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	01/04/2022

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 a COVID-19 Focused Infection Control Survey. This visit included a Residential COVID-19 Quality Assurance Walk Through. Survey date: January 4, 2022 Facility number: 000125 Provider number: 155220 AIM number: 1002566740 Census Bed Type: SNF/NF: 121 Residential: 36 Total: 157 Census Payor Type: Medicare: 37 Medicaid: 62 Other: 22 Total: 121 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 1/11/22.	F 0000	The facility respectfully requests a desk review	
F 0880 SS=E Bldg. 00	483.80(a)(1)(2)(4)(e)(f) Infection Prevention & Control §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control			

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

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	program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin			

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	lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.			
	Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not wearing personal protective equipment (PPE) correctly when entering a transmission based precaution (TBP) isolation room, wearing soiled gloves in the hallway, multi-use resident equipment not being disinfected between use during random observations, and not monitoring residents who were in TBP for COVID-19 or suspected COVID-19 for 3 of 4 residents reviewed for infection control. This had the potential to affect 56 residents who resided on the East Unit. (Residents 2, 4, 3, and 6) Findings include: 1. During a random observation on the East Unit	F 0880	**Dyer Nursing and Rehab** **Survey: 1-4-2022** 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. **POC F-880 Infection Prevention & Control** **Corrective actions which will be accomplished for those**	01/14/2022

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	on 1/4/22 at 9:45 a.m., RA 1 was observed walking out of a room wearing soiled gloves in the hallway. She had just removed soiled linens from a bed. Interview at the time, indicated she was unaware she could not wear gloves in the hallway. Interview with the Nurse Consultant on 1/4/21 at 3:15 p.m., indicated the RA should not have worn gloves in the hallway. 2. During a random observation on the East Unit on 1/4/21 at 9:49 a.m. QMA 2 was observed donning PPE to enter Resident 6's room, who was in TBP . She donned the appropriate PPE and walked into the room with a wrist blood pressure cuff. After checking the resident's blood pressure, she walked out of the room and threw her gloves into the trash can on the side of the medication cart. She performed hand hygiene, however she did not remove her isolation gown. She reached into her shirt pocket and pulled out the keys to unlock the medication cart and touched the front of the dirty isolation gown. She pulled the medication cart close to her, so she was standing half inside the room and half in the hallway. The QMA prepared and poured the resident's medications. She placed all of the punch cards back into the drawer, performed hand hygiene, and donned a clean pair of gloves to both hands and walked back into the resident's room, still wearing the same isolation gown, and administered the medications. Interview with the Nurse Consultant on 1/4/21 at 3:15 p.m., indicated the QMA should have removed her gown after leaving the room initially. 3. During a random observation on the East Unit		**residents found to have been affected by the deficient practice:** QMA immediately re-educated on cleaning multi-use equipment in between each resident use. QMA was immediately re-educated related putting her arms in the arm holes of the isolation gown and securing the isolation gown appropriately. RA was immediately re-educated related to not wearing gloves in the hallway. QMA was immediately re-educated related to not wearing isolation gowns in the halls, removing the gown before exiting residents' room and the need to change the gown in between each resident use. Covid assessments were completed on Res 2,3,4,5,6. **How the facility will identify other residents having the potential to be affected by the same deficient practice:** All residents have the potential to be affected by the alleged deficient practice. **The measures the facility will take or systems the facility will**	

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	on 1/4/22 at 9:59 a.m., QMA 1 was observed donning PPE to enter Resident 4's room who was in TBP. She donned a blue isolation gown and placed the neck opening over head and tied the sleeves around her back, therefore, her arms were exposed. She walked into the resident's room with a multi-use blood pressure machine, pulse oximeter, and thermometer in the basket. She checked the resident's vital signs, including his temperature and oxygen saturation. She removed the gown and gloves inside the room and performed hand hygiene to both hands by using hand gel. She documented the vital signs on the paper on the outside of the door. The QMA removed a sanitizer wipe and cleaned the thermometer, however, she did not wipe down the blood pressure machine, cuff, cords, or pulse oximeter. At 10:13 a.m., QMA 1 was observed to prepare and pour medication for Resident 3 who resided in the next room. She donned PPE as the resident was in TBP. The QMA took the multi-use blood pressure machine into the resident's room and checked his vital signs, including temperature and oxygen saturation. She came out of the room at 10:20 a.m. and performed hand hygiene. She documented the vital signs on the paper on the outside of the room door. She opened up her medication book and signed out the medication and removed a sanitizer wipe and again wiped down the thermometer, however, she did not wipe down the blood pressure machine, cuff, cords, or pulse oximeter. Interview with QMA 1 on 1/4/22 at 10:30 a.m., indicated she wiped down the thermometer after each use, however, she did not wipe down the blood pressure cuff, pulse oximeter or the machine after each use and in between residents.		**alter to ensure that the problem will be corrected and will not recur:** Extended Care Clinical Nurse Consultant with Infection Preventionist Certification re-educated the facility Administrator, Director of Nursing and Assistant Director of Nursing related to cleaning multi-use equipment, DONNING/DOFFING PPE, not wearing PPE in the halls, when to DON/DOFF PPE, Changing PPE in between residents and the need for frequent COVID assessments. Staff re-educated related to the cleaning all multi-use equipment in between each resident use. Clinical staff re-educated related to how to properly DON isolation gowns. Clinical staff re-educated related to not wearing gowns and gloves in the halls and when and how to properly DOFF PPE. Clinical staff re-educated related to the need to change PPE in between residents. Clinical staff also re-educated on the need for daily COVID assessments on all residents. **Quality Assurance Plans to monitor facility performance to**	

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	Interview with the Nurse Consultant on 1/4/21 at 3:15 p.m., indicated the blood pressure machine was to be cleaned after every resident use. The current and revised 3/27/20 "High Touch Surface Cleaning and Disinfecting" policy provided by the Nurse Consultant, indicated routine and targeted cleaning of environmental surfaces as indicated by the level of resident contact and degree of soiling will be required. Medical equipment will be cleaned after every use. 4. The record for Resident 2 was reviewed on 1/4/22 at 1:30 p.m. The resident tested positive for COVID-19 on 12/30/21 and was moved to the red zone. A COVID-19 assessment which included resident symptoms, resident observed symptoms and an assessment of lung sounds was completed on 12/30/21 at 4:16 p.m., 12/31/21 at 12:48 p.m., 1/1/22 at 2:50 p.m., and 9:49 p.m., 1/2/22 at 5:50 a.m., and 12:18 p.m., 1/3/22 at 5:52 p.m., and 1/4/22 at 8:22 a.m. A respiratory assessment including lung sounds was documented in nursing progress notes on 1/3/22 at 1:50 p.m., and 11:57 p.m. A respiratory assessment had not been completed at least three times a day after the resident tested positive for COVID-19. 5. The record for Resident 4 was reviewed on 1/4/22 at 1:45 p.m. Nurses' Notes, dated 12/31/21 at 11:08 a.m., indicated the resident was incontinent with		**make sure that corrections are achieved and are permanent:** · A) The D.O.N. or designee, will conduct surveillance observation audits for 10 residents 3 times weekly to ensure improvement of infection control practices. · Administrator/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. **Dates when corrective action will be completed** Completion date: 1-14-22	

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	diarrhea. A rapid antigen test was performed and the resident tested negative for COVID-19. At 2:39 p.m., he was moved to a TBP isolation room due to having signs and symptoms of COVID-19. A COVID-19 assessment, dated 12/31/21 at 8:43 a.m., indicated the resident had diarrhea and his lung sounds were clear. This was the last documented COVID-19 assessment. Nurses' Notes, dated 1/1/22 at 9:53 p.m., indicated the resident was in no respiratory distress. This was the last documented entry in Nursing Progress Notes. There was no assessment completed at least three times a day of the resident's respiratory status. 6. The record for Resident 3 was reviewed on 1/4/22 at 1:55 p.m. Nurses' Notes, dated 12/31/21 at 10:49 a.m., the resident had a poor appetite for breakfast and complained of nausea. A rapid COVID test given and was negative. Nurses' Notes, dated 12/31/21 at 3:10 p.m., indicated the resident was transferred to a TBP isolation room due to having diarrhea times 3. The last documented COVID-19 assessment was dated 12/31/21 at 8:38 a.m., which indicated the resident had nausea and stomach discomfort and new confusion and his lung sounds were clear. There were no Nursing Progress Notes for 1/1, 1/2, or 1/3/22. The last documented Nurses' Note was on 1/4/22			

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	at 2:12 a.m., which indicated the resident was resting in bed with no distress noted. No voiced pain/discomfort. No hypo/hyperglycemia noted. Safety maintained, call light within reach. There was no assessment completed at three times a day of the resident's respiratory status. Interview with LPN 2 on 1/4/22 at 9:40 a.m., indicated there were 2 QMAs and herself working on the East Unit. When asked how she assessed and monitored the residents who were in TBP, she indicated she had a "Run" and the 2 QMAs had a "Run" to pass medications. She assessed all of her residents who were in TBP, however, the QMAs checked vital signs for their own residents in TBP on their "Run." Interview with the Nurse Consultant on 1/4/21 at 3:15 p.m., indicated the facility followed CDC guidance for monitoring COVID-19 positive and yellow zone TBP residents. The Indiana Department of Health current and updated 1/4/22 "Long-term Care COVID-19 Clinical Guidance" policy indicated, "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter. · Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection." 3.1-18(b)			
F 0886 SS=D	483.80 (h)(1)-(6) COVID-19 Testing-Residents & Staff			

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Bldg. 00	§483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and			

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	(ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results.			
	Based on record review and interview, the facility failed to conduct COVID-19 testing for staff per guidelines for 2 of 3 staff records reviewed. (CNA 1 and CNA 2) Findings include: The COVID-19 testing documentation was reviewed on 1/4/22 at 3:45 p.m. CNA 1, an unvaccinated employee, worked the week of 11/28/21 on 11/28, 11/30, 12/1 and 12/3/21. The CNA only had COVID-19 test results for	F 0886	**Dyer Nursing and Rehabilitation** **Survey: 1-4-2022** 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.	01/14/2022

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	12/2/21. CNA 2, an unvaccinated employee, worked on 12/1, 12/2, 12/6, 12/8-12/13, 12/15, 12/17, 12/18, 12/20, 12/22-12/27, 12/29/21 and 1/3/22. The CNA only had COVID-19 test results for 12/7, 12/9, 12/23/21 and 1/3/22. The Indiana Department of Health document, "Long-term Care COVID-19 Clinical Guidance", updated 1/4/22, testing table indicated when community COVID-19 activity was high, greater than 10% positivity rate, unvaccinated staff should be tested a minimum of two times weekly. Interview with the Administrator on 1/4/22 at 5:30 p.m., indicated any further testing results for the above employees were not available for review.		**POC F-886** **COVID-19 Testing Residents and Staff** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice;** · Staff are in compliance with the unvaccinated staff testing frequency guidelines based on the community transmission level. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what action will be taken;** All residents and staff have the potential to be affected by the same alleged deficient practice. The facility has identified all unvaccinated staff. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Extended Care Clinical Nurse Consultant with Infection Preventionist Certification re-educated the facility Administrator, Director of Nursing and the two Assistant Directors of Nursing regarding CMS and IDOH guidelines related to the frequency of testing for unvaccinated staff.	

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			Unvaccinated staff will complete COVID-19 testing based on the county transmission rate. The facility will ensure unvaccinated staff are tested. Staff that are unable to test on a scheduled testing day will be tested prior to working. Administrator/Designee will review the county transmission level twice weekly using the https://covid.cdc.gov/covid-data-tracker website and ensure the facility testing frequency is in compliance with the county transmission level. Administrator/Designee will be responsible for communicating the testing frequency to the staff responsible for COVID-19 testing/swabbing. **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;** Administrator/Designee will randomly audit 3 unvaccinated staff weekly for compliance with COVID testing frequency as per the transmission level. The Administrator/Designee will present a summary of audits to the Quality Assurance Committee	

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			monthly for 6 months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing. **Dates by which systemic corrections will be implemented: 1-14-22**	
R 0000 Bldg. 00	This visit was for a Residential COVID-19 Quality Assurance Walk Through. This visit included a Nursing Home COVID-19 Focused Infection Control Survey. Survey date: January 4, 2022 Facility number: 000125 Residential Census: 36 This State Residential Finding is cited in accordance with 410 IAC 16.2-5. Quality review completed on 1/11/22.	R 0000	The facility respectfully requests a desk review	
R 0407 Bldg. 00	410 IAC 16.2-5-12(b)(1-4) Infection Control - Noncompliance (b) The facility must establish an infection control program that includes the following: (1) A system that enables the facility to analyze patterns of known infectious			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	symptoms. (2) Provides orientation and in-service education on infection prevention and control, including universal precautions. (3) Offering health information to residents, including, but not limited to, infection transmission and immunizations. (4) Reporting communicable disease to public health authorities. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not monitoring residents daily for COVID-19 for 3 of 3 residents reviewed for infection control. (Residents 2, 3, and 4) Findings include: 1. The record for Resident 2 was reviewed on 1/4/22 at 1:30 p.m. Physician's Orders, dated 6/30/21, indicated "Monitor every shift for flu-like symptoms, For positive, flu like symptoms, immediately place resident in droplet isolation. Place a mask on the resident and ensure their door is closed. Post signage. Notify Clinical Management. Vital signs every shift, as needed nasal/nasopharyngeal swab." The 12/2021 and 1/1-1/4/22 Medication Administration Records (MAR) indicated the resident was not monitored at least daily for COVID-19 including temperature, vital signs and pulse oximeter. 2. The record for Resident 3 was reviewed on 1/4/22 at 2:00 p.m.	R 0407	**Dyer Nursing and Rehab** **Survey: 1-4-2022** 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. **POC R407 Infection Prevention & Control** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** Residents 2, 3, and 4 had no adverse effects related to not monitoring for COVID-19. **How the facility will identify other residents having the potential to be affected by the same deficient practice:**	01/14/2022

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	01/04/2022

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	Physician's Orders, dated 3/14/21, "Monitor every shift for flu-like symptoms, For positive, flu like symptoms, immediately place resident in droplet isolation. Place a mask on the resident and ensure their door is closed. Post signage. Notify Clinical Management. Vital signs every shift, as needed nasal/nasopharyngeal swab." Physician's Orders, dated 4/1/21 indicated vital signs every shift. The Medication Administration Record for 12/2021 and 1/2022 indicated the resident was not monitored at least daily for COVID-19 including temperature, vital signs and pulse oximeter. 3. The record for Resident 4 was reviewed on 1/4/33 at 2:30 p.m. Physician's Orders, dated 3/14/21, "Monitor every shift for flu-like symptoms, For positive, flu like symptoms, immediately place resident in droplet isolation. Place a mask on the resident and ensure their door is closed. Post signage. Notify Clinical Management. Vital signs every shift, as needed nasal/nasopharyngeal swab." Physician's Orders, dated 4/1/21 indicated vital signs every shift. The Medication Administration Record for 12/2021 and 1/2022 indicated the resident was not monitored at least daily for COVID-19 including temperature, vital signs and pulse oximeter. Interview with LPN 1 on 1/4/22 at 2:45 p.m., indicated the residents were not monitored at least daily for COVID-19. There were many blanks on the MARs for the assessments.		All residents have the potential to be affected by the alleged deficient practice. **The measures the facility will take or systems the facility will alter to ensure that the problem will be corrected and will not recur:** Nursing staff educated related to infection control guidelines, including daily COVID monitoring **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** · The DON/designee, will conduct audits of 3 residents weekly to ensure improvement of infection control practices. · Administrator/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. **Dates when corrective**	

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	The Indiana Department of Health document, "Long-term Care COVID-19 Clinical Guidance", policy updated 1/4/22, indicated "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximetry."		**action will be completed** Completion date: 1-14-22.	