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	11/27/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00422105. Complaint IN00422105 - Federal/state deficiencies related to the allegations are cited at F580, F624, F744, and F842. Survey date: November 27, 2023 Facility number: 013462 Provider number: 155840 AIM number: 201330210 Census Bed Type: SNF/NF: 7 SNF: 91 Residential: 29 Total: 127 Census Payor Type: Medicare: 33 Medicaid: 7 Other: 58 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 12/1/23.	F 0000	Ignite Medical Resorts Dyer 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.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Megan Matula | General Manager | 12/14/2023

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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on record review and interview, the facility failed to ensure a resident's family was notified of behaviors, medication changes, and transfers to the Emergency Room, for 1 of 5 residents reviewed for family notification. (Resident B) Finding includes: Resident B's record was reviewed on 11/27/23 at 10:40 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 10/26/23, indicated short and long term memory problems, no behaviors, and received an antipsychotic, and anti-anxiety, and an antidepressant medication. An Admission Cognitive Evaluation, dated 10/20/23, indicated a severely impaired cognitive status. The Nursing Progress Notes, dated 10/25/23 at 6:57 a.m., 10/31/23 at 10:18 p.m., 11/4/23 at 8:07 p.m., 11/7/23 at 5:23 p.m., 11/10/23 at 5:30 p.m., 11/20/23 at 7:05 p.m., 11/24/23 at 12:53 p.m., and 11/24/23 at 11:47 p.m., indicated the resident had agitated behaviors. The Nursing Progress Notes, dated 11/4/23 at 8:07 p.m. and 11/25/23 at 12:05 a.m., indicated the resident had been transferred to the Emergency Room related to her agitated behaviors. The Physician's Orders, dated 10/23/23, 10/25/23,	F 0580	**POC for F580 Notify of Changes (Injury/Decline/Room, etc.)** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. Resident B no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed for all residents transferred to Hospital to ensure POA/Family notification is in place. House audit was completed for all medication changes to ensure POA/Family notification is in place.	12/14/2023

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	11/9/23, 11/14/23, and 11/22/23, indicated new orders and/or dosage change orders for Seroquel and Rexulti (antipsychotics). Cross reference F744. The family had not been notified of the behaviors, the transfer to the Emergency Room, or the new orders for the medications. During an interview on 11/27/23 at 3:06 p.m., the Director of Nursing indicated there had been no documentation the family had been notified of the behaviors, Physician's Orders, and transfers to the Emergency Room. A facility family notification policy, dated 5/2023 and received from the Director of Nursing as current, indicated family/Powers of Attorney would be notified of changes of condition. This citation relates to Complaint IN00422105. 3.1-5(a)(2) 3.1-5(a)(3)		House audit was completed to ensure all residents displaying behaviors have POA/Family notification in place. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing team and IDT team educated on notification requirements and ensuring notification is communicated to POA/appropriate family member and resident, when appropriate, as it pertains to transfers to hospital, medication changes, and behaviors. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** CNO/Designee will audit all Hospital transfers daily in clinical IDT meeting to ensure appropriate documentation and notification is in place. CNO/Designee will audit medication order changes daily in morning clinical IDT meeting to ensure appropriate documentation and notification is in place.	

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			GM/Designee will audit all behavior documentation daily in morning clinical IDT meeting to ensure appropriate notification is in place. The CNO/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 12/14/2023**	
F 0624 SS=D Bldg. 00	483.15(c)(7) Preparation for Safe/Orderly Transfer/Dschrg §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. Based on record review and interview, the facility failed to provide and document sufficient information for a resident who was being transferred to the hospital Emergency Room related to Transfer Forms/assessments not completed for 1 of 1 resident reviewed for transfer	F 0624	**POC for F624 Preparation for Safe/Orderly Transfer/Dschrg** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	12/14/2023

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	to an Emergency Room. (Resident B) Findings includes: Resident B's record was reviewed on 11/27/23 at 10:40 a.m. The diagnoses included, but were not limited to, dementia. The Nurses' Progress Notes, dated 11/4/23 at 8:07 p.m. and 11/25/23 at 12:05 a.m., indicated the resident was transferred to the Emergency Room related to behaviors. There was no transfer form with information about the resident's status sent with the resident to the Hospital. During an interview on 11/27/23 at 3:06 p.m., the Director of Nursing indicated there were no transfer forms for the Emergency Room Transfer completed. This citation relates to Complaint IN00422105. 3.1-12(a)(21)		**practice?** No residents were affected by this alleged deficient practice. Resident B no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed for all residents transferred to the Hospital to ensure transfer form/assessment is completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Nursing team educated on completing transfer form with assessment for all residents being transferred to the Hospital. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance program will be put into place? CNO/Designee will audit all Hospital transfers daily in clinical IDT meeting to ensure transfer forms are completed for all residents being transferred to the Hospital. The CNO/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 12/14/2023**	
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia §483.40(b)(3) A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being. Based on observation, record review and interview, the facility failed to ensure a resident with dementia received appropriate treatment and services to meet her needs, related to ongoing behaviors without input from the Interdisciplinary	F 0744	**F744-Treatment/services for dementia** **What corrective action(s) will be accomplished for those resident(s) found to have been**	12/14/2023

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	Team (IDT) and Social Service, no updated Care Plan with interventions for the behaviors, no interventions attempted and/or no documented effectiveness of the interventions, for 1 of 3 residents reviewed for dementia/behaviors. (Resident B) Finding includes: During an observation on 11/27/23 at 10:48 a.m., Resident B was being assisted to the bathroom by Employee 1. Employee 1 moved slowly and explained each movement prior to assisting her. The resident was calm and cooperative. During an interview, Employee 1 indicated the resident could be resistive and combative. The behaviors usually occurred when she was tired and when she was assisted into the bed and left alone for a short time, she would usually calm down. Resident B's record was reviewed on 11/27/23 at 10:40 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 10/26/23, indicated short and long term memory problems, no behaviors, and received an antipsychotic, and anti-anxiety, and antidepressant medications. An Admission Cognitive Evaluation, dated 10/20/23, indicated a severely impaired cognitive status. A Care Plan, dated 11/3/23 and revised on 11/27/23, indicated behaviors of wandering, pacing or roaming were present and symptoms were manifested by becoming agitated, oppositional, and combative when re-directed when pacing, roaming, or wandering in and out of		**affected by the deficient practice?** No harm came to Resident B related to alleged deficient practice. Resident B no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents with behaviors have the potential to be affected by this alleged deficient practice. A full house audit was completed to identify resident with current behaviors and/or dementia with behaviors received appropriate treatment and services to meet needs related to; Residents with ongoing behaviors are addressed with documented input from interdisciplinary team members including but not limited to nursing and social service department. Care-plans are updated with appropriate interventions for behaviors. Any attempted interventions with effectiveness are documented in the medical records. **What measure will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Staff was educated on;	

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	other resident's rooms. The interventions, initiated on 11/3/23, included the staff would reassure the resident that she was safe and they would monitor their body language to avoid triggers for the resident. A Physician's Order, dated 10/19/23, indicated Seroquel (antipsychotic), 25 milligrams (mg), 1/2 tablet was to be administered every evening as a mood stabilizer. A Physician's Order, dated 10/23/23, indicated Seroquel 25 mg, 1/2 tablet was to be given every evening for adjustment disorder with mixed disturbance of emotions and conduct. A Progress Note, dated 10/25/23 at 6:57 a.m., indicated she was very aggressive with the staff all shift. She spit in a staff members face and had also scratched her hand while attempts were made to redirect her. She hit a staff member as they walked by her. She also would spit her medications out when attempted to administer them. She was very hard to redirect and would not listen to the staff. Staff continued to educate and redirect her as needed. The only interventions used were redirection and education and both were ineffective. A Nurse Practitioner's Progress Note, dated 10/25/23 at 1:59 p.m., indicated she had been informed by Nursing the resident had been aggressive toward the staff and refused her medications. A Psychiatric Nurse Practitioner would visit the resident today and medications were adjusted. A Physician's Order, dated 10/25/23, indicated		Monitoring and documenting behaviors and reporting all behaviors to the nurse for evaluation, assessment and documentation in the clinical record Charge nurse reporting pertinent findings from the behavior assessment to the physician and representative as appropriate Monitoring specifically identified behaviors on a continuous basis and documenting observed behaviors in the residents clinical record on a real- time basis along with interventions attempted and success of those interventions Interdisciplinary team, including but not limited to social service department, clinical leadership, and MDS department were educated on; Developing person-centered, individualized care plan for each resident related to behaviors and documenting ongoing behavior needs. Evaluating current behavior management plan of care and interventions and updating as needed based on behavioral changes/needs. Monitoring specifically identified behaviors on a continuous basis and documenting observed behaviors in the resident's clinical record on a real- time basis along with interventions attempted and	

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	Seroquel 25 mg, 1/2 tablet was to be administered every eight hours for atypical psychosis related to dementia. The Psychiatric Nurse Practitioner's Progress Note, dated 10/25/23, indicated the resident was cognitively impaired to place and time and only partially oriented to situation. She demonstrated severe deficits in abstract reasoning and judgement. Change of medications were explained to the resident and consulted Nursing and Social Service staff. A Physician's Order, dated 10/25/23, was received for Rexulti (agitation associated with dementia/atypical antipsychotic), 0.5 mg daily for dementia with psychotic disturbance. A Progress Note, dated 10/31/23 at 10:18 p.m., indicated the Psychiatric Nurse Practitioner was notified due to the resident had spit and cursed at the staff, was paranoid and accused staff of taking items. The resident was redirected and the intervention was not successful. No other interventions had been attempted. A Progress Note, dated 11/4/23 at 8:07 p.m., indicated aggressive behaviors and increased anxiety was present. She refused her medications. She would not sit still and would push the wheelchair over. When staff would move closer to her, she would become more aggressive, knocked over objects, and would throw objects. She had hit a staff member in the head and would spit at staff. Orders were received to transfer her to the Hospital Emergency Room. No interventions other interventions had been attempted. There were no further Progress Notes for return from the hospital or for behaviors until 11/7/23.		success of those interventions **How will the corrective action(s) be monitored to ensure the deficient practice will not recur, ie., what quality assurance program will be put into place?** Five days a week the General Manager/Designee will review residents who have new or continued behaviors to ensure there is ongoing IDT documentation with social services input at least weekly including any new or changes in behaviors and interventions. The CNO/Designee will review 10 resident charts weekly to ensure careplans are updated for residents with behaviors and interventions are appropriate and effective. CNO and General Manager will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. Date of compliance: 12/14/23	

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	A Progress Note, dated 11/9/23 at 5:26 p.m., indicated on 11/7/23 at 5:23 p.m., the resident had behaviors of unassisted transfers. When she was redirected, she became physically aggressive and would hit and spit at the staff. She was not easily redirected. The Nurse Practitioner and the Psychiatric Nurse Practitioner were notified. Redirection was the only intervention attempted. A Physician's Order, dated 11/9/23, indicated the Seroquel was increased to 25 mg every 12 hours and the Rexulti 0.5 mg was increased to two tablets daily. The Seroquel was discontinued on 11/12/23. A Physician's Order, dated 11/14/23, indicated Seroquel 25 mg every eight hours as needed for psychosis. A Progress Note, dated 11/20/23 at 7:05 p.m., indicated she was wandering into other resident's rooms and she was not easily redirected. A Nurse Practitioner Progress Note,dated 11/22/23 at 2:08 p.m., indicated she had spit out her morning medications and became combative. There was no other documentation from the facility staff or what interventions had been attempted. A Physician's Order, dated 11/22/23, indicated Seroquel 25 mg was administered STAT (immediately) for agitation and Rexulti 0.5 mg had been increased to four tablets daily. A Progress Note, dated 11/24/23 at 11:47 p.m., indicated she was very aggressive with staff and had tried to fight other residents and staff members. She had spit on a staff member. She was			

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	unable to be redirected and would fight the staff and spit on them when redirections was attempted. A Progress Note, dated 11/25/23 at 12:05 a.m., indicated the resident had been transferred to the Emergency Room due to erratic behavior. A Progress Note, dated 11/25/23 at 6:39 a.m., indicated she had returned from the hospital with no new orders. The Care Plan and interventions had not been updated with the increased behaviors. The staff attempted only redirection for the above behaviors. There was no Interdisciplinary Team or Social Service input for the behaviors and interventions. During an interview on 11/27/23 at 2:19 p.m., the Social Service Director indicated the wandering behaviors had caused the other behaviors. He indicated if the facility still had a Memory Care Unit, she would have been transferred to the Unit and the Care Plan would have been updated and more interventions would have been added. During an interview on 11/27/23 at 3:06 p.m., the Director of Nursing indicated the Care Plan had not been updated, there were no interventions listed for the behaviors, and there were no other interventions used other than redirection on some of the behaviors. A, "Behavior Emergency Policy", dated 4/2023 and received from the Director of Nursing as current, indicated staff were to offer empathy and reassurance of safety, and set verbal limits. The resident could be escorted to a private area to help decrease the external stimulation, one on one			

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	care could be initiated, and medication could be offered. If the resident became violet to staff or others, the resident would be transferred to the Emergency Room for outside interventions. After the incident, documentation in the Progress Notes was to include the behavior, the events that potentially contributed to the behavior, an assessment of the resident, each intervention utilized, and notification of the family and physician with subsequent orders. This citation relates to Complaint IN00422105. 3.1-37			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records,			

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	155840	A. BUILDING 00 B. WING	11/27/2023

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
	regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and			

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	determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure a resident's record was complete and accurate, related to no documentation of a resident's return from the Emergency room, no documentation of of an appeal of a NOMNC (Notice of Medicare Non-Coverage) letter, and events that occurred during a potential discharge of a resident and reasons for discharge from the facility, for 2 of 5 residents reviewed for medical records. (Residents B and E) Findings include: 1. Resident B's record was reviewed on 11/27/23 at 10:40 a.m. The diagnoses included, but were not limited to, dementia. An Admission Minimum Data Set assessment, dated 10/26/23, indicated short and long term memory problems. An Admission Cognitive Evaluation, dated 10/20/23, indicated a severely impaired cognitive status. The Nurse's Progress Note, dated 11/4/23 at 8:07 p.m., indicated the resident was transferred to the Emergency Room related to agitated behaviors. There was no documentation when the resident returned from the Emergency Room or treatment summary from the Emergency Room. A Social Service Progress Note, dated 11/16/23 at 1 p.m., indicated a NOMNC letter was given by	F 0842	**POC for F842 Resident Records – Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No residents were affected by this alleged deficient practice. Resident B no longer resides in the facility. Resident E no longer resides in the facility. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents have the potential to be affected by this alleged deficient practice. House audit was completed for all residents transferred to Hospital to ensure return documentation is in place along with any new orders or changes to resident care. House audit was completed	12/14/2023

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	telephone to the resident's family. The last covered day of service was 11/19/23 and first day of resident payment for stay would be 11/20/23. The family was provided the information about the appeal process and the phone number to appeal the discharge from Medicare. They were educated on the importance of appealing by 11/18/23. The family member had not indicated she would be appealing the NOMNC. During an interview on 11/27/23 at 2:19 p.m., the Social Service Director indicated the NOMNC information was given to the family member over the phone and the NOMNC form was still at the facility to be given to the family member. He received a call from the company who oversees the appeals and was informed an appeal was requested, and they had requested copies of the medical record which were sent. The appeal request was not documented in the record. A Social Service Progress Note, dated 11/20/23 at 3:01 p.m., indicated discharge planning had been completed and Home Health Services had been set up. The family indicated they were not in need of any medical equipment at the time of discharge. The family indicated they would transport the resident home. When the family arrived at the facility, they refused to transport or discharge the resident and left the facility. The resident remained at the facility. There was no documentation why the discharge was refused or the events that had occurred during the potential discharge. During an interview on 11/27/23 at 3:06 p.m., the Assistant Administrator indicated the family member refused to take the resident home due to the resident's aggression. The family member left		for all guests receiving a NOMNC to ensure appeal information including outcome is documented in chart. House audit was completed for all guests to ensure discharge/transfer information including any unusual occurrences and/or barriers that prohibit discharge/transfer are clear and thoroughly documented. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** Interdisciplinary team members and nurses educated on completing documentation pertaining to transfers to and from Hospital including any new orders and or changes to residents care. Interdisciplinary team members and nurses educated on documenting any appeals including results from outcome, all discharge planning including transfers to a new facility, and any potential barriers that arise with discharge planning. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put**	

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	the facility without the resident. She indicated there had been no documentation of the events in the resident's record. 2. Resident E's record was reviewed on 11/27/23 at 1:30 p.m. The diagnoses included, but were not limited to, Alzheimer's disease. An Admission Minimum Data Set assessment, dated 8/18/23, indicated a severely impaired cognitive status and no behaviors. A Nurse's Progress Note, dated 11/14/23 at 9:27 a.m., indicated the resident's family was at the facility and was discharging the resident to another facility. A Social Service Progress Note, dated 11/24/23 at 11:54 a.m., indicated the resident had been accepted at another facility and was transported to the other facility by her family. During an interview on 11/27/23 at 4 p.m., the Social Service Director indicated the family was informed the Unit on which the resident resided was no longer going to be a Memory Care Unit and they wanted her in Memory Care Unit. They located another facility on their own and information was sent to the facility for an approved admission. The events of the transfer/discharge should have been documented. This citation relates to Complaint IN00422105. 3.1-50(a)(1) 3.1-50(a)(2)		**into place?** CNO/Designee will audit all Hospital transfers daily in Clinical IDT meeting to ensure readmission and transfer to hospital documentation is in place along with any new orders or changes to residents care. General Manager/Designee will audit 10 NOMNCs weekly to ensure appeal information is documented in EMR. General Manager/Designee will audit 10 discharges weekly to ensure residents have discharged as planned and any barriers or unusual occurrences that may have taken place are documented in EMR. The CNO/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 12/14/2023**	