) dance with 42 CFR 483.73(c) ractice could affect all rices at 10:42 a.m. on ality's communication plan did as and contact information for aff (ii) Entities providing agement (iii) Residents' er LTC facilities (v) Volunteers. with the Director of rices at 10:42 a.m. on not able to provide a list of the diviewed with the General General Manager, and the mental Services at the exit	TAG	with all applicable federal and state regulations regarding emergency preparedness communication plans as outli in 42 CFR 483.73(c)(1). Corrective Action Taken: The Director of Environmental Set developed and implemented comprehensive emergency preparedness communication that includes contact informations for: (i) all facility staff member including their names, position and current contact information different contact informations attending physician other long term care facilities; (v) all facility volunteers. This information has been compiled both electronic and hard copy formats, with backup copies stored in multiple secure local within the facility. Identification of Other Areas with Potential to be Affected The Director of Environmental services conducted a facility-assessment to identify any of emergency preparedness documentation or communical systems that could be affected similar deficiencies. This revision included all emergency responses to the communication procedures throughout the factor of Systemic Changes and Measures Implemented: Implemented a new poliand procedure for maintaining and procedure for maintai	ned e rvices a i plan ion s, ns, on; s; (iv) and d in / tions i: il wide her ution d by ew nse cility.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155840	B. WING	G		05/15/	/2025
				CTDEET A	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
I ICNUTE N	AEDICAL DESCRI	DVEDILO			ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYER LLC		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					updating the emergency		
					preparedness communication	plan	
					annually		
					Created an electronic		
					database system to store and		
					maintain all required contact		
					information		
					Scheduled mandatory		
					in-service training for all		
					department heads on 05/29/20	025	
					regarding the new communica	ition	
					plan maintenance procedures		
					Created redundant syste	ems	
					for accessing contact informat	ion	
					during emergencies, including		
					both electronic and hard copy		
					formats.		
					Monitoring and Quality		
					Assurance: The Director of		
					Environmental Services/Desig	nee	
					will conduct monthly audits of		
					communication plan to ensure	all	
					contact information remains		
					current and complete. Results	of	
					these audits will be reported to	the	
					Quality Assurance Performand	ce	
					Improvement (QAPI) Committe	ee	
					monthly for six consecutive		
					months, then annually thereaf	ter.	
					The QAPI Committee will anal	yze	
					the data for patterns and trend	ls	
					and make additional		
					recommendations as needed	until	
					substantial compliance is		
					achieved and maintained.		
					Date of Completion: 6/6/2025		
E 0031	403.748(c)(2), 41	6.54(c)(2), 418.113(c)(
SS=F	Emergency Offici	als Contact Information					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING COMPLET			LETED	
		155840	B. W	ING		05/15	/2025
		•		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF I	PROVIDER OR SUPPLIEI	R			ALUMET AVENUE		
IGNITE N	MEDICAL RESORT	DYER LLC		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		view and interview, the facility	E 0	031	E-031 Emergency		06/06/2025
		Emergency Preparedness			Officials Contact		
	Communication Plan includes: (2) Contact				Officials Contact		
		following: (i) Federal, State,			Information		
	-	l local emergency preparedness Licensing and Certification			It is the facility's policy to com	ply	
		Office of the State Long-Term			with all applicable federal and		
		(iv) Other sources of assistance			state regulations regarding		
		42 CFR 483.73(c)(2). This			emergency preparedness		
		ould affect all occupants.			communication plans as outlir	ned	
					in 42 CFR 483.73(c)(2).		
	Findings include:				Corrective Action Taken: The		
	_				Director of Environmental Ser	vices	
	Based on record re-	view with the Director of			updated the Emergency		
	Environmental Serv	vices at 10:45 a.m. on			Preparedness Communication	ו	
		nergency Preparedness			Plan to include the required		
		an included contact information			contact information for the Ind		
	_	artment of Health, but did not			Department of Health (IDOH),		
	include Gateway.is	_			specifically adding Gateway.isdh.in.gov. The		
		gov as contact information for			Emergency Preparedness		
	_	ana Department of Health			Communication Plan was revi	ewed	
	` ′	interview with the Director of			in its entirety to ensure all requ		
		vices at 10:45 a.m. on			contact information is included		
		nowledged the emergency formation did not include the			and current for Federal, State		
	contact information				tribal, regional, and local	,	
	Contact information	101 10011.			emergency preparedness staf	f, the	
	This finding was re	viewed with the General			State Licensing and Certificati	on	
		General Manager, and the			Agency, the Office of the State		
		nmental Services at the exit			Long-Term Care Ombudsmar	ı, and	
	conference.				other sources of assistance.		
					Identification of Other Areas		
					with Potential to be Affected		
					The Director of Environmental	I	
					Services conducted a		
					comprehensive review of all		
					emergency contact lists and		
					communication protocols throughout the facility to ensur	rα	
					completeness and accuracy.		
					completeness and accuracy.	11113	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION _ 	COM	e survey pleted 5/2025
	ROVIDER OR SUPPLIE		1532 C	ADDRESS, CITY, STATE, ZIP CO CALUMET AVENUE IN 46311	OD	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	RECTION IOULD BE PPROPRIATE	(X5) COMPLETION DATE
				review included all emergoreparedness document posted contact informal electronic records maint the facility. Systemic Changes and Measures Implemented A new policy has implemented requiring verification of all emergored contact information by of Environmental Service The facility's Emergeredness Committer review the communicated during monthly meeting ongoing compliance. Staff training on updated Emergency Precommunication Plan we conducted by 05/30/20 Monitoring and Quality Assurance: The Direct Environmental Services will conduct monthly audengency Preparedness Communication Plan to required contact information Plan to required contact information Plan to required contact informations current and act Results of these audits reported to the Quality and Performance Impro (QAPI) Committee more months. Any identified deficiencies will be immore corrected and may result additional monitoring and determined by the QAF Committee. Date of Compliance: 6/	ntation, and ntained by d ded: been annual gency the Director ces. ergency tee will tion plan gs to ensure the reparedness vill be 25. y tor of s/Designee adits of the ess of ensure all nation courate. will be Assurance overment on the form of six mediately alt in selections.	

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ENTERS FO	R MEDICARE & MEDIC	CAID SERVICES			OMB NO. 0938-039		
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING			COMPLETED	
		155840	B. W	NG		05/15/2025	
		<u> </u>		CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF	PROVIDER OR SUPPLIE	R			CALUMET AVENUE		
IGNITE MEDICAL RESORT DYER LLC				IN 46311			
IGNITE	WIEDICAL RESORT	DTER LLC		DIEK,	111 40311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	- I	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
E 0032	403 748(c)(3) 41	.748(c)(3), 416.54(c)(3), 418.113(c)(
SS=F		Primary/Alternate Means for Communication					
Bldg	1 minary// incmate	Means for Communication					
g.	Based on record re	view and interview, the facility	E 00	132	E 022 Drimon, and		06/06/2025
		emergency preparedness	L 0032		E-032 Primary and		00/00/2023
		in includes (3) Primary and			Alternate Means for	r I	
	_	communicating with the					
		ring: (i) LTC facility's staff (ii) Federal, State,			Communication	ommunication	
	• .,	local emergency management			It is the facility's policy to comp	ly	
		es in accordance with 42 CFR 483.73(c) (3).			with all applicable federal and		
	_	tice could affect all residents,			state regulations regarding		
	staff and visitors.	,			emergency preparedness		
					communication plans as outline	ed	
	Findings include:				in 42 CFR 483.73(c)(3).		
	i manigs merade.				Corrective Action Taken: The		
	Based on record re	view with the Director of			Director of Environmental Serv	ices	
		vices at 10:50 a.m. on			revised the facility's Emergence	y	
		nergency preparedness			Preparedness Communication		
		in provided did not address			Plan to include specific primary	/	
	_	ate means for communication.			and alternate means of		
		with the Director of			communication. The plan now		
		vices at 10:50 a.m. on			explicitly details communication	n	
		nowledged the emergency			protocols with both facility staff		
		in did not address primary and			and Federal, State, tribal, region	nal,	
	alternate communic				and local emergency managen	nent	
					agencies.		
					Identification of Other Areas		
	This finding was re	eviewed with the General			with Potential to be Affected:		
	_	General Manager, and the			The Emergency Preparedness		
		nmental Services at the exit			Committee conducted a		
	conference.				facility-wide assessment on		
					05/16/2025 to identify all areas		
					requiring communication capal	oility	
					during emergencies.		
					Systemic Changes and		
					Measures Implemented:		
					Updated Emergency		
					Preparedness Communication		

Plan to include detailed primary and alternate communication

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	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 05/15/2025	
	PROVIDER OR SUPPLIE			1532 CA	ADDRESS, CITY, STATE, ZIP COD ALUMET AVENUE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ιΤΕ	(X5) COMPLETION DATE
					methods Conducted staff training revised communication plan a use of emergency communication plan a use of emergency communication equipment Monitoring and Quality Assurance: The Director of Environmental Services/Design will conduct monthly audits of emergency communication systems and equipment to enfunctionality and compliance. Results will be documented us the Emergency Communication Audit Tool. The Director of Environmental Services/Designee will report monitoring results to the mont Quality Assurance and Performance Improvement (Quality Assurance Improvement (Quantities) and Committee for six consecutive months. Date of Compliance: 6/6/2025	gnee the sure sing ons I thly	
E 0039 SS=F Bldg	EP Testing Requ		F 000	20			06/06/2025
	failed to conduct education plan at least twice unannounced staff procedures. The L' following: (i) Participate in an is community-based a. When a community-based function in the LTC facility based function b. If the LTC facility	drills using the emergency IC facility must do the annual full-scale exercise that d; or nity-based exercise is not t an annual individual,	E 003	39	Requirements It is the facility's policy to comwith all applicable federal and state regulations regarding emergency preparedness test requirements under 42 CFR 483.73(d)(2). Corrective Action Taken: The Director of Environmental Services, in collaboration with facility Administrator, developed	e the	06/06/2025

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	r í	UILDING	ONSTRUCTION	(X3) DATE COMPI 05/15	LETED
NAME OF I	PROVIDER OR SUPPLIER	}		STREET .	ADDRESS, CITY, STATE, ZIP COD	•	
					ALUMET AVENUE		
IGNITE	MEDICAL RESORT	DYER LLC		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	_	TAG			DATE
		lan, the LTC facility is exempt			and implemented a comprehe		
		ext required full-scale			emergency preparedness test	ing	
		or individual, facility-based			schedule. The facility has		
		l exercise for 1 year following			scheduled a community-base		
	the onset of the actu				full-scale exercise for 7/9/202	b in	
	1 1	itional exercise that may			coordination with CHUG.		
	· ·	imited to the following:			Additionally, a facility-based n		
	a. A second full-sca	or an individual, facility-based			disaster drill was completed o	n	
	functional exercise.	•			5/29/2025. Documentation	4-	
					templates have been created		
b. A mock disaster drill; or c. A tabletop exercise or workshop that is led by a					record and analyze all emerge	ency	
	facilitator that includes a group discussion, using				preparedness exercises. Identification of Other Areas		
	a narrated, clinically relevant emergency scenario,				with Potential to be Affected		
		n statements, directed			The Director of Environmenta	-	
	•	red questions designed to			Services conducted a facility-		
	challenge an emerg	-			assessment to identify all area		
		TC facility's response to and			requiring emergency prepared		
		ation of all drills, tabletop			testing. This review included	111033	
		gency events, and revise the			evaluation of current emerger	iCV	
		gency plan, as needed in			procedures, staff knowledge of	-	
	accordance with 42			emergency protocols, and			
		ice could affect all residents,			documentation systems for		
	staff and visitors.	,			recording exercises.		
					Systemic Changes and		
	Findings include:				Measures Implemented: The		
	-				facility implemented a new		
	Based on record rev	view with the Director of			Emergency Preparedness Te	sting	
	Environmental Serv	vices at 11:08 a.m. on			Program that includes:	· ·	
	05/15/2025, the fac	ility failed to provide			May 29, 2025:		
	documentation of a	ny exercises to test the			Facility-based disaster drill		
	emergency prepared	dness plan. Based on interview			June 5, 2025: Full Scale	!	
		/15/2025, the Director of			Exercise - Active Shooter		
	Environmental Serv	vices was not aware of any			July 9, 2025: Community	y —	
	exercises that were	conducted in the last year.			based full-scale exercise		
					Quarterly unannounced	staff	
	_	viewed with the General			drills beginning July 1, 2025		
		General Manager, and the					
		imental Services at the exit			Staff training on emergency		
	conference.				procedures will be conducted:		

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 05/15/2025		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
				Initial training: May 26 – May 30 Quarterly updates there New hire orientation Monitoring and Quality Assurance: The Director of Environmental Services/Designation will maintain an Emergency Preparedness Testing Log to all exercises, participation, ar outcomes. Results will be repto the Quality Assurance Performance Improvement (Committee monthly for six consecutive months. Date of Compliance: 6/6/2028	gnee track and corted		
K 0000							
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). This visit was in cor Code Preoccupancy 05/15/25.	Recertification and State as conducted by the Indiana th in accordance with 42 CFR njunction with the Life Safety Survey that exited on	K 0000	Ignite Medical Resorts Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability be facility and is submitted only it response to the regulatory requirement.	e an by the		
	Resort Dyer LLC, v with Requirements Medicare/Medicaid	3462 55840 30210 Code survey, Ignite Medical was found not in compliance		This facility respectfully requedesk review for the given cita in this survey. Please see all attached documentation for y consideration.	tions		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	01	COMPLETED	
		155840	B. WING		05/15/2025	
	PROVIDER OR SUPPLIER		1532 C	ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE	ID	DROWINERIC DI ANI OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	Code (LSC), Chapte Occupancies. This two-story facil Type V (111) constr 2-hour fire wall is p into two separate bubilding is subdivid compartments. Sepa healthcare occupance residential occupance horizontal floor/ceil	ity was determined to be of ruction and fully sprinklered. A rovided to divide the facility filldings. Each separate ed into two smoke fraction between the first-floor by and the second-floor by is divided by a 2-hour ing assembly and fire barriers. In g system is supported by a fire facility has a fire				
	alarm system with he resident rooms, in conthe corridors. The beby a 175-kW diesel facility has a capacity at the time of this Quality Review control of the second	pard-wired smoke detection in corridors and in spaces open to building is partially protected powered generator. The ty of 100 and had a census of s survey.				
K 0920 SS=E Bldg. 01	Extens Based on observation failed to ensure flex not used as a substitut smoke compartment wiring and equipment NFPA 70, National Edition, Article 400 specifically permitted shall not be used as a structure.	ent - Power Cords and on and interview, the facility ible cords and adapters were tute for fixed wiring in 1 of 10 ts. LSC 9.1.2 requires electrical ent shall be in accordance with Electrical Code. NFPA 70, 2011 .8 requires that, unless ed, flexible cords and cables a substitute for fixed wiring of the could affect staff in 1 of 10 ts.	K 0920	K-920 Electrical Equipment – Powe Cords and Extens It is the facility's policy to composite with all applicable federal and state regulations regarding electrical equipment safety, specifically NFPA 70 National Electrical Code Article 400.8 at NFPA 99 sections 10.2.3.6 and 10.2.4, concerning the proper	ply and d	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155840		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/15/2025			
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT DYER LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311				
IGNITE MEDICAL RES (X4) ID SUMI PREFIX (EACH DE TAG REGULATO Findings inch Based on obs Environmenta 05/15/2025, a directly into a power to two power strips p equipment an power to a fo power to tele equipment wa administrative desk. Directo a.m. on 05/15 power strips v strip providin This finding v Manager, Reg	ORT DYER LLC MARY STATEMENT OF DEFICIENCIE FICIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION	1532 CALUMET AVENUE	CORRECTION DATE COMPLETION DATE COMPLE			
		power strips and ele requirements. Monitoring and Qu Assurance: The Di Environmental Serv will conduct weekly electrical connectio strip usage. Results documented on the	rector of rices/Designee audits of all ns and power s will be			

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
		IDENTIFICATION NUMBER					COMPLETED	
155840		B. WING 05/15/2025						
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT DYER LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311						
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID				
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	(X5) COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
K 0921 SS=F Bldg. 01		ent - Testing and riew and interview, the facility e required maintenance and	K 0	921	safety inspection checklist. The Director of Environmental Services/Designee will review findings and immediately address and identified issues. Audit reswill be reported monthly to the Quality Assurance Performance Improvement (QAPI) Committee for six consecutive months. Date of Completion: 6/6/2025	all ress sults	06/06/2025	
maintain complete documentation of inspections for Patient Care Related Electrical Equipment (PCREE). NFPA 99 2012 edition, sections 10.3 and		documentation of inspections			Equipment – Testir	าg		
				and Maintenance				
	10.5 states the physical leakage current, and and portable PCREI 10.3. Testing interval policies and protococare rooms is tested 10.3.6 before being repair or modification several electrical apcompliance with NF Service manuals, improvided by the manuals required by 10.5. development of a promaintenance. Electronal maintenance mand safety labels and instructions on the approach of electrical equipment modifications is manual process.	ical integrity, resistance, I touch current tests for fixed E is performed as required in als are established with ols. All PCREE used in patient in accordance with 10.3.5.4 or put into service and after any on. Any system consisting of pliances demonstrates FPA 99 as a complete system. structions, and procedures nufacturer include information 3.1.1 and are considered in the rogram for electrical equipment rical equipment instructions anuals are readily available, d condensed operating appliance are legible. A record tent tests, repairs, and intained for a period of time to ance in accordance with the			It is the facility's policy to composite with all applicable federal and state regulations regarding Pater Care Related Electrical Equipmed (PCREE) testing and maintenary requirements as specified in NFPA 99 (2012 edition), section 10.3 and 10.5. Corrective Action Taken: The Director of Environmental Servinitiated a comprehensive inventory of all PCREE in the facility. Testing includes physicintegrity, resistance, leakage current, and touch current test required by section 10.3. The facility has established a centralized documentation system for maintaining records of all PCREE testing, repairs, and modifications.	etient ment ance ons et vices cal		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. B	UILDING	01	COMPL	COMPLETED	
155840		B. WING 05/15/2025				2025		
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF P	ROVIDER OR SUPPLIER				ALUMET AVENUE			
IGNITE N	MEDICAL RESORT	DYER LLC			IN 46311			
_		-			T	1	OV.5	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)	
PREFIX TAG	· ·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
IAU		rsonnel responsible for the	+	TAG	Identification of Other Areas		DATE	
		e and use of electrical			with Potential to be Affected			
	appliances receive of				The Director of Environmental	-		
		ice could affect all residents,			Services conducted a facility-			
	staff and visitors.	ree could affect all residents,			assessment to identify all area			
	starr and visitors.				where PCREE is in use. This	13		
	Findings include:				included patient rooms, therap	,,		
	1 manigo morado.				areas, and all clinical spaces. An			
	Based on record rev	riew with the Director of			inventory database was create			
		rices at 11:10 a.m. on			track all PCREE equipment,	J4 10		
		ility failed to provide			including manufacturer			
		esting of Patient Care Related			specifications, maintenance			
		nt (PCREE) in use in the facility			requirements, and testing			
		on 10.5.6.2 of NFPA 99, Health			schedules.			
		e. Based on interview with the			Systemic Changes and			
	Director of Environmental Services at 11:10 a.m.				Measures Implemented: The			
	on 05/15/2025, he provided several documents				facility developed and			
	including but not limited to HVAC inspections,				implemented a new PCREE			
	-	n check lists; however, none of			Testing and Maintenance Poli	cv		
	_	ained testing of PCREE, stated			that includes:			
	he was not aware of	f the testing requirements of			Testing intervals for all			
	PCREE.				PCREE equipment			
					Documentation			
	This finding was re-	viewed with the General			requirements for all tests, repa	airs,		
	Manager, Regional	General Manager, and the			and modifications			
	Director of Environ	mental Services at the exit			Procedures for testing n	ew		
	conference.				equipment before putting it int	o		
					service			
	3.1-19(b)				Requirements for			
					maintaining manufacturer serv	/ice		
					manuals and instructions			
					By 6/1/2025, the facility will			
					implement a computerized			
					maintenance management sy	stem		
					to track all PCREE testing			
					schedules and maintenance			
					records – TELS			
					Monitoring and Quality			
					Assurance: The General			
				Manager/Designee will condu	ct			

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155840	(X2) MULTIPLE C A. BUILDING B. WING	onstruction 01	(X3) DATE SURVEY COMPLETED 05/15/2025
	PROVIDER OR SUPPLIE		1532 (ADDRESS, CITY, STATE, ZIP COD CALUMET AVENUE , IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				monthly audits of PCREE test records to ensure compliance established testing intervals a documentation requirements. Results of these audits will be reported to the Quality Assura and Performance Improvemer (QAPI) committee monthly for months The Director of Environmental Services/Designee will maintatesting and maintenance reco that includes: - Equipment inventory and location - Testin dates and results - Maintenan and repair records The facility's QAPI committee monitor compliance with these measures until substantial compliance with all PCREE testing and maintenance requirements is achieved and maintained for a minimum of sconsecutive months. Date of compliance: 6/6/2025	with nd ance nt six I ain a rd ag ce will
K 0927 SS=F Bldg. 01	NFPA 101 Gas Equipment -	Transfilling Cylinders			
		on and interview, the facility of 1 oxygen storage/transfer	K 0927	K-927 Gas	06/06/2025
	location was used p	properly and in accordance PA 99, Health Care Facilities		Equipment –	
	Code, 2012 Edition	n, Section 11.5.2.3.1(1) states,		Transfilling	
	separated from any	ccur in) A designated area portion of a facility wherein		Cyclinders It is the facility's policy to com	ply
	barrier of 1 hour fir	l, examined, or treated by a fire re-resistive construction. This ould affect all residents, staff		with all applicable federal and state regulations regarding ox storage and transfilling operat specifically NFPA 99, Health (ygen ions,

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		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			A. BUILDING 01		COMPLETED		
		155840	B. WING 05/15/2025			2025	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD		
					ALUMET AVENUE		
IGNITE N	MEDICAL RESORT	DYER LLC		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	TC' 1' ' 1 1				Facilities Code, 2012 Edition,		
	Findings include:				Section 11.5.2.3.1(1).		
	Dagad on abaamiati	on with the Director of			Corrective Action Taken: On		
		vices at 11:57 a.m. on			05/15/2025, the Director of		
		ygen storage/transfill room on			Environmental Services		
		Kendall hall of the facility			reorganized the oxygen storage/transfill room on the "(~ "	
		oxygen containers, 3 portable			side of Kindle hall to ensure	,	
		I five "E" tank oxygen carts.			adequate space for staff to sa	felv	
		transfill room did not have			enter and perform transfilling	ioiy	
		o enter the room. A LPN was			operations. Excess oxygen		
		demonstrate entering the room			containers and tanks were		
	-	illable tank. The LPN was not			relocated to the facility's		
	*	om to perform the task and held			secondary oxygen storage are	ea.	
	the door open with his body. Based on interview				Identification of Other Areas		
	with the Director of Environmental Services at				with Potential to be Affected		
	11:57 a.m. on 05/15/2025, when asked if staff				The Director of Environmenta	I	
	normally leave the door open to perform				Services conducted a facility-v	vide	
	transfilling, he indi	cated it was not and stated			assessment of all oxygen stor	age	
	"Usually only have	two tanks."			areas to ensure compliance w	ith	
					NFPA 99 requirements. This		
	_	viewed with the General			included verification of proper		
		General Manager, and the			barrier construction, ventilation	٦,	
		mental Services at the exit			and adequate space for safe		
	conference.				operation.		
	2.1.10/1-)				Systemic Changes and		
	3.1-19(b)				Measures Implemented:	and	
					Revised oxygen storage	and	
					transfilling policy to include specific requirements for		
					maximum room capacity and s	safe	
					operating procedures	oaic	
			1		Implemented daily oxyge	en	
					storage room inspection check		
					to monitor compliance with		
					storage limits and accessibility	/	
					requirements.		
			1		Conducted mandatory		
					in-service training for all nursir	ng	
					staff and environmental servic	-	
			1				i

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AND PLAN	OF CURRECTION	IDENTIFICATION NUMBER 155840	B. WING		<u>UI</u>	05/15/2025	
NAME OF PROVIDER OR SUPPLIER IGNITE MEDICAL RESORT DYER LLC		STREET ADDRESS, CITY, STATE, ZIP COD 1532 CALUMET AVENUE DYER, IN 46311					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	ALGEL TORY OF				personnel on proper oxygen storage and transfilling proce Monitoring and Quality Assurance: The Director of Environmental Services/Desi will conduct weekly inspection the oxygen storage/transfill reto ensure proper storage cap and accessibility are maintain as well as daily oxygen storal inspection log is being comply. The Director of Nursing/Desi will conduct 5 random observations of transfilling procedures on alternating shensure staff compliance with safety protocols. The Director of Environmental Services/Designee will report monitoring results to the Qual Assurance and Performance Improvement (QAPI) commit monthly for six consecutive months. Date of Completion: 06/06/20	ignee ons of com cacity ned ge eted. gnee iffs to al t lity	

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