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	11/20/2025

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 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 a resident received treatment and care in accordance with professional standards, related to medications not administered timely and as ordered by the Physician, for 1 of 7 residents reviewed for quality of care. (Resident D)Finding includes:Resident D's record was reviewed on 11/18/25 at 11:27 a.m. The diagnoses included, but were not limited to, urine retention, hypertension, osteomyelitis, chronic kidney disease, heart failure, and edema.An admission Minimum Data Set (MDS) assessment, dated 9/22/5, indicated an intact cognitive status, no behaviors, dependent for toileting, incontinent of bowel and bladder, received intravenous (IV) medications, and had a central line.An admission Physician's Order, dated 9/19/25 at 7:24 p.m., indicated carvedilol (heart medication) 3.125 milligrams (mg) was to be given twice a day with meals for hypertension.The Medication Administration Record (MAR), dated 9/2025, indicated the carvedilol was scheduled for 8:00 a.m. and 5:00 p.m. and was received as ordered on 9/20/25 and 9/21/25.The MAR indicated the medication had not been given on at 8:00 a.m. and 5:00 p.m. on 9/22/25 and 9/23/25.The Nurses' Progress Notes, dated 9/23/25 at 9:33 a.m. and 9/23 at 6:08 p.m., indicated the medication was on order.There was no documentation the physician had been notified of the carvedilol not administered as ordered.The Pharmacy Emergency Medication Kit (EDK) medication inventory list, dated 1/5/24 and received from the Director of Nursing (DON) as the Pharmacy used by the facility in September and October, indicated the carvedilol was available in the EDK.A Physician's Order, dated 9/19/25 at 8:33 p.m., indicated Midodrine HCL (medication for hypotension) 10 mg was to be administered three times a day for hypotension.The MAR, dated 9/2025, indicated the Midodrine HCL was scheduled for 9:00 a.m., 1:00 p.m., and 5:00 p.m. The Midodrine HCL had not been administered on 9/23/25 at 9:00 a.m. and 1:00 p.m. and 9/24/25 at 9:00 a.m. and 1:00 p.m.There was no documentation in the Nurses' Progress Notes, nor on the MAR that indicated why the medication had not been administered and the Physician had been notified.A Physician's Order, dated 9/19/25 at 1:39 p.m., indicated vancomycin (antibiotic) 250 mg, was to be administered four times a day.The MAR, dated 9/2025, indicated the medication was scheduled for 9:00 a.m., 1:00 p.m., 5:00 p.m., and 9:00 p.m.The Mar indicated the vancomycin had not been administered on 9/22/25 at 9:00 a.m., 9/22/25 at 5 p.m., and 9/23/25 at 1:00 p.m.There was no documentation in the Nurses' Progress Notes, nor on the MAR, that indicated why the medication had not been administered or that the phad been notified.A Physician's Order, dated 9/19/25 at 10:24 a.m., indicated enoxaparin sodium solution (blood thinner) 40 mg/0.4 milliliter was to be injected one time a day for prevention of blood clots for 30 days.The MAR, dated 9/2025, indicated the medication was scheduled for 9:00 a.m. daily. The medication had not been given at 9:00 a.m. on 9/20/25, 9/22/25, and 9/23/25. The 9:00 a.m. dose on 9/21/25 had been administered.A Nurse's Progress Note, dated 9/20/25 at 5:51 p.m., indicated the medication was on order.A Nurse's Progress Note, dated 9/23/25 at 9:11 a.m., indicated the medication had been re-ordered.The Pharmacy EDK medication inventory list, dated 1/5/24 and received from the Director of Nursing (DON) as the Pharmacy used by the facility in September and October, indicated the medication was available in the EDK.There was no documentation in the Nurses' Progress Note why the medication had not been given on 9/22/25 or that the physician had been notified of the medication not given on 9/20/22, 9/22/25, and 9/23/25.During an interview on (continued on next page)

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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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/19/25 at 9:28 a.m., the DON acknowledged the medications had not been administered as ordered. The facility had a new Pharmacy as of 11/1/25, due to problems with medication delivery. He was not sure if the medications were not available in the EDK or why the EDK had not been used. He had not been notified that the medications were not available.The prior Pharmacy delivery policy, dated 10/2023 and received from the Nurse Consultant as current for September and October 2025, indicated the original physician's order was to be sent to the pharmacy as soon as it was written. The first dose may be available from the EDK. Refill orders were to be sent when there was only a three day supply left of the medication. Delivery Monday through Friday was 2:30 p.m. to 5:30 p.m. if ordered before 8:00 a.m. and 12:30 a.m.-3:30 am., if ordered before 5:00 p.m. Orders before 2:00 p.m. on Saturday and Sunday were delivered between 9:30 p.m. and 12:30 a.m.The Hospital Transfer re-admission Physician's orders, dated 10/4/25, indicated orders of metoprolol succinate ER (extended release) (heart medication) 25 mg daily and empagliflozin (diabetic medication) 10 mg daily.The Physician's Orders and the MAR, dated 10/2025, indicated the orders had not been transcribed until 10/6/25.The MAR, dated 10/2025, indicated the metoprolol succinate ER was first administered on 10/7/25 at 9:00 a.m. and the empagliflozin was first administered on 10/8/25 at 9:00 a.m.There was no documentation that indicated the resident and physician had been notified of the delay in treatment.During an interview on 10/19/25 at 1:48 p.m., the DON indicated the omitted orders were found during an audit on 10/6/25.A Physician's Order, dated 10/6/25 at 6:53 p.m., indicated midodrine HCL, 10 mg was to be administered twice a day for hypotension. The medication was not to be administered if the systolic blood pressure was greater than 90.The MAR, dated 10/2025, indicated the medication was scheduled for 8:00 a.m. and 5:00 p.m.The medication had been administered on October 8-11, 2025 and October 13 - 31, 2025 at 8:00 a.m. There was no blood pressure checked prior to the administration of the medication on October 9, 11, and 13, 2025. The blood pressure on October 8, 14 -31, 2025 at 8:00 had a systolic pressure over 90.The medication had been given at 5:00 p.m. on October 8, 9, 11, 12, 14-31, 2025. There was no blood pressure obtained prior to the administration of the medication on October 8, 9, 11, and 12, 2025. The blood pressure on October 14-31, 2025 had a systolic pressure over 90.The MAR, dated 11/2025, indicated the medication had been administered November 1-17, 2025 at 8:00 a.m. with the systolic blood pressure over 90. The 5:00 p.m. dose was administered November 1-4 and 7-17, 2025 with a systolic blood pressure over 90.During an interview on 11/19/25 at 1:48 p.m. the DON and Nurse Consultant acknowledged the medications had been administered with a systolic blood pressure over 90.This citation relates to Intakes 2656197 and 2664121.3.1-37(a)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on record review and interview, the facility failed to ensure residents were provided with laboratory (lab) services, related to lab tests not completed as ordered for 2 of 3 residents reviewed for lab services. (Residents D and E)Findings include:1. Resident D's record was reviewed on 11/18/25 at 11:27 a.m. The diagnoses included, but were not limited to, urine retention, hypertension, osteomyelitis, chronic kidney disease, heart failure, and edema.An admission Minimum Data Set (MDS) assessment, dated 9/22/25, indicated an intact cognitive status, no behaviors, dependent for toileting, incontinent of bowel and bladder, received intravenous (IV) medications, and had a central line.A Physician's Order, dated 9/19/25 indicated a complete blood count (CBC), C-reactive protein (CRP) (measures protein in the blood), comprehensive metabolic panel (CMP) (measures chemical balance, electrolyte levels, kidney and liver function), and erythrocyte sedimentation rate (ESR)(monitor for inflammation) blood tests were to be obtained on 9/29/25. There was no documentation the blood tests were completed, the reason the tests were not completed or that the physician had been notified the tests had not been completed.A Physician's Order, dated 10/16/25, indicated a vitamin B1 level (thiamin level) was to be obtained on 10/27/25. There was no documentation the blood test had been completed, the reason it was not completed or that the physician had been notified the test had not been completed.A Physician's Order, dated 10/22/25, indicated a stool sample was to be obtained to test for occult blood. There was no documentation the test had been completed, the reason it was not completed or that the physician had been notified the test had not been completed.A Physician's Order, dated 11/4/25, indicated a CMP blood test was to be completed on 11/5/25. There was no documentation the test had been completed, the reason it was not completed or that the physician had been notified the test had not been completed.During interviews on 11/19/25 from 2:40 p.m. through 3:11p.m., the Director of Nursing (DON) acknowledged there were orders for the above lab tests and no documentation why they were not completed or that the physician had been notified. He indicated when the Physician's Order is typed into the computer, it goes directly to the Laboratory Company who is contracted to complete the facility labs. 2. Resident E's record was reviewed on 11/20/25 at 8:23 a.m. The diagnoses included, but were not limited to, urinary tract infection, diabetes mellitus, Parkinson's disease, and dementia.An admission MDS assessment, dated 11/2/25, indicated a moderately impaired cognitive status and no behaviors.A Physician's Order, dated 10/31/25, indicated a urinalysis was to be completed. There was no documentation the test had been completed, no results in the record, or that the Physician had been notified the test had not been completed.During an interview on 11/20/25 at 9:12 a.m., the DON indicated it was documented it had been collected but the lab had not picked it up.A facility policy for lab orders, dated 11/2025 and received as current from the DON, indicated the lab was integrated with the facility's electronic medical record and the results would be downloaded to the record.This citation relates to Intake 2656197.3.1-37(a)

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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. Based on record review and interview, the facility failed to ensure residents' records were accurate and complete, related to documentation of the amount of urine found after bladder scans were completed, for 2 of 4 residents reviewed for bladder scans. (Residents D and E)Findings include:1. Resident D's record was reviewed on 11/18/25 at 11:27 a.m. The diagnoses included, but were not limited to, urine retention, hypertension, osteomyelitis, chronic kidney disease, heart failure, and edema.An admission Minimum Data Set (MDS) assessment, dated 9/22/25, indicated an intact cognitive status, no behaviors, dependent for toileting and was incontinent of bowel and bladder.A Physician's Order, dated 9/24/25 at 4:52 p.m., indicated a post void bladder scan was to be completed daily for one week. The results were to be documented and the physician's office was to be notified of the results daily.The Medication Administration Record (MAR), dated 9/2025, indicated by initials and a check mark, the order was completed on day shift on 9/25 through 9/30/25.There was no documentation of the amount of urine found during the scan on the MAR or the Nurses' Progress Notes. There were no Bladder Scan Evaluations completed.During an interview on 11/19/25 at 8:21 a.m., the Unit Manager indicated the bladder scans were completed and she had personally e-faxed (notification per computer) the physician's office. She indicated the bladder scans were to be documented on the Bladder Scan Evaluation form and in the Nurses' Progress Notes.During an interview on 11/19/25 at 8:21 a.m., the Director of Nursing (DON) indicated there was no documentation of the amount of urine found during the scans other than for 9/25/25 at 7:02 p.m., which was 240 cubic centimeters. 2. Resident E's record was reviewed on 11/20/25 at 8:23 a.m. The diagnoses included, but were not limited to, urinary tract infection, diabetes mellitus, Parkinson's disease, and dementia.An admission MDS assessment, dated 11/2/25, indicated a moderately impaired cognitive status and no behaviors.A Physician's Order, dated 10/31/25, indicated a bladder scan was to be completed every eight hours for three days.The MAR, dated 11/1/25, indicated the bladder scan was scheduled for 6:00 a.m., 2:00 p.m., and 10:00 p.m. from 11/1/25 through 11/3/25.On 11/1/25 at 2:00 p.m. and 10:00 p.m. and 11/2/25 at 6:00 a.m. and 2:00 p.m., there were initials and a check mark on the MAR that the scan was completed. The amount of urine found during the scan was not documented.There was no documentation in the Nurses' Progress Notes and there were no Bladder Evaluation forms completed.During an interview on 11/202/5 at 10:54 a.m., the DON indicated there was no documentation of the amount of urine found during the scan.A facility bladder scan policy, dated 11/2025 and received as current from the Nurse Consultant as current, indicated the amount of urine found during the scan would be recorded.This citation relates to Intake 2656197.3.1-50(a)(1)3.1-50(a)(2)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 1 and CNA 2) when providing care to a residents who were in Enhanced Barrier Precautions (EBP) for 2 of 4 residents reviewed for EBP. (Residents F and J) Findings include:1. During an observation on 11/17/25 at 9:25 a.m., Resident F's outside doorframe had a magnetic sign that indicated EBP was to be utilized during care and there was a PPE bin located below the sign. Upon entering the room, the resident was in bed and CNA 1 was providing incontinence care. The CNA had gloves on but had not donned a gown. The CNA was interviewed after the care was completed. She indicated she should have worn a gown while providing the resident's care. Resident F's record was reviewed on 11/20/25 at 11:19 a.m. The diagnoses included, but were not limited to, gastrostomy tube (feeding tube). A Care Plan, dated 11/5/25, indicated EBP was required. The interventions indicated PPE, specifically gowns and gloves, during high contact resident care were to be worn. A Physician's Order, dated 11/5/25, indicated EBP was required related to the feeding tube. 2. During an observation on 8/19/25 at 8:18 a.m., Resident J's door had a magnetic sign on the outside door frame that indicated EBP was required. Upon entering the room, CNA 2 was in the room and had just transferred the resident from the bed to the wheelchair and was making the bed. She indicated she had just provided care to the resident. She was wearing gloves and a gown was not worn. She indicated she should have wore a gown while providing care to the resident. Resident J's record was reviewed on 11/20/25 at 3:02 p.m. The diagnoses included, but were not limited to, peripheral vascular disease. A Care Plan, dated 10/10/25, indicated EBP was required. The interventions indicated PPE, specifically gowns and gloves, during high contact resident care were to be worn. The Physician's Order Summary (POS) indicated an order on 10/13/25 that EBP was to be utilized. On 11/17/25, the POS indicated the resident received a midline intravenous catheter, and on 11/19/25 an order for a treatment and dressing for an open area on the right toe. A facility EBP policy, dated 3/2025 and received from the Nurse Consultant as current, indicated residents with wounds, indwelling medical devices, and feeding tubes were to have EBP utilized during high contact care. Gowns and gloves were to be worn with care. This citation relates to Intake 2655001. 3.1-18(b)