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	03/04/2025

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 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. 48383 Based on record review and interview, the facility failed to ensure the physician was notified in a timely manner of a medication that was unavailable for 1 of 3 residents reviewed for notification of change. (Resident E) Finding includes: Resident E's record was reviewed on 3/3/25 at 11:23 a.m. Diagnoses included, but were not limited to, heart failure, gout (increase level of uric acid), muscle weakness, and chronic obstructive pulmonary disease (COPD). The Admission Minimum Data Set (MDS) assessment, dated 2/19/25, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 2/12/25, indicated the resident was to receive Vericiguat (chronic heart failure medication) 10 milligram (MG) oral tablet once a day for heart failure. A Nurse's Note, dated 2/14/25 at 12:29 p.m., indicated Vericiguat oral tablet was not available and pharmacy was aware. A Nurse's Note, dated 2/15/25 at 9:50 a.m., indicated Vericiguat oral tablet was pending delivery from pharmacy. A Nurses Note, dated 2/16/25 at 6:24 p.m., indicated the nurse and the physician notified the resident's spouse of the vericiguat medication being a high cost medication and requested she bring the prescription in. There was no documentation prior to 2/16/25 of the physician being notified of the delayed medication order. During an interview on 3/3/25 at 1:42 p.m., the Director of Nursing (DON) indicated he received notification from the pharmacy on 2/18/25 at 1:20 p.m. that vericiguat was a high cost medication and required approval. He approved the medication the same day and the resident's family did not have to supply the medication. He indicated a physician should be notified of a medication delay after 48 hours of not receiving a medication. (continued on next page)

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

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/4/25 at 10:18 a.m., the DON indicated there was no documentation indicating the physician was notified prior to 2/16/25. A facility policy for medications on back-order, dated 11/2024 and received from the DON as current, indicated if the medication was not available in the Emergency/Convenience Boxes, the staff nurse was to call the physician for a possible and/or appropriate alternative. 3.1-5(a)(2)

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 20580 Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff member (CNA 1) when providing care to a resident (Resident G) who was in Enhanced Barrier Precautions (EBP) for 1 of 4 residents reviewed for EBP. Finding includes: During an observation on 3/3/25 at 9:04 a.m., there was a container on Resident G's outside door that contained PPE of gowns, gloves, and masks. There was a sign on the door frame that indicated the resident required EBP. Resident G was lying in bed, was uncovered and wore a clean incontinent brief. A family member was assisting the resident to lie on his right side and CNA 1 was on the left side of the bed and placed a clean and rolled incontinent pad under the resident. The resident was then rolled to the left side and the incontinent pad was pulled through to be placed under the resident. CNA 1 was not wearing a gown. She then started to leave the room to find assistance to position the resident in the bed. At that time, she indicated a gown should have been worn during care. During an interview on 3/4/25 at 8:41 a.m., the resident's family member indicated CNA 1 had answered the call light and provided incontinent care when observed on the morning of 3/3/25. Resident G's record was reviewed on 3/3/25 at 2:43 p.m. The diagnoses included, but were not limited to, stroke. A Physician's Order, dated 1/20/25, indicated EBP was required due to a feeding tube being present. A facility EBP policy, dated 3/2024 and identified as current by the Director of Nursing, indicated staff were to don a gown and gloves during high-contact resident care. EBP PPE was to be used for residents with a feeding tube. This citation relates to Complaint IN00450991. 3.1-18(b)