STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 00 B. WING	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00374097, IN00376183, IN00376331, IN00376606, and IN00377184. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00374097 - Substantiated. Federal/State deficiencies related to the allegations are cited at F692, F695, F757, and F760. Complaint IN00376183 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376331 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00376606 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684, F686, F692, F760, and F776. Complaint IN00377184 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Survey dates: April 12, 13, and 14, 2022 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 98 Residential: 32 Total: 130 Census Payor Type:	F 0000		

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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.

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	Medicare: 20 Medicaid: 62 Other: 16 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 4/18/22.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure non-pressure skin areas and signs and symptoms of constipation were assessed, monitored, and documented for 1 of 3 residents reviewed for non-pressure areas and 1 of 3 residents reviewed for a change in condition. (Residents C and J) Findings include: 1. On 4/13/22 at 11:00 a.m., CNA 1 was observed checking Resident C for incontinence. At that time, she was asked to remove the resident's bed linens so both feet and legs could be observed. The resident had a bandage on her lower right leg and her second toe on the left foot was discolored.	F 0684	**Dyer nursing and Rehab Complaint Survey: 4-14-2022 F684 Quality of Care** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C has been reviewed the	05/06/2022

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	The record for Resident C was reviewed on 4/13/22 at 10:15 a.m. The resident was admitted on 2/17/22 from the hospital. Diagnoses included, but were not limited to, cellulitis of the left lower limb, dementia, high blood pressure, peripheral vascular disease, anemia, and angina. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. She weighed 108 pounds, had no oral problems or weight loss, and received a mechanically altered diet. An initial wound exam, performed by the Wound Physician, dated 2/21/22, indicated the resident had an arterial wound on the left dorsal second toe which measured 2 centimeters (cm) by 1 cm. The wound was a dried fibrous exudate (scab). The treatment of Betadine (a skin disinfectant) was put into place. A current and last Wound Physician note, dated 4/12/22, indicated the left second toe arterial wound had improved and measured 1.5 cm by 1 cm and was 100% dermis tissue. Physician's Orders, dated 3/15/22, indicated to monitor the left dorsal second toe each shift for any changes and report to MD/NP (Medical Doctor/Nurse Practitioner). The Treatment Administration Record (TAR) for 4/2022, indicated the treatment had been signed out one time on 4/7/22 on the day shift. Documentation of the toe being monitored was not completed 4/1-4/6/22 for all three shifts and 4/7 (eves and midnights) to 4/12/22 (all shifts). Interview with the Wound Nurse on 4/13/22 at		by wound physician. The treatment order for resident C has been updated. Resident J has been discharged from the facility **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with ordered non-pressure skin assessment/treatments have been identified and reviewed and have the potential to be affected by the same alleged deficient practice. All resident have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The facility nursing staff including CNA's, charge nurses, therapist, and nursing leadership has been re-inserviced regarding the importance of monitoring resident's for bowel movement and accurately recording any bowel movement in the clinical record. Additionally, nursing staff have been educated on not the following: · Implementation of interventions with no bowel	

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	11:00 a.m., indicated the Wound Physician wanted the toe monitored more frequently because it was still dark and discolored even though there was no treatment in place. Nursing staff were supposed to assess the wound every shift. 2. The record for Resident J was reviewed on 4/12/22 at 10:05 a.m. Diagnoses included, but were not limited to, major depressive disorder, PTSD (post traumatic stress disorder), high blood pressure, and weakness. The Annual Minimum Data Set (MDS) assessment, dated 12/8/21, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 person physical assist with bed mobility and toilet use. The resident was always incontinent of bowel and bladder. There was no Care Plan for constipation. Nurses' Notes, dated 4/1/22 at 6:02 a.m., indicated the resident's abdomen was noted as hard and distended. The resident had 2 bowel movements that shift. The stool was noted as watery and non-formed. Staff had noted this issue and stated it was more distended than the previous day. The assessment was to be passed on to the doctor. The next entry in the Nursing Notes was on 4/2/22 at 6:27 a.m. (24 hours later), which indicated the resident remained with firmness and distention to the abdomen without tenderness on palpation. He had a bowel movement over night and appeared comfortable at that time. Would continue to monitor. The next documented entry in Nurses' Notes was on 4/4/22 at 12:56 p.m., indicating the resident had a rapid COVID-19 test and it was negative. There		movement after 3 days · Interviewing and assessing resident for any missed bowel movement or GI symptoms such a pain, cramping, abdominal distention, excess gas, · notification of the physician/NP for any resident that has not had a bowel movement in 4 days. · Running and auditing the MATRIX no bowel movement report The facility treatment nurse and the charge nurses have been re-educated regarding following physician orders and ensuring non-pressure skin areas are assessed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit the MATRIX bowel movement report every day reviewing bowel movements and monitoring the number of days with no bowel movement to ensure interventions have been implemented and documented in the clinical record, the physician has been notified, and any new orders have been carried out. A summary of audit findings will be reviewed at the QAPI meeting monthly. DON/Designee will audit all TAR's twice weekly to ensure	

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	was no documentation regarding the resident's abdomen. Nurses' Notes, dated 4/5/22 at 5:10 a.m., indicated, "called to room per CNA who stated the resident didn't look right. Writer observed the resident to be pale in color and called the resident's name multiple times with no response. The resident was not responding to verbal or tactile stimuli. The resident was repositioned and still did not respond." Vital signs were taken and the resident was a full code, so 911 was initiated. At 5:26 a.m., the resident remained unresponsive upon leaving the facility, but had a pulse and noted breaths. The resident was admitted to the hospital and was still in the hospital at this time. A hospital note, dated 4/5/22, indicated a Cat Scan (CT) of the abdomen was obtained. The impression was a "massively dilated colon in particular affecting the transverse and sigmoid colon, with preserved haustral pattern. The rectum is also dilated and fluid filled." Another CT of the abdomen was obtained on 4/6/22 which indicated a massively distended colon but possibly stable or slightly improved. A CT of the abdomen was obtained on 4/9/22 which indicated the colon was still massively dilated with air and a rectal tube was present, however, it was stable from the previous days. Physician's Orders, dated 2/5/21, indicated Colace (a stool softener) 100 milligrams (mg) daily prn (as needed). The Medication Administration Record (MAR) for the months of 3/2022 and 4/2022, indicated the Colace was not administered.		non-pressure areas have been assessed as ordered. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/6/2022**	

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	The bowel movement (bm) record indicated the following: 3/22-large and medium bm 3/23-medium bm 3/24-3/26 no bm 3/27-small bm 3/28-3/31-no bm 4/1-medium bm 4/2-small and large bm 4/3-large bm 4/4-no bm 4/5-large bm Interview with the Assistant Director of Nursing on 4/13/22 at 2:30 p.m., indicated she was unaware the resident had abdominal distention prior to his hospitalization and she was also unaware the resident had not had a bm for several days. This Federal tag relates to Complaints IN00376606 and IN00377184. 3.1-37(a)			
F 0686 SS=D Bldg. 00	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to			

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	promote healing, prevent infection and prevent new ulcers from developing. Based on record review and interview, the facility failed to ensure Registered Dietitian recommendations related to wound healing were carried out in a timely manner for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on 3/4/22. Prior to admission, the resident was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. The resident was admitted with one Stage 3 pressure area and 4 unstageable pressure areas. Registered Dietitian (RD) progress notes, dated 3/10/22 at 2:43 p.m., indicated per the 3/5/22 wound care management notes, the resident had areas to the right heel, left heel, sacrum, mid lower back and right ear. The resident received MVI with mineral (multivitamin) to aid in healing. The resident may benefit from adding additional protein for wound healing. The resident was at risk for malnutrition due to diagnoses of cancer,	F 0686	**Dyer nursing and Rehab Complaint Survey: 4-14-2022** **F686 Treatment/Svcs to Prevent/Heal Pressure Ulcers** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F is no longer at the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with recommendations from the dietician have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The facility nursing leadership and	05/06/2022

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	diabetes mellitus, congestive heart failure, and hypertension, inability to swallow regular liquids and impaired skin integrity. Recommend-No Concentrated Sweet, No Added Salt diet and 30 cubic centimeters (cc) of Prostat (a supplement for wound healing) twice a day. Will continue to follow as needed. The resident did not have an order for the Prostat. There was also no documentation indicating if the Physician had been contacted about the RD's recommendations. Interview with the Director of Nursing on 4/14/22 at 2:20 p.m., indicated the Physician should have been contacted about the RD's recommendations. This Federal tag relates to Complaint IN00376606. 3.1-40(a)(2)		the charge nurse’s have been re-inserviced on reviewing the dietary recommendations after each visit and obtaining physician orders for any recommendations that require physician orders and ensuring recommendations are implemented. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit all dietary recommendations each week to ensure that orders have been obtained if needed and dietary recommendations have been implemented. A summary of audit findings will be reviewed at the QAPI meeting monthly. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/6/2022**	
F 0692 SS=D Bldg. 00	483.25(g)(1)-(3) Nutrition/Hydration Status Maintenance §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy			

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	tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			
	Based on observation, record review, and interview, the facility failed to consistently monitor food and fluid intake for at risk residents for 2 of 3 residents reviewed for nutrition. (Residents F and C) Findings include: 1. The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on 3/4/22. Prior to admission, the resident was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis	F 0692	**Dyer Nursing and Rehab Center Complaint Survey 04-14-2022** **INFORMAL DISPUTE RESOLUTION** **F692 Nutrition Hydration Status Maintenance** On behalf of Dyer Nursing and Rehab Center, we are requesting an informal dispute resolution for F684 referenced on the enclosed 2567. The facility respectfully requests the reduction in scope and severity upon review of the following information. As required, the facility has prepared a Plan of Correction for this deficiency; however, we set forth the following	05/06/2022

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	(bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. She also needed supervision with eating. The resident was admitted with one Stage 3 pressure area and 4 unstageable pressure areas. Registered Dietitian (RD) Progress Notes, dated 3/10/22 at 2:43 p.m., indicated per the 3/5/22 wound care management notes, the resident had areas to the right heel, left heel, sacrum, mid lower back and right ear. The resident received MVI (multivitamin) with minerals to aid in healing. The resident had fair oral intake per food consumption records, 25-75% of most meals were recorded. The resident may benefit from adding additional protein for wound healing. The resident was at risk for malnutrition due to diagnoses of cancer, diabetes mellitus, congestive heart failure, and hypertension, inability to swallow regular liquids and impaired skin integrity. The general nursing interventions, dated 3/4/22, indicated document breakfast, lunch and dinner in the point of care response section. No food consumption was documented on 3/6, 3/10, 3/11, and 3/12/22. No dinner intake was documented on 3/13/22. Interview with the Director of Nursing on 4/14/22 at 2:20 p.m., indicated the resident's meal intake should have been documented. 2. On 4/13/22 at 9:10 a.m., Resident C was observed in bed, eating breakfast. She was feeding herself without any difficulty.		facts. **The facility maintains that the facility provided adequate nutrition and hydration for resident F and resident C. There are a variety of components that the dietician and the facility use to assess any resident's nutritional status. Food and fluid intakes are only one component. The facility does have omissions in the food consumption records and the facility and dietician expects to routinely have omissions. The expectation that the facility would have 100% compliance is not a realistic goal nor is this the policy of the facility.** **There are additional areas the facility would like to focus on in this dispute:** *1.* The order referenced in the 2567 to Document breakfast, lunch, and dinner in the point of care response section is not a physician's order. In order for directions/guidance to be electronically viewed by the CNA on the POINT OF CARE DEVICES that are located in the hallways, and near the dining rooms this information must be entered into the facilities EMR system. This entered information is then able to be viewed by the	

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	The record for Resident C was reviewed on 4/13/22 at 10:15 a.m. The resident was admitted on 2/17/22 from the hospital. Diagnoses included, but were not limited to, cellulitis of the left lower limb, dementia, high blood pressure, peripheral vascular disease, anemia, and angina. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. She weighed 108 pounds, had no oral problems or weight loss, and received a mechanically altered diet. There was no Care Plan for nutrition. Nurses' Notes, dated 2/17/22 at 9:25 p.m., indicated the resident arrived to the facility per EMS. A Registered Dietitian's (RD) Note, dated 2/24/22 at 10:32 a.m., indicated the resident's weight was 108 pounds with a Body Mass Index of 20. She was noted with pressure injuries to her legs. The resident may benefit from nutritional supplements due to variable oral intake and to aid in healing. The resident was at risk for malnutrition due to diagnoses of dementia, anemia, high blood pressure, variable oral intake and skin impairment. Recommend a MVI (multivitamin) with minerals, 30 cc (cubic centimeters) Prostat (a supplement to promote wound healing) twice a day and a 4 ounce ready care shake twice a day. An admission weight was not obtained until 2/22/22 (5 days after the resident had been admitted). The resident's weight was 108 pounds. The meal consumption log for 2/2022 indicated there was no documentation of any meals on 2/17,		CNA's and the system allows the CNA's to click the kiosk and enter data. **These are not orders from any physician, these are directions entered in the system by the nurses.** At any time, the facility can turn on points of data (we call that highlighting so they light up) and the facility can turn off points of data (these items will not be highlighted). Highlighted area "light up brighter" on the point of care kiosk and helps prompt staff to click on the kiosk for any highlighted item. These items also work as guides for the staff. In an "age of Long-Term Care" in which the staff include agency staff, prn staff, and part times staff, which are different every day, these POINT of Care kiosks provide necessary information for staff to provide care. The facility has attached an example of this for this IDR. The MATRIX system does label this an order but if you review each individually it states "general nursing", "Nursing POC task". *There is a physician's order for every diet that is ordered. The physician must electronically sign for each of these orders. The general nursing task orders are not physician's orders and do not require any physician to sign electronically.(Attachment A)* *2. The facility had a QAPI program in place as a result of a F692 deficiency. This deficiency survey started on 2/2/2022 and*	

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DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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	2/18, 2/19, 2/20, and 2/21/22. The first meal documentation was on 2/22/22 for breakfast. Physician's Orders, dated 2/21/22, indicated document breakfast, lunch and dinner in the point of care response section. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated the meal consumption logs were to be completed after every meal. This Federal tag relates to Complaints IN00374097 and IN00376606. 3.1-46(a)(1)		*remained out of compliance until 3/29/2022. The facility was actively reviewing resident's meal intakes and trends in meal intakes weekly during the NAR meeting. These reviews focused on resident's meal intakes, specifically meals in which the residents had poor meal intakes recorded or no meal intakes recorded. These reviews give a snap shot on resident's meal consumption day to day and week to week. The facility and the dietician do not need 100% compliance to intervene and again use a variety of tools. The meals provided at the facility exceed the calorie requirements for every resident in hope that there are enough choices in meals provided throughout the day in which the calories they do need are consumed. Both Resident F and Resident C were reviewed in these meetings during this period of non-compliance. This NAR review with the dietician present included what food consumptions were available to review and dietary recommendations were made with the full knowledge by the dietician that 100% of meals consumptions were not available for review. (Attachment B)* ***The references in the 2567 for Resdient F and Resident C all occurred in a time period in which the facility was not in substantial compliance. The***	

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			facility will review below what the facility to meet each of these resident's nutritional needs and will present additional records for review. 1. Resident F was admitted to the facility on 3/4/22 and remained in the facility for 10 days. The facility is submitting FACILITY RECORDS INCLUDING blood glucose monitoring records from the MAR, breakfast, lunch and dinner amounts consumed recorded by the nursing staff, fluid intake recorded by nursing staff, urine output recorded by nursing staff, bowel movements recorded by nursing staff, lab values for A1C, BUN creatine, Sodium, Albumin, facility weight. Additionally, the family visited the resident often and frequently brought the resident food similar as they did in the hospital. (Attachment C facility records) a. Hospital Records prior to admission which include resident weights, labs BUN, creatine, diet order. (Attachment D preadmission to facility) b. Hospital Record upon discharge to the hospital (post facility stay) which includes weights, labs BUN, creatine, diet order. (Attachment E post discharge hospital records) 2. Resident C was admitted on 2/17/2022. The facility has submitted meal intakes, weights, urine output bowel movements,	

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and dietician reviews along with the NAR reviews as described above for the QAPI in #2. (Attachment F)

Resident F weight, labs, diet, all remained unchanged from preadmission from hospital to discharge to hospital.
Resident C had adequate monitoring during her stay from evidence submitted on the facility records, NAR review, and dietician visits.
="" p="">
The facility respectfully requests the deletion of F684 upon review of the submitted information.

Dyer nursing and Rehab Complaint Survey: 4-14-2022

F692 Nutrition/Hydration Status Maintenance

Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.
What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
Resident F is no longer at the facility.

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			Resident C is no longer at the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The facility and dietician use a variety of sources to review resident’s nutritional status which may include hospital records, resident/family interviews, recorded facility weights, dietician reviews which include reviews of meal consumptions, physician/practitioner examination and orders, resident feedback related to meals, food and fluid consumption, staff offers for meal substitutions, review of laboratory values, oral/dental issues, and the resident’s physical appearance. Nurses have been re-educated on obtaining weights, recording meal and fluid consumptions, discussing nutrition with residents and family when needed, implementation of physician orders and dietary recommendations, review of lab values impacting nutrition, review	

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			of oral dental issues. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/Designee will audit resident MATRIX meal intakes and review residents with missing meal intakes and multiple meal intakes of less than 50% for interventions including review by the dietician. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/6/2022**	
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and Suctioning § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the			

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	comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. Based on observation, record review and interview, the facility failed to ensure tracheostomy care was provided as ordered for 2 of 2 tracheostomy residents reviewed. (Residents K and E) Findings include: 1. On 4/12/22 at 2:15 p.m., Resident K was observed in bed, he was awake, alert and oriented, and indicated he had been in the facility since last Thursday. The resident was observed with a tracheostomy and an oxygen mask over the trach, there was no drain sponge noted around the trach. The resident indicated it had fallen off a couple of days ago and no staff person had replaced it. He lived at home with his wife and has had a tracheostomy for the last 12 years, so he was very familiar with what needed to be done on a daily basis. He was able to cough up a lot of the sputum on his own, however, there was a suctioning device set up for him to do his own suctioning. The resident indicated trach care had only been completed one time since admission. There was a box of supplies on top of the table and inside the drawer, there were 2 boxes of inner cannulas, many suctioning kits, and 2 spare tracheostomies. The record for Resident K was reviewed on 4/12/22 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), congestive heart failure, type 2 diabetes, chronic respiratory failure, cellulitis right and left lower limbs, high blood pressure, chronic kidney disease, tracheostomy status, and asthma.	F 0695	**Dyer Nursing and Rehab Complaint Survey: 4-14-2022** **F695 Respiratory/Tracheostomy care and Suctioning** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E and K were provided tracheostomy care. The nurse was counseled about completing tracheostomy care prior to signing the medication administration record. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents, who have a tracheostomy, have the potential to be affected by the same alleged deficient practice. The facility has	05/06/2022

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	The Admission Minimum Data Set (MDS) was still in process. A Nurses' Note, dated 4/8/22 at 2:39 p.m., indicated the resident was alert and oriented times 3 and was able to make needs known. The Respiratory Therapist was in the facility and set up the resident for the tracheostomy supplies. A Respiratory Note, dated 4/9/22 at 3:59 p.m., indicated a request to set up equipment for 0.28 trach collar. Compressor and concentrator set up and all supplies reviewed. Current supplies were present for trach collar, suction, nebulizer and trach care. Set up yanker (a device used for suctioning) for resident to use in order to keep mouth clear. Trach care was completed and reviewed all processes with nursing. Resident was a long term trach patient. Physician's Orders, dated 4/7/22, indicated tracheostomy care and suctioning every shift and prn (as needed). Change disposable inner cannula daily. Change trach ties weekly and prn. The Medication Administration Record (MAR), dated 4/2022, indicated the tracheostomy care and suctioning was not signed out as being completed for the day shift on 4/10 and 4/11. The trach care for the evening shift was not signed out as completed on 4/8-4/10/22. Trach care was not signed out as being completed on the midnight shift from 4/8-4/11/22. The 4/2022 MAR for changing the inner cannula daily indicated it had been signed out as being completed 4/8, 4/9, 4/10, and 4/12/22. There were no initials on 4/11/22 to indicate it had been completed. The trach ties were not signed out as		completed an audit and has identified all residents with a tracheostomy. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurse managers and facility leadership were re-educated on performing tracheostomy care according to the physician orders and documentation of care provided in the clinical record. The nurse have completed nurse competencies with return demonstration for each nurse responsible for tracheostomy care. Nurse managers will complete the tracheostomy care if a nurse is not available that has completed a competency. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place;** DON/designee will complete observations of trach care 3x each week for any resident with a tracheostomy to ensure the physicians order is followed for completing tracheostomy care and documented in the clinical record. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.	

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being completed on 4/11/22.

Interview with Agency LPN 1 on 4/12/22 at 2:30 p.m., indicated she had been taking care of the resident that day. She did not do trach care, due to not being able to find any trach supplies in the room, however, her initials were in the box for the day shift on all trach related items for 4/12/22. When questioned about signing out treatments that were not completed, the LPN stated "I should not have marked it as being done when I had not completed trach care. I could not find any supplies in the room to provide the care."

Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated tracheostomy care should be completed as ordered.

2. The closed record for Resident E was reviewed on 4/12/22 at 3:30 p.m. The resident was admitted to the facility on 2/15/22 and discharged to the hospital on 2/21/22. Diagnoses included, but were not limited to, throat and neck cancer, viral pneumonia, high blood pressure, tracheostomy, peg tube, repeated falls, aphasia, dysphagia, and weakness.

The 5 day Minimum Data Set (MDS) assessment, dated 2/21/22, indicated the resident was alert and oriented and needed extensive assist with 1 person physical assist for transfers and bed mobility. The resident had a tracheostomy and oxygen while a resident.

Nurses' Notes, dated 2/15/22 at 1:44 p.m., indicated the resident arrived to the facility per EMS. He was alert, could make his needs known in Spanish, but understood some English. A tracheostomy was in place and respirations were even and unlabored.

Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.

Date by which systemic corrections will be completed: 5/6/2022

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	Physician's Orders, dated 2/16/22, indicated tracheostomy care and suctioning every shift and change disposable inner cannula daily. The Medication Administration Record (MAR) for 2/2022, indicated the trach care was not signed out as being completed for the day shift on 4/20, evening shift on 4/19, and the midnight shift on 4/18/22. The inner cannula had not been signed out as being changed 4/17 and 4/19/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated tracheostomy care should be completed as ordered. This Federal tag relates to Complaint IN00374097. 3.1-47(a)(4)			
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse			

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	consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure a resident's medications were signed out as being administered for 3 of 4 residents reviewed for unnecessary medications. (Residents C, D, and E) Findings include: 1. The record for Resident C was reviewed on 4/13/22 at 10:15 a.m. The resident was admitted on 2/17/22 from the hospital. Diagnoses included, but were not limited to, cellulitis of the left lower limb, dementia, high blood pressure, peripheral vascular disease, anemia, and angina. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. She weighed 108 pounds, had no oral problems or weight loss, and received a mechanically altered diet. Physician's Orders, dated 2/17/22, indicated medications as follows: - Levothyroxine (a thyroid medication) 100 micrograms (mcg) daily, scheduled for 6:00 a.m. - Caltrate 600 plus D (Calcium carbonate-vitamin D3) 600 milligrams(mg)-20 mcg daily, scheduled for 9:00 a.m. - Atorvastatin (a cholesterol medication) 40 mg daily, scheduled for 9:00 p.m. The Medication Administration Record (MAR) for 2/2022, indicated the Levothyroxine was not	F 0757	**Dyer Nursing and Rehab Complaint Survey: 4-14-2022** **F 757 Drug Regimen is Free Unnecessary Drugs Plan of Correction** Submission of this Plan of Correction by Dyer Nursing and Rehabilitation Center is not a legal admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. · **How will corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The facility is unable to make any corrections for residents C, D, and E for the February medications not signed out. · **How will the facility will identify other residents having the potential to be affected by**	05/06/2022

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	signed out as being administered on 2/18 and 2/19/22. The Caltrate was not signed out as being administered on 2/18/22 and the Atorvastatin was not signed out as being administered on 2/18, 2/20, and 2/22/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated medication should be administered as ordered by the doctor. 2. The record for Resident D was reviewed on 4/13/22 at 9:45 a.m. Diagnoses included, but were not limited to, status post pancreatosplenectomy due to abscess on abdominal wall. The resident was sent out to the hospital on 1/27/22 and returned on 2/8/22 at 2:32 p.m. At that time, he had his pancreas and spleen removed. The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/22, indicated the resident was cognitively intact and had major surgery for removal of the spleen. In the last 7 days, he had 5 doses of an antibiotic medication. Physician's Orders, dated 2/9/22, indicated medications as follows: - Protonix (a medication for gastric reflux) 40 milligrams (mg) daily at 6:00 a.m. - Cyclobenzaprine (a muscle relaxer) 10 mg three times a day at 9:00 a.m., 2:00 p.m., and 8:00 p.m. - Colace (a stool softener) 100 mg daily at 9:00 a.m. - buspirone (an anti-anxiety medication) 5 mg three times a day at 9:00 a.m., 2:00 p.m., and 8:00 p.m. - Metoprolol (a heart medication) 100 mg daily at 9:00 a.m. - Nifedipine (a heart medication) 30 mg daily at 9:00 a.m.		**the same deficient practice?** All residents with medication orders have been reviewed and medication have been reconciled and are available. · **What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?** • Director of Nursing or designee re-educated staff nurses on the facility Medication Administration policy, specifically on administering medications as ordered and signing the Medication Administration Record immediately post administration. · **How will the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?** DON/designee will complete MAR audits twice weekly for each resident to ensure medications are signed out on the MAR for 6 months. The results of the monitoring and audits done under this POC will be submitted to the QA/QI Committee for review and follow up. **Date by which systemic corrections will be completed:**	

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	The Medication Administration Record (MAR) for 2/2022, indicated the Protonix was not signed out as being administered on 2/9, 2/10, and 2/12-2/18/22. The Cyclobenzaprine was not signed out as being administered on 2/9 at 9:00 a.m. and 2:00 p.m., and the Colace was not signed out as being administered on 2/9 and 2/10/22. The buspirone was not signed out as being administered on 2/9 at 9:00 a.m. and 2:00 p.m., 2/15 and 2/18 at 2:00 p.m., and 2/24 at 9:00 a.m. The Metoprolol and Nifedipine was not signed out as being administered on 2/9, 2/11, and 2/24/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated medication should be administered as ordered by the doctor. 3. The closed record for Resident E was reviewed on 4/12/22 at 3:30 p.m. The resident was admitted to the facility on 2/15/22 and discharged to the hospital on 2/21/22. Diagnoses included, but were not limited to, throat and neck cancer, viral pneumonia, high blood pressure, tracheostomy, peg (a tube inserted in the stomach) tube, repeated falls, aphasia, dysphagia, and weakness. The 5 day Minimum Data Set (MDS) assessment, dated 2/21/22, indicated the resident was alert and oriented and needed extensive assist with 1 person physical assist for transfers and bed mobility. The resident had a tracheostomy and oxygen while a resident. Nurses' Notes, dated 2/15/22 at 1:44 p.m., indicated the resident arrived to the facility per EMS. He was alert, could make his needs known in Spanish, but understood some English. A tracheostomy was in place and respirations were even and unlabored.		**5/6/2022**	

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	Physician's Orders, dated 2/15/22, indicated medications as follows: - Levothyroxine (a thyroid medication) 300 (micrograms) mcg daily at 6:00 a.m. - Carvedilol (a blood pressure medication) 6.25 milligrams (mg) at 6:00 a.m. and 6:00 p.m. - Eliquis (a blood thinner) 5 mg at 6:00 a.m. and 6:00 p.m. - Amlodipine (a blood pressure medication) 10 mg daily at 6:00 a.m. - Atorvastatin (a cholesterol medication) 40 mg daily at 6:00 a.m. - Famotidine (a medication for gastric reflux) 20 mg at 6:00 a.m. and 6:00 p.m. - Furosemide (a diuretic) 20 mg at 6:00 a.m. and 6:00 p.m. The Medication Administration Record for 2/2022, indicated the Levothyroxine was not signed out as being administered on 2/16-2/18/22. The amlodipine and atorvastatin were not signed out as being administered on 2/16/22. The Eliquis, Carvedilol, famotidine, and furosemide were not signed out for the 6:00 a.m. dose on 2/16 and 2/20/22 and the 6:00 p.m. dose on 2/17/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated medication should be administered as ordered by the doctor. This Federal tag relates to Complaint IN00374097. 3.1-48(a)(3)			
F 0760 SS=J Bldg. 00	483.45(f)(2) Residents are Free of Significant Med Errors The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. Based on observation, record review and	F 0760	**Dyer Nursing and Rehab**	05/06/2022

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	155220	A. BUILDING 00 B. WING	04/14/2022

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	interview, the facility failed to ensure residents were free of any significant medication errors related to not receiving anticoagulant (blood thinner) medications which resulted in a re-hospitalization for pulmonary emboli (blood clots in lungs) and new onset cardiomegaly (enlarged heart) for 2 of 3 residents reviewed for anticoagulant use. (Residents F and R) The facility also failed to ensure insulin and intravenous (IV) antibiotics were administered for 2 of 4 residents reviewed for unnecessary medications. (Residents F and D) The immediate jeopardy began on 3/5/22 when the resident's anticoagulant was not delivered to the facility after admission from the hospital. The pharmacy had contacted the facility on 3/6 and 3/10/22 for a clarification order with no response from facility staff. On 3/10 and 3/14/22, the resident had complaints of chest pain and shortness of breath. The resident was sent out 911 on 3/14/22 after an abnormal EKG and was admitted to the hospital with bilateral large pulmonary emboli with new onset cardiomegaly. The Administrator was notified of the immediate jeopardy at 11:00 a.m. on 4/14/22. Findings include: 1. The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on 3/4/22. a. Prior to admission, Resident F was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with		**Complaint Survey: 4-14-2022** **F 760 Residents are Free of Significant Med Errors** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F has been discharged from the facility. LPN1 and RN1 were interviewed via phone regarding this resident and communication with pharmacy and re-educated regarding significant medication error for R1. Specifically, nurses must immediately follow up with any notification from pharmacy for the need of physician/NP order clarification for any anticoagulation medication. Additionally, nurses are required to follow-up with the pharmacy for any anticoagulation medication order in the medication administration record (MAR) that is not available at the time prescribed. Resident D received clarification regarding his allergies and the IV	

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	large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. A Physician's Order, dated 3/4/22, indicated the resident was to receive Enoxaparin (a blood thinner) syringe 100 milligrams (mg)/milliliters (ml) 112.5 mg subcutaneous daily. The order was discontinued on 3/12/22. A Physician's Order, dated 3/12/22, indicated the resident was to receive Eliquis (a blood thinner) 5 mg by mouth twice a day. The March 2022 Medication Administration Record (MAR) was not available for review. The Administrator indicated the Diabetic Flowsheet was found but not the MAR with the resident's other medications. Interview with the Pharmacist on 4/13/22 at 4:41 p.m., indicated the resident's Enoxaparin had not been sent to the facility due to a clarification order being needed. On 3/6/22, the Pharmacist spoke with LPN 1, indicating a clarification order needed to be obtained. He indicated he never received a response from the facility. On 3/10/22, another Pharmacist spoke with RN 1 and indicated a clarification order for the Enoxaparin needed to be obtained so it could be sent to the facility. The Pharmacy received no response from the facility. Nurse Practitioner (NP) Progress Notes, dated 3/10/22 at 4:15 p.m., indicated the resident had reported midsternal chest pain without radiation or changes with breathing. The resident denied		antibiotic was initiated on 2/10/22. The facility is unable to correct any missing nurse initials days the nurse failed to sign the MAR. Resident R has been discharged. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with orders for medications have the potential to be affected by the alleged deficient practice. The pharmacy verified on 14/14/2022 that there are no outstanding orders requiring clarification. An audit of all residents with orders for anticoagulants was completed on 4/14/2022. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Facility licensed nurses, agency nurses working on site at the facility, and QMA's were in-serviced regarding prompt follow-up with the pharmacy for any anticoagulant medication order in the medication administration record that is missing. Evidence of this training was provided to the surveyor. The facility is re-inservicing licensed	

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	nausea, dizziness, or headache. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. NP Progress Notes, dated 3/14/22 with a time stamp of 5:32 p.m., indicated the resident had her EKG that day. The resident continued to complain of chest pain and some shortness of breath (SOB). STAT EKG results were abnormal. Continued complaints of midsternal chest pain with occasional SOB. Discussed results with Physician. Sending resident out for further evaluation to determine if resident was having an active MI (heart attack). No abdominal pain or fevers were noted per nursing report. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. Breath sounds clear but diminished to bilateral bases. The resident was sent out 911 on 3/14/22 at 4:00 p.m. The Hospital Admission Note, dated 3/14/22, indicated the resident was a recent admission for bilateral pulmonary emboli on full dose Lovenox (a blood thinner). The repeat CT scan redemonstrated bilateral pulmonary emboli with infiltrates. On 3/14/22, CT Chest Angiography with MIP Imaging showed, "bilateral large pulmonary emboli with cardiomegaly. Diffuse consolidative infiltrates bilaterally with small bibasilar effusions. Cardiomegaly is identified." The cardiomegaly (enlarged heart) was new onset. A two view Chest X-Ray Report, completed on 1/31/22 during the resident's previous hospital		nursing staff on the following: 1.Pharmacy notification for any anticoagulation medication that requires clarification from the NP/physician so the medication can be dispensed by pharmacy. 2.Prompt pharmacy notification for any anticoagulant medication listed in the medication administration record that is missing. 3.Physician/NP notification for any anticoagulant medication not able to be filled by pharmacy for alternative orders. 4.Notification of the DON and facility leadership for anticoagulation medications that have been clarified but have not been delivered. 5.The facility does have an emergency medication (KAPSA) machine on site. KAPSA can be accessed for missing anticoagulant medication and pharmacy can be called for any difficulty with access to the KAPSA machine. 6.Nurses have been re-educated regarding recording medication administration in the MAR. For any staff that has not received this in-service due to PRN status, agency status, or being unable to reach at this time, the facility will complete the above in-service prior to the start of their next scheduled shift.	

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	stay, indicated "the resident's heart size was grossly within normal limits." Interview with the Administrator on 4/13/22 at 4:45 p.m., indicated the resident's March MARs still could not be found. The resident's Enoxaparin should have been received as ordered and the facility should have followed up with the pharmacy regarding the clarification order. b. Resident F had a Physician's Order, dated 3/4/22, which indicated blood glucose monitoring was to be done four times a day. The Physician was to be notified if the resident's blood sugar was less than 60 or greater than 400. The March 2022 Insulin/Diabetic Flowsheet, indicated the resident's blood sugar was not monitored on the following dates and times: - 3/6/22 at 12:00 p.m. and 8:00 p.m. - 3/8/22 at 8:00 a.m., 12:00 p.m., and 8:00 p.m. - 3/10/22 at 8:00 a.m. A Physician's Order, dated 3/4/22, indicated the resident was to receive Tresiba Flex Touch insulin pen 50 units subcutaneously daily. The March 2022 Insulin/Diabetic Flowsheet, indicated the Tresiba insulin was not given as ordered at 8:00 a.m. on 3/6, 3/8, and 3/13/22. A Physician's Order, dated 3/4/22, indicated the resident was to receive Novolog insulin, 27 units three times a day (tid). The March 2022 Insulin/Diabetic Flowsheet, indicated the Novolog insulin was not given as ordered at 8:00 a.m. on 3/6, 3/8, and 3/13/22. The 12:00 p.m. dose of insulin was not given on 3/8 and 3/13/22.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place;** The facility Director of Nursing/designee will audit each new admission and readmission to verify that anticoagulant medications ordered have been delivered and secured in the medication cart. The pharmacy will be contacted immediately for any missing anticoagulant medication. The facility will complete a random audit twice weekly for all resident with orders for medications to ensure the medication is available and is being given as ordered and signed out on the MAR. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections**	

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	Interview with the Director of Nursing on 4/14/22 at 2:20 p.m., indicated the insulin should have been given as ordered. He also indicated the resident's blood sugar should have been monitored as ordered. 2. The record for Resident D was reviewed on 4/13/22 at 9:45 a.m. Diagnoses included, but were not limited to, status post pancreatosplenectomy due to abscess on abdominal wall. The resident was sent out to the hospital on 1/27/22 and returned on 2/8/22 at 2:32 p.m. At that time, he had his pancreas and spleen removed. The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/22, indicated the resident was cognitively intact and had major surgery for removal of the spleen. In the last 7 days, he had 5 doses of an antibiotic medication. A Nurses' Note, dated 2/8/22 at 2:45 p.m., indicated during report from another nurse, it was stated this resident was on IV (intravenous) Zosyn (an antibiotic), the order could not be found on the medication list from the hospital, also the resident had new allergies to Zosyn per the discharge papers. The nurse called admissions asking if they had the current medication list to see what antibiotic the resident was supposed to be on and were awaiting a call back. Nurses' Notes, dated 2/9/22 at 5:49 a.m., indicated an order for Zosyn every 8 hours x 28 days confirmed with admissions and Physician. If side effects such as itching or rash occur, reach out to Physician for order to cope with effects. Physician's Orders, dated 2/9/22, indicated Piperacillin-Tazobactam (Zosyn) 3.375 grams, 1		**will be completed: 5/6/2022**	

bag IV every 8 hours times 28 days. Administration times were 12:00 a.m., 8:00 a.m., and 4:00 p.m.

The Medication Administration Record (MAR) for 2/2022 and 3/2022, indicated the IV antibiotic was not signed out as being administered on the following dates and times:
- 12:00 a.m. on 2/10, 2/17, 2/28, and 3/8/22
- 8:00 a.m. on 2/9, 2/10, 2/13, 2/25, 2/26, 2/27, 2/28, 3/3, 3/4, and 3/7/22
- 4:00 p.m. on 2/9, 2/10, 2/13, 2/14, 2/15, 2/16, 2/26, 2/27, 2/28, 3/5, 3/6, and 3/7/22

Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated the Zosyn was not given when the resident came back from the hospital due to a new documented allergy of Zosyn. They called the doctor to clarify and he indicated to go ahead and give the IV Zosyn and monitor the resident for itching or an allergic reaction. The Zosyn should have been administered as ordered by the doctor.

3. The record for Resident R was reviewed on 4/14/22 at 11:00 a.m. The resident was admitted to the facility on 4/13/22 at 2:05 p.m. Diagnoses included, but were not limited to, fusion of cervical spine, neuropathy, low back pain, cardiac murmur, and spinal stenosis.

Nurses' Notes, dated 4/13/22 at 3:04 p.m., indicated the resident arrived to the facility per EMS. The resident was alert and oriented times 4 and able to make his needs known.

Physician's Orders, dated 4/13/22, indicated Heparin (a blood thinner) 5000 units/milliliters (ml) 0.5 ml (5000 units) three times a day, scheduled times were 6:00 a.m., 12:00 p.m., and 6:00 p.m.

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	every 8 hours times 30 days. The fax sent to pharmacy from nursing staff indicated, "heparin (porcine) solution; 5,000 unit/ml Directions: amount 0.5 mls (5,000 units); injection; three times a day special instructions: Inject (5,000 units) into skin every 8 hrs x 30 days." The discharge instructions from the hospital, dated 4/13/22, indicated the Heparin was last administered on 4/13/22 at 5:37 a.m. Interview with Agency LPN 2 on 4/14/22 at 11:00 a.m., indicated she just printed off the resident's medication sheets, as he was admitted yesterday afternoon, and before the ambulance left, the family wanted a private room, so they moved him to a different room. He was only in that room for maybe 30 minutes. LPN 2 had worked a double shift that day, east unit in the morning and west unit for the evening shift. She helped the nurse with the admission and put the Physician's Orders into the computer. The LPN indicated she typed in "three times a day" and not every 8 hours, so the computer came up with those times. She had overlooked the "every 8 hours" directive and did not double check the order or call the doctor and clarify the order. She came back today and was working on the east unit where the resident resided. There were no medication sheets available for review, so she had to print new medication sheets. She had not administered any of his medications today. The medication cart was observed at 11:20 a.m., and the resident's oral medications were located in the cart, however, the Heparin medication was not in the cart. The LPN was unsure if the heparin medication was available in the EDK (Emergency			

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Drug Kit).

Interview with the Risk Management Consultant on 4/14/22 at 12:30 p.m., indicated the Heparin order was faxed to the pharmacy yesterday, however, the wrong dose was documented/transcribed, therefore, the pharmacy did not send the medication because they needed a clarification.

The immediate jeopardy that began on 3/5/22 was removed on 4/14/22 after the facility implemented a systemic plan that included the following actions: the pharmacy provided their policy related to clarification of medication orders, facility licensed nurses and agency nurses working onsite at the facility were inserviced regarding prompt follow up with the Physician/NP for any anticoagulant medication requiring order clarification when notified by the pharmacy, facility licensed nurses and agency nurses working onsite at the facility were inserviced regarding prompt follow up with the pharmacy for any anticoagulant medication order in the Medication Administration Record (MAR) that was missing, an audit of all residents with orders for anticoagulants was completed. All residents with orders for anticoagulants had the medication present and available. The facility requested the pharmacy to review any resident anticoagulant orders that had not been filled due to requiring clarification from the NP/Physician. The pharmacy verified there were no outstanding orders requiring clarification. The facility inserviced licensed nursing staff on pharmacy notification for any anticoagulation medication that required clarification from the NP/Physician so the medication could be dispensed by the pharmacy, prompt pharmacy notification for any anticoagulant medication listed in the medication

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	administration record that was missing, Physician/NP notification for any anticoagulant medication not able to be filled by pharmacy for alternative orders, and notification of the DON and facility leadership for anticoagulation medications that had been clarified but had not been delivered. The facility did have an emergency medication (KAPSA) machine on site. The KAPSA could be accessed for missing anticoagulant medication and pharmacy could be called for any difficulty with access to the KAPSA machine. For any staff who had not received the inservice due to PRN status, agency status, or being unable to reach at the time, the facility would complete the above inservice prior to the start of their next scheduled shift. The DON/designee would complete an investigation for anticoagulants in which orders were not filled to determine the root cause of why the medication ordered was not filled/dispensed to the facility. The facility DON/designee would audit each new admission and readmission to verify that anticoagulant medications ordered had been delivered and secured in the medication cart. The pharmacy would be contacted immediately for any missing anticoagulant medication. The facility would complete a random audit twice weekly for all residents with orders for anticoagulant medications to ensure the medication was available and was being given as ordered and signed out on the MAR. An emergency QA meeting was held with the Medical Director, Administrator, DON, Social Service Director, HIM Director, and the Director of Nursing at Pharmacy on 4/14/22 at 2:00 p.m. The immediate jeopardy was removed on 4/14/22, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been educated and			

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	monitoring of the implemented systems was ongoing. This Federal tag relates to Complaints IN00374097 and IN00376606. 3.1-48(c)(2)			
F 0776 SS=D Bldg. 00	483.50(b)(1)(i)(ii) Radiology/Other Diagnostic Services §483.50(b) Radiology and other diagnostic services. §483.50(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.			
	Based on record review and interview, the facility failed to ensure diagnostic services were obtained in a timely manner related to obtaining a STAT (immediate) chest x-ray and electrocardiogram (EKG) for 1 of 3 residents reviewed for change in condition. (Resident F) Finding includes: The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung)	F 0776	**Dyer Nursing and Rehab Complaint Survey: 4-14-2022** **F776 Radiology/Other Diagnostic Services** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory	05/06/2022

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	without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on 3/4/22. Prior to admission, the resident was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. Nurse Practitioner (NP) progress notes, dated 3/10/22 at 4:15 p.m., indicated the resident had reported midsternal chest pain without radiation or changes with breathing. The resident denied nausea, dizziness, or headache. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. A STAT EKG was ordered since the resident had a history of atrial fibrillation. A STAT chest x-ray was also ordered. There was no documentation of the resident's chest pain in the nursing progress notes and the STAT orders. NP Progress Notes, dated 3/14/22 with a time stamp of 5:32 p.m., indicated the resident had her EKG that day. The resident continued to complain of chest pain and some shortness of breath (SOB). STAT EKG results were abnormal. Continued complaints of midsternal chest pain with occasional SOB. Discussed results with Physician. Sending resident out for further evaluation to determine if resident was having an active MI (heart attack). No abdominal pain or		requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F has been discharged from the facility. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents that have orders for Radiology/Other Diagnostic Services and STAT orders for these services have the potential to be affected by the alleged deficient. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurse managers and charge nurses have been re-inserviced on the verification of orders and carrying out new physician orders including laboratory orders, radiology orders, and other diagnostic orders. This includes STAT orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put in place;** DON/designee will audit/check all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 00 B. WING	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
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	fevers were noted per nursing report. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. Breath sounds clear but diminished to bilateral bases. The resident was sent out 911 on 3/14/22 at 4:00 p.m. and hospitalized. The STAT EKG and CXR weren't completed until 3/14/22. There was no documentation in the nursing progress notes related to the delay and no Physician or NP notification. . Interview with the Nurse Consultant on 4/14/22 at 5:30 p.m., indicated staff should have reached out to the diagnostic company to see why the EKG and CXR had not been completed STAT as ordered. She also indicated documentation of the delay should have been completed in the nursing progress notes. This Federal tag relates to Complaint IN00376606. 3.1-49(g)		new MATRIX orders each day to ensure new orders have been verified and carried out by pulling the MATRIX order report each day. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 5/6/2022**	