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	06/18/2024

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 Complaints IN00431978 and IN00435661. Complaint IN00431978 - Federal/State deficiencies related to the allegations are cited at F573. Complaint IN00435661 - No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: June 17 & 18, 2024 Facility number: 013462 Provider number: 155840 AIM number: 201330210 Census Bed Type: SNF/NF: 2 SNF: 97 Residential: 27 Total: 126 Census Payor Type: Medicare: 42 Medicaid: 2 Other: 55 Total: 99 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/18/24.	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.	
F 0573 SS=D Bldg. 00	483.10(g)(2)(i)(ii)(3) Right to Access/Purchase Copies of Records			

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

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	Based on record review and interview, the facility failed to provide residents' medical records to the resident/Power of Attorney (POA) in a timely manner after a request was made for 2 of 3 residents reviewed for medical record requests. (Residents G and H) Finding includes: 1. Resident G's closed record was reviewed on 6/18/24 at 8:51 a.m. The diagnoses included, but were not limited to, congested heart failure. An Admission Minimum Data Set assessment, dated 3/12/24, indicated no cognitive problems. A Request and Authorization for Release of Health Information form, indicated the complete medical record was requested by the resident and the POA on Friday 5/31/24. The record was not received by the resident and POA until 6/7/24. During an interview on 6/17/24 at 3:24 p.m., the Business Office Manager indicated once the request form for the medical record was filled out, it was scanned and sent to the Corporate Office. The Legal Department reviewed the request and would then contact the facility when the records could be released. The facility also had to wait for therapy and other third party departments to give them their records since there was no access to them through the facility record system. 2. Resident H's record was reviewed on 6/18/24 at 9:04 a.m. The diagnoses included, but were not limited to, congestive heart failure. An Admission Minimum Data Set assessment, dated 4/21/24, indicated no cognitive problems.	F 0573	**POC for F573 Right to Access/Purchase Copies of Records** **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 G and H no longer reside 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 open medical requests to ensure requests have been completed. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** HIM and BOM have been educated on regulation of filling	06/28/2024

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	A Request and Authorization for Release of Health Information form, indicated the complete medical record was requested by the resident and the POA on Tuesday 5/14/24. The medical records were received by resident and the POA on 5/19/24. During an interview on 6/18/24 at 9:15 a.m., the Business Office Manager indicated she had not received the therapy records until 5/17/24 and she printed them out on 5/19/24 and added the notes to the medical record for the resident and POA. A medical records policy, dated 5/2023 and received from the Business Office Manager as current, indicated the facility would allow the resident to obtain a copy of the records or any portion of the records, which included electronically or paper, upon request and two working days advance notice to the facility. This citation relates to Complaint IN00431978. 3.1-4(b)(2)		requests within 2 days excluding weekends/holidays, and should there be a delay to make sure family is notified and documented in PCC. **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?** GM/Designee will audit all medical record requests weekly to ensure records are fulfilled within a timely manner. The GM/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: 6/28/24**	
F 0880 SS=D Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control Based on observation, interview, and record review, the facility failed to ensure correct	F 0880	**POC for F880 – Infection Prevention & Control**	06/28/2024

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	Personal Protective Equipment (PPE) was used by a staff member (CNA 1) when emptying out a urinary catheter drainage bag for a resident who was in Enhanced Barrier Precautions (EBP) for 1 of 1 random observation. (Resident J) Finding includes: During an random observation on 6/17/24 at 11:54 a.m., CNA 1 was in Resident J's room and was emptying the resident's urinary catheter drainage bag. There was no EBP sign on the door and no PPE in a cart next to the door. CNA 1 was wearing gloves and no gown. CNA 1 indicated she thought she had education on EBP and stated if the resident was on EBP there would be a sign on the door and a PPE cart in the hallway next to the door. She indicated if the resident had an urinary tract infection, an ostomy, or a urinary catheter, the residents were to supposed to be in EBP. CNA 1 acknowledged she had not donned a gown prior to emptying the urinary catheter drainage bag. During an interview on 6/17/24 at 11:59 a.m., LPN 2 indicated residents with clostridium difficile (C-diff) and COVID-19 were to be in EBP. LPN 2 indicated she had just completed the education on EBP. She indicated a sign that indicated EBP was required was to be placed on the door and a cart with PPE was in the hallway outside the resident's room. A resident with an urinary catheter was to be placed in EBP and the nurse who had admitted Resident J should have put a sign on the door and a PPE container outside the room. During an interview on 6/17/24 at 12:02 p.m., LPN 3 indicated she has had education on EBP and residents with wounds, indwelling medical devices, and certain infections were to be placed in EBP. She indicated the Infection Control Nurse		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** No harm came to any resident from this alleged deficient practice. Resident J no longer resides in facility. CNA 1 and LPN 2 re-educated on Enhanced Barrier Precautions and the importance of wearing proper PPE. **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. Full house audit completed for all residents in isolations, including but not limited to EBP, to ensure that order is place, signage is posted, and PPE is	

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	placed the signs on the doors and the PPE cart outside of the doors. When the Infection Control Nurse was not in the facility, the nurses have access to signs and carts and it was their responsibility to ensure they were in place. During an interview on 6/17/24 at 12:09 p.m., the LPN Infection Control Nurse indicated when she completed resident rounds this morning, she missed that Resident J had a urinary catheter. The resident had been admitted during the weekend and had been without the EBP signage and PPE cart outside the door. The nurse who admitted the resident was responsible to ensure the signage and PPE were initiated. She indicated she had just completed a full house education on EBP with staff. Resident J's record was reviewed on 6/18/24 at 9:28 a.m. The diagnoses included, but were not limited to, multiple sclerosis. A Care Plan, dated 6/16/24, indicated an urinary catheter was present. The interventions included, EBP would be initiated. A Pre-Admission Physician's Order, dated 6/14/24, indicated EBP was to be initiated related to the urinary catheter. A facility EBP policy, dated 3/2024, and received from the LPN Infection Control Nurse, indicated residents with indwelling medical devices, which included urinary catheters, were to placed in EBP. The signage was to placed on the door or on the wall outside the room. Gown and gloves were to be available near or outside the resident's room. 3.1-18(b)		available. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All staff educated on Enhanced Barrier Precautions and the importance of wearing PPE. Nursing staff educated on the requirement that isolation, including but not limited to EBP, be initiated on admission, and as needed orders in place, isolation sign placed outside of room, and PPE made available. **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 10 staff members weekly on random shifts to ensure appropriate PPE is worn based on isolation status. CNO/Designee will audit all new admissions to ensure guest	

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			is placed in appropriate isolation precautions, orders are in place, signage is posted, and PPE is available. CNO/Designee will review all new orders to ensure if someone obtains a medical device requiring EBP, guest is placed in appropriate isolation precautions, orders are in place, signage is posted, and PPE is available. CNO/Designee will present the summaries of the audits to the Quality Assurance committee monthly for six months. Thereafter, if determined by the Quality Assurance committee that further monitoring is needed, audit will continue. **Date of compliance: 6/28/24**	