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	06/29/2026

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure dependent residents received Activities of Daily (ADL) assistance related to bathing, hair washing, repositioning and eating for 2 of 3 residents reviewed for ADLs. (Residents F and G) Findings include: 1. During a random observation on 6/22/26 at 12:15 p.m., Resident F was observed lying in bed. Her lunch tray was on the over bed table in front of her, however she was not eating it. The resident indicated she had asked the person who brought in the tray to reposition her so she could eat. He told her he was not able to do that, and left the room. The resident indicated there was no way she could eat being so far down in the bed. The resident also indicated she had not had a shower or her hair washed since she had been admitted . During an interview on 6/24/26 at 10:07 a.m., the resident indicated she did not eat breakfast because no one would help her reposition in bed. She told someone, but they never came back to help and her food was cold. During an observation on 6/25/26 at 10:13 a.m., the resident was observed sitting up in a wheelchair by her bed. The resident indicated she was very tired and had asked staff a little bit ago to be put to bed. She indicated they told her she would be back but no one had come back to put her to bed. At 10:15 a.m., LPN 2 was observed across the hall passing medications. She was asked who the CNA was for Resident F. The LPN indicated it was CNA 4, and she was busy with other residents and would get to her when she had a chance. The nurse was asked why she could not help put the resident back to bed, and had no answer for the question. At 10:17 a.m., LPN 2 pushed her medication cart by Resident F's door and prepared and poured her medications. At 10:20 a.m., CNA 5 was observed entering a door from the outside and talking on her cell phone. She walked over to the lounge area and hung up her phone and put it away. At that time, LPN 2 asked CNA 5 to come over to her and help her put Resident F to bed. CNA 5 quickly responded and stated, I have to go get [resident name] up and help her. But there is CNA 4 [name] right now, you can ask her. CNA 5 walked away from LPN 2 and proceeded toward another resident's room. At 10:25 a.m., LPN 2 walked away from Resident F's room and to the nurses' station looking for someone to help her put the resident back to bed. At 10:35 a.m., CNA 4 and LPN 2 entered the resident's room to put her back to bed. At 12:05 p.m., the Dietary Aide delivered the resident's lunch tray to her walked out of the resident's room. At that time, the resident's call light came on. The resident indicated she needed to be repositioned in bed so she could eat. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	At 12:10 p.m., LPN 2 sat down to feed another resident on the unit and CNA 5 was making sure all the residents received a lunch tray. At 12:17 p.m., CNA 5 entered a resident's room to feed them and Resident F's call light was still on. She had not been repositioned nor had started to eat her lunch. At 12:20 p.m., LPN 2 entered the resident's room to answer the call light and the resident told her she needed to be changed and repositioned in bed so she could eat her lunch. During an interview on 6/25/26 at 3:30 p.m., the resident indicated her hair still had not been washed since she had been in the facility. The record for Resident F was reviewed on 6/25/26 at 11:35 a.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, heart failure, COPD, acute respiratory failure with hypoxia, history of lung cancer, high blood pressure, heart disease, atrial fibrillation, chronic kidney disease, and pulmonary hypertension. The 6/21/26 admission Minimum Data Set (MDS) assessment indicated the resident was cognitively intact for daily decision making and needed supervision or touching assistance with eating and was dependent on staff for bathing, The resident needed partial to moderate assistance with bed mobility and substantial to max assist with transfers. A Care Plan, dated 6/17/26 indicated the resident had ADL self-care performance deficits and limitations in physical mobility. On 6/25/26 at 12:00 p.m., CNA 4 brought out the shower sheets in a binder for the unit. The shower sheets were reviewed and there was no shower sheet for Resident F in the book. The Unit Manager provided a list of how the showers were determined. The resident was to receive a shower on Wednesday and Saturdays in the evening. A shower sheet for the resident was found in the Unit Manager's office and was not in the book. The shower sheet indicated the resident received a bed bath on 6/20 and 6/24/26, however, her hair was not washed since she had been in the facility. During an interview on 6/25/26 at 11:40 a.m., CNA 4 indicated after a resident had a shower completed, they would fill out the shower sheet for that resident. During an interview on 6/26/26 at 11:15 a.m., the Director of Nursing indicated the resident's hair was just washed on 6/26/26. He indicated there needed to be a better system for tray delivery and helping with meals. He had no other additional information to provide. 2. During a random observation on 6/22/26 at 11:18 a.m., Resident G was in bed with her head elevated. Her uneaten, covered breakfast was on the table in front of her. She was holding a covered cup of juice. She slowly lifted the lidded cup to her mouth, was unable to drink, then put the cup down. After four unsuccessful attempts, the resident fell asleep. On 6/22/26 at 12:56 p.m., the uneaten, covered breakfast remained on the resident's table. At that time, Dietary Aide 1 brought the resident's lunch tray to nurses station. She indicated that was what (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	she did with the trays of all residents who needed to be fed. She had not delivered the breakfast trays that day. During an interview on 6/22/26 at 1:00 p.m., CNA 3 indicated the resident needed to be fed, and she was not there for breakfast that day. The resident's record was reviewed on 6/25/26 at 12:38 p.m. Diagnoses included, but were not limited to, muscle weakness, need for assistance with personal care, and dementia. The Minimum Data Set (MDS) assessment, dated 4/26/26, indicated the resident had severe cognitive impairment, and was dependent in activities of daily living (ADLs). A Care Plan, dated 4/22/26, indicated the resident had an ADL self-care deficit and was dependent in eating. During an interview on 6/25/26 at 3:15 p.m., the Director of Nursing was informed of the finding and had no additional information to provide. This citation relates to Intakes 3051819 and 3051964. 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(2)(B) 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(2)(D) 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(3)(B)