

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/22/2016
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00191515.</p> <p>Complaint IN00191515- Substantiated. Federal/State deficiency related to the allegation is cited at F309.</p> <p>Survey date: February 22, 2016</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Census bed type: SNF/NF: 135 Residential: 47 Total: 182</p> <p>Census payor type: Medicare: 41 Medicaid: 60 Other: 34 Total: 135</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 26143 on</p>	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0309 SS=D Bldg. 00	<p>February 24, 2016.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide the necessary treatment and services to maintain the resident's highest practicable well being related to the administration of medication by a non Nursing staff member, failure to monitor the administration, and assess the physical status of the resident prior to and after the administration of the medication for 1 of 4 residents reviewed for medication administration in a sample of 4. (Resident #C)</p> <p>Finding includes:</p> <p>The closed record for Resident #C was reviewed on 2/22/16 at 9:50 a.m. The resident's diagnoses included, but were not limited to, fracture of the 2nd cervical</p>	F 0309	<p><b>Dyer Nursing and Rehabilitation</b></p> <p>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.</p> <p><b>F 309</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>R C is no longer at the facility. No corrective actions can be made.</p>	03/02/2016

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	<p>vertebra, obstructive pulmonary disease, heart failure, anemia, rheumatoid arthritis, and gout.</p> <p>Review of the 11/10/15 Minimum Data Set (MDS) significant change assessment indicated the resident's BIMS (Brief Interview for Mental Status)s score was (14). A score of (14) indicated the resident's cognitive patterns were intact. The assessment indicated the resident was dependent on two staff members for bed mobility, transfers, and personal hygiene. The assessment indicated the resident required extensive assistance of one staff member for eating. The assessment indicated the resident had experienced pain during the (7) day reference period and rated the intensity of the pain at a level of (6) on a pain scale of 1-10.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 11/14/15 indicated the resident had complaints of acute pain related to a cervical neck fracture. Care plan interventions included for Nursing staff to administer pain medications as ordered, evaluate, record, report the effectiveness of the medication, and any side effects of the medication. Nursing staff were also to monitor the resident for any non verbal signs of pain.</p>		<p><b>How the facility will identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken;</b></p> <p>All facilityresidents with PRN pain medication orders have the potential to be affected bythe same alleged deficient practice. TheDirector of Nursing met with L.P.N. #1 and the Social Service Director. A list of residents with PRN pain medicationswas compiled.</p> <p><b>What measures will be put into place orwhat systemic changes will be made to ensure that the deficient practice doesnot recur;</b></p> <p>Non-Licensed facilitystaff were in-serviced 3/2/16 on:</p> <ul style="list-style-type: none"> <li>·Neveraccept medication from a licensed nurse and administer it to a resident</li> </ul> <p>Licensed Nurseswere in-serviced 3/2/16 on:</p> <ul style="list-style-type: none"> <li>·Whoin the facility is authorized to administer medications</li> <li>·Monitoringmedication administration</li> <li>·Completinga physical assessment of the resident prior to and after the administration ofthe PRN pain medication</li> </ul>				

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	<p>The 11/2015 Medication Administration Record was reviewed. There was a Physician's order for the resident to receive acetaminophen (a medication for pain relief) two 325 milligram tablets every six hours as needed.</p> <p>Review of the 11/16/15 Nursing Progress Notes, Events notes, and Medication Notes indicated there was no record of the resident complaining of or having any signs or symptoms of pain. There were no assessments of the resident related to pain.</p> <p>A "Resident Grievance/Complaint Form" report filed by Resident #C's family member on 11/24/15 was reviewed. The form indicated an incident with medication administration occurred on 11/16/15. The form was completed by the Director of Nursing and indicated the resident's Daughter voiced concerns about the residents medications. The form indicated the Director of Nursing spoke with the Nurse named in the report on the above day. A "Corrective Action Note" was completed on 11/24/15. The form indicated a family member witnessed LPN #1 handing Resident #C's medication to a non nursing staff member and telling the staff member to give medication to Resident #C. The Note</p>		<ul style="list-style-type: none"> <li>·Followingthe plan of care interventions</li> <li>·Documentingthe residents' complaints and/or signs and symptoms related to pain</li> <li>·Documentationof the response of the PRN pain medication</li> </ul> <p><b>How the corrective action(s)will be monitored to ensure the deficient practice will not recur, i.e., whatquality assurance programs will be put into place;</b></p> <p>The DON / designee will monitor the administration of 5 PRN pain medicationadministrations on various shifts weekly to ensure that only licensed nursingstaff or Q.M.A.'s are administering the PRN pain medications.</p> <p>The DON / designee will monitor 10 PRN pain medication administrationrecords weekly to ensure that an assessment of the residents physical status iscompleted prior to and after the administration of the PRN pain medication.</p> <p>TheDON /designee will present a summary of the audits to the Quality Assurancecommittee monthly for six (6) months. Thereafter, if determined by the Quality Assurance committee, auditingand monitoring will be done quarterly</p>		

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	<p>indicated the above was against all Nursing policies and scope of practice. LPN #1 was suspended. A note dated 11/24/15 indicated the Director of Nursing met with LPN #1 on 11/24/15 at approximately 2:00 p.m. to discuss the incident which occurred on 11/16/15. The LPN indicated she had several isolation rooms on her side and she had to keep gowning up to go into isolation rooms. The Social Service Director was inside the resident's room and the LPN gave the Social Service Director the pill to administer to Resident #C.</p> <p>When interviewed on 2/22/16 at 11:17 a.m., the Director of Nursing indicated Resident #C's Daughter called to speak to her on 11/24/15 and voiced concerns about a medication pass which occurred on a prior date in November. A Grievance was written and investigated at that time. The LPN involved was working at this time and was called off the Unit and suspended at that time. The Director of Nursing indicated the LPN stated she had been caring for several residents in Isolation rooms and was gowning up back and forth between isolation rooms and also had a Family member requesting her, and was trying to help answer call lights. The LPN admitted she gave the Social Service Director the resident's medication to give</p>		<p>and present quarterly at the QAmeeting. Monitoring will be on going.</p> <p><b>Date by which systemic corrections willbe completed.</b> March 2, 2016</p>		

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	<p>to her.</p> <p>When interviewed on 2/22/16 at 11:38 a.m., the SSD (Social Service Director) indicated she was asked to give medicine to Resident #C . The SSD indicated she had been "gowned up" in isolation gear and was in the residents room with the resident and her Daughter. LPN #1 said "here" and gave her the medication in applesauce to give to the resident. The SSD indicated she did not request the Nurse let her give the resident the medication herself.</p> <p>When interviewed on 2/22/16 at 1:50 p.m., the Director of Nursing indicated she had spoke to LPN and verified rhea medication given the to SSD to administer was Tylenol. The Director of Nursing indicated Nurses were required to stay with residents while administering the medication and to assess the resident if pain medication were given and document the responses.</p> <p>The facility Pharmacy policies were reviewed. A policy titled "Medication Administration" was reviewed on 2/22/16 at 12:05 p.m. The policy had a date of 11/30/14. The Director of Nursing provided the policy and indicated the policy was current. The policy indicated medications were to be administered with</p>				

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	<p>good Nursing principle only Licensed Nursing medical professionals and Pharmacy personnel were to administer medications. The policy indicated the resident was to be observed after administration to ensure the dose was completely ingested.</p> <p>This Federal tag relates to Complaint IN00191515.</p> <p>3.1-37(a)</p>				