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	09/02/2021

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

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F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included a State Residential Licensure Survey. Survey dates: August 25, 26, 27, 30, 31, and September 1 and 2, 2021 Facility number: 000125 Provider number: 155220 AIM number: 1002566740 Census Bed Type: SNF/NF: 118 Residential: 39 Total: 157 Census Payor Type: Medicare: 38 Medicaid: 55 Other: 25 Total: 118 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/13/21.	F 0000	Please accept the following as the facility's plan of correction. 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. The facility would like to request a desk review.	
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each			

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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	resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.			
	Based on observation, record review and interview, the facility failed to ensure each resident's dignity was maintained related to hospital gowns being used during the day while in bed for 1 of 5 residents reviewed for dignity. (Resident 205)	F 0550	**Dyer Nursing and Rehab Annual Survey:** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	09/13/2021

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	Finding includes: On 8/25/21 at 3:00 p.m., Resident 205 was observed in bed wearing a hospital gown. On 8/26/21 at 10:51 a.m., the resident was observed in bed wearing a hospital gown. On 8/27/21 at 9:30 a.m., 11:00 a.m., 1:30 p.m., and 3:09 p.m., the resident was observed in bed wearing a hospital gown. On 8/30/21 at 9:33 a.m., and 11:36 a.m., the resident was observed in bed wearing a hospital gown. On 8/31/21 at 2:56 p.m., the resident was observed in bed wearing a hospital gown. On 9/1/121 at 9:58 a.m., the resident was observed in bed wearing a hospital gown. The record for Resident was reviewed on 8/27/21 at 9:43 a.m. The resident was admitted on 8/3/21. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, osteoarthritis, high blood pressure, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 8/9/21, indicated the resident was moderately impaired for decision making. It was very important for her to choose what clothes to wear. The resident was totally dependent with 1 staff physical help for dressing. There was no Care Plan the resident preferred to be dressed in a hospital gown. Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated there was no Care		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F550 Respect, Dignity/Right to have Personal Property** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident preferences were reviewed with focus on residents in bed in hospital gowns and updated for Resident 205. **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;** Clinical and non-clinical staff were re-educated on ensuring that all residents that want to dress in clothes other than hospital gowns daily will be assisted to dress in those clothes. **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**	

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	Plan the resident preferred to be dressed in a hospital gown. 3.1-3(t)		**into place;** SSD/Designee will audit all residents for preferences of how they choose to dress daily. 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. **Date by which systemic corrections will be completed: 9/13/21**	
F 0636 SS=A Bldg. 00	483.20(b)(1)(2)(i)(iii) Comprehensive Assessments & Timing §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns.			

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	(iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for			

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	hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. Based on record review and interview, the facility failed to ensure the Admission Minimum Data Set (MDS) assessments were completed timely within 14 days of admission for 2 of 26 residents whose MDS assessments were reviewed. (Residents 208 and 260) Findings include: 1. The record for Resident 208 was reviewed on 8/27/21 at 10:25 a.m. The resident was admitted to the facility on 7/30/21. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated it was still in process and not completed. Interview with MDS Coordinator 1 on 8/27/21 at 11:45 a.m., indicated the MDS was not completed within 14 days of admission.2. Resident 260's record was reviewed on 8/27/21 at 3:02 p.m. The Admission MDS (Minimum Data Set) assessment, dated 8/17/21, indicated it was still in progress. The resident was admitted to the facility on 8/11/21. Interview with the Administrator on 8/31/21 at 11:18 a.m., indicated the assessment had not been completed timely. 3.1-31(d)	F 0636	**Dyer Nursing and Rehab Annual Survey:** 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. **F636 Comprehensive assessments and timing** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** MDS for resident 260 and 208 submitted. **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;** MDS staff were re-educated on ensuring the MDS is submitted in a timely manner. **How the corrective action(s)**	09/13/2021

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			will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; MDS/designee will audit 10 scheduled MDS's weekly including all types of MDS Assessments to ensure the timely submission of the MDS for all areas. Any non-compliance will be corrected. Auditors will not audit their own work. MDS/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: 9/13/21**	
F 0657 SS=E Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident.			

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	(C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.			
	Based on record review and interview, the facility failed to provide documentation of care conferences held with the resident and facility staff for 3 of 7 residents reviewed for care planning decisions. (Residents 4, 37, and 3) The facility also failed to ensure Care Plans were revised as needed related to medication use for 1 of 26 Care Plans reviewed. (Resident 22) Findings include: 1. Interview with Resident 4 on 8/26/21 at 12:08 p.m., indicated she did not recall being invited to a care conference. The record for Resident 4 was reviewed on 8/26/21 at 2:42 p.m. Diagnoses included, but were not limited to, fracture of right humerus, osteoarthritis, osteoporosis, and dementia without behavior disturbance.	F 0657	**Dyer Nursing and Rehab Annual Survey:** 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. **F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Care plans were immediately updated for Resident 22. Care conferences invitations were	09/13/2021

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	The Annual Minimum Data Set (MDS) assessment, dated 8/10/21, indicated the resident was moderately impaired for daily decision making and she participated in her assessment. A Care Conference note, dated 5/25/21, indicated the writer spoke with the family for a scheduled Care Plan meeting to discuss the plan of care via phone. The writer went over current medications, nursing concerns, overall health updates, dietary updates were discussed, and food consumption. The writer also went over current wound status. Care Plan and interventions were reviewed. The family had no concerns at that time. A Care Conference was scheduled for 8/6/21. There was no documentation indicating the Care Conference had been held. There was also no documentation indicating the resident had been invited to her 5/25/21 Care Conference. Interview with the Administrator on 8/30/21 at 3:00 p.m., indicated documentation should have been completed related to the resident being invited to her Care Plan meeting. 2. The record for Resident 22 was reviewed on 8/30/21 at 1:41 p.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, major depressive disorder, dementia with behavior disturbance, anxiety and thrombocytopenia (low platelet count). The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/21, indicated the resident was cognitively impaired for daily decision making.		sent for Residents 4, 37, and 3 this includes invitations to both the resident and responsible party. **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 this 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;** Staff responsible for reviewing and revising care plans based on resident's assessments have been re-educated on updating care plans timely. Staff responsible for hosting care plan conferences were re-educated on ensuring the resident, responsible party, and members of the IDT are involved/invited to the care conferences. Care conference attendees should be documented accordingly. **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;** Nurse manager/designee will conduct weekly audits of care plans for 10 different residents	

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	A Physician's Order, dated 4/13/21, indicated the resident was to receive Seroquel (an antipsychotic medication) 25 milligrams (mg) twice a day. On 5/11/21, the Seroquel was increased to three times a day. On 5/26/21, the Seroquel was discontinued. A Physician's Order, dated 4/14/21, indicated the resident was to receive Clonazepam (an anti-anxiety medication) 1 mg at bedtime as needed (prn). The medication was discontinued on 4/27/21. A Care Plan, dated 4/14/21, indicated the resident received an anti-anxiety medication. A Care Plan, dated 4/14/21, indicated the resident was at risk for adverse consequences related to receiving an antipsychotic medication. Interview with the Director of Nursing on 9/1/21 at 2:40 p.m., indicated the resident's Care Plan needed to be updated related to the anti-anxiety and antipsychotic medications. 3. During an interview on 8/26/21 at 10:41 a.m., Resident 37 indicated he had not been invited or attended a Care Conference. The record for Resident 37 was reviewed on 8/27/21 at 1:40 p.m. Diagnoses included, but were not limited to, paraplegia, contracture of left and right lower legs, heart failure, schizophrenia, chronic kidney disease, stage 4, high blood pressure, and depressive episodes. The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/21, indicated the resident was alert and oriented. The resident was totally dependent on staff with 1 person physical assist for personal hygiene.		each week to ensure care plans are reviewed and revised based on resident assessments. The Social Service Director/designee will audit care conference's weekly to ensure resident, responsible party, and members of the IDT attendance is documented. The DON/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: 9/13/21**	

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The last documented Care Conference was on 6/10/21, and only the MDS Coordinator attended. The Care Conference note, indicated "Writer spoke with family (name) for scheduled care plan meeting to discuss the plan of care. Writer went over current medication, nursing concerns, went over weight, food consumption, diet, wound updates, and current health conditions."

There was no documentation the resident was invited or attended.

Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated there should have been documentation the resident was invited to attend the care conference.4. Interview with Resident 3 on 8/26/21 at 10:31 a.m., indicated she had not been invited to any Care Plan Conferences.

The record for Resident 3 was reviewed on 8/30/21 at 11:26 a.m. Diagnoses included, but were not limited to, anxiety disorder, hypertension, and type 2 diabetes mellitus.

The Quarterly Minimum Data Set (MDS) assessment, dated 8/9/21, indicated the resident was cognitively intact.

The Care Conference records, dated 2/17/21 and 5/25/21, indicated Care Plan meetings had been completed with the resident's family. There was lack of documentation indicating the resident had been invited to her care conferences.

Interview with the Administrator on 8/30/21 at 4:10 p.m., indicated she would look for documentation that the resident had been invited to her Care Plan meeting. She felt the family preferred having the

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	meetings without the resident present. 3.1-35(d)(2)(B)			
F 0676 SS=D Bldg. 00	483.24(a)(1)(b)(1)-(5)(i)-(iii) Activities Daily Living (ADLs)/Mntn Abilities §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,			

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	§483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. Based on observation, record review and interview, the facility failed to ensure a resident who needed limited assistance with meals was provided assistance for 1 of 9 residents reviewed for activities of daily living (ADL's). (Resident 57) Finding includes: On 8/26/21 at 12:15 p.m., Resident 57 was observed in her room in bed. Her lunch tray was on the over bed table on the other side of her room. The tray was covered and no set up had been provided. On 8/27/21 at 12:07 p.m., the resident was in her room in her bed eating lunch. The resident was served a pureed diet. A plate guard was on her tray and not positioned around the plate. Her beverages had not been opened and neither had the resident's frozen treat. The resident was attempting to feed herself. There was a styrofoam cup on her tray that had been knocked over and water was on the over bed table as well as the tray. On 8/30/21 at 4:55 p.m., the resident was in her room in bed eating dinner. The resident was slouched down in her bed and she was trying to feed herself. There was food spilled on her tray and there was food spillage on the front of the resident's gown. Her ice cream was also knocked over and her plate guard was on her tray and not around the plate. The record for Resident 57 was reviewed on 8/26/21 at 2:55 p.m. Diagnoses included, but were	F 0676	**Dyer Nursing and Rehab Annual Survey:** 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. **F676 Activities of Daily Living (ADLs)/Maintain Abilities** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 57 was assisted with meals. **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 requiring limited assistance 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;** Staff were re-educated on	09/13/2021

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	not limited to, dementia without behavior disturbance and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 7/12/21, indicated the resident was cognitively impaired for daily decision making and required limited assistance with eating. The resident had a 5% weight loss in the last month or a loss of 10% or more in the last 6 months. She received a mechanically altered diet. A Care Plan, dated 7/8/21, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, assure resident was in good body alignment while eating/drinking and provide assistance at the level the resident required. A Physician's Order, dated 7/22/21, indicated the resident was to receive a pureed diet with honey thick liquids. Frozen nutritional treat at all meals, super cereal at breakfast and a plate guard at all meals. Interview with the Director of Nursing on 9/1/21 at 2:39 p.m., indicated the plate guard should have been in use and the resident assisted with her meal. 3.1-38(a)(2)(A)		providing residents with assistance with ADLs per resident's plan of care including assistance with meals. **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;** Facility Guardian Angels will Audit 15 residents 3 times weekly with a focus on resident's requiring ADL assistance to ensure assistance with meals are provided per plan of care. 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: 9/13/21**	
F 0677 SS=E Bldg. 00	483.24(a)(2) ADL Care Provided for Dependent Residents §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene;			

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	Based on observation, record review and interview, the facility failed to ensure dependent residents received assistance with ADL's (activities of daily living) related to hair washing, shaving, nail care, and bathing for 5 of 9 residents reviewed for ADL's. (Residents 77, 37, 206, 27, and 259) Findings include: 1. On 8/26/21 at 1:25 p.m., Resident 77's hair was disheveled and greasy in appearance. On 9/1/21 at 2:25 p.m., the resident's hair remained disheveled and greasy in appearance. She indicated her hair was in "bad shape" and her daughter had come out once to wash her hair. She also indicated staff had offered once to help her wash her hair. The record for Resident 77 was reviewed on 8/27/21 at 11:39 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, anxiety, and type 2 diabetes. The resident was admitted to the facility on 7/28/21. The Admission Minimum Data Set (MDS) assessment, dated 8/3/21, indicated the resident was cognitively intact and she required extensive assistance with personal hygiene and total assistance with bathing. She had received a partial bed bath on 7/30, 8/1, 8/2, 8/11, 8/22, 8/23, 8/25, and 8/26/21. The August 2021 shower sheet, indicated the resident's shower days were Tuesday and Friday. A skin assessment was documented on 8/27/21, however, there was no documentation to indicate if the resident had received a shower or a	F 0677	**Dyer Nursing and Rehab Annual Survey:** 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. **F677 ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R77 was assisted with washing her hair. R37 was assisted with shaving and nails were trimmed and cleaned. R206 was given a bath. R27 nails were trimmed. R259 facial hair was trimmed and shaved. **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 dependent 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**	09/13/2021

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	shampoo. Interview with the East Unit Manager on 9/1/21 at 2:30 p.m., indicated the resident would be assisted with getting her hair washed. 2. During an interview with Resident 37 on 8/26/21 at 10:43 a.m., indicated he likes a "clean shave." He indicated his nails were long and dirty and wanted them cleaned as well. On 8/27/21 at 9:33 a.m., 11:09 a.m., 1:30 p.m., and 3:04 p.m., the resident was observed in bed. At those times he was unshaven and his nails were long and dirty. On 8/30/21 at 9:34 a.m., the resident was observed in bed, and remained unshaven with long dirty fingernails. The record for Resident 37 was reviewed on 8/27/21 at 1:40 p.m. Diagnoses included, but were not limited to, paraplegia, contracture of left and right lower legs, heart failure, schizophrenia, chronic kidney disease, stage 4, high blood pressure, and depressive episodes. The Quarterly Minimum Data Set (MDS) assessment, dated 6/23/21, indicated the resident was alert and oriented. The resident was totally dependent on staff with 1 person physical assist for personal hygiene There was no Care Plan for personal hygiene. Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated the resident was to be offered to be shaved and have his nails cleaned and/or trimmed on shower days. 3. During an interview on 8/25/21 at 3:17 p.m.,		**ensure that the deficient practice does not recur;** Staff were re-educated on providing residents with assistance with ADLs per resident's plan of care including showers, bed baths, hair washing, shaving, and nail care. **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;** Facility Angels will Audit 15 residents 3 times weekly with a focus on dependent resident's requiring ADL assistance to ensure showers including hair washing, bed baths, nail care, shaving, and assistance with all ADLs are provided per plan of care. 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: 9/13/21**	

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with Resident 206's granddaughter, she indicated the family had been in visiting the last 2 days and the resident had been full of bowel movement and it had been dried on the sheet. She indicated she did not think he had been bathed.

The record for Resident 206 was reviewed on 8/30/21 at 10:40 a.m. The resident was admitted to the facility on 8/20/21. Diagnoses included, but were not limited to, osteomyelitis, pressure ulcer of sacral region, stage 4, high blood pressure, peripheral vascular disease, weakness, type 2 diabetes mellitus, and congestive heart failure.

The Admission Minimum Data Set (MDS) assessment, dated 8/26/21, was in process.

An initial Baseline Care Plan was completed on 8/20/21 and indicated the resident was dependent on toileting, bathing and personal hygiene.

The bath sheets indicated the resident had only 1 complete bed bath on 8/31/21.

Interview with the East Wing Unit Manager on 9/2/21 at 2:30 p.m., indicated the resident only had 1 bed bath since admission.4. On 8/25/21 at 11:23 a.m., Resident 27 was observed lying in bed. Her fingernails were long.

On 8/27/21 at 11:15 a.m., the resident was observed lying in bed. Her fingernails were long. She indicated she felt her nails were long and needed to be trimmed.

The resident's record was reviewed on 8/27/21 at 2:08 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, hypertension, and hypothyroidism.

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The Quarterly Minimum Data Set (MDS) assessment, dated 6/2/21, indicated the resident was moderately cognitively impaired. She required an extensive assist of one with personal hygiene and was totally dependent on staff for bathing.

The Bath and Skin Report sheet indicated the resident was to receive bathing on Tuesdays and Fridays. The bathing had been signed off as completed on 8/24/21, 8/20/21, 8/17/21, and 8/13/21 and indicated the resident's nails had not been trimmed.

Interview with the Administrator on 8/31/21 at 11:18 a.m., indicated the resident's nails would be trimmed.

5. On 8/26/21 at 9:36 a.m., Resident 259 was observed lying in bed. She was unshaven with white facial hair on her chin. She indicated she preferred to have the facial hair removed.

On 8/27/21 at 10:01 a.m., the resident was observed lying in bed. She was unshaven with white facial hair on her chin.

On 8/27/21 at 1:58 p.m., the resident was observed lying in bed. She was unshaven with white facial hair on her chin.

The resident's record was reviewed on 8/30/21 at 12:20 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, hypertension, and anxiety disorder.

The Admission Minimum Data Set (MDS) assessment, dated 8/10/21, indicated the resident was cognitively intact. She was totally dependent on staff for personal hygiene and bathing.

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	The Bath and Skin Report sheet indicated the resident was to receive bathing on Tuesdays and Fridays. The bathing had been signed off as completed and the resident had been shaved on 8/27/21, 8/24/21, and 8/20/21. Interview with the Administrator on 8/31/21 at 11:18 a.m., indicated the resident's facial hair would be taken care of. 3.1-38(a)(3)(B) 3.1-38(a)(3)(D) 3.1-38(a)(3)(E)			
F 0679 SS=D Bldg. 00	483.24(c)(1) Activities Meet Interest/Needs Each Resident §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.			
	Based on observation, record review and interview, the facility failed to ensure an ongoing activity program was implemented for a room bound dependent resident for 1 of 2 residents reviewed for activities. (Resident 63) Finding includes: On 08/25/21 10:34 a.m., Resident 63 was observed in bed with her eyes open. There was no television or radio on in the room.	F 0679	**Dyer Nursing and Rehab Annual Survey:** 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.	09/13/2021

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	On 8/26/21 at 10:57 a.m., the resident was observed in bed with her eyes open. There was no television or radio on in the room. On 8/27/21 at 9:25 a.m., 11:07 a.m., and 1:26 p.m., the resident was observed in bed with her eyes open. There was no television or radio on in the room. On 8/30/21 at 9:37 a.m., 11:10 a.m., and 11:24 a.m., the resident was observed in bed with her eyes open. There was no television or radio on in the room. On 8/31/21 at 9:34 a.m., and 3:00 p.m., the resident was observed in bed with her eyes closed. There was no television or radio on in the room. On 9/1/21 at 9:55 a.m., the resident was observed in bed with her eyes open. There was no television or radio on in the room. The record for Resident 63 was reviewed on 8/27/21 at 2:25 p.m. Diagnoses included, but were not limited to, Parkinson's disease, congestive heart failure, depressive disorder, cognitive communication deficit, high blood pressure, osteoarthritis of right knee, dementia with behavioral disturbance, Alzheimer's disease, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 7/16/21, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility. She has an unstageable and/or deep tissue injury pressure sore.		**F 679 Activities Meets Interest/Needs of each resident** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Activity staff reviewed the care plan and implemented 1:1 visits and sensory stimulation per resident's preferences. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all dependent facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Activity staff educated on 1:1 visits and activities for dependent residents based on the residents preferences. **What quality assurance plans**	

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	The Care Plan, updated 8/23/21, indicated the resident was alert with some confusion. The resident has Alzheimer's disease and dementia. She preferred privacy/independent leisure in her room. She likes resting, reading and watching Fox News/TV. She likes animals/cats and socials, such as ice cream social/pop and corn social. The approaches were to have staff offer weekly pop-in-visits for sensory stimulation and social support and staff will provide settings in which activities were preferred. The Annual Activity assessment, dated 8/23/21, indicated the most common use of the resident's time was television. Movies and television were her current interests. An Activity Progress Note, dated 8/23/21 at 3:56 p.m., indicated the resident preferred privacy and independent leisure in her room. The resident liked watching news programs on television . Interview with the East Unit Manager on 9/1/21 at 10:30 a.m., indicated the resident chooses to stay in bed. Interview with the Activity Director on 9/1/21 at 10:55 a.m., indicated they have 1 staff member to do 1 to 1 visits throughout the entire facility. The resident was not on 1 to 1 visits at this time, she "pops in" from time to time to see how she is doing. The resident does like to watch television. 3.1-33(a)		**will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Activities Director/designee will audit 5 dependent residents visit documentation weekly to ensure they are involved in activities of their preference. 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. **Date by which systemic corrections will be completed: 9/13/21**	
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			

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	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 assess and monitor areas of bruising for 1 of 2 residents reviewed for skin conditions (non-pressure related). (Resident 22) Finding includes: On 8/25/21 at 2:35 p.m., Resident 22 was observed with multiple areas of reddish/purple discoloration to his right forearm and the top of his right hand. On 8/26/21 at 10:29 a.m., the discoloration remained to the resident's right forearm and hand. On 8/27/21 at 10:34 a.m. and 1:34 p.m., the discoloration remained to the resident's right forearm and hand. On 8/30/21 at 12:05 p.m., 1:25 p.m., and 4:54 p.m., the discoloration remained to the resident's right forearm and hand. On 9/2/21 at 1:10 p.m., the resident's right hand was observed with the West Unit Manager. The resident had reddish/purple discoloration to the top of his right hand. The resident was wearing a long sleeve jacket and she indicated she would check the resident's right forearm as well. At that time, the Unit Manager indicated when bruising was noted, nursing as well as herself were to be notified and the area monitored until healed.	F 0684	**Dyer Nursing and Rehab Annual Survey:** 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. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 22- The bruises to the right forearm and right hand were assessed and new orders were received to monitor bruises. **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**	09/13/2021

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	The record for Resident 22 was reviewed on 8/30/21 at 1:41 p.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, major depressive disorder, dementia with behavior disturbance, anxiety and thrombocytopenia (low platelet count). The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/21, indicated the resident was cognitively impaired for daily decision making. He required extensive assistance with bed mobility and transfers. The August 2021 Physician's Order Summary (POS), indicated the resident was to receive Aspirin 81 milligrams (mg) daily and Prednisone (a steroid) 10 mg daily. There was no order to monitor the bruising to the right hand and forearm until it was healed. Interview with the Director of Nursing on 9/1/21 at 2:39 p.m., indicated the bruising should be monitored until healed. Nurses' Notes, dated 9/1/21 at 4:47 p.m., indicated the resident had 2 bruises to the back of his right hand that were reddish/blue in color and measured 2 centimeters (cm) x 2 cm and 3 cm x 3 cm. There was no documentation related to the bruising on his right forearm. 3.1-37(a)		**practice does not recur;** Nurses were re-educated on addressing and assessing changes in skin condition, obtaining orders for treatment, implementation of treatment, treatments and interventions are in place per physician orders and/or re-applied if missing. Assistive clinical staff were educated on notifying the nurse of any change in skin condition **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;** Facility Angels/ designee will complete observation rounds on 15 residents 3 times per week to ensure areas of bruising have been assessed and new physician orders are in place. 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: 9/13/21**	
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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Bldg. 00	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 promote healing, prevent infection and prevent new ulcers from developing.			
	Based on observation, record review and interview, the facility failed to ensure each resident received the necessary treatment and services to promote healing for pressure ulcers related to completing treatments and the administration of intravenous (IV) antibiotics for a wound infection as ordered for 3 of 3 residents reviewed for pressure ulcers. (Residents 63, 206, and 102) Findings include: 1. On 9/1/21 at 2:30 p.m., the East Wing Unit Manager performed a skin assessment for Resident 63. The resident was observed with a pressure sore to the right heel. The area was black and scabbed over. There was no bandage on the area. The record for Resident 63 was reviewed on 8/27/21 at 2:25 p.m. Diagnoses included, but were not limited to, Parkinson's disease, congestive heart failure, depressive disorder, cognitive communication deficit, high blood pressure,	F 0686	**Dyer Nursing and Rehab Annual Survey:** 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. **F686 Treatment/Services to Prevent/Heal Pressure Ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The treatment for R63 was completed. R206 continues to be on antibiotics for wound infection and receives daily treatments to the sacral wound. The nurses	09/13/2021

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	osteoarthritis of right knee, dementia with behavioral disturbance, Alzheimer's disease, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 7/16/21, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility. She has an unstageable and/or deep tissue injury pressure sore. The Care Plan, dated 7/19/21, indicated the resident has a pressure ulcer to the right heel. Nurses' Notes, dated 7/13/21 at 1:31 p.m., indicated the resident had a pressure ulcer to the right heel. The area measured 2 centimeters (cm) by 1.2 cm. New orders were obtained. Physician's Orders, dated 7/16/21, indicated right heel-cleanse with normal saline, apply dry dressing every Monday, Wednesday, and Friday (MWF), prn if soiled or loose. Physician's Orders, dated 7/27/21, indicated right heel-cleanse with normal saline, pat dry wipe with skin prep and leave open to air daily for 30 days. Physician's Orders, dated 8/12/21, indicated right heel-cleanse wound with normal saline or wound cleanser. Pat peri wound dry and apply skin prep to peri wound and apply collagen sheet to wound bed M-W-F, cover with a dry padded foam border gauze. The Treatment Administration Record (TAR), for the month of 7/2021 indicated the 7/16/21 order for the right heel was not signed out as being completed on 7/23 and 7/26/21.		responsible for R206 were re-educated regarding signing out IV medications timely. The treatments for R102 are being completed as ordered. The treatment/wound nurse was re-educated on ensuring that all wound treatments and documentation is completed timely. **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 wounds 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;** Clinical Staff were re-educated on ensuring all treatment and IV antibiotics for wounds are being documented on timely. **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;** Nurse managers will randomly audit 5 residents with wounds twice a week to ensure that the treatment and IV antibiotic documentation is being done timely.	

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	There was no TAR for the treatment dated 7/27/21 for the right heel. There was no documentation the treatment had been completed. There was no TAR for the treatment dated 8/12/21 for the right heel. There was no documentation the treatment had been completed. The wound care documentation indicated the right heel pressure ulcer was an acquired deep tissue injury on 7/16/21. The ulcer measured 2.5 cm by 3 cm. and was closed. A measurement on 7/20/21, indicated the wound measured 3 cm by 3 cm and was closed. A measurement on 7/27/21, indicated the wound measured 1.7 cm by 2 cm and had 100% of granulation tissue. The wound measured 1.4 cm by .7 cm on 8/2/21. On 8/9/21, the wound measured 1.3 cm by .6 cm and had 90% of necrotic tissue. The area was still classified as a deep tissue injury. On 8/16/21, the wound measured 1.3 cm by .5 cm and had 10% granulation tissue and 90% necrotic tissue. The area was opened and classified as a Stage 3 pressure ulcer. The last documented wound measurement was on 8/30/21. The ulcer measured 1 cm by .5 cm and had 100% necrotic tissue. The wound was a black with a non movable scab. The area was classified as a Stage 3 pressure ulcer. Interview with Nurse Consultant 1 on 9/2/21 at 2:45 p.m., indicated they were unable to find the		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. **Date by which systemic corrections will be completed: 9/13/21**	

treatment sheets for the right heel. The treatments were to completed as ordered by the physician.

2. During an interview with the Resident 206's granddaughter on 8/25/21 at 3:32 p.m., indicated she had spoken to the Wound Nurse at the facility and wanted the pressure ulcer treatment orders clarified. She was unsure the facility had been changing the dressing and doing the treatments as ordered.

On 9/1/21 at 2:18 p.m., the resident was observed in bed. The Wound Nurse was at the resident's side performing the treatment to the resident's sacral area. The wound was very large (the size of an orange) and deep with yellow necrotic tissue. There was a large amount of bloody drainage noted.

Interview with the Wound Nurse at that time, indicated the pressure ulcer had been debrided in the hospital. The Wound Physician had seen the resident on 8/30/21 and ordered a wound vac for the ulcer.

The record for Resident 206 was reviewed on 8/30/21 at 10:40 a.m. The resident was admitted to the facility on 8/20/21. Diagnoses included, but were not limited to, osteomyelitis, pressure ulcer of sacral region, stage 4, high blood pressure, peripheral vascular disease, weakness, type 2 diabetes mellitus, and congestive heart failure.

The Admission Minimum Data Set (MDS) assessment, dated 8/26/21, was in process.

A Care Plan, dated 8/22/21, indicated the resident was at risk for pressure ulcers.

Nurses' Notes, dated 8/20/21 at 7:19 p.m.,

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indicated the resident arrived at the facility and there was a wound to the coccyx area.

Physician's Orders, dated 8/21/21, indicated Piperacillin (an antibiotic) 3.375 grams IV every 8 hours.
Sacral wound: cleanse with normal saline, moisten kerlix roll with dakins solution and lightly pack wound bed cover with 4 by 4 and dry abd pad twice a day.

Physician's Orders, dated 8/25/21, indicated a pressure reducing mattress.

An infectious disease Nurse Practitioner Note, dated 8/26/21 at 11:39 p.m. indicated the resident was seen for osteomyelitis of the sacral wound. The resident was currently receiving IV antibiotics for the wound infection.

Wound documentation, dated 8/22/21, indicated a Stage 4 sacral wound. The wound measured 9 cm by 12 cm by 3.5 cm deep, and had bloody drainage with 50% of granulation tissue.

The Medication Administration Record dated 8/2021 indicated the IV antibiotic of Piperacillin was not signed out as being administered on 8/21 and 8/22 at 12:00 a.m., 8/22, 8/23, 8/25, 8/27, 8/28, and 8/29/21 at 8:00 a.m., and 8/26/21 at 4:00 p.m.

The Treatment Administration Record (TAR) for 8/2021 indicated the sacral wound treatment was not signed out as being completed on 8/27 p.m., 8/28, and 8/29 both a.m. and p.m.

Interview with the Wound Nurse on 8/30/21 at 2:00 p.m., indicated she had worked double shifts from 8/26 to 8/29/21 and she had completed the treatments, just did not sign them out.

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The Wound Nurse's time card indicated she only worked 8 hours from 3 p.m. to 11 p.m. on 8/28/21 and was not there during the day time.

Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated the treatment sheets were not signed out as being completed for the right heel wound and the sacral wound.3. On 8/25/21 at 12:06 p.m., Resident 102 was observed lying in bed. She had an air mattress in place to her bed. She indicated she had wounds to her buttocks, and she thought staff would do treatments to the areas "sometimes."

On 9/1/21 at 10:54 a.m., the Wound Nurse was observed completing the wound treatment to the resident's coccyx. There was an open area, about the size of a baseball, noted to the center of the resident's buttocks. The area was about 1 inch deep. There was a wound vac treatment in place.

Resident 102's record was reviewed on 8/26/21 at 3:00 p.m. The diagnoses included, but were not limited to, malignant neoplasm of the breast, hypertension, and type 2 diabetes mellitus.

The Admission Minimum Data Set (MDS) assessment, dated 8/2/21, indicated the resident cognitively intact. She had one stage II, one stage III, and one stage IV pressure ulcer.

A current Care Plan, indicated the resident had pressure ulcers. The interventions included, "...Treatment application of ointment/medication and/or dressings to site per physician order..."

The Wound Physician's Note, dated 8/23/21, indicated the resident had a stage IV pressure ulcer to the coccyx, a stage II pressure ulcer to the

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right buttock, and a stage III pressure ulcer to the right ischium.

The Physician's Order Summary, dated 8/2021, indicated the following treatment orders for the resident's coccyx wound:
- 8/2/21-8/9/21 Oil emulsion dressing, santyl, and foam border gauze, change Monday/Wednesday/Friday (MWF)
- 8/9/21-8/26/21 Wound vac (vacuum), set at 125 mmhg (millimeter of mercury), change MWF
- 8/26/21-9/1/21 Silver alginate and dry border gauze, change MWF

The Physician's Order Summary, dated 8/2021, indicated the following treatment orders for the resident's right ischium wound:
- 8/2/21-9/1/21 Oil emulsion dressing and dry dressing, change MWF

The Treatment Administration Record (TAR), dated 8/2021, indicated there was no treatment documentation for the coccyx wound from 8/2/21 through 8/19/21. The coccyx wound treatment had not been signed out as completed on 8/20/21, 8/23/21, 8/25/21, and 8/27/21. There was no treatment documentation for the right ischium wound from 8/2/21 through 8/19/21. The right ischium wound treatment had not been signed out as completed on 8/27/21.

Interview with the Wound Nurse on 8/30/21 at 4:54 p.m., indicated she had completed all the resident's treatments as ordered but sometimes would forget to come back and sign them out on the TAR. She would do rounds with the Wound Physician on Mondays and then make any changes to the treatment orders in the computer that he recommended. She would then print out an updated treatment sheet and place it in the

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	TAR. Any of the old treatment sheets she would turn backwards and leave in the TAR. 3.1-40(a)(2)			
F 0687 SS=E Bldg. 00	483.25(b)(2)(i)(ii) Foot Care §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.			
	Based on observation, record review and interview, the facility failed to ensure residents received foot care and had routine visits with a podiatrist related to long and thick toenails for 4 of 9 residents reviewed for ADL's. (Residents 14, 63, 27 and 28) Findings include: 1. During an interview on 8/25/21 at 2:40 p.m., with Resident 14, indicated his toenails were very long and were in need of trimming. "There has been no podiatrist here for a long time." The record for Resident 14 was reviewed on 9/01/21 at 1:31 p.m. Diagnoses included, but were not limited to, insomnia, major depressive disorder, anxiety disorder, high blood pressure, chest pain, and age-related physical debility.	F 0687	**Dyer Nursing and Rehab Annual Survey:** 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. **F687 Foot Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 63, 14, 28 were seen 9/7/2021 by the podiatrist. Resident 27 is scheduled to be	09/13/2021

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	The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/21, indicated the resident was alert and oriented. The resident needed assist with personal hygiene. The Podiatrist Progress Note, dated 3/17/21, indicated the resident's nails were trimmed times 10. Follow up in 2 to 3 months or prn for a more acute problem. This was the last time the Podiatrist had been in the facility. Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated they have had a problem with getting the podiatrist out to the facility. Interview with the Administrator on 9/1/21 at 12:45 p.m., indicated the podiatrist had not been to the facility the last couple of months but was scheduled to come out on 9/10/21. 2. On 9/1/21 at 2:30 p.m., Resident 63 was observed in bed. The resident's toenails were long and thick. The record for Resident 63 was reviewed on 8/27/21 at 2:25 p.m. Diagnoses included, but were not limited to, Parkinson's disease, congestive heart failure, depressive disorder, cognitive communication deficit, high blood pressure, osteoarthritis of right knee, dementia with behavioral disturbance, Alzheimer's disease, and muscle weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 7/16/21, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 2 person physical assist for bed mobility.		seen by the podiatrist on 9/29/2021. **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;** Staff were educated to notify the nurse and/or social services of any resident in need of foot care so that they may be added to the podiatry schedule. The facility has reached out to Preferred Podiatry to discuss podiatrist scheduling conflicts and any barriers to residents being seen timely. **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;** Social Service Director/designee will audit weekly to ensure that new admissions as well as residents with need for foot care are added to the podiatry schedule accordingly and that podiatry visits are occurring as scheduled. Social Service Director/designee will present a summary of the	

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	The Podiatrist Progress Note, dated 3/17/21, indicated all 10 toenails were debrided. It was recommended for follow up in 2 to 3 months or prn. This was the last time the Podiatrist had been in the facility. Interview with the East Unit Manager on 9/1/21 at 2:30 p.m., indicated the resident's toenails were in need of trimming.3. On 8/25/21 at 11:23 a.m., Resident 27 was observed lying in bed. Her toenails were long and thick. On 8/27/21 at 11:15 a.m., Resident 27 was observed lying in bed. Her toenails were long and thick. The resident's record was reviewed on 8/27/21 at 2:08 p.m. Diagnoses included, but were not limited to, dementia without behavioral disturbance, hypertension, and hypothyroidism. The resident was admitted to the facility 10/26/20. The Quarterly Minimum Data Set (MDS) assessment, dated 6/2/21, indicated the resident was moderately cognitively impaired. She required an extensive assist of one with personal hygiene and was totally dependent on staff for bathing. There was a lack of any podiatry consultation notes. Interview with the Administrator on 8/30/21 at 4:10 p.m., indicated the podiatrist had canceled the last two visits but was being rescheduled in the next week. She was not sure why the resident had never seen the podiatrist. 4. Interview with Resident 28 on 8/25/21 at 2:22 p.m., indicated his toenails had not been cut in a		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: 9/13/21**	

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	long time and he needed them cut. The resident's record was reviewed on 8/30/21 at 3:38 p.m. Diagnoses included, but were not limited to, cerebral palsy, hypertension, and anemia. The Annual Minimum Data Set (MDS) assessment, dated 8/3/21, indicated the resident was cognitively intact. He required a limited assist of one with personal hygiene and was totally dependent on staff for bathing. A podiatry consultation note, dated 3/17/21, indicated the resident's nails were long, mildly thick, and painful. His nails were trimmed and follow up was recommended every 2-3 months. Interview with the Administrator on 8/30/21 at 4:10 p.m., indicated the podiatrist had canceled the last two visits but was being rescheduled in the next week. Continued interview on 9/1/21 at 2:43 p.m., indicated the podiatrist was scheduled to be in soon and they were going to check every resident in the facility. 3.1-47(a)(7)			
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Incontinence, Catheter, UTI §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's			

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	comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.			
	Based on observation, record review, and interview, the facility failed to ensure orders were obtained for foley catheters for 1 of 1 residents reviewed for urinary catheters. (Resident 159) Finding includes: On 8/25/21 at 2:20 p.m., Resident 159 was observed in his room. The resident had a foley catheter in use. On 8/30/21 at 9:40 a.m., 10:17 a.m., and 11:58 a.m., the resident was observed in his room in bed. The resident's foley catheter was draining clear yellow urine.	F 0690	**Dyer Nursing and Rehab Annual Survey:** 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. **F690 Bowel/Bladder Incontinence, Catheter, UTI** **What corrective action(s) will be accomplished for those**	09/13/2021

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	On 9/1/21 at 9:47 a.m., the resident was again observed in bed. His foley catheter was draining clear yellow urine. On 9/2/21 at 9:42 a.m., the resident was observed in bed. The resident's foley catheter drainage bag was laying on top of the floor mat next to the bed. The record for Resident 159 was reviewed on 8/27/21 at 2:42 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and benign prostatic hyperplasia (prostate gland enlargement) with lower urinary tract symptoms. The resident was admitted to the facility on 8/17/21. The August 2021 Physician's Order Summary (POS), indicated there was no order for the foley catheter as well as catheter care. There were no orders listed on the August 2021 Medication Administration Record (MAR) and the resident did not have a Treatment Administration Record (TAR) for the month of August. A Care Plan, dated 8/31/21, indicated the resident required an indwelling urinary catheter related to obstructive uropathy (difficulty urinating). Interventions included, but were not limited to, change catheter per physician's order, catheter per physician's order, and provide catheter care as needed. Nurses' Notes, dated 8/18/21 at 12:35 p.m., indicated the resident's foley catheter was draining clear yellow urine. Interview with the East Unit Manager on 9/1/21 at		**residents found to have been affected by the deficient practice;** Resident 159 was assessed with no adverse effects noted. MD order was received and noted for the foley catheter. **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 foley catheters 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;** Clinical Staff were in-serviced on ensuring we have physician orders for residents who have a foley catheter. **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;** Nurse Managers will randomly audit 5 residents with foley catheters weekly to ensure there are physician orders in place. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months.	

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	2:30 p.m., indicated the resident should have had an order for the foley. Interview with the West Unit Manager on 9/2/21 at 10:00 a.m., indicated the resident was admitted with the foley catheter and orders should have been obtained on admission. She also indicated the foley catheter should have been assessed for removal as well. 3.1-41(a)(2)		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: 9/13/21**	
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 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 record review and interview, the facility failed to ensure residents maintained acceptable parameters of nutritional status related to meal consumption records not completed for residents	F 0692	**Dyer nursing and Rehab Annual Survey:** Please accept the following as the facility's credible allegation of	09/13/2021

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	who were nutritionally at risk for 2 of 3 residents reviewed for nutrition. (Residents 22 and 208) Findings include: 1. The record for Resident 22 was reviewed on 8/30/21 at 1:41 p.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, major depressive disorder, dementia with behavior disturbance, anxiety and thrombocytopenia (low platelet count). The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/21, indicated the resident was cognitively impaired for daily decision making. He required extensive assistance with eating. A Care Plan, dated 4/14/21, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, observe and record intake of food/fluids. The resident's admission weight on 4/14/21 was 191 pounds. On 8/5/21, the resident weighed 168 pounds, a 13.6% weight loss since admission. A Physician's Order, dated 4/15/21, indicated the resident was to receive a mechanical soft diet. The food consumption log for August 2021, indicated there was no documentation for the following meals and/or dates: No breakfast documented on 8/4, 8/9, and 8/20/21. No lunch documented on 8/4, 8/9, 8/16, 8/20, and 8/27/21.		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. **F692 Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 22- Meal consumption was updated. Resident208- Meal Consumption was updated. **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;** Nursing staff was in-serviced on documenting meal intake in point of care. **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;**	

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	No dinner documented on 8/2, 8/16, 8/22, 8/23, and 8/27/21. There was no documentation of food consumption on 8/7, 8/8, 8/11, and 8/13/21. Interview with the Director of Nursing on 9/1/21 at 2:39 p.m., indicated the food consumption log should have been signed out as completed. 2. On 8/30/21 at 12:12 p.m., Resident 208 was observed eating her lunch meal. She was served a regular texture diet and was feeding herself. The record for Resident 208 was reviewed on 8/27/21 at 10:25 a.m. The resident was admitted to the facility on 7/30/21. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, acute kidney failure, dementia without behavioral disturbance, and peripheral vascular disease. The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated it was still in process and not completed. There was no Care Plan for nutrition or weight loss. The resident weighed 141 pounds on 7/30/21 and on 8/19/21 she weighed 132 pounds. Physician's Orders, dated 7/30/21 indicated to document breakfast, lunch, and dinner. Physician's Orders, dated 8/5/21, indicated a regular diet with thin liquids. A Registered Dietitian's Note, dated 8/19/21 at 3:36 p.m., indicated the resident had a 10 pound weight loss over the past 2 weeks. The resident		Nurse Managers will audit meal intake documentation and significant weight loss for 10 residents in Point of Care 2 times per week to ensure documentation compliance. 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: 9/13/21**	

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	has variable oral intake per food consumption records. The meal consumption logs for 8/2021 indicated the breakfast meal was not documented on 8/1-8/6, 8/8, 8/10, 8/11, 8/14-8/18, 8/21, 8/24, and 8/26/21. The lunch meal was not documented on 8/1-8/3, 8/5, 8/6, 8/8, 8/10. 8/11, 8/14-8/18, 8/21, 8/24, and 8/26/21. The dinner meal was not documented on 8/1-8/7, 8/10-8/16, 8/24, and 8/26/21. Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated the meal consumption logs were to be completed for every meal. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy 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)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of			

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	enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure a resident's enteral feeding was infusing into the peg tube (a tube in the resident's abdomen) according to Physician's orders and water flushes were administered as ordered for 1 of 1 residents reviewed for tube feeding. (Resident 206) Finding includes: On 8/27/21 at 9:30 a.m., Resident 206 was observed in bed. His enteral feeding was infusing at 85 cubic centimeters (cc) per hours. On 8/27/21 at 11:00 a.m., the resident was observed in bed and the enteral feeding was turned off. On 8/27/21 at 3:12 p.m., The resident was observed in bed. The enteral tube feeding remained off. On 8/30/21 at 9:32 a.m., and 10:55 a.m., the resident was observed in bed. The enteral tube feeding was turned off. On 8/31/21 at 9:28 a.m., and 2:58 p.m., the resident was observed in bed and the enteral tube feeding was infusing at 85 cc per hour. On 9/1/21 at 10:00 a.m., the resident was observed in bed and the enteral tube feeding was infusing at 85 cc per hour. The record for Resident 206 was reviewed on 8/30/21 at 10:40 a.m. The resident was admitted to	F 0693	**Dyer Nursing and Rehab Annual Survey:** 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. **F693 Tube Feeding Management/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The physician order for the peg tub feeding for R206 was clarified to align with RD recommendations. The tube feeding rate on pump was corrected . Nurses have been re-trained to make sure water flushes are documented in the MAR. **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 receiving tube feedings have the potential to be affected by the same alleged	09/13/2021

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	the facility on 8/20/21. Diagnoses included, but were not limited to, osteomyelitis, pressure ulcer of sacral region, stage 4, high blood pressure, peripheral vascular disease, weakness, type 2 diabetes mellitus, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 8/26/21, was in process. An initial Baseline Care Plan for tube feeding was completed on 8/20/21. Physician's Orders, dated 8/20/21, indicated the resident was NPO and was to have an enteral feeding by pump via peg tube of Glucerna 1.5 at 85 cc/hr. On at 3:00 p.m., and off at 9:00 a.m. for 18 hours. Enteral feeding flush of 100 cc of water every 4 hours. A Registered Dietitian's Note, dated 8/26/21 indicated the resident's weight, tube feeding and pressure ulcers were addressed. "Recommend Glucerna 1.2 at 80 cc/hour times 20 hours with 250 milliliters (ml) water flush every shift." Physician's Orders, dated 8/27/21, indicated "enteral feeding of Glucerna 1.2 at 8 cc [sic] per hour times 20 hours. On at 3:00 p.m. and off at 11:00 a.m. Flush peg tube with 250 cc of water every shift." Physician's Orders, dated 8/31/21, indicated "enteral feeding of Glucerna 1.2 at 80 cc/hr per hour times 20 hours. On at 3:00 p.m. and off at 11:00 a.m." The Treatment Administration Record (TAR) dated 8/2021, indicated the enteral water flush of 100 cc every 4 hours was not documented as being administered 8/20-8/27/21.		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;** Clinical staff were re-educated on ensuring that all g-tube feedings are administered at the right rate and time and that orders align with RD recommendations. Clinical staff were also re-educated on ensuring that water flush documentation is completed. **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;** Nurse manager will randomly audit/observe weekly all g-tube resident's feedings for rate and time. Nurse Managers will also ensure that all water flush documentation is complete. DON/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: 9/13/21**	

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	Interview with the East Unit Manager on 9/1/21 at 10:30 a.m., indicated the rate of the tube feeding was to be at 80 cc per hour. The tube feeding should be off at 11:00 a.m., and back on at 3:00 p.m. The water flushes were to be documented each shift. 3.1-44(a)(2)			
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences.			
	Based on observation, record review and interview, the facility failed to care for an implanted venous port in accordance with professional standards of practice for 1 of 1 residents reviewed for intravenous (IV) care. (Resident 102) Finding includes: On 8/25/21 at 2:25 p.m., Resident 102 was observed lying in bed. The implanted venous port to her left chest was accessed. A transparent dressing was intact over the needle and was dated 8/12/21. On 8/27/21 at 11:21 a.m., Resident 102 was observed lying in bed. The implanted venous port to her left chest was accessed. The right side of the transparent dressing over the needle was coming up from the skin and it was dated 8/12/21.	F 0694	**Dyer Nursing and Rehab Annual Survey:** 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. **F694 Parenteral/IV Fluids** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 102 was immediately assessed with no adverse effects noted. MD made aware and order received to de- access port-a-cath.	09/13/2021

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	On 8/27/21 at 2:00 p.m., Resident 102 was observed lying in bed. The implanted venous port to her left chest was accessed. The right side of the transparent dressing over the needle was coming up from the skin and it was dated 8/12/21. Resident 102's record was reviewed on 8/26/21 at 3:00 p.m. The diagnoses included, but were not limited to, malignant neoplasm of the breast, hypertension, and type 2 diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 8/2/21, indicated the resident cognitively intact. She had one stage II, one stage III, and one stage IV pressure ulcer, and received IV medications. A Care Plan, dated 8/16/21, indicated the resident was receiving IV antibiotic therapy through intravenous access. The interventions included, when the access site was in use, to flush it before and after each infusion with 10 ml (milliliters) of normal saline and if non valved to follow with 5 ml of heparin. Change the dressing weekly and as needed. The Physician's Order Summary, dated 8/2021, indicated an order for Piperacillin-Tazobactam (an antibiotic medication) 3.375 grams intravenous every 8 hours from 7/28/21 to 8/28/21 for a wound infection. There were also orders to change the Huber needle (non-coring needle) used to access the implanted venous port and change the transparent dressing to the area weekly on Mondays and as needed. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 8/2021, indicated the resident had received the IV antibiotic medication as ordered. There		Orders carried out and documented. **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 IV access 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;** Clinical Staff were in-serviced on ensuring that all residents who have IV access have the following: o Care central venous catheter dressing changes are completed every 5-7 days per policy and physician orders. Additionally, dressing are changed PRN when soiled, wet, or not intact. o Intermittent use-flush with SASH method o Accessed but not in use flush once per day with 5ml of normal saline and 5 ml of 100 unit/ml of heparin o Only non-coring needles are to be used and are to be changed every 5-7 days or with any suspicion of contamination. o Documentation in the clinical record for dressing changes, needle changes, and flushes. **How the corrective action(s)**	

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	was lack of documentation the venous port access had been flushed before and after the antibiotic infusions. The transparent dressing change to the venous port had only been signed out as completed on 8/2/21 and 8/28/21. The Huber needle change had not been signed out as completed at all. Interview with the Administrator on 8/30/21 at 4:10 p.m., indicated she would have nursing look in to the IV orders. Continued interview on 8/31/21 at 11:18 a.m., indicated the resident's venous port was no longer in use. Her antibiotics had been completed and the orders had been clarified. A current facility policy, titled "Catheter Insertion and Care Flushing Protocol for Implanted Venous Port," indicated, "...5. If the port is accessed with non-coring needle: a. Intermittent use-flush with SASH method (5 ml normal saline, administer medication, 5 ml of normal saline, 5 ml of 100 unit/ml heparin). b. Accessed but not in use-flush once a day with 5 ml normal saline, 5 ml of 100 unit/ml heparin...6. Only specially designed non-coring safety needles are to be used when accessing an implanted port. These needles are to be changed every 5-7 days or upon suspicion of contamination..." A current facility policy, titled "Catheter Insertion and Care Central Venous Catheter Dressing Changes," indicated, "...5. Change transparent semi-permeable membrane (TSM) dressings every 5 to 7 days and PRN (when wet, soiled, or not intact) ..." 3.1-47(a)(2)		**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 randomly audit 5 residents with IV access weekly to ensure dressing changes and flushes are being done as ordered. DON/Designee will also ensure documentation is completed. 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: 9/13/21**	
F 0695 SS=D	483.25(i) Respiratory/Tracheostomy Care and			

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Bldg. 00	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 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 oxygen was applied at the correct flow rate and per Physician's Orders. The facility also failed to ensure oxygen tubing was dated for 2 of 3 residents reviewed for oxygen. (Residents 153, 205, and 208) Findings include: 1. On 8/26/21 at 11:44 a.m., Resident 153 was observed with oxygen in use by the way of a nasal cannula. The resident's oxygen tubing was not dated. On 8/27/21 at 11:03 a.m. and 1:28 p.m., the resident's oxygen concentrator was set at 4 1/2 liters. The oxygen tubing was not dated. On 8/30/21 at 9:40 a.m., 11:55 a.m., and 4:50 p.m., the resident's oxygen concentrator was set at 4 1/2 liters. The oxygen tubing was not dated. On 8/31/21 at 9:37 a.m. and 3:01 p.m., the resident's oxygen tubing was not dated. The record for Resident 153 was reviewed on 8/27/21 at 11:07 a.m. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia and pneumonia. The resident was	F 0695	**Dyer Nursing and Rehab Annual Survey:** 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. **F695 Respiratory** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The oxygen flow rate was corrected, oxygen tubing was labeled for R153 The oxygen flow rate was corrected for R205 and the oxygen tubing was replaced and dated. R208 was placed on oxygen 2L via nasal canula as ordered by the physician. The tubing was labeled and dated. **How the facility will identify**	09/13/2021

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	admitted to the facility on 8/23/21. A Physician's Order, dated 8/25/21, indicated the resident was to receive oxygen 5 liters per nasal cannula continuously. The oxygen tubing and/or mask was to be changed weekly and as needed (prn). A Care Plan, dated 8/25/21, indicated the resident required oxygen therapy to relieve hypoxia (low oxygen levels) related to the diagnosis of chronic respiratory failure with hypoxia. Interventions included, but were not limited to, administer oxygen as ordered and change oxygen tubing weekly or as ordered. Interview with the East Unit Manager on 9/1/21 at 2:30 p.m., indicated the resident's oxygen concentrator should have been set and 5 liters and his oxygen tubing dated. 2. On 8/25/21 at 3:00 p.m., Resident 205 was observed in bed. The resident was wearing oxygen per nasal cannula at 1.5 liters per minute. The oxygen tubing was not labeled or dated. On 8/26/21 at 10:51 a.m., the resident was observed in bed. The resident was wearing oxygen per nasal cannula at 1.5 liters per minute. The oxygen tubing was not labeled or dated. On 8/27/21 at 9:30 a.m., 11:00 a.m., 1:30 p.m., and 3:09 p.m., the resident was observed in bed. The resident was wearing oxygen per nasal cannula at 1.5 liters per minute. The oxygen tubing was not labeled or dated. On 8/30/21 at 9:33 a.m., and 11:36 a.m., the resident was observed in bed. The resident was wearing oxygen per nasal cannula at 4 liters per minute.		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents receiving oxygen 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;** Staff were re-educated on oxygen care with focus on: oxygen administered at the correct flow rate as per order, ensuring oxygen tubing is changed and labeled appropriately, and ensuring residents are wearing oxygen as ordered. **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;** Facility Angels/designee will audit 15 residents 3 times per week to ensure oxygen tubing is dated, oxygen is set at the correct flow rate, and oxygen is on the resident as ordered. 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,	

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	On 8/31/21 at 2:56 p.m., the resident was observed in bed. The resident was wearing oxygen per nasal cannula at 4 liters per minute. On 9/1/121 at 9:58 a.m., the resident was observed in bed. The resident was wearing oxygen per nasal cannula at 1.5 liters per minute. The record for Resident was reviewed on 8/27/21 at 9:43 a.m. The resident was admitted on 8/3/21. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, osteoarthritis, high blood pressure, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 8/9/21, indicated the resident was moderately impaired for decision making. The resident was totally dependent with 1 person physical assist for dressing. The resident did not require oxygen as a resident. A Baseline Care Plan, dated 8/3/21, indicated the resident had COPD and oxygen was being used. The approach was to administer oxygen as ordered. Physician's Orders, dated 8/26/21, indicated oxygen 2 liters nasal cannula for COPD. This was the first order for the oxygen since admission on 8/3/21. Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated the resident's oxygen was to be at 2 liters per minute continuously. 3. On 8/25/21 at 2:12 p.m., Resident 208 was observed sitting in her wheelchair. She was not wearing any oxygen.		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: 9/13/21**	

On 8/26/21 at 10:09 a.m., the resident was observed sitting in her wheelchair. At that time, she was not wearing any oxygen.

On 8/27/21 at 9:25 a.m., 11:06 a.m., and 3:04 p.m., the resident was observed sitting in her wheelchair. At those times, she was not wearing any oxygen.

On 8/30/21 at 9:36 a.m., at 11:14 a.m., the resident was observed sitting in her wheelchair. At those times, she was not wearing any oxygen.

On 9/1/21 at 9:57 a.m., the resident was observed sitting in her wheelchair. At that time, she was not wearing any oxygen.

The record for Resident 208 was reviewed on 8/27/21 at 10:25 a.m. The resident was admitted to the facility on 7/30/21. Diagnoses included, but were not limited to, type 2 diabetes mellitus, high blood pressure, acute kidney failure, dementia without behavioral disturbance, and peripheral vascular disease.

The Admission Minimum Data Set (MDS) assessment, dated 8/5/21, indicated it was still in process and not completed.

The Care Plan, dated 8/25/21, indicated the resident required oxygen therapy to relieve hypoxia. The approaches were to administer oxygen as ordered.

Physician's Orders, dated 7/30/21, indicated oxygen at 2 liters nasal cannula continuous.

Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated the order for the

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	oxygen was continuous. 3.1-44(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure each resident who had been expressing pain received the correct scheduled and prn (as needed) pain medications and had pain assessments completed for 2 of 2 residents reviewed for pain. (Residents 86 and 206) Findings include: 1. During an interview with Resident 86 on 8/25/21 at 11:14 a.m., indicated her pain medication does not always work. "They kept changing my pain medication and did not always tell me, now I can have Tylenol in between." The record for Resident 86 was reviewed on 9/1/21 at 10:59 a.m. Diagnoses included, but were not limited to, cancer of the endometrium and peritoneum, stroke, osteoarthritis, and stiffness of unspecified joint. The Annual Minimum Data set (MDS) assessment, dated 7/21/21 indicated the resident was alert and oriented. The resident received prn pain medication and at the time of the assessment had no pain.	F 0697	**Dyer Nursing and Rehab Annual Survey:** 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. **F697 Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Pain assessment completed and pain medication scheduled for Resident 86. The resident was notified of the orders for all pain medication. Nurses were in-serviced regarding the removal and destruction of any discontinued medications. Resident has orders for both topical Lidoderm patch and oral	09/13/2021

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	A Care Plan, dated 7/24/20, indicated the resident was at risk for pain related to cancer. The approaches were to administer medications as ordered. A pain assessment, dated 1/12/21, indicated the resident had no complaints of pain. There was no other current pain assessment completed. Physician's Orders, dated 1/12/21, indicated "Hydrocodone (a narcotic pain medication) 10-325 milligrams (mg) every 6 hours prn pain. Pain scale/evaluation every shift." The medication was discontinued on 2/1/21. Physician's Orders, dated 2/1/21, indicated "Hydrocodone 7.5-325 mg 1 twice a day prn pain." The medication was discontinued on 2/8/21. Physician's Orders, dated 2/12/21, indicated "Hydrocodone 5-325 mg 1 twice a day prn pain." There was no documentation the resident was informed of the changes in the dose for the Hydrocodone. There was no documentation the resident was informed the Hydrocodone had been completely discontinued on 2/8/21. Nurses' Notes, dated 2/12/21 at 2:33 p.m., indicated a new order was received and noted for Hydrocodone 5-325 mg twice a day prn for pain. The resident was aware of the new order. The Medication Administration Record (MAR) for 2/2021, indicated Hydrocodone 7.5-325 mg was signed out as being administered to the resident after it had been discontinued on 2/10/21 at 12:00 a.m., 2/13 at 8:00 p.m., 2/14 at 8:00 p.m., and 2/16/21		pain medication. Resident was assessed for pain and given pain medication as ordered. Nursing staff will assess resident for pain routinely. **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 facility residents that require pain management 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;** Nurses were re-educated on administering medications as per ordered, completing pain assessments as needed, ensuring residents pain medications schedules are followed per the physicians order, informing residents of the pain medication plan and any changes in pain medications, and the removal and destruction of any discontinued medications to prevent medication errors. **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;** Nurse Manager will randomly audit	

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	at 8:00 p.m. Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated her Hydrocodone was reduced from the higher dose to a lower dose due to possibly having an ileus. The lower dose was discontinued on 2/8/21. There was no documentation the resident was notified of the Hydrocodone being completely discontinued. Interview with Nurse Consultant 1 on 9/2/21 at 2:45 p.m., indicated there was no order for the Hydrocodone 2/9-2/12/21. 2. During an interview with Resident 206's granddaughter on 8/25/21 at 3:19 p.m., she indicated her and her mother had changed the resident when they arrived. At that time, there was a Lidoderm pain patch dated 8/20/21 on his lower back. The granddaughter indicated he has severe pain and they have asked for pain meds but no one seems to be getting him any. The resident was agitated and indicated his butt hurts all the time. The record for Resident 206 was reviewed on 8/30/21 at 10:40 a.m. The resident was admitted to the facility on 8/20/21. Diagnoses included, but were not limited to, osteomyelitis, pressure ulcer of sacral region, stage 4, high blood pressure, peripheral vascular disease, weakness, type 2 diabetes mellitus, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 8/26/21, was in process. A Care Plan, dated 8/25/21, indicated to observe the resident for complaints of acute pain related to wounds. The approaches were to administer medications and evaluate if any side effects.		5 residents' medication administration record 2 times per week to ensure mediations are provided as per orders. Nurse Managers will also audit 5 random residents pain assessments to ensure they are being completed as needed and pain medication is being scheduled as the resident needs. 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: 9/13/21**	

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	Monitor and record any complaints of pain and non verbal signs of pain. A pain assessment, dated 8/20/21, indicated the resident was moderately impaired for decision making, and had no complaints of pain. Physician's Orders, dated 8/20/21, indicated Lidoderm patch 5% once a day on a 9:00 a.m. and off at 9:00 p.m. Physician's Orders, dated 8/25/21, indicated Tramadol (an opioid pain medication) 50 milligrams (mg) 1 three times a day prn (as needed) for pain. Nurses' Notes, dated 8/25/21 at 4:27 p.m., indicated the Nurse Practitioner was here and wrote a script for Tramadol 50 mg three times a day prn. Nurse' Notes, dated 8/25/21 at 5:50 p.m., indicated the Tramadol was pulled from the EDK box and given to the resident. Nurses' Notes, dated 8/30/21 at 2:47 p.m. indicated a new order was received from the NP to make the Tramadol scheduled and routine three times a day per family request. The Medication Administration Record (MAR), dated 8/2021 indicated the Tramadol 50 mg prn was administered on 8/25/21 at 5:30 p.m., 8/26 at 9:00 a.m., 8/26 at 6:15 a.m., and 8:00 p.m., 8/27, 8/28, and 8/29/21 at 8:00 p.m. The MAR, dated 8/2021, indicated the Lidoderm patch was initialed but circled on 8/21 and 8/24/21, which indicated it was not available. The Lidoderm patch was not signed out as being			

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	administered on 8/26/21. The MAR, dated 8/2021, indicated the resident's pain scale and evaluation was coded as a 6 out of 10 on 8/22 and 8/24/21, however, there was no pain medication ordered for the resident at that time. Interview with the East Unit Manager on 9/1/21 at 10:30 a.m., indicated the resident had pain so the first order received from the NP was a prn order for Tramadol, however, she was unsure the resident was aware he needed to ask for it every time. Per the family request they just got a new order for scheduled doses of the Tramadol. 3.1-37(a)			
F 0698 SS=D Bldg. 00	483.25(l) Dialysis §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on observation, record review, and interview, the facility failed to provide the necessary care and services for residents who received hemodialysis related to not assessing and monitoring the resident's dialysis access site for 1 of 1 residents reviewed for dialysis. (Resident 33) Finding includes: Interview with Resident 33 on 8/26/21 at 10:46 a.m., indicated she went to dialysis on Monday, Wednesday, and Friday. She had a fistula	F 0698	**Dyer Nursing and Rehab Annual Survey:** 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. **F698 Dialysis** **What corrective action(s) will be accomplished for those**	09/13/2021

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	(dialysis access site created by joining an artery and a vein) in her left arm for dialysis access and the staff at the facility "had not checked on the site very often." The record for Resident 33 was reviewed on 8/30/21 at 9:33 a.m. Diagnoses included, but were not limited to, dependence on renal dialysis, anemia, and chronic kidney disease. The Annual Minimum Data Set assessment, dated 6/20/21, indicated the resident was cognitively intact and received dialysis. A Care Plan, indicated the resident required renal dialysis. The interventions included to observe the AV fistula as ordered and to observe and report signs of infection. The 7/2021 and 8/2021 Treatment Administration Records (TAR) and Medication Administration Records (MAR) lacked any monitoring or assessment of the left arm fistula for any signs of infection or for bruit (a sound created by blood flow through the fistula) and thrill (a vibration created by blood flow through the fistula). The Progress Notes, dated 8/2021, lacked documentation the dialysis access site had been assessed daily. Interview with the Administrator on 8/31/21 at 11:18 a.m., indicated there was no documentation of monitoring the dialysis access site. They had now added orders for monitoring. A current facility policy, titled "Post Dialysis Monitoring and Observation with Implanted AV Shunt Policy," indicated, "Policy: Charge Nurse to conduct access site observations one time per		**residents found to have been affected by the deficient practice;** Resident 33- Dialysis site assessed for bruit, thrill and S/S of infection. Orders received to monitor site daily for bruit, thrill and S/S of infection **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 receive dialysis 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;** Nursing staff was in-serviced on assessing dialysis sites, for residents receiving dialysis, for bruit, thrill and S/S of infection daily. **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;** Nurse Managers will audit all residents receiving dialysis weekly to ensure their dialysis sites are being assessed for bruit, thrill and S/S of infection. The Director of Nursing/designee	

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	day...To monitor site: 1. Check shunt area for bruit with stethoscope. Palpitation over site should reflect a thrill. chart on MARs. 2. Monitor site daily for redness or signs of inflammation..." 3.1-37(a)		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: 9/13/21**	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort			

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	to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.			
	Based on record review and interview, the facility failed to ensure there was an indication for the use of as needed (prn) antipsychotic medications. The facility also failed to ensure anti-anxiety medications were given as ordered for 3 of 5 residents reviewed for unnecessary medications. (Residents 22, 159, and 14) Findings include: 1. The record for Resident 22 was reviewed on 8/30/21 at 1:41 p.m. Diagnoses included, but were not limited to, dementia with Lewy bodies, major depressive disorder, dementia with behavior disturbance, anxiety and thrombocytopenia (low platelet count).	F 0758	F 758 Unnecessary Medication **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R 22, 14, 159 assessed and no adverse effects noted. R 22, 14, 159 had orders for PRN anti-anxiety and anti-psychotic medication discontinued, by physician order, for no indication for use and non-use.	09/13/2021

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	The Quarterly Minimum Data Set (MDS) assessment, dated 6/1/21, indicated the resident was cognitively impaired for daily decision making. He required extensive assistance with bed mobility and transfers. A Physician's Order, dated 4/18/21, indicated the resident was to receive Haldol (an antipsychotic medication) 5 milligrams (mg) per milliliter (ml) inject 0.5 mls once a day as needed (prn). There was no indication for the use of the medication listed on the order. The prn Haldol was discontinued on 5/26/21. The April 2021 Medication Administration Record (MAR), indicated the resident received the prn Haldol on 4/26/21. There was no documentation in the nursing progress notes or on the MAR indicating what type of behavior the resident was having and what interventions were attempted prior to giving the medication. The May 2021 MAR, indicated the resident received the prn Haldol on 5/15/21. There was no documentation in the nursing progress notes or on the MAR indicating what type of behavior the resident was having and what interventions were attempted prior to giving the medication. Interview with the West Unit Manager on 9/2/21 at 1:10 p.m., indicated there was no documentation as to why the resident received the prn Haldol and what interventions were attempted first. 2. The record for Resident 159 was reviewed on 8/27/21 at 2:42 p.m. Diagnoses included, but were not limited to, dementia with behavior disturbance and benign prostatic hyperplasia (prostate gland enlargement) with lower urinary tract symptoms. The resident was admitted to the facility on		**How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. PRN antipsychotic medications have an indication for use and authorized use for longer than 14 days as needed. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff educated on the following: § Discontinuing prn psychotropic medication after 14 days § Obtaining authorization for use longer than 14 days § Obtaining appropriate diagnosis for medications § Documenting in the clinical record the resident behavior and any non-pharmacy interventions attempted prior to administering a PRN medication § Obtaining prior authorizations timely **What quality assurance plans will be implemented to monitor facility performance to ensure**	

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	8/17/21. A Physician's Order, dated 8/17/21, indicated the resident was to receive Zyprexa (an antipsychotic medication) 10 milligrams (mg), give 5 mg IM (intramuscular) every 4 hours prn (as needed) for agitation. Interview with the West Unit Manager on 9/2/21 at 1:10 p.m., indicated the medication was ordered because the resident could be combative with care. Interview with the Director of Nursing and Nurse Consultant 1 on 9/2/21 at 1:30 p.m., indicated Zyprexa should not be used as a prn medication and the order should have been re-evaluated after 14 days.3. During an interview on 8/25/21 at 11:31 a.m., Resident 14 indicated, "They do not send my medications in for refills timely. They wait too long, and then I do not get my Xanax." The record for Resident 14 was reviewed on 9/1/21 at 1:31 p.m. Diagnoses included, but were not limited to, insomnia, major depressive disorder, anxiety disorder, high blood pressure, chest pain, and age-related physical debility. The Quarterly Minimum Data Set (MDS) assessment, dated 8/4/21, indicated the resident was alert and oriented. The resident needed assist with personal hygiene. In the last 7 days the resident received anti-anxiety medication. A Care Plan, dated 11/07/19, indicated the resident was prescribed anti-anxiety medication and was at risk of adverse reactions. Physician's Orders, dated 3/1/21, indicated Xanax .5 milligrams (mg) three times a day.		**corrections are achieved and permanent?** DON/ designee will audit all prn medications each week x 3 months to ensure medication is discontinued after 14 days/authorization is received for longer than 14 days, an appropriate diagnosis is in place, and non-pharmacy interventions are attempted and documented along with any behaviors the resident is exhibiting prior to a prn being given. A summary of the audits will be presented to the Quality Assurance Committee monthly x 3 months or until compliance is met. **By what date the systemic changes will be completed: 9/13/21**	

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Nurses' Notes, dated 6/9/21 at 8:58 a.m., indicated "Resident in room, in bed. yelling at writer for his Xanax. Called writer a "liar" and told writer "I know what my rights are, even HIPPA" . Calmly explained resident that writer will call MD (Medical Doctor) again, SS (Social Service) also called to room. NP (Nurse Practitioner) was here this a.m. but stated psych is to write his script, there was an agreement made for psych to write Xanax script and manage all psych meds. Psych MD called and message left to call unit for Xanax." (sic)

Nurses' Notes, dated 6/9/21 at 9:29 a.m., indicated Physician called and requested script for Xanax. Stated to fax order to his office number and he would call the pharmacy.

Nurses' Notes, dated 6/9/21 at 11:32 a.m., indicated Pharmacy called, and stated that Xanax will need a prior authorization from Medicaid and the provider would need to reach out to Medicaid to try and get the medication covered.

Nurses' Notes, dated 6/9/2021 at 12:00 p.m., indicated a fax was received from the pharmacy and given to the DON to sign. The DON signed for the facility to pay for cost of a 20 day supply of Xanax. Signature page immediately faxed back to the pharmacy and authorization request to pull from the EDK requested.

Nurses' Notes, dated 6/9/21 at 12:30 p.m. indicated the Xanax medication was pulled from the EDK box and the 1:00 p.m. dose was administered as ordered.

Nurses' Notes, dated 6/10/21 at 5:06 a.m., indicated the pharmacy was called and a message was left

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to call facility ASAP as the Xanax 0.5 mg was not delivered as promised.

Nurses' Notes, dated 7/11/21 at 12:10 p.m., indicated this writer called the pharmacy to check on the Xanax medication. They stated they needed the DON to sign for the medication due to insurance was not covering the medication.

Physician Progress Notes, dated 7/13/21 at 9:54 a.m., indicated the resident's chief complaint was sleep disturbance and anxiety. The patient was seen today and appeared agitated. He continues to be upset about his Xanax and has increased agitation and frustration when he does not sleep well and does not get his Xanax.

The Medication Administration Record (MAR), dated 6/2021 indicated the Xanax .5 mg was not administered as ordered on 6/8/21 at 9:00 a.m., 2:00 p.m., and 8:00 p.m., and on 6/9/21 at 9:00 a.m. The nurse's initials were documented with a circle around them.

The Medication Administration Record (MAR), dated 7/2021 indicated the Xanax .5 mg was blank and not administered as ordered on 7/7/21 at 9:00 a.m. and 2:00 p.m., and on 7/9/21 at 1:00 p.m. The Xanax was also not administered on 7/10/21, 7/11/21 and 7/12/21 at 9:00 a.m., 2:00 p.m., and 8:00 p.m. The nurse's initials were documented with a circle around them.

Interview with the Administrator on 9/2/21 at 11:50 a.m., indicated she was aware the Xanax needed to be authorized prior to getting refilled for insurance purposes.

Interview with Nurse Consultant 1 on 9/2/21 at 2:45 p.m., indicated when the medication was not

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	available, the nurse will put their initials on the MAR and then circle it. 3.1-48(a)(4) 3.2-48(a)(6)			
F 0791 SS=D Bldg. 00	483.55(b)(1)-(5) Routine/Emergency Dental Srvcs in NFs §483.55 Dental Services The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(b) Nursing Facilities. The facility- §483.55(b)(1) Must provide or obtain from an outside resource, in accordance with §483.70(g) of this part, the following dental services to meet the needs of each resident: (i) Routine dental services (to the extent covered under the State plan); and (ii) Emergency dental services; §483.55(b)(2) Must, if necessary or if requested, assist the resident- (i) In making appointments; and (ii) By arranging for transportation to and from the dental services locations; §483.55(b)(3) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay; §483.55(b)(4) Must have a policy identifying			

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	those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; and §483.55(b)(5) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the State plan.			
	Based on record review and interview, the facility failed to ensure dental referrals for tooth extractions were completed as ordered for 1 of 1 residents reviewed for dental services. (Resident 17) Finding includes: Interview with Resident 17 on 8/26/21 at 10:44 a.m., indicated he was waiting to have his 3 remaining teeth pulled so he could have dentures made. He indicated nobody had gotten back to him to arrange anything. The record for Resident 17 was reviewed on 8/30/21 at 10:10 a.m. Diagnoses included, but were not limited to, Parkinson's disease, stroke, dementia without behavior disturbance, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/21, indicated the resident had moderate cognitive impairment. He needed limited assistance with eating, required a mechanically altered therapeutic diet, and had broken teeth or a loosely fitting full or partial denture.	F 0791	**Dyer Nursing and Rehab Annual Survey:** 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. **F791 Routine/Emergency Dental Services in SNFs** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A dental appointment for tooth extraction appointment made for Resident 17. **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	09/13/2021

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	Dental Progress Notes, dated 3/1/21, indicated to refer to outside dentist for extraction of #21, 22, 27, and 28. After healing, dentist can make new full upper and lower dentures. Dental Progress Notes, dated 4/6/21, indicated the resident said it occasionally hurt to chew with his remaining teeth. He said they were jagged. The resident also indicated he would like to have his remaining teeth extracted and new dentures made. He needed a follow up with the dentist at the earliest possible convenience. Interview with the West Unit Manager on 9/2/21 at 9:50 a.m., indicated Social Service received the dental progress notes. She was not aware recommendations were made for the resident to have his remaining teeth extracted and Social Service should have arranged it. 3.1-24(a)(3)		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;** Social Services staff re-educated regarding ensuring that follow up dental appointments are made. **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;** Social Services/Designee will audit all dentist documentation for any needed follow up appointments and ensure those appointments are made. Social Services will also ensure all new admissions needing dental care on placed on the list to see the dentist and consent is obtained. Social Services Staff/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: 9/13/21**	

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F 0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.			
	Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related to food being transported uncovered on 1 of 2 units. This had the potential to affect 18 of 54 residents who received oral diets on the East Unit. Finding includes: On 8/25/21 at 12:02 p.m., the second and third food carts were delivered to the East Unit from the kitchen. One of the carts was not covered and the trays were exposed. The cart contained 18 trays. All 18 of the fruit cups on the cart were uncovered.	F 0812	**Dyer Nursing and Rehab Annual Survey:** 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. **F812 Food Procurement, Store/Prepare/Serve-Sanitary**	09/13/2021

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	Interview with the Administrative Consultant on 9/2/21 at 12:59 p.m., indicated the fruit cups should have been covered. 3.1-21(i)(3)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Upon notification of food being transported without being covered this practice was immediately corrected. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Dietary aid educated on ensuring food is covered before transporting in the hallway. Facility staff educated on covering food/beverages when transporting in the hallway. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?**	

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			Dietary manager/designee will audit 3 meals weekly x 6 months on various shifts to ensure food/beverages are covered in the hallway. 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. **By what date the systemic changes will be completed: 9/13/21**	
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 program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:			

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	§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 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.			

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	§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 hand hygiene not completed after direct resident contact and glove removal, not wearing the appropriate personal protective equipment (PPE) while COVID-19 testing and when entering transmission based precaution (TBP) isolation rooms, and not covering a peripherally inserted central catheter (PICC) line port for 4 of 11 medication pass observations, 1 of 1 COVID-19 testing observations, 4 of 6 residents in transmission based precautions, and 1 of 1 residents with a PICC line. (Residents 160, 50, 204, 39, 85, 206, and 3) Findings include: 1. On 8/25/21 at 11:06 a.m., the Assistant Director of Nursing (ADON) was observed in Resident 160's room talking with the resident. The ADON was within 6 feet of the resident and was wearing a surgical mask and no other personal protective equipment (PPE). A sign on the resident's door,	F 0880	**POC F-880 Infection Prevention & Control** **Corrective actions which will be accomplished for those residents found to have been affected by the deficient practice:** The ADON was immediately re-educated related to the donning of gloves, gown, protective eyewear and an N95 when entering a residents room on TBP The CNA2 was immediately re-educated related to donning gloves, gown, protective eyewear, and an N95 when entering the room of a resident on TBP.	09/13/2021

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	indicated she was in a "yellow" room and in transmission based precautions (TBP). The ADON was seen from the doorway talking to the resident for several minutes. Information posted on the door indicated a gown, gloves, N95 mask and protective eyewear was to be donned when entering the room. Upon exiting the room, the ADON was asked why she wasn't wearing PPE while in the room. She indicated she removed it in the room before exiting. When asked why she was talking to the resident with no PPE in use, she did not say anything. 2. On 8/25/21 at 12:13 p.m., CNA 2 entered a TBP isolation room to deliver a lunch tray. She donned a gown and gloves and entered the room wearing a surgical mask. 3. On 8/25/21 at 12:17 p.m., CNA 3 entered a TBP isolation room to deliver a lunch tray. She donned a gown, gloves and face shield. The CNA was wearing a surgical mask beneath her face shield. 4. On 9/2/21 at 9:12 a.m., LPN 1 was observed preparing medications for Resident 50. She entered the room and handed the resident his medication cup and a glass of water. The LPN proceeded to the medication cart and started to prepare Resident 204's medications. She did not use hand sanitizer and/or wash her hands before preparing Resident 204's medications. At 9:17 a.m., the LPN gave Resident 204 his medications and assisted him with his inhaler. After returning to the medication cart, the LPN used hand sanitizer.		CNA 3 was re-inserviced related to donning an N95 when entering the room of a resident on TBP. LPN1 was re-inserviced related to the hand hygiene prior to preparing medications, this included leaving the med cart to obtain supplies and again performing hand hygiene, hand hygiene before and after entering a resident room, and between contact with residents. The PICC line ports were capped for R206 The DON was in-serviced on donning an N95 face mask when collecting specimens for Point of Care or Rapid Testing for COVID-19. **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 alter to ensure that the problem will be corrected and will not recur:** Staff re-educated related to wearing proper PPE in all transmission-based precaution	

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	At 9:23 a.m., the LPN prepared Resident 39's medication. The LPN put the medication cup in the medication drawer and indicated she had to go to the kitchen to get some pudding for the resident. The LPN returned with a container of yogurt. She removed the medication cup from the drawer and proceeded to crush the medication and placed it in some yogurt. The LPN did not sanitize her hands when she returned from the kitchen. She then proceeded into the resident's room and donned a pair of gloves. She did not hand sanitize before donning the gloves. The LPN assisted the resident with her medication, removed her gloves, and returned to the medication cart and started preparing Resident 85's medications. The LPN did not hand sanitize or wash her hands after removing her gloves and preparing Resident 85's medications. At 9:27 a.m., Resident 85 received her medications. The LPN left the resident's room and again did not hand sanitize or wash her hands prior to moving on to the next resident. Interview with the Director of Nursing and Nurse Consultant 1 on 9/2/21 at 1:30 p.m., indicated hands should be washed and/or sanitized in between each resident contact and before and after glove removal. The Handwashing/Hand Hygiene policy provided by Nurse Consultant 1 on 9/2/21 at 1:43 p.m., indicated the following: "When hands are not visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in the following situations: a. before direct contact with residents. b. after direct contact with a resident but prior to direct contact with another resident.		rooms. and while performing COVID testing. Staff responsible for swabbing were in-serviced on donning an N95 face mask, gown, gloves, protective eyewear when collecting specimens for Point of Care or Rapid AntigenTesting for COVID-19. Clinical staff re-educated related to hand hygiene during a medication pass, before and after donning and doffing gloves, when entering or leaving a resident room, and between patients. Clinical staff also re-educated on applying caps to all PICC/Midline/Peripheral and accessed port lines when not in use or after use, and prn if a cap becomes dislodged. **Quality Assurance Plans to monitor facility performance to make sure that corrections are achieved and are permanent:** · A) The D.O.N. or designee, will conduct Infection Prevention surveillance observations daily x 6 weeks then 3 x weekly for 6 months, including the observation of med pass, swab testing for COVID19, during meal tray pass, and during routine care of residents to ensure compliance and improvement of infection control practices. · Administrator/designee will	

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	c. before donning gloves m. after removing gloves." 5. During an interview with Resident 206's granddaughter on 8/25/21 at 3:00 p.m., she indicated the peripherally inserted central catheter (PICC) line had no caps for the ports. On 8/27/21 at 9:30 a.m., 11:00 a.m., and 3:12 p.m., Resident 206 was observed in bed. There was no cap on his PICC line port. On 8/30/21 at 9:32 a.m., and 10:55 a.m.,11:37 a.m., and 1:27 p.m., the resident was observed in bed. There was no cap on his PICC line port. On 8/31/21 at 9:28 a.m., and 2:58 a.m., the resident was observed in bed. There was no cap on his PICC line port. On 9/1/21 at 10:00 a.m., the resident was observed in bed. There was no cap on his PICC line port. The record for Resident 206 was reviewed on 8/30/21 at 10:40 a.m. The resident was admitted to the facility on 8/20/21. Diagnoses included, but were not limited to, osteomyelitis, pressure ulcer of sacral region, stage 4, high blood pressure, peripheral vascular disease, weakness, type 2 diabetes mellitus, and congestive heart failure. The Admission Minimum Data Set (MDS) assessment, dated 8/26/21, was in process. Physician's Orders, dated 8/21/21, indicated Piperacillin (an antibiotic) 3.375 grams IV every 8 hours Interview with the East Unit Manager on 9/1/21 at 10:30 a.m., indicated the PICC line ports were to be capped after use.		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: 9/13/21**	

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6. On 8/26/21 at 8:54 a.m. the Director of Nursing (DON) was observed swabbing the employees in the rehab dining room. The DON was dressed in an isolation gown, a face shield, disposable gloves, and a surgical face mask. The DON continued to swab the employees changing out her gloves after each swab and performing hand hygiene.

Interview with the DON at that time, indicated she was not sure if she needed to wear a N95 face mask during employee testing for COVID-19.

The updated 7/8/21 CDC guidance for "Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing," indicated "For personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use recommended personal protective equipment (PPE), which could include an N95 or higher-level respirator (or face mask if a respirator is not available), eye protection, gloves, and a lab coat or gown."

7. On 8/26/21 at 10:03 a.m., CNA 1 was observed walking into Resident 3's room wearing a surgical face mask and a face shield. She was carrying cup of ice water to give to the resident.

Information posted on the door indicated a gown, gloves, N95 mask and protective eyewear was to be donned when entering the room.

The record for Resident 3 was reviewed on 9/2/21 at 12:30 p.m.

Physician's Orders, dated 8/13/21, indicated droplet isolation.

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	Interview with the East Wing Unit Manager on 9/1/21 at 10:30 a.m., indicated the CNA should have been wearing full PPE (personal protective equipment) before entering the room. 3.1-18(b)			
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.			
	Based on observation and interview, the facility failed to maintain a functional, sanitary and homelike environment related to marred and chipped doors and walls, discolored and dirty floor tiles, lime build up in bathroom sinks, missing drain plugs and missing baseboards for 2 of 2 units observed. (East and West) Findings include: During the Environmental Tour on 8/30/21 from 2:23 p.m.-2:45 p.m. with the Maintenance Supervisor and the Housekeeping Supervisor, the following was observed: 1. East Unit a. In room 110, there were marred and chipped walls . Two residents resided in this room. b. In room 118, there were marred walls and chipped paint. The plastic on the front door was chipped and missing a piece of baseboard near the closet. Two residents resided in this room. c. In room 125, there was chipped paint on the	F 0921	**Dyer Nursing and Rehab Annual Survey:** 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. **F921** **Safe/Functional/Sanitary/Comfortable Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Missing drain plugs replaced and lime build up removed from faucets. All marred walls, door frames and baseboards repaired. Floors cleaned in room 181. **How the facility will identify other residents having the**	09/13/2021

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	wall, chipped paint on the light fixture above the bed and chipped plastic on the door. Two residents resided in this room. d. In room 151, the wall was marred and paint chipped. In the bathroom there was lime build up on the sink faucet and missing the sink plug. One resident resided in this room. e. In room 153, the floor tile was discolored and the paint was peeling around the window sill. The tile in the bathroom was dirty and discolored and the toilet seat was peeling. There were no caps on toilet bolts and there was no plug in the sink. Two residents resided in this room. 2. West Unit a. In room 178, there were marred walls. The door was marred and the baseboard was coming off near the door. Two residents resided in this room. b. In room 179, the room door was missing a piece towards the bottom and the walls were gouged near the closet. Two residents resided in this room. c. In room 181, the floors were dirty with food debris. Two residents resided in this room. Interview with the Maintenance Director and Housekeeping Supervisor, on 8/30/21 at 2:45 p.m., indicated these items were in need of cleaning or repair. 3.1-19(f)		**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;** Staff were re-educated on the procedure of notifying maintenance/environmental services of any necessary repairs/cleaning needed. **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;** Environmental services supervisor/designee will audit 10 rooms per week on alternating floors for Environmental/cleaning issues. Any identified issues will be corrected. Maintenance supervisor/ designee will audit 10 rooms per week on alternating floors for Maintenance issues. Any identified issues will be corrected. 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,	

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			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: 9/13/21**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey. Survey dates: August 25, 26, 27, 30, 31 and September 1 and 2, 2021 Facility number: 000125 Residential Census: 39 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 9/13/21.	R 0000	Please accept the following as the facility's plan of correction. 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. The facility would like to request a desk review.	
R 0246 Bldg. 00	410 IAC 16.2-5-4(e)(6) Health Services - Deficiency (6) PRN medications may be administered by a qualified medication aide (QMA) only upon authorization by a licensed nurse or physician. The QMA must receive appropriate authorization for each administration of a PRN medication. All contacts with a nurse or physician not on the premises for authorization to administer PRNs shall be documented in the nursing notes indicating the time and date of the contact. Based on record review and interview, the facility	R 0246	**R 246 Health Services**	09/13/2021

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	failed to ensure a PRN (as needed) medication was authorized by a licensed nurse prior to being administered by a QMA (qualified medication assistant) for 1 of 7 records reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 8/30/21 at 11:07 a.m. Diagnoses included, but was not limited to, cellulitis of the lower limbs and general weakness. A Physician's Order, dated 1/9/20, indicated Tylenol 500 milligrams (mg) three times a day as needed for pain. The August 2021 Medications flow sheet indicated the resident had taken the Tylenol eleven times and had been signed out by the same staff member. The Assisted Living (AL) Director indicated the staff member was a QMA. The document, "Medication Administration Policy", was provided by the Director of Nursing, on 8/30/21 at 3:50 p.m., indicated", "...PRN medications may only be administered by a QMA after authorization from a licensed nurse or physician.... Interview with AL Director, on 8/30/21 at 1:22 p.m., indicated the QMA worked nights and there wasn't a nurse present. She indicated she did not need a nurses' authorization because it was only Tylenol.		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** R3 experienced no ill effects related alleged deficiency **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 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;** QMA/Licensed nurses were in-serviced on: PRN medication needs approval from a licensed nurse prior to administration. **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;**	

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			Sheffield Nurse Supervisor/Designee will audit 5 resident's MARs weekly for 6 months to ensure prn mediations had prior approval from a licensed nurse. The Supervisor will present a summary of the audits to the Quality Assurance Committee and monitoring will be done quarterly and presented quarterly at the QA meeting. Monitoring will be ongoing by director and facility staff. **Date of Completion: 9/13/21**	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure complete and accurate clinical records were maintained related to a lab not completed as ordered and insulin not recorded as given for 2 of 7 records reviewed. (Residents 7 and 3)	R 0349	**R 349 Clinical Records** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient**	09/13/2021

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	Findings include: 1. Resident 7's closed record was reviewed on 8/30/21 at 12:15 p.m. The resident's diagnoses included, but were not limited to, Parkinson's disease and chronic obstructive pulmonary disease. The resident was discharged from the facility on 8/5/21. On 5/13/21, the Physician ordered a medication to be initiated and to recheck the resident's TSH (thyroid function) in one week. There was no evidence the repeat TSH had been completed in one week. Interview with the Assisted Living Director, on 8/30/21 at 3:35 p.m., indicated she was unable to locate the lab result and it may not have been done. 2. Record review for Resident 4 was completed on 8/30/21 at 10:55 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus and vascular dementia. The August 2021 Physician's Order Summary (POS) indicated orders for: - Novolog (insulin); administer 8 units three times a day - Novolog; inject 1 unit if blood sugar (BS) is greater than 200, 2 units if greater than 250, and 3 units if greater than 300 three times a day. The August 2021 Medication Administration Record (MAR) indicated the resident received the incorrect amount of insulin on the following dates and times. - 8/3/21 at 4:00 p.m., BS 263, received 8 units of Novolog, should have received 2 extra units to equal 10 units - 8/10/21 at 4:00 p.m., BS 219, received 8 units of		**practice?** R4 experienced no ill effects related to deficient practice. R7 experienced no ill effects related to deficient practice. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. Review of all facility residents completed and administration record in place in order to document insulin administration. Review of all facility residents lab orders completed to ensure labs completed as ordered. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Sheffield Manor licensed nursing staff educated on following physician orders and utilizing the administration record. **What quality assurance plans will be implemented to monitor facility performance to ensure**	

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	Novolog, should have received 1 extra unit to equal 9 units - 8/13/21 at 11:00 a.m., BS 226, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/18/21 at 4:00 p.m., BS 221, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/19/21 at 4:00 p.m., BS 248, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/23/21 at 4:00 p.m., BS 206, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/24/21 at 4:00 p.m., BS 245, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/26/21 at 4:00 p.m., BS 216, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/27/21 at 4:00 p.m., BS 218, received 8 units of Novolog, should have received 1 extra unit to equal 9 units - 8/29/21 at 6:00 a.m., BS 256, received 8 units of Novolog, should have received 2 extra units to equal 10 units Interview with the Assisted Living Director on 8/30/21 at 2:59 p.m., indicated the staff should have marked on the MAR the extra units of insulin that was given and they did not.		**corrections are achieved and permanent?** DON/designee will review 3 residents record weekly x 6 months to ensure the licensed staff are following physician orders and documenting insulin. A summary will be presented to the Quality Assurance committee monthly x 6 months or until compliance is met. **By what date the systemic changes will be completed:9/13/21**	