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	11/14/2024

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure the resident's responsible party was promptly notified after a significant change in status related to an intravenous (IV) site placement, changes in medications and medication times for 1 of 3 residents reviewed for notification of change. (Resident D) Finding includes: During a phone interview on 11/12/24 at 2:30 p.m., Resident D's responsible party indicated her husband had dementia and she was his primary caretaker. During his stay at the facility, she was never notified of medication changes, times of medications, or the need for IV fluids and the placement of an IV site. The closed record for Resident D was reviewed on 11/12/24 at 1:30 p.m. The resident was admitted to the facility on [DATE] and discharged home on 9/24/24. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes mellitus, dementia, pain in the left foot, high blood pressure, atrial fibrillation, chronic kidney failure, anemia, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 9/16/24, indicated the resident was cognitively impaired for daily decision making. A Nurse's Note, dated 9/16/24 at 10:22 p.m., indicated new orders were received for IV fluids. Peripheral IV insertion was attempted times two, however, the line infiltrated when flushed each time. The resident was informed that a peripheral inserted central catheter (PICC) line nurse would be coming within the next two hours to insert a midline (a type of IV). The resident signed an informed consent and a call was placed to request the PICC team for line insertion. A Nurse's Note, dated 9/16/24 at 11:15 p.m., indicated the PICC line Nurse was in the facility and inserted a single lumen midline to the right upper arm. IV fluids were initiated at 100 milliliters (ml) per hour. Physician's Orders, dated 9/16/24, indicated to insert a peripheral IV or midline stat (immediately) for IV hydration. Administer Sodium Chloride Solution 0.9 %, use 100 ml/hr intravenously times 24 hours for IV hydration. (continued on next page)

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

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Physician/Physician Assistant (PA)/Nurse Practitioner (NP) Progress Note, dated 9/17/24 at 1:32 p.m., indicated On my evaluation today patient is sitting up in bed. Labs reviewed, wbc [white blood cells] 7.58, hgb [hemoglobin] 11.5, plt [platelets] 280, bun [blood urea nitrogen] 46, create [creatinine] 3.00, na [sodium] 140, k [potassium] 4.9. BUN and creatinine are rising. Patient with known CKD [chronic kidney disease]. IVF [IV fluids] will be ordered. Collaborated with gabapentin will be decreased to nightly. Discussed with nursing A Physician's Order, dated 9/17/24, indicated the resident was to receive a Gabapentin (a medication used to treat nerve pain) capsule 300 milligrams (mg), one capsule by mouth in the evening for neuropathy. A Nurse's Note, dated 9/17/24 at 10:07 p.m., indicated the resident accidentally pulled the PICC line out while removing his shirt. The NP was notified and did not want the line replaced at that time. The PICC line was intact and there was no bleeding or irritation noted at the site. A Physician/PA/NP Progress Note, dated 9/18/24 at 11:22 a.m., indicated the Gabapentin was changed to nightly due to an elevated BUN/CR. Collaborated with the Physical Medical and Rehabilitation Physician and will start the resident on Lyrica. A Physician's Order, dated 9/18/24, indicated the resident was to receive Lyrica (a medication used to treat nerve pain) 25 mg, give 1 capsule by mouth in the morning for pain. A Physician's Order, dated 9/23/24, indicated the resident was to receive Sodium Polystyrene Sulfonate Suspension (a medication used to treat high potassium levels in the blood) 15 grams (gr)/60 ml, give 15 gr by mouth one time for one day. There was no documentation the resident's responsible party was notified of the PICC line insertion or need for consent, the IV fluids that were administered, the Gabapentin medication time change and adding the new medication of Lyrica. There was no documentation the responsible party was notified the resident had a high potassium level and had received a medication to lower the level. During an interview, on 11/13/24 at 3:30 p.m., the Chief Nursing Officer (CNO) indicated there was no documentation the resident's responsible party was notified of the changes in medication, and the PICC line insertion as well as the IV fluids. The current and revised 10/2021 Notification of the Physician policy, provided by the CNO on 11/14/24 at 11:00 a.m., indicated nursing would notify the resident's physician when there was a significant change in the resident's status. Once the physician had been notified and a plan developed, the nursing or social service staff would alert the resident and family of the issue and physician orders. The communication with the resident and their responsible party as well as the physician would be documented in the resident record or other appropriate documents. This citation relates to Complaint IN00444812. 3.1-5(a)(2) 3.1-5(a)(3)

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure activities of daily living (ADLs) were completed for residents who needed assistance related to long fingernails for 1 of 5 residents reviewed for ADLs. (Resident F) Finding includes: On 11/12/24 at 11:30 a.m., Resident F was observed in their room. The resident had long fingernails. During an interview with the resident at that time, Resident F indicated they did not have any nail clippers or they would have taken care of the nails themselves. The resident also indicated staff had not asked them if they would like their fingernails cut. On 11/13/24 at 1:30 p.m., the resident was observed in their bed watching television. The resident's fingernails remained long and the resident asked if there was anyone who could cut their nails. On 11/14/24 at 9:00 a.m., the resident's fingernails were observed to have been cut. The record for Resident F was reviewed on 11/12/24 at 11:43 a.m. Diagnoses included, but were not limited to, fracture of left femur, osteoarthritis, and lack of coordination. The resident was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 10/21/24, indicated the resident was cognitively intact. The resident required supervision with personal hygiene and partial to moderate assistance with bathing. During an interview, on 11/13/24 at 3:15 p.m., the Chief Nursing Officer indicated that he would ask the resident if they would like their fingernails trimmed. This citation relates to Complaints IN00444812, IN00445480, IN00445567, and IN00446247. 3.1-38(a)(2)(A)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 10326 Based on observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 3 residents reviewed for skin conditions non-pressure related. (Resident K) Finding includes: On 11/12/24 at 11:05 a.m., Resident K was observed in their room watching television. Scattered areas of reddish/purple discolorations were observed to the right and left forearms and hands. The record for Resident K was reviewed on 11/13/24 at 9:17 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following surgical amputation, cellulitis of the left lower limb, type 2 diabetes, and atherosclerotic heart disease. The Admission Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact and they had received an anticoagulant (blood thinner) during the last seven days. There was no care plan related to the bruising and/or the anticoagulant use. A Physician's Order, dated 8/23/24, indicated the resident was to receive Rivaroxaban (a blood thinner) 2.5 milligrams (mg) daily for deep vein thrombosis (DVT) prevention. A Physician's Order, dated 8/28/24, indicated the resident was to have a skin check on Wednesdays and Saturdays. The skin assessment was signed out as being completed on 11/13/24 on the November 2024 Medication Administration Record (MAR), but there was no documentation to indicate any new skin concerns were observed. During an interview, on 11/14/24 at 11:15 a.m., the Chief Nursing Officer indicated an order was obtained to monitor the bruising to the bilateral arms and a care plan related to the anticoagulant use was initiated. This citation relates to Complaint IN00446247. 3.1-37(a)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure a peripheral intravenous (IV) catheter was maintained, monitored and assessed for patency for 2 of 3 residents reviewed for IV catheters. (Residents G and D) Findings include: 1. On 11/14/24 at 9:46 a.m., Resident G was observed in their room in bed. A peripheral intravenous (IV) catheter was observed in the resident's right upper arm. The record for Resident G was reviewed on 11/12/24 at 2:34 p.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and extended spectrum beta lactamase (ESBL) resistance. The Admission Minimum Data Set (MDS) assessment, dated 8/23/24, indicated the resident was cognitively impaired for daily decision making. Physician's Orders, dated 11/6/24, indicated the resident was to receive Meropenem (an antibiotic) one gram IV every eight hours for ESBL in the urine for 10 days. The IV was to be flushed with one unit of normal saline every 24 hours as needed for midline flush protocol and flushed with 10 milliliters (ml's) of normal saline before and after infusing the medication. The November 2024 Medication Administration Record (MAR), indicated the normal saline flush had not been signed out as being administered before and after the Meropenem was infused from 11/6/24 through 11/14/24. During an interview, on 11/14/24 at 1:15 p.m., the Chief Nursing Officer indicated the flush order was listed on the MAR as PRN (as needed) and not routine. He indicated the MAR was updated to reflect the flush orders for before and after the antibiotic administration. 10770 2. During a phone interview on 11/12/24 at 2:30 p.m., Resident D's responsible party indicated her husband had dementia and she was his primary caretaker. She had visited one evening and her husband had complained about a pain in his upper right arm. At that time, she removed his shirt and discovered an IV had been inserted in his deltoid (shoulder muscle). The site was bloody and red and was bothering him. The closed record for Resident D was reviewed on 11/12/24 at 1:30 p.m. The resident was admitted to the facility on [DATE] and discharged home on 9/24/24. Diagnoses included, but were not limited to, acute kidney failure, type 2 diabetes mellitus, dementia, pain in the left foot, high blood pressure, atrial fibrillation, chronic kidney failure, anemia, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 9/16/24, indicated the resident was cognitively impaired for daily decision making. (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse's Note, dated 9/16/24 at 10:22 p.m., indicated new orders were received for IV fluids. Peripheral IV insertion was attempted times two, however, the line infiltrated when flushed each time. The resident was informed that a peripheral inserted central catheter (PICC) line nurse would be coming within the next two hours to insert a midline (a type of IV). The resident signed an informed consent and a call was placed to request the PICC team for line insertion. A Nurse's Note, dated 9/16/24 at 11:15 p.m., indicated the PICC line Nurse was in the facility and inserted a single lumen midline to the right upper arm and IV fluids were initiated at 100 milliliters (ml) per hour. Physician's Orders, dated 9/16/24, indicated to insert a peripheral IV or midline stat (immediately) for IV hydration. Administer Sodium Chloride Solution 0.9 %, use 100 ml/hr intravenously times 24 hours for IV hydration. A Physician/Physician Assistant (PA)/Nurse Practitioner (NP) Progress Note, dated 9/17/24 at 1:32 p.m., indicated On my evaluation today patient is sitting up in bed. Labs reviewed, wbc [white blood cells] 7.58, hgb [hemoglobin] 11.5, plt [platelets] 280, bun [blood urea nitrogen] 46, create [creatinine] 3.00, na [sodium] 140, k [potassium] 4.9. BUN and creatinine are rising. Patient with known CKD [chronic kidney disease]. IVF [IV fluids] will be ordered A Nurse's Note, dated 9/17/24 at 10:07 p.m., indicated the resident accidentally pulled the PICC line out while removing his shirt. The NP was notified and did not want the line replaced at that time. The PICC line was intact and there was no bleeding or irritation noted at the site. There were no Physician's Orders to monitor the PICC line site for signs and symptoms of infection as well as no orders to maintain patency with normal saline flushes. During an interview, on 11/13/24 at 3:30 p.m., the Chief Nursing Officer (CNO) indicated there were no orders to monitor the PICC line for signs and symptoms of infection, nor were there orders for saline flushes. The current 6/2024 Administration of IV Fluids policy, provided by the CNO on 11/14/24 at 11:30 a.m., indicated the IV site would be monitored for signs of IV infiltration. Staff were to inspect the insertion site and surrounding area for inflammation, redness, warmth, tenderness, and swelling. This citation relates to Complaint IN00444812. 3.1-47(a)(2)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to falls for 1 of 3 residents reviewed for falls. (Resident E) The facility also failed to document that treatments were completed as ordered for 1 of 3 residents reviewed for pressure ulcers and 1 of 3 residents reviewed for skin conditions non-pressure related. (Resident K) Findings include: 1. The record for Resident K was reviewed on 11/13/24 at 9:17 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following surgical amputation, cellulitis of the left lower limb, type 2 diabetes, and atherosclerotic heart disease. The Admission Minimum Data Set (MDS) assessment, dated 8/27/24, indicated the resident was cognitively intact. The resident had a surgical wound and a Stage 3 (a deep wound that involves full thickness tissue loss, but does not expose bone, tendon, or muscle) pressure ulcer. The current Care Plan, indicated the resident had a pressure injury to the left heel. Interventions included, but were not limited to, dressing change per physician's order. A Physician's Order, dated 8/26/24, indicated the resident's right above the knee amputation (AKA) was to be cleansed with normal saline, apply Xerofoam (a wound dressing), followed by a dry dressing on Monday, Wednesday, and Friday and as needed (PRN). The October 2024 Treatment Administration Record (TAR), indicated the treatment had not been signed out as being completed on 10/11/24, 10/16/24, and 10/28/24. A Physician's Order, dated 9/12/24, indicated the resident's left forefoot and the left heel were to be cleansed with normal saline, apply alginate with silver (a wound dressing), followed by a dry dressing every Monday, Wednesday, and Friday and PRN. The October 2024 TAR, indicated the treatment had not been signed out as being completed on 10/11/24 and 10/16/24. During an interview, on 11/14/24 at 1:15 p.m., the Wound Nurse indicated she completed the treatments as ordered on the above dates but she did not sign them out on the TAR. 10770 2. During a phone interview on 11/12/24 at 2:34 p.m., Resident E's responsible party indicated the resident had fallen three times while at the facility and the facility was aware she had dementia. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The closed record for Resident E was reviewed on 11/12/24 at 11:02 a.m. The resident was admitted to the facility on [DATE] and discharged on [DATE]. Diagnoses included, but were not limited to, congestive heart failure, falls, stroke, hemiplegia (muscle weakness/paralysis) to the right side, type 2 diabetes mellitus, osteoporosis, dementia with psychotic disturbance, physical debility, high blood pressure, heart failure, weakness, and osteoarthritis. The 5-day Medicare Minimum Data Set (MDS) assessment, dated 8/30/24, indicated the resident was not cognitively intact for daily decision making. The resident needed partial assistance from another person to complete any activities of daily living and had a limited range of motion function on one side to the upper extremity. The resident had a fall in the last 2 to 6 months prior to admission and in the last month prior to admission. A Nurse's Note, dated 8/23/24 at 7:53 p.m., indicated the resident had arrived to the facility with her daughter. The resident was a high risk for falls and had tried to climb out of the bed while her daughter was present. A Care Plan, dated 8/24/24, indicated the resident was at risk for falls. The approaches were to ensure the bed brakes were locked, and to follow the facility fall protocol. A Nurse's Note, dated 9/1/24 at 4:54 a.m., indicated Resident noted to be in bed asleep with eyes close and no s/s of adverse reactions, she appeared to attempt to get up without assist. (sic) A Care Plan, dated 9/1/24, indicated the resident had an actual fall. The approaches were to put a fall mat on the side of the bed. A Fall Risk Evaluation, identified as a late entry for 9/1/24 at 4:38 a.m., and created on 9/3/24 at 1:56 p.m., by the Chief Nursing Officer (CNO), indicated the reason for the evaluation was for a post fall. The resident was confused at the time of the fall and sustained no injury. An IDT (Interdisciplinary Team Note), dated 9/3/24 at 1:57 p.m., indicated the resident sustained a fall on 9/1/24 at 4:38 a.m. The resident was observed sitting on the floor next to the bed and was unable to describe what had happened. There were no injuries related to the fall and the physician and family were notified immediately. A fall mat would be placed at the bedside when the resident was in bed and to be removed when out of bed. During an interview, on 11/13/24 at 3:10 p.m., the CNO indicated the nurse on duty that night only completed the internal risk assessment regarding the fall, which was not part of the resident's clinical record. The fall happened on a weekend, so the next work day he had reviewed what had happened and realized a fall risk evaluation had not been completed. He called the nurse to have him complete it, but the nurse indicated he did not have a computer, so he completed the evaluation with the nurse over the phone. During an interview, on 11/14/24 at 11:00 a.m., the CNO indicated the fall risk evaluation form was to be completed right after a fall as well as any documentation related to the fall in nursing progress notes. The undated and identified as current Fall Protocol policy, provided by the CNO on 11/14/24 at 11:00 a.m., indicated fall risk evaluations were completed upon admission and after every fall. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This citation relates to Complaints IN00443720, IN00445316, IN00446247, and IN00446301. 3.1-50(a)(1) 3.1-50(a)(2)