STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155840	A. Building B. Wing	06/18/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ignite Medical Resort Dyer Llc.	1532 Calumet Avenue Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 20580 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. 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. (continued on next page)

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

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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 20580 Based on observation, interview, and record review, the facility failed to ensure correct 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 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. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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)