

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155840	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/08/2024
NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort Dyer Llc.		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0624</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Prepare residents for a safe transfer or discharge from the nursing home.</p> <p>20580</p> <p>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 (ER), related to the circumstances of a resident being transferred to the ER not documented in the resident's record and transfer information was not provided to the Emergency Medical Services (EMS) and hospital, for 1 of 3 residents reviewed for transfers and discharges. (Resident E)</p> <p>Finding includes:</p> <p>Resident E's record was reviewed on 8/6/24 at 10:25 a.m. The diagnoses included, but were not limited to, metabolic encephalopathy.</p> <p>The Census Form indicated the resident was discharged from the facility on 7/19/24.</p> <p>The discharge status was not listed on the Discharge, return not anticipated Minimum Data Set assessment, dated 7/19/24.</p> <p>There was no documentation in the Nurses' Progress Notes, dated 7/19/24, the resident had a change of condition, was transferred to the ER, and/or discharged from the facility.</p> <p>There was no Transfer Form or Discharge Form that indicated the resident had been transferred or discharged from the facility.</p> <p>The Hospital ER Notes, dated 7/19/24, indicated the resident had lost consciousness when he had been transferred from the bed to the chair. There was no prolonged loss of consciousness.</p> <p>During an interview on 8/6/24 at 11:41 a.m., the Director of Nursing (DON) indicated the family member had called 911 for the transfer. There was no documentation in the record that indicated the resident had a change of condition and no transfer sheet had been completed. The DON was unable to determine if any paperwork was sent with the resident or if the hospital ER was notified with information about the resident. He indicated the circumstances about the transfer should have been documented in the record.</p> <p>This citation relates to Complaint IN00438865.</p> <p>3.1-12(a)(21)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure Minimum Data Set (MDS) assessments were accurately completed related to falls, medications, and behaviors for 2 of 8 MDS assessments reviewed. (Residents G and J)</p> <p>Findings include:</p> <p>1. Resident G's record was reviewed on 8/8/24 at 9:21 a.m. The diagnoses included, but were not limited to, dementia.</p> <p>An Admission MDS assessment was completed on 6/26/24. The MDS indicated there had been no behaviors, no falls, and the resident had not received an antipsychotic medication.</p> <p>The Nurses's Progress Notes indicated the resident had fallen on 6/22/24 at 11:06 a.m., 6/23/24 at 9:45 a.m., and 6/24/24 at 10:33 p.m.</p> <p>The Physician's Orders, dated 6/23/24, indicated olanzapine (antipsychotic) 10 milligrams daily was ordered for bipolar disorder with behaviors.</p> <p>The Medication Administration Record, dated 6/2024, indicated the resident had 4 episodes of behaviors on 6/24/24 on the evening shift.</p> <p>A Nurse's Progress Note, dated 6/24/24 at 11:33 p.m., indicated Resident G was in the Unit Dining Room with magazines and a cup of water in front of him. He stood from the wheelchair, lost his balance and fell. There were no injuries.</p> <p>A Nurse's Progress Note, dated 6/25/24 at 1:04 a.m., indicated the resident transferred himself out of bed and propelled himself to the bathroom in the wheelchair. A CNA attempted to assist him and he became agitated, yelling, cursing, and calling the staff names. Resident G attempted several times to hit the staff with his fist. Redirection, one on one care, and assistance with toileting was attempted and were unsuccessful. He continued to yell foul language and told the staff to leave. He was offered snacks and juice. The Psychiatric Nurse Practitioner was notified.</p> <p>During an interview on 8/8/24 at 11:49 a.m., MDS LPN 2, indicated the Admission MDS had not been coded correctly.</p> <p>2. Resident J's record was reviewed on 8/8/24 at 2:11 p.m. The diagnoses included, but were not limited to, diabetes mellitus.</p> <p>An Admission MDS assessment, dated 6/26/24, indicated there had been no falls since admission into the facility.</p> <p>A Nurse's Progress Note, dated 6/21/24 at 12 p.m., indicated the resident had an unwitnessed fall and was found on the floor in her room next to her bed.</p> <p>(continued on next page)</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Director of Nursing was informed of the incorrect MDS on 8/8/24 at 3:38 p.m., no further information was provided.</p> <p>This citation relates to Complaint IN00439371.</p> <p>3.1-31(i)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure individualized Care Plans were developed and implemented related to a knee immobilizer and behaviors for 2 of 8 residents reviewed for care plans. (Resident J and G)</p> <p>See F744 for additional information regarding Resident G.</p> <p>Findings include:</p> <p>1. During an observation on 8/5/24 at 10:53 a.m., Resident J was in the bathroom sitting in a wheelchair. There was a knee immobilizer on the left lower extremity. The resident indicated she had a pressure sore from the immobilizer that started out as a blister.</p> <p>During an observation on 8/6/24 at 11:04 a.m. with LPN Wound Nurse 3 and LPN Wound Nurse 4, LPN Wound Nurse 3 completed a treatment on the left heel wound and left posterior ankle wound. Both areas were dried. LPN Wound Nurse 3 indicated the immobilizer slid down and the staff continued to pull the immobilizer back up. There was a pad that went under the immobilizer to prevent pressure issues. The treatments were applied and the immobilizer was reapplied with the padding underneath to assist with pressure prevention.</p> <p>Resident J's record was reviewed on 8/8/24 at 2:11 p.m. The diagnoses included, but were not limited to, diabetes mellitus and left knee fracture.</p> <p>A Physician's Order, dated 6/20/24, indicated a left leg immobilizer was to remain on at all times.</p> <p>There was no care plan for the left knee immobilizer and care to assist with prevention of pressure ulcers.</p> <p>During an interview on 8/8/24 at 3:38 p.m., the Director of Nursing indicated there had been no care plan for the left leg immobilizer.</p> <p>2. Resident G's record was reviewed on 8/8/24 at 9:21 a.m. The diagnoses included, but were not limited to, dementia.</p> <p>Cross Reference F744.</p> <p>The Medication Administration Record (MAR), dated 6/2024, indicated episodes of behaviors were documented on the following days:</p> <p>On 6/24/24, evening shift, there were four episodes of behaviors. He was redirected, one on one given and the provider was notified of the changes. The interventions were effective.</p> <p>On 6/28/24, evening shift, there were four episodes of behaviors. There were no interventions provided.</p> <p>(continued on next page)</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/29/24, evening shift, there were four episodes of behaviors. He was redirected and one on one care was given. The outcome of the interventions was not documented.</p> <p>On 6/30/24, day shift, there were 4 episodes of behaviors. He was redirected and one on one care provided. The outcome of the interventions was not documented</p> <p>The Medication Administration Record (MAR), dated 7/2024, indicated episodes of behaviors were documented on the following days:</p> <p>On 7/1/24, day shift there was one episode. He was redirected and removed from his peers. The interventions were effective.</p> <p>On 7/1/24, evening shift, there were three episodes, he was redirected and the the intervention was effective.</p> <p>On 7/2/24, evening shift, there were three episodes, he was redirected and the intervention was effective.</p> <p>On 7/3/24, evening shift, there were two episodes, he was redirected and the intervention was effective.</p> <p>On 7/5/24, evening shift, there was one episode, he was removed from the environment and the intervention was not effective.</p> <p>On 7/6/24, day shift, there was one episode, no interventions documented.</p> <p>On 7/6/24, evening shift, there were two episodes, he was redirected and the intervention was effective.</p> <p>On 7/7/24, day shift, there were two episodes. There were no interventions documented.</p> <p>On 7/12/24, evening shift, there were three episodes. He was redirected and the intervention was effective.</p> <p>On 7/13/24, day shift, there was one episode, he was redirected and the intervention was effective.</p> <p>The resident had no care plan for behaviors.</p> <p>During an interview on 8/8/24 at 1:27 p.m., the Social Service Director indicated there was no care plan for the resident's behaviors.</p> <p>This citation relates to Complaint IN00439585.</p> <p>3.1-25(a)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure a resident received the necessary care and services related to antibiotics not administered, a blood sugar level not obtained, and physician notification of elevated blood sugar levels not completed as ordered for 1 of 8 residents reviewed for quality of care. (Resident B)</p> <p>Finding includes:</p> <p>Resident B's record was reviewed on 8/5/24 at 11:10 a.m. The diagnoses included, but were not limited to, diabetes mellitus and an abscess of the abdominal wall.</p> <p>An Admission Minimum Data Set assessment, dated 6/14/24, indicated the resident received insulin, an antibiotic, and a hypoglycemic medication.</p> <p>A Care Plan, dated 6/17/24, indicated insulin was received. The interventions included the blood glucose would be monitored as ordered and hyperglycemia protocol would be followed as ordered by the physician.</p> <p>(a) A Physician's Order, dated 6/17/24, indicated ceftriaxone sodium (antibiotic), 1 gram was to be administered once a day for seven days for an abdominal wall abscess.</p> <p>The Medication Administration Record (MAR), dated 6/2024 indicated the ceftriaxone sodium was marked as not administered on 6/18/24. The antibiotic was administered on June 19, 20, 21, 22, 23, and 24, 2024 and was only administered for six days.</p> <p>A Physician's Order, dated 6/29/24, indicated cephalexin (antibiotic) 500 milligrams (mg), one capsule was to be administered three times a day for a urinary tract infection.</p> <p>The MAR, dated 6/2024, indicated the antibiotic had not been administered on 7/6/24 at 5 p.m.</p> <p>(b) A Physician's Order, dated 6/24/24, indicated the blood glucose was to be checked three times a day before meals and Novolog (regular insulin) was to be administered per the results of the blood glucose results (sliding scale). The dose of insulin was to be 10 units if the blood glucose result was 351 or more and the physician was to be notified.</p> <p>The MAR, dated 7/2024, indicated the blood glucose had not been monitored and insulin administration not received if needed at 4 p.m. on 7/6/24.</p> <p>The following blood glucose results were 351 or above. The physician had not been notified of the high blood glucose levels:</p> <p>On 6/24/24 at 4 p.m., the blood glucose was 484.</p> <p>On 6/25/24 at 4 p.m., the blood glucose was 351.</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/26/24 at 11 a.m., the blood glucose was 400.</p> <p>On 6/27/24 at 6 a.m., the blood glucose was 391, at 11 a.m. it was 515, and at 4 p.m. it was 462.</p> <p>On 6/28/24 at 6 a.m., the blood glucose was 483 and at 4 p.m. it was 368.</p> <p>The MAR, dated 7/2024, indicated on 7/11/24 at 4 p.m., the blood glucose was 375 with no physician notification.</p> <p>During an interview on 8/5/24 at 2:06 p.m., the Director of Nursing indicated the the antibiotics had not been administered and the blood glucose had not been obtained as ordered.</p> <p>During an interview on 8/5/24 at 3:43 p.m., the Director of Nursing indicated there had been no documentation that indicated the physician had been notified of the blood glucose results of 351 and over.</p> <p>This citation relates to Complaints IN00438865 and IN00439585.</p> <p>3.1-37</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>20580</p> <p>Based on record review and interview, the facility failed to ensure a thorough investigation of a fall was completed which included the root cause of the fall and failed to initiate an intervention related to the circumstances of the fall, for 1 of 3 residents reviewed for falls. (Resident D)</p> <p>Finding includes:</p> <p>Resident D's record was reviewed on 8/6/24 at 9:11 a.m. The diagnoses included, but were not limited to, dementia.</p> <p>An Admission Cognitive Assessment, completed on 7/18/24 by Social Service, indicated a severe cognitive impairment.</p> <p>An Admission Fall Risk Assessment, completed by nursing staff on 7/18/24, indicated a high risk for falls.</p> <p>A Care Plan, dated 7/18/24, indicated a risk for falls. The interventions included a possible root cause of the fall would be determined and the potential cause of the fall would be altered and/or removed.</p> <p>A Nurse's Progress Note, dated 7/22/24 at 10:38 p.m., indicated there resident was observed on the floor. The resident had indicated he just wanted to see what the world looked like from the bottom up. He denied falling. He was assisted off the floor and back into the wheelchair by two staff members. He was educated to use the call light.</p> <p>The Fall Investigation, dated 7/22/24 at 8:45 p.m. and received from the Director of Nursing (DON), indicated the resident was found on the floor, was assessed for injuries and then placed back into the wheelchair prior to being assisted with changing and getting ready for bed. The predisposing situation factors included, the call light was in reach, a wheelchair had been in use, footwear was in place, and the wheelchair was unlocked. A note at the end of the investigation, dated 7/23/24, indicated a fall mat was placed at the bedside.</p> <p>A Nurse's Note, dated 7/23/24 at 8:55 a.m., indicated an un-witnessed fall occurred on 7/22/24 and the resident had been observed on the floor beside the bed. He was unable to describe the circumstances leading up to the fall and a fall mat had been placed immediately by the bedside.</p> <p>The investigation had not indicated when the resident had been observed prior to the fall nor the root cause of the fall. The intervention initiated immediately after the fall indicated he was educated to use the call light. The resident was assessed with a severely impaired cognitive status.</p> <p>During an interview on 8/6/24 at 1:24 p.m., the DON indicated he thought the resident had rolled out of bed and the intervention post-fall was a mat was placed on the floor next to the bed. The investigation had not included the last time the resident had been observed prior to the fall or the root cause of the fall.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 8/6/24 at 1:50 p.m., the DON indicated staff discussed falls every morning and thought the resident had fallen from the bed.</p> <p>During an interview on 8/6/24 at 2:11 p.m., LPN 1 indicated she was the nurse on duty at the time of the fall. The resident had been sitting in his wheelchair before the fall but no prior observation time was documented.</p> <p>The facility's fall prevention policy, dated 5/2024 and received from the DON as current, did not include a post fall protocol.</p> <p>This citation refers to Complaint IN00439371.</p> <p>3.1-45(a)</p>		

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<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Post nurse staffing information every day.</p> <p>20580</p> <p>Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information was current and included only the staff who were scheduled for Long Term Care. This had the potential to affect all residents who resided in the facility during July and August, 2024.</p> <p>Findings include:</p> <p>1. The facility was entered on 8/5/24 at 7:34 a.m. The Nurse Staffing Information was posted at the Receptionist Desk by the entry door to the facility. The date on the Nurse Staffing Information was 8/1/24.</p> <p>During an interview on 8/5/24 at 9:22 a.m., the Director of Nursing indicated he would leave the posting information in a binder for the Weekend Manager to post.</p> <p>2. The schedules and Nurse Staffing Information Postings for July 1 through July 31, 2024 were reviewed on 8/5/24 at 5:00 p.m.</p> <p>During an interview on 8/6/24 at 7:49 a.m., the Administrator indicated the Nurse Staffing Information postings included the Assisted Living Staff also and just realized on 8/5/24 they were included on the postings.</p> <p>This citation relates to Complaint IN00439585.</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia.</p> <p>20580</p> <p>Based record review and interview, the facility failed to ensure a resident with dementia received appropriate treatment and services to meet his needs, related to ongoing behaviors without input from the Interdisciplinary Team (IDT) and Social Service, no identification of behavior type, no Care Plan with interventions for the behaviors, no updated nursing interventions for the behaviors, no interventions attempted, and no interventions attempted for the behaviors before medication was administered, for 1 of 1 resident reviewed for dementia/behaviors. (Resident G)</p> <p>Finding includes:</p> <p>Resident G's record was reviewed on 8/8/24 at 9:21 a.m. The diagnoses included, but were not limited to, dementia.</p> <p>An Admission Minimum Data Set assessment, dated 6/26/24, indicated a severely impaired cognitive status, no behaviors, no impairment of the bilateral upper extremities, impairment of the bilateral lower extremities, moderate assistance required with chair to bed transfers, supervision with wheelchair mobility, moderate assistance with ambulation of 10 feet, no falls, and received an anti-anxiety medication.</p> <p>There was no Care Plan for behaviors.</p> <p>A Physician's Order, dated 6/21/24, indicated, resident specific targeted behavior/s: (specify) ., no behaviors were listed. The interventions were, #1 - redirect, #2 - remove from environment, #3 - remove objects of self harm, #4 - remove peers from area, #5 - provide 1 on 1 time/validation, #6 - notify providers of clinical changes. The outcome of the interventions and the number of episodes were to be documented.</p> <p>A Physician's Order, dated 6/21/24, indicated, TARGETED BEHAVIOR: Resident specific targeted behavior/s (specify) . The interventions were #1 - redirect, #2 - remove from environment, #3 - see notes, #4 - PRN (as needed) given. The outcome to the interventions and number of episodes were to be documented.</p> <p>A Physician's Order, dated 6/21/24, indicated prior to the administration of any PRN psychotropic medication (antidepressants, anti-anxiety, stimulants, antipsychotics, and mood stabilizers), non-pharmacological interventions were to be attempted and the response was to be documented.</p> <p>A Psychiatry Consult, dated 6/22/24 at 7:03 a.m., indicated they would follow the resident for management of psychotropic medications.</p> <p>(continued on next page)</p>

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Nurse's Behavior Progress Note, dated 6/23/24 at 6:51 a.m., indicated the resident was restless throughout the night shift. There were multiple exit seeking attempts made through the emergency exit doors. He was verbally abusive and at times was combative with attempts to redirect. He continued to stand from the wheelchair and walk around the the unit while he looked for an exit door and voiced he was going home. Scheduled medications to treat the restlessness were ineffective. One on one care was recommended.</p> <p>Physician's Orders, dated 6/23/24, indicated olanzapine (antipsychotic) 10 mg (milligrams) daily for behaviors and lorazepam (anti-anxiety) 0.5 mg every 12 hours for anxiety.</p> <p>A Nurse's Progress Note, dated 6/23/24 at 4:11 p.m., indicated the resident stood up from the wheelchair, attempted to walk and fell . There were no injuries.</p> <p>A Nurse's Progress Note, dated 6/24/24 at 11:33 p.m., indicated the resident was in the Unit Dining Room with magazines and a cup of water in front of him. He stood from the wheelchair, lost his balance and fell . There were no injuries.</p> <p>A Nurse's Progress Note, dated 6/25/24 at 1:04 a.m., indicated the resident transferred himself out of bed and propelled himself to the bathroom in the wheelchair. A CNA attempted to assist him and he became agitated, yelling, cursing, and calling the staff names. He attempted several times to hit the staff with his fist. Redirection, one on one care, and assistance with toileting was attempted and were unsuccessful. He continued to yell foul language and told the staff to leave. He was offered snacks and juice. The Psychiatric Nurse Practitioner was notified.</p> <p>A Psychiatric Nurse Practitioner Progress Note, dated 6/28/24 at 4:30 p.m., indicated there were concerns with dementia with psychosis and adjustment anxiety disorder. The staff reported psychotic behaviors of agitation, yelling, cursing, and inappropriate language. He attempted several time to hit the nursing staff with his fist. Staff provided one on one care and toileting and they were unsuccessful. The resident had made several attempts to exit the facility. The olanzapine and lorazepam was to be continued.</p> <p>A Nurse's Behavior Note, dated 6/29/24 at 2:51 p.m., indicated the resident was not easily directed and required extensive monitoring from the staff. He was displaying exit seeking behavior and would stand from the wheelchair and had an unsteady gait.</p> <p>A Nurse's Progress Note, dated 6/29/24 at 10:39 p.m., indicated the resident was ambulating in his room. The nursing staff attempted to assist the resident and he began to yell obscenities towards the staff and told them to get out. The nursing staff continued to monitor and supervise the resident. He attempted to enter other residents' rooms. The nursing staff provided one on one redirection and food. He accepted the food.</p> <p>A Nurse's Behavior Note, dated 6/30/24 at 2:30 p.m., indicated the resident required frequent monitoring. He would stand up from his wheelchair and has an unsteady gait. The staff assisted with toileting needs, meals, and fluids were given. He verbalized he wanted to get to his car and go home. He propelled himself to the exit doors and attempted to leave the facility. He became verbally hostile while staff attempted to redirect. He cursed at the staff and threatened to hit the staff.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER  Ignite Medical Resort Dyer Llc.		STREET ADDRESS, CITY, STATE, ZIP CODE  1532 Calumet Avenue Dyer, IN 46311	
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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The Medication Administration Record (MAR), dated 6/2024, indicated episodes of behaviors were documented on the following days:</p> <ul style="list-style-type: none"> <li>- On 6/24/24, evening shift, there were four episodes of behaviors. He was redirected, one on one care was given and the provider was notified of the changes. The interventions were effective.</li> <li>- On 6/28/24, evening shift, there were four episodes of behaviors. There were no interventions provided.</li> <li>- On 6/29/24, evening shift, there were four episodes of behaviors. He was redirected and one on one care was given. The outcome of the interventions was not documented.</li> <li>- On 6/30/24, day shift, there were 4 episodes of behaviors. He was redirected and one on one care provided. The outcome of the interventions was not documented.</li> </ul> <p>There were no specific targeted behaviors listed. There were no times documented when the behavior occurred.</p> <p>The MAR, dated 6/2024, indicated, TARGETED BEHAVIOR: Resident specific targeted behavior/s (specify) . The interventions were #1 - redirect, #2 - remove from environment, #3 - see notes, #4 - PRN (as needed) given. The outcome to the interventions and number of episodes were to be documented. were monitored. Each day and shift was initialed with a check mark. There was no number of episodes, interventions attempted or outcomes documented.</p> <p>A Behavior Progress Note, dated 7/1/24 at 8:15 a.m., indicated the resident ambulated out of his room. He had urinated on the floor. The staff redirected him back to his room. He was yelling and cursing at the staff. The staff were unable to get his clothes and brief changed. He had hit a nurse three times. The nurse left the room. The other staff attempted to get his clothing changed and he drew a fist and stated to leave him alone and verbally threatened to hit the staff. Staff redirected the resident and after several attempts he allowed the staff to clean him and change his clothing.</p> <p>A Nurse's Progress Note, dated 7/3/24 at 1:10 a.m., indicated the resident was combative and verbally abusive toward the staff. He had grabbed and pulled a staff member's arm multiple times while being redirected to the wheelchair. He cursed throughout the shift. The Nurse Practitioner was notified and orders were obtained to transfer the resident to the emergency room for an evaluation.</p> <p>A Nurse's Progress Note, dated 7/3/24 at 2 a.m., indicated the resident returned to the facility from the emergency room with no new orders.</p> <p>A Social Service Note, dated 7/3/24 at 9:39 a.m., indicated referrals for long term care placement would be sent as requested from the resident's family.</p> <p>Physician's Orders, dated 7/3/24, indicated olanzapine 10 mg every 12 hours for dementia/psychotic disturbances, trazodone (anti-anxiety) 50 mg at bedtime, and lorazepam 0.5 mg every 12 hours as needed for adjustment disorder with anxiety for 14 days.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Medication Administration Note, dated 7/5/24 at 7:15 p.m., indicated the resident was very anxious and aggressive. The lorazepam 0.5 mg was administered. There was no documentation of any prior interventions attempted.</p> <p>The MAR, dated 7/2024, indicated the lorazepam 0.5 mg was administered on 7/5/24 at 7:15 p.m. and was ineffective.</p> <p>A Nurse's Behavior Note, dated 7/5/24 at 10:03 p.m., indicated the resident was voicing a strong desire to leave the facility and displayed aggressive behavior towards the staff. He was resistant to redirection and had not responded to the lorazepam 0.5 mg.</p> <p>A Nurse's Progress Note, dated 7/6/24 at 1:00 p.m., indicated the nurse attempted to assess the resident, he became combative and resistant. Care was stopped and would be re-attempted at a later time.</p> <p>A Medication Administration Note, dated 7/10/24 at 7:38 a.m., indicated lorazepam, 0.5 mg was administered. There was no reason documented and there were no interventions attempted prior to the administration of the lorazepam.</p> <p>The MAR, dated 7/2024, indicated the lorazepam 0.5 mg was administered on 7/10/24 at 7:38 a.m. and was effective.</p> <p>A Nurse's Progress Note, dated 7/12/24 at 1:47 a.m., indicated the resident had continuously attempted to get in and out of bed most of the shift when he fell . There were no injuries from the fall.</p> <p>The Medication Administration Record (MAR), dated 7/2024, indicated episodes of behaviors were documented on the following days:</p> <ul style="list-style-type: none"> <li>- On 7/1/24, day shift there was one episode. He was redirected and removed from his peers. The interventions were effective.</li> <li>- On 7/1/24, evening shift, there were three episodes, he was redirected and the the intervention was effective.</li> <li>- On 7/2/24, evening shift, there were three episodes, he was redirected and the intervention was effective.</li> <li>- On 7/3/24, evening shift, there were two episodes, he was redirected and the intervention was effective.</li> <li>- On 7/5/24, evening shift, there was one episode, he was removed from the environment and the intervention was not effective.</li> <li>- On 7/6/24, day shift, there was one episode, no interventions documented.</li> <li>- On 7/6/24, evening shift, there were two episodes, he was redirected and the intervention was effective.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>- On 7/7/24, day shift, there were two episodes. There were no interventions documented.</p> <p>- On 7/12/24, evening shift, there were three episodes. He was redirected and the intervention was effective.</p> <p>- On 7/13/24, day shift, there was one episode, he was redirected and the intervention was effective.</p> <p>There were no specific targeted behaviors listed. There were no times documented when the behaviors occurred.</p> <p>The MAR, dated 7/2024, indicated, TARGETED BEHAVIOR: Resident specific targeted behavior/s (specify) . The interventions were #1 - redirect, #2 - remove from environment, #3 - see notes, #4 - PRN (as needed) given. The outcome to the interventions and number of episodes were to be documented. were monitored. Each day and shift was initialed with a check mark. There were no number of episodes, interventions attempted and outcomes documented.</p> <p>A Psychiatric Nurse Practitioner Progress Note, dated 7/14/24 at 9:15 a.m., indicated the resident was seen for a follow up visit for medication management evaluation due to concerns with dementia with psychotic disturbance and adjustment disorder with anxiety. The facility staff reported psychotic behaviors of agitation, yelling, cursing, and inappropriate language. The resident had attempted several time to hit the the nursing staff with his fist. His behaviors had improved with medication adjustments during the last visit. The frequency and intensity had decreased. (Last medication change was 7/3/24)</p> <p>During an interview on 8/8/24 at 1:27 p.m. with the Social Service Director (SSD), Director of Nursing (DON), and the Administrator, the SSD indicated there was no care plan with interventions for the resident's behaviors and there had been no social service involvement with behavior modification. There had been no updated interventions for the behaviors. The Administrator indicated the facility had spoken with the family and the conversation had not been documented. The DON indicated there was no specific behavior documented on the MAR to indicated what behaviors the resident was exhibiting. The SSD indicated social services should have been involved with the resident's behaviors and the CNA's were to document the behaviors on the Plan of Care in the computer, which would communicate to social service there was a behavior and the nurse was to document the behaviors.</p> <p>The DON acknowledged there were no interventions attempted prior to the PRN lorazepam administration.</p> <p>During an interview on 8/8/24 at 2 p.m., the DON indicated there CNA's were not to mark the behaviors on the Plan of Care in the computer and there was not a place for them to do that. They were to tell the nurse on duty, who was then supposed to document the behavior. The DON indicated not all the behaviors were documented.</p> <p>(continued on next page)</p>		

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<p>F 0744</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The behavioral management policy, dated 4/2023 and received from the DON as current, indicated all behaviors related to any/all types of dementia were to be monitored and documented for the purpose of tracking and trending the behaviors for the development of person-centered, individualized dementia care plan programming for each resident to identify triggers of behaviors and unmet needs, development of care plan interventions, and to evaluate current behavior management programming interventions. Direct care staff were to monitor and document behaviors and all behaviors were to be reported to the nurse. The nurse was to evaluate, assess and document the behaviors in the clinical record.</p> <p>3.1-37</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>20580</p> <p>Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (LPN Wound Nurse 3 and LPN Wound Nurse 4) when providing pressure ulcer treatments for 1 of 1 random observation (Resident J). This had the potential to affect 13 residents who required wound treatments.</p> <p>Finding includes:</p> <p>During an observation on 8/5/24 at 11:04 a.m., Resident J's room was entered with LPN Wound Nurse 3 and LPN Wound Nurse 4. There was no sign on the resident's door that indicated Enhanced Barrier Precautions (EBP) were to be used. The dressing had already been taken off the pressure sores on the left heel and the left posterior ankle. The Wound Nurses had applied gloves. LPN Wound Nurse 3 indicated Enhanced Barrier Precautions only had to be implemented if the wounds had drainage. LPN Wound Nurse 3 continued to complete the wound treatments on the left heel and left posterior ankle.</p> <p>A facility enhanced barrier precaution policy, dated 3/2024 and received as current from the Director of Nursing, indicated EBP was to be used for wounds, including any skin opening that required a dressing.</p> <p>3.1-18(b)</p>		