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	07/31/2025

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 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. Based on record review and interview, the facility failed to ensure treatment orders were updated and completed as ordered for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident H) Finding includes: Resident H's record was reviewed on 7/31/25 at 11:17 a.m. Diagnoses included, but were not limited to, orthopedic aftercare following surgical amputation, chronic osteomyelitis (bone infection) of the right ankle and foot, cellulitis (skin infection) of the left and right lower limb, and type 2 diabetes mellitus. The admission Minimum Data Set (MDS) assessment, dated 6/27/25, indicated the resident was cognitively intact for daily decision making and had 1 unstageable pressure injury. A Care Plan, dated 6/20/25, indicated the resident had actual impairment to the skin integrity. Interventions included, but were not limited to, evaluate and treat per physician order and wound consult as needed. A Physician's Order, dated 6/21/25, indicated cleanse the second toe on the right foot with normal saline, pat dry, apply Xeroform (fine mesh gauze occlusive dressing), wrap with Kerlix (medical gauze), and secure with tape, Monday, Wednesday, Friday, and as needed. A Physician's Order, dated 6/21/25, indicated cleanse the fourth toe on the right foot with normal saline, pat dry, apply Xeroform, wrap with Kerlix, and secure with tape Monday, Wednesday, Friday, and as needed. A Physician's Order, dated 6/20/25, indicated cleanse the right lateral foot with normal saline, apply skin prep and leave open to area every day and as needed. A Physician's Order, dated 6/21/25, indicated cleanse the right medial foot with normal saline, pat dry, apply Xeroform, wrap with Kerlix, and secure with tape Monday, Wednesday, Friday, and as needed. The July 2025 Medication and Treatment Administration Record indicated the orders for wound care were administered as ordered by the physician. An After Visit Summary, dated 7/2/25, indicated, Instructions - Have the facility change dressings to all open wounds. On open wounds apply Iodosorb followed by xeroform, gauze roll, and tap. Apply betadine to deep tissue injuries/eschar. A Progress Note, dated 7/2/25 at 4:34 p.m., indicated the resident returned from a podiatry appointment with new orders for for iodosorb (gel for wound treatment) followed by adaptive dressing and rolled gauze and to apply betadine to deep tissue injury. An After Visit Summary, dated 7/11/25, indicated, Wound Care Discharge Instructions .Dressing Change Instructions: Have nurse at facility change dressings every 2-3 days. Keep clean and dry. Right lateral foot - apply betadine to deep tissue injuries followed by ABD and gauze roll. All other wounds to bilateral feet - apply xeroform, ABD, and gauze roll . A Progress Note, dated 7/11/25 at 12:00 p.m., indicated the resident returned from a wound care appointment with new orders for wound care nurse to change dressing every 2-3 days. The right lateral foot wound care order was to apply betadine to the deep tissue injury followed by abdominal (ABD) gauze pad and gauze roll. All other wounds to the bilateral feet were to apply Xeroform, ABD, and gauze roll. The Physician's Orders and Medication Administration Record for July 2025 indicated the wound care orders were not updated and implemented after the 7/2 and 7/11/25 wound care visits. During an interview on 7/31/25 at 4:10 p.m., the Wound Care Nurse indicated she had put in the progress notes for the order updates and did not update on the Physician Order Summary. This citation relates to Complaint 2573709. 3. 1-37(a)

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to initiate and update effective resident-specific interventions to prevent the elopement from the facility of a resident with a diagnosis of dementia and history of exit-seeking behaviors for 1 of 5 residents reviewed as elopement risk. The resident had indicators of being an elopement risk and behaviors of wanting to exit the facility. The resident exited the building without supervision, through the main front door entrance, and the facility was unaware of the resident's whereabouts. The resident ambulated approximately 0.15 miles from the facility on a highly traveled four lane road and was returned to the facility by Emergency Services staff. (Resident B)The Immediate Jeopardy began on 7/27/25, when the facility was unaware that the resident had exited the facility without supervision. The resident walked independently and was found across the street from the facility at approximately 9:03 p. m. by Emergency Services staff, who assisted the resident back to the facility. The Administrator, Director of Nursing (DON), and [NAME] President of Clinical Operations were notified of the immediate jeopardy on 7/30/25 at 1:30 p.m. The immediate jeopardy was removed on 7/30/25 and the deficient practice corrected on 7/28/25, prior to the start of the survey and was therefore Past Noncompliance.Finding includes:Resident B's closed record was reviewed on 7/30/25 at 9:06 a.m. Diagnoses included, but were not limited to, dementia and abnormalities of gait and mobility. The resident was admitted to the facility on [DATE]. A Wander/Elopement Risk Evaluation, dated 7/9/25, indicated the resident was not an elopement risk. The Initial/Baseline Care Plan, dated 7/9/25, indicated the resident had cognitive impairment, was at risk for falls, and was not an elopement risk. A Fall Risk Evaluation, dated 7/9/25, indicated the resident was at high risk for falls. A Social Service Note, dated 7/10/25 at 7:10 p.m., indicated the resident was currently exit-seeking. The resident's daughter was notified and informed the resident would need alternate placement. Education was provided on facilities with a memory care unit. The resident's daughter indicated the family was exploring other facilities.There was no documentation to indicate any interventions were implemented by the facility to address the resident's exit-seeking behavior identified by Social Services to the family on 7/10/25. An Initial Psychiatric Evaluation, dated 7/10/25, indicated given acuity of cognitive symptoms, she is not a good candidate for psychotherapy at this time. Will only follow-up in the future if requested by medical team or family. A Physician Note, dated 7/11/25 at 9:04 a.m., indicated the resident had profound dementia. Found to be wandering in the hall on 9 occasions yesterday and set off the door alarms on several occasions. This will be reviewed with psych services to determine if any therapy is needed. There was no documentation to indicate any new interventions were attempted for the wandering behaviors on 7/11/25. A Progress Note, dated 7/12/25 at 7:16 p.m., indicated the resident was actively trying to elope. She had tried to get out the emergency exits on both doors on the unit. She was difficult to redirect. A Behavior Progress Note, dated 7/12/25 at 8:23 p.m., indicated the resident was attempting to leave the unit again and indicated she wanted to go outside. She was redirected multiple times and continued to wander. A Behavior Progress Note, dated 7/12/25 at 9:13 p.m., indicated the resident was attempting to go out the emergency exit door on the unit and asking to go outside. A Behavior Progress Note, dated 7/12/25 at 9:28 p.m., indicated the resident was attempting to exit the building through the emergency exit. A Behavior Progress Note, dated 7/12/25 at 9:41 p.m., indicated the resident was wandering the halls asking to go outside. She was not easily redirected and did not understand why she was at the facility. A Behavior Progress Note, dated 7/12/25 at 9:57 p.m., indicated the resident was exit seeking and the door alarm was sounding as the resident was attempting to leave the building. The resident's daughter was notified and indicated the resident's family had been at the facility visiting most of the day and had taken the resident outside for much of that time. The resident lived on her own prior to being hospitalized and was accustomed to going outside whenever she wanted to. There was no documentation to indicate new resident-specific interventions were implemented to address the continued exit-seeking on 7/12/25 or the resident's previous lifestyle and routine to go outside with supervision. A new Elopement Risk Screening, dated 7/12/25, indicated the resident was at risk for elopement. The admission Minimum Data Set (MDS) assessment, dated 7/13/25, indicated the resident was severely cognitively impaired, had wandering behaviors 1 to 3 days, and wandering placed her at significant risk of getting to a potentially dangerous place. A Progress Note, dated 7/14/25 at 10:50 a.m., indicated the resident was observed ambulating toward the exit and was redirected by staff. There was no documentation to indicate any new interventions were attempted for the wandering/exit-seeking behaviors on 7/14/25. A

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to ensure oxygen was available on the crash cart (mobile unit with life-saving equipment used in medical emergencies) for 1 of 2 crash carts reviewed. (A Wing) Finding includes:On 7/31/25 at 1:25 p.m., the A wing crash cart near Room A160 was observed with the A Wing Unit Manager. The oxygen tank on the cart were empty. During an interview at that time, the A Wing Unit Manager indicated the oxygen tank was empty and she would replace it. She was unsure how often the oxygen tank level was checked but the crash cart supplies were checked daily. During an interview on 7/31/25 at 2:08 p.m., the Director of Nursing (DON) indicated the crash cart oxygen should be checked daily. A facility policy, titled Oxygen Storage and received from the DON as current, indicated, . Check oxygen nightly on crash cart. This citation relates to Complaint 2573709. 3.1-47(a)(6)