

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  07/28/2015
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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 IN00175035.</p> <p>Complaint IN00175035- Substantiated. Federal/State deficiencies related to the allegation are cited at F282 and F323.</p> <p>Survey dates: July 27 &amp; 28, 2015</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Census bed type: SNF/NF: 131 Residential: 46 Total: 177</p> <p>Census payor type: Medicare: 32 Medicaid: 62 Other: 37 Total: 131</p> <p>Sample: 11</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. 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.	

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 0282 SS=D Bldg. 00	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Care Plan interventions were followed related to padding not in place on wheel chair arms for 1 of 3 residents reviewed for the implementation of care plan interventions in a sample of 11. (Resident #G)</p> <p>Finding includes:</p> <p>On 7/28/15 at 7:17 a.m., CNA #1 and CNA #2 were observed providing care for Resident #G. The CNA's used the Hoyer lift ( a mechanical device) to transfer the resident into a wheel chair. No padding was in place on the right arm rest of the resident's wheel chair. The CNA's then transported the resident out of the room in the wheel chair with no padding on place on the right arm of the wheel chair.</p> <p>The yellow care card in the resident's room was reviewed with CNA#1 at this time. The card indicated both arm rests on the resident's wheel chair were to be</p>	F 0282	<p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. 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. <b>DYER NURSING &amp; REHABILITATION CENTER PLAN OF CORRECTION COMPLAINT SURVEY JULY 2015</b> 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-282</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Resident G right wheelchair arm padded. <b>How the facility will identify other residents having the potential</b></p>	08/07/2015			

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	<p>padded.</p> <p>The record for Resident #G was reviewed on 7/27/15 at 7:08 a.m. The resident's diagnoses included, but were not limited to, anemia, cardiomegaly (enlarged heart), diabetes, and congestive heart failure.</p> <p>Review of the 6/1/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (14). A score of (14) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of staff for transfers and personal hygiene.</p> <p>A Care Plan initiated on 3/2/15 indicated the resident was at risk for impaired skin integrity, bruising, and skin tears related to laboratory draws and the use of aspirin. The Care Plan was last updated with a revised target goal date of 10/16/15. Care Plan approaches included, but were not limited to, left elbow pad, and pads in place on bilateral arm rests. These approaches were initiated on 4/14/15.</p> <p>When interviewed on 7/27/15 at 8:30 a.m., the Nurse Consultant indicated</p>		<p><b>to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. At minimum 20 residents care plans will be reviewed per week for current and appropriate interventions until completion of resident roster. A modification will be completed for any inaccuracies. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 8/7/15 by Director of Nursing/designee regarding the following: 1. Upon the start of the shift, staff members should observe each resident assigned to their run and review the care card to ensure all coded interventions are in place and working properly. 2. If any intervention is not in place, notify nursing/restorative or the appropriate staff member to obtain the necessary intervention(s). Emergency boxes with extra interventions, batteries, etc. are located in the medication room on each unit. 3. If you observe any items on the care card that are not current or have changed as notify nursing as soon as possible so the appropriate corrections can be made to the care card. 4. After caring for a resident, prior to leaving, ensure all necessary</p>		

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F 0323 SS=D Bldg. 00	padding was to be in place on the residents right and left wheel chair arms.  This Federal tag relates to Complaint IN00175035.  3.1-35(g)(2)  483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to provide adequate supervision related to fall and safety interventions not in place for 1 of 3	F 0323	interventions are in place. <b>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;</b> Director of Nursing/designee will audit 10 residents on each unit weekly, and observe that interventions coded on the care card related to bruising are in place. Any interventions observed not in place, will be corrected immediately by nursing staff. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for six 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. <b>Date by which systemic corrections will be completed: August 7, 2015</b>  Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible	08/07/2015	

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	<p>residents reviewed for falls in a sample of 11. (Resident # G)</p> <p>Finding includes:</p> <p>On 7/27/15 at 4:20 a.m., 4:50 a.m., 5:40 a.m., 6:12 a.m., and 6:40 a.m., Resident #G was observed asleep in bed. There was a mat on the floor. No bed alarm was in place. The resident's call light cord was draped across the foot of the bed. The call button was dangling over the foot of the bed and not in the resident's reach.</p> <p>On 7/28/15 at 7:17 a.m., CNA #1 and CNA #2 were observed providing care for Resident #G. The CNA's used the Hoyer lift ( a mechanical device) to transfer the resident into a wheel chair. There was no alarm attached to the bed. The CNA's removed the linens and blankets from the bed and no bed alarm was observed in the bed or on the bed frame.</p> <p>The yellow care card in the residents room was reviewed with CNA#1 at this time. The card indicated the resident was to have a bed alarm in place. The CNA indicated the resident did not have a bed alarm in place as listed on her care card.</p> <p>The record for Resident #G was reviewed</p>		<p>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. <b>DYER NURSING &amp; REHABILITATION CENTER PLAN OF CORRECTION COMPLAINT SURVEY JULY 2015</b> 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-323</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b> Resident G bed alarm put in place and call light was placed in reach. Bed alarm was checked for proper function. <b>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;</b> All facility residents requiring alarms have the potential to be affected by the same alleged deficient practice. Residents fall care plans were reviewed for current and appropriate interventions and then compared to the care cards in the room for</p>				

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	<p>on 7/27/15 at 7:08 a.m. The resident's diagnoses included, but were not limited to, anemia, cardiomegaly (enlarged heart), diabetes, and congestive heart failure.</p> <p>Review of the 6/1/15 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (14). A score of (14) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of staff for transfers and personal hygiene.</p> <p>A 6/18/15 Fall Risk Observation note indicated the resident's score was (21). A score of (21) indicated the resident was at high risk for falls.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 3/3/15 indicated the resident was at risk for falling related to muscle weakness, difficulty walking, osteoporosis, and a stroke. The Care Plan was last revised with a target goal date of 10/16/15. Care plan approaches included, but were not limited to, bed alarm in place, wheel chair alarm, and to keep personal and frequently used items within in reach.</p>		<p>accuracy. Any differences observed between the care card and the card plan were immediately corrected. <b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b> In-service held on 8/7/15 by Director of Nursing/designee regarding the following: 1. Upon the start of the shift, staff members should observe each resident assigned to their run and review the care card to ensure all coded interventions are in place and working properly. 2. If any intervention is not in place, notify nursing/restorative or the appropriate staff member to obtain the necessary intervention(s). Emergency boxes with extra interventions, batteries, etc. are located in the medication room on each unit. 3. If you observe any items on the care card that are not current or have changed as notify nursing administration as soon as possible so the appropriate corrections can be made to the care card. 4. After caring for a resident, prior to leaving, ensure all necessary interventions are in place. <b>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;</b> Director of Nursing/designee will audit 10 residents on each unit weekly,</p>	

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	<p>A Fall Event note was completed on 6/18/15 at 6:40 a.m. This note indicated the resident slid out of bed onto her left side. The note also indicated the resident was in bed prior to the fall. The note indicated the resident complained of tenderness to her extremities and head/neck areas. A Progress Note completed by Nursing staff at 6:40 a.m., indicated the resident was observed lying on her left side with her left arm hyperextended behind her back. The resident was crying. An entry made at 6:50 a.m. indicated the resident was transported to the hospital by ambulance.</p> <p>A Fall Event note was completed on 7/14/15 at 10:20 p.m. This note indicated the resident was observed lying on her left side on the floor with her left arm underneath her. The note also indicated the resident was lying in bed prior to the fall. A Full Body Observation note was also completed with the Fall Event note. The Full Body Observation note indicated the resident complained of her head hurting and laceration was noted to the bridge of her nose.</p> <p>When interviewed on 7/28/15 at 8:10 a.m., the Director of Nursing indicated the resident's care plan interventions should have been in place.</p>		<p>and observe that interventions coded on the care card related to falls are in place. Any interventions observed not in place, will be corrected immediately by nursing staff. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for six 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. <b>Date by which systemic corrections will be completed: August 7, 2015</b></p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/19/2015

FORM APPROVED

OMB NO. 0938-0391

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