

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/20/2014
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NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F000000	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00147484. This visit included a State Residential Licensure Survey.</p> <p>Complaint IN00147484-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: May 12, 13, 14, 15, 16, 17, 18, 19, &, 20, 2014</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Survey team: Heather Tuttle, RN-TC 5/12-5/17 and 5/19-5/20/14 Lara Richards, RN 5/12-5/16 and 5/19-5/20/14 Yolanda Love, RN 5/12-5/16 and 5/18-5/20/14 Cynthia Stramel, RN 5/13-5/17 and 5/19-5/20/14</p> <p>Census bed type: SNF/NF: 141 Residential: 48 Total: 189</p>	F000000	<p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F000164 SS=D	<p>Census payor type: Medicare: 35 Medicaid: 73 Other: 81 Total: 189</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 22, 2014, by Janelyn Kulik, RN.</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's</p>						

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	<p>records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>Based on observation, record review and interview, the facility failed to ensure privacy was provided while administering a gastrostomy tube medication for 1 of 1 residents observed for gastrostomy tube medications. The facility also failed to ensure a resident's gastrostomy tube was not exposed for 1 of 1 residents reviewed for tube feeding of the 1 resident who met the criteria for tube feeding. (Residents #8 and #158)</p> <p>Findings include:</p> <p>1. On 5/16/14 at 1:44 p.m., LPN #2 entered Resident #158's room to administer a medication by the way of the resident's gastrostomy (a tube inserted through the stomach) tube. The resident was seated in a geri-chair recliner at this time. The LPN proceeded to raise the resident's shirt exposing her stomach to administer the medication. The LPN did not close the door to the resident's room nor did she pull the privacy curtain around the resident. The resident was visible from the hallway.</p> <p>Interview with the LPN at the time, indicated that she should have closed the</p>	F000164	<p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>F-164 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 158 is as follows: The nurse was re-educated regarding maintaining privacy during procedures involving the gastrostomy tube. The corrective action for resident 8 is as follows: The shirt was pulled down over the residents peg tube so it was no longer in view upon observation during rounds. The nurse was re-educated to pull the privacy curtain while performing any procedures involving the PEG tube to maintain privacy and to ensure the PEG tube is inside the resident's shirt/gown after the procedure. How the facility will identify other residents having the potential to be affected by the same deficient practice and</p>	06/06/2014

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	<p>resident's door or pulled the privacy curtain.</p> <p>Interview with the Director of Nursing (DoN) on 5/19/14 at 12:05 p.m., indicated the LPN should have closed the door and/or pulled the privacy curtain while giving the medication.</p> <p>The record for Resident #158 was reviewed on 5/19/14 at 1:12 p.m. The resident's diagnoses included, but were not limited to, cerebral thrombosis with infarction and senile dementia.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 3/7/14, indicated the resident had severe cognitive impairment based on her brief interview for mental status (BIMS) interview.</p>		<p>what corrective action will be taken; All facility residents with peg tubes have the potential to be affected by the same alleged deficient practice. Rounds were made to ensure no other peg tubes were visible from the hallway or while in the rooms. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-serviced held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Ensuring the resident room door is closed and/or privacy curtain is pulled so the peg tube is not visible from the hallway or during any procedure involving the PEG tube. 2. Ensuring a resident's PEG tube is not visible when they are in the hallway or in the room by keeping it contained inside their shirt or gown. 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; Weekly, the Unit Manager/designee will observe 6 residents who have a peg tube to ensure their privacy is maintained during any procedure involving the PEG tube and/or while the resident is in the hallway/room. The facility managers have been assigned a group of residents and their associated rooms. Weekly</p>		

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F000246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>Based on observation and interview, the facility failed to ensure each resident's call light was within reach for 3 of 3 resident's reviewed for call light observation of the 3 residents who met the criteria for call light observation. (Residents #8, #32, and #133)</p> <p>Findings include:</p>	F000246	<p>the managers will audit their residents that have PEG tubes. If the resident has a PEG tube, the manager will ensure the resident's privacy is maintained by keeping the PEG tube under the shirt or gown of the resident. If they observe the PEG tube is visible, the manager will pull down the shirt/gown of the resident to cover the PEG tube. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three 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.</p> <p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p>	06/06/2014	

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	<p>1. On 5/12/2014 at 8:45 p.m., Resident #32 was observed sitting in a wheelchair in his room by his bed. At that time, the resident's call light was located behind him in the lazy boy recliner chair. The call light was completely out of reach for the resident to use. The resident indicated at the time, he could not reach the call light.</p> <p>Interview with CNA #3 on 5/14/14 at 9:30 a.m., indicated the resident could use his call light.</p> <p>2. On 5/13/14 at 9:12 a.m., during an interview with Resident #133, the resident's call light was observed laying on the bed behind the resident who was seated in her wheelchair.</p> <p>On 5/14/14 at 1:40 p.m. the resident was observed sitting in her wheelchair in her room. The residents call light was located laying on her bed and completely out of reach for the resident.</p> <p>Interview with LPN #2 on 5/17/14 at 7:40 a.m., indicated the resident was capable of using her call light.</p> <p>3. On 5/13/2014 at 8:16 a.m., Resident #8 was observed lying in bed. At that time, his call light was noted to be on the</p>		<p>F-246 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for residents 8, 32, and 133 are as follows: Their call lights were placed within their reach. 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 have the potential to be affected by the same alleged deficient practice. Rounds were made to ensure call lights were in reach for the residents who were in their rooms and functioning. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-serviced held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Ensuring the call light is in reach of the resident when they are in bed and/or if sitting in their room or in a recliner 2. Using the clip to hook to attach the call light in reach to prevent the call light from falling off of the bed and/or wheelchair/recliner 3. Ensuring the resident is able to use the particular call light that is available at the bedside. If they are not able to activate the push button call light, alert management so a different type</p>		

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F000278 SS=D	<p>floor behind the oxygen concentrator machine. The call light was completely out of reach for the resident's use.</p> <p>On 5/14/14 at 12:25 p.m., the resident was observed sitting up in a broda chair by his bed. His call light was located behind his left shoulder and he was not able to reach it.</p> <p>On 5/15/14 at 8:25 a.m., and 9:25 a.m., the resident was lying in bed. The resident's call light was laying in the lazy boy chair and was completely out of reach for the resident.</p> <p>Interview with the East Wing Unit Manager on 5/19/14 at 11:34 a.m., indicated all of the above residents could use their call lights.</p> <p>3.1-3(v)(1)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p>		<p>may be provided. 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; The facility managers have been assigned a group of residents and their associated rooms. Weekly 25 room inspections will be completed to ensure the call light is in reach while the resident is in their room in bed or the wheelchair/recliner. Any call light observed not in reach, will be attached immediately by the person completing the audit. A summary of the audits will be presented to the Quality Assurance committee monthly by Administrator/designee for three 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.</p>				

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	<p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure the Minimum Data Set (MDS) Assessment was accurately coded related to the use of an antianxiety medication for 2 of 5 residents reviewed for unnecessary medications. (Residents #24 and #75)</p> <p>Findings include:</p> <p>1. The record for Resident #24 was reviewed on 5/16/14 at 7:53 a.m. The resident's diagnoses included, but were not limited to, anxiety and depressive disorder.</p> <p>A Physician's Order dated 12/18/13 and listed on the May 2014 Physician's Order Summary (POS), indicated the resident</p>	F000278	<p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>F-278</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 24 is as follows: MDS assessment dated 5/7/14 was modified on 5/19/14 MDS assessment dated 2/11/14 was modified on 5/27/14 The corrective action for resident 75 is</p>	06/06/2014

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	<p>was to receive Buspar (an antianxiety medication) 10 milligrams (mg) three times a day.</p> <p>Review of the 2/11/14 and 5/7/14 Quarterly Minimum Data Set (MDS) Assessments, indicated the resident was coded as a "0" for receiving antianxiety medications within the past 7 days for Section N Medications.</p> <p>Interview with MDS Staff Member #1 on 5/19/14 at 12:14 p.m., indicated that she coded the Buspar inaccurately. She indicated that she coded it as an antidepressant rather than as an antianxiety medication.</p>		<p>as follows: MDS assessment dated 2/16/14 was modified on 5/19/14 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 have the potential to be affected by the same alleged deficient practice. Current MDS's were reviewed by the MDS team and any sections coded inaccurately were amended. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service to be held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Coding accurate classifications of medications information for the MDS Section N 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; Director of Nursing/designee will audit 5 MDS's weekly to ensure the classifications of medications have been coded accurately in Section N. Audit tool attached. If any sections were coded incorrectly, the MDS will be modified as soon as possible. A summary of the audits will be presented to the Quality Assurance committee monthly by</p>		

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to the administration of insulin for 1 of 5 residents reviewed for unnecessary medications. The facility also failed to ensure that a CNA did not perform duties outside of her scope of practice related to applying medicated ointments for 1 of 3 residents reviewed for urinary catheter use of the 3 who met the criteria for urinary catheter use. (Residents #24 and #223)</p> <p>Findings include:</p> <p>1. The record for Resident #24 was reviewed on 5/16/14 at 7:53 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p>	F000282	<p>Director of Nursing/designee for three 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.</p> <p>F-282 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What correctiveaction(s) will be accomplished for those residents found to have been affectedby the deficient practice;</p> <p>Thecorrective action for resident 24 is as follows: Thecare plan and current orders were reviewed to identify any necessary changes tothe current interventions listed. The resident had no negative outcomes relatedto the insulin not being signed out to show it was given as ordered.</p>	06/06/2014

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	<p>A Physician's Order dated 4/22/14, indicated the resident was to receive Novolog (a type of insulin) by the way of a sliding scale four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The resident was to receive the following dose of insulin based on her blood sugar:</p> <p>151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units Call MD (Medical Doctor) if blood sugar below 60 or above 400</p> <p>Review of the May 2014 Diabetic flow sheet indicated the following:</p> <p>5/2/14 at 6:00 a.m., blood sugar 200 no insulin signed out as given.</p> <p>5/9/14 at 6:00 a.m., blood sugar 288 no insulin signed out as given.</p> <p>5/12/14 at 4:00 p.m., blood sugar 183 no insulin signed out as given.</p> <p>5/13/14 at 8:00 p.m., blood sugar 338 no insulin signed out as given.</p> <p>5/16/14 at 8:00 p.m. no blood sugar documented.</p>		<p>The corrective action for resident 223 is as follows: The Nystop powder was removed from the bed side cabinet. The resident did not have any negative outcomes from the Certified Nursing Assistant applying the treatment. The resident was assessed and Nystop discontinued.</p> <p>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;</p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. The care plans and orders of the diabetic residents were reviewed for any necessary changes. Care plans were updated as needed. Rounds were made of the bedside cabinets to identify any other treatment products that should be kept in the treatment cart. Any products that were found were immediately removed and stored in the treatment cart.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>In-service held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Reading the insulin orders to identify when blood sugars should</p>				

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	<p>Review of the 5/2014 Medication Administration Record (MAR), indicated to "see flow sheet" for the sliding scale insulin administration.</p> <p>Review of the plan of care dated 10/6/13, which was reviewed on 4/30/14, indicated the problem of Potential for acute hypo/hyperglycemia (low and high blood sugar) episode secondary to diagnosis of diabetes mellitus. The interventions included, but were not limited to, administer medications as ordered and monitor blood sugars as ordered by the Physician and record.</p> <p>Interview with the West Unit Manager on 5/19/14 at 10:35 a.m., indicated the resident's insulin should have been documented as given on the diabetic flow sheet.</p>		<p>be taken and whatcoverage should be administered</p> <p>2.Recordingthe blood sugars on the glucose record form 3. Recordingthe amount of insulin administered based on the physician orders 4. Whattreatments may be applied by a C.N.A. 5 Appropriateitems that may be stored at the bed side</p> <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance programs will be put into place;</p> <p>Weekly,the Unit Manager/designee will audit 15 diabetic residents insulin and glucoseflow sheets to ensure the blood sugars are being recorded and the properinsulin coverage is being provided according to the physician orders.</p> <p>The facility managers have been assigned a group of residents and their associatedrooms. Weekly 25 room inspections will be completed to ensure only appropriateitems are stored at the bedside. Any inappropriate item observed at the bedside will be removed by the manager immediately and stored in the appropriatelocation such as the treatment cart.</p> <p>A summary of the audits will be presented to the Quality Assurance committeemonthly by Director of Nursing/designee for six months. Thereafter, if</p>		

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F000325 SS=D	<p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident -</p> <p>(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and</p> <p>(2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>Based on observation, record review, and interviews, the facility failed to ensure each resident received the necessary treatment and services to maintain acceptable parameters of nutrition related to providing ongoing monitoring for residents with significant weight loss for 2 of 3 residents reviewed for nutrition of the 9 who met the criteria for nutrition. (Residents #8 and #75)</p> <p>Findings include:</p> <p>1. On 5/14/14 at 12:25 p.m., Resident #8 was observed sitting up in a broda chair by his bed. At that time, there was a enteral feeding pump located by his bed, however, it was turned off.</p>	F000325	<p>determined by the QualityAssurance committee, auditing and monitoring will be done quarterly and presentquarterly at the QA meeting. Monitoringwill be on going.</p> <p>F-325 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. Whatcorrective action(s) will be accomplished for those residents found to havebeen affected by the deficient practice; Thecorrective action for resident 8 is as follows: Resident8 was reviewed in NAR on 5/28/14, no new recommendations. Resident has had nosignificant weight change</p>	06/06/2014	

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	<p>The record for Resident #8 was reviewed on 5/16/14 at 8:45 a.m. The resident's diagnoses included, but were not limited to, Percutaneous Endoscopic Gastrostomy (PEG) tube, anxiety, dementia, nausea, pain, diverticulosis, dysphasia, behavioral problems, muscle weakness, esophageal reflux, and mental disorder.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment dated 4/21/14, indicated the resident was not alert and oriented and had memory problems and was moderately impaired for decision making. The resident had no mood or behavior problems. He was an extensive assist with the assist of two for bed mobility, transfers and toilet use. He was an extensive assist with the assist of one for dressing and eating. The resident had no oral problems and his weight was 160 pounds with no weight loss or gain noted in the last month or six months. The resident had a feeding tube as well as a mechanically altered diet. He received 51% or more of his nutrition through enteral feedings. The resident was currently receiving the services of Hospice.</p> <p>Review of the resident's weight record indicated the following:</p>		<p>in the past 5 months and is above BMI. The corrective action for resident 75 is as follows: Resident 75 was reviewed in NAR on 5/28/14, no new recommendations. Continue with weekly weights. 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 have the potential to be affected by the same alleged deficient practice. Seating charts were reviewed to identify those who need assistance feeding and to evaluate where they are currently seating and if they need to be moved to a feeder table. Food consumption records were audited to identify trends/patterns. Weekly weight records were reviewed to identify any missing entries and any resident that has had a downward trend in weights. Any resident identified with a downward trend in weight was added to next the Nutrition at Risk meeting. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service was held on May 30, 2014 by Director of Nursing/designee regarding</p>				

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	<p>12/7/13 he weighed 175 pounds 12/10/13 he weighed 170 pounds 12/10/13 reweigh of 170 pounds 12/17/13 he weighed 164 pounds 12/24/13 he weighed 165 pounds 1/1/14 he weighed 152 pounds 1/15/14 he weighed 155 pounds</p> <p>Review of the Registered Dietitian's (RD) Progress Notes dated 12/11/13 indicated significant weight changes over past six months. Most wounds healed but one declined. Resident still within ideal weight range and Body Mass Index (BMI). No recommendations at this time. Continue to monitor.</p> <p>An RD Progress Note dated 12/18/13 indicated follow up weight of 164 pounds. Resident with 5.8 pound weight loss over past week. Discussed in Nutrition At Risk (NAR) today. Recommend supercereal at breakfast and continue to monitor. The next documented RD note was not until 1/1/14 (14 days later) which indicated the resident now weighed 152 pounds. The resident's labs, skin, and his significant weight loss over past month of 13% were all addressed. The resident's oral intake was poor. Recommend 120 cubic centimeters(cc) of the house supplement two times a day and an appetite stimulant.</p>		<p>thefollowing:</p> <ol style="list-style-type: none"> 1.Recordingthe amount of food consumption for each resident for every meal. 2.Checkingthe weekly weight binder to identify those residents who require a weeklyweight. 3.UnitManagers are to review the weekly weights to identify any resident who has had a significant change. Those residents will be reviewed in the upcomingNutrition at Risk meeting 4.Forthose residents who require assistance in feeding, trays will not be placed infront of them until staff is ready to assist them. Once the tray is placed infront of the resident, prepare the tray and then start offering the meal. <p>How the correctiveaction(s) will be monitored to ensure the deficient practice will not recur,i.e., what quality assurance programs will be put into place;</p> <p>Directorof nursing/designee will audit the food consumption records 3 times weekly for10 residents on each unit. Any missing entries will be addressed with the staffmember responsible for the entry.</p> <p>Directorof nursing/designee will audit the weekly weight binder each week to identifyany resident who was not weighed. A weight will be obtained immediately.</p>				

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	<p>Review of Physician Orders from 8/29/13 through 11/14/13 indicated the resident was to receive a mechanical soft diet with honey thick liquids. On 11/14/13 a new Physician Order was obtained for the resident to receive a pureed diet with honey thick liquids.</p> <p>Review of the food consumption logs from 12/1-12/31/13 indicated many meal intakes were missing and/or not documented. There were no recorded meal intakes for breakfast on 12/1, 12/3,12/4,12/5, 12/6, 12/7, 12/9, 12/10, 12/11, 12/13, 12/14, 12/15, 12/17, 12/23-12/26, 12/28, 12/29, and 12/31/13. There were no recorded meal intakes for lunch on 12/1, 12/3-12/7, 12/9-12/15, 12/17-12/21, and 12/23-12/31/13. There were no recorded meal intakes for dinner on 12/1, 12/5, 12/8, 12/11, 12/14, 12/15, 12/20, and 12/24-12/30/13.</p> <p>Review of Nursing Progress Notes dated 1/6/14 indicated the resident was admitted to the hospital and returned on 1/16/14 with a PEG tube and on Hospice care.</p> <p>Interview with the East Wing Unit Manager on 5/19/14 at 11:34 a.m., indicated she was not the Unit Manager back in December. She indicated the</p>		<p>Anymissing weights will be addressed with the staff member assigned to obtain theweight.</p> <p>Directorof nursing/designee will observe each meal twice weekly to ensure trays havenot been set in front of a resident without assistance present. If a residentis observed needing assistance, a staff member will be assigned immediately. Re-educationwill be provided to the staff member who set the tray in front of them prior tostaff being ready to assist with feeding.</p> <p>Asummary of the audits will be presented to the Quality Assurance committeemonthly by Director of Nursing/designee for three months. Thereafter, if determined by the Quality Assurancecommittee, auditing and monitoring will be done quarterly and present quarterlyat the QA meeting. Monitoring will be ongoing.</p>				

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	<p>resident's food consumption logs were incomplete.</p> <p>Interview with the Director of Nursing on 5/19/14 at 2:10 p.m., indicated the resident's food consumption logs were incomplete. She further indicated the NAR committee reviews residents when there was a change in their weight, so the resident would not have been reviewed again until the 13 pounds weight loss identified on 1/1/14.</p> <p>2. On 5/14/14 at 12:05 p.m., Resident #75 was observed sitting in her wheelchair in the East Unit Dining Room. At that time, the resident received a pureed diet of fish, cauliflower, peas, and cake. The resident also received thickened milk, juice, coffee, and water.</p> <p>Continued observation at 12:19 p.m., indicated the resident still had not been helped with her meal. At 12:25 p.m., a nurse sat down to assist the resident with her meal.</p> <p>On 5/15/14 at 8:15 a.m., the resident was observed sitting up in her wheelchair at a table in the East Unit Dining Room. Further observation indicated there was a spoon in her hot cereal, but no staff were observed helping her eat her meal. There was one CNA sitting beside her feeding</p>						

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	<p>another resident, but paying no attention to Resident #75. At 8:25 a.m. the CNA turned to the resident to assist her with her meal.</p> <p>The record for Resident #75 was reviewed on 5/14/14 at 12:07 p.m. The resident's diagnoses included, but were not limited to, high blood pressure, diabetes mellitus, dementia, depressive disorder, hypoglycemia, nausea, anxiety, congestive heart failure, pain, weakness, adult failure to thrive, and dysphasia.</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment dated 2/16/14 indicated the resident was not alert and oriented. The resident had no behaviors. The resident was an extensive assist with a 2 person assist for bed mobility and transfers. She was an extensive assist with one person assist for eating. The resident had no swallowing problems, no weight loss or weight gain in past month or last six months.</p> <p>Review of Physician Orders on the current 5/2014 recap indicated a pureed diet with nectar thick liquids and supercereal at breakfast. There was also an order dated 2/20/14 which indicated house supplement 90 cubic centimeters (cc) twice a day. Continued review of Physician Orders dated 3/5/14 indicated</p>			

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	<p>weekly weights times four weeks.</p> <p>Review of the weight record indicated the following:</p> <p>11/1/13 the resident weighed 112 pounds 12/3/13 the resident weighed 106 pounds 1/1/14 the resident weighed 104 pounds 2/4/14 the resident weighed 107 pounds 3/1/14 the resident weighed 103 pounds 3/11/14 the resident weighed 103 pounds 3/18/14 the resident weighed 102 pounds 3/25/14 the resident weighed 103 pounds 3/19/14 the resident weighed 102 pounds 4/9/14 the resident weighed 99 pounds 4/9/14 the resident weighed 105 pounds 5/5/14 the resident weighed 100 pounds</p> <p>Review of the Registered Dietitian's (RD) Progress Notes dated 12/11/13 indicated the resident's weight was 106 pounds. Last month's weight was 112 pounds. There was a significant weight loss of 5% over past month. Oral intakes were 25-75%. Recommend 60 cc house supplement twice a day to help prevent further weight loss.</p> <p>Review of the NAR note dated 12/11/14 indicated recommend weekly weights and house supplement 60 cc twice a day.</p> <p>The next RD Progress Note was not until 2/19/14 which indicated the resident had</p>				

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	<p>a 5.6% weight loss over the past six months. The resident's weight was stable over last two months. The resident's Body Mass Index (BMI) was low. Recommend to increase house supplement to 90 cc twice a day due to continued low BMI.</p> <p>Review of a NAR note dated 3/5/14 indicated a recommendation of weekly weights times one month.</p> <p>The next documented note in Dietary was by the Dietary Food Manager (DFM) dated 3/25/14 which indicated the resident was on a mechanical altered pureed diet with nectar thick liquids. Will review resident's weight at NARS.</p> <p>The next and last RD Progress Note was dated 5/7/14. The RD indicated the resident's weight was 100 pounds and had been stable over last 5 months. There were no recent labs for review. The weight report indicated the resident has had a significant weight loss of 10.3% over the last six months. There were no recommendations at that time.</p> <p>Interview with the Director of Nursing on 5/14/14 at 10:35 a.m., indicated there were no December weekly weights completed for the resident. She further indicated the resident was only reviewed</p>			

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F000329 SS=D	<p>in Nutrition at Risk on 12/11/13 and 3/5/14. She further indicated the RD visited the facility on a weekly basis.</p> <p>Interview with the RD at that time, indicated she would only review a resident in NAR if they would trigger for something, like a significant weight loss, a new pressure ect.... She further indicated she would not have known if the resident needed to be reviewed after 12/11/13 because there was no triggered weight loss due to no weekly weights obtained.</p> <p>3.1-46(a)(1)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and</p>			

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	<p>residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review and interview, the facility failed to ensure Physician's orders and/or the plan of care were followed as written related to the administration of insulin for 1 of 5 residents reviewed for unnecessary medications. (Resident #24)</p> <p>Findings include:</p> <p>The record for Resident #24 was reviewed on 5/16/14 at 7:53 a.m. The resident's diagnosis included, but was not limited to, diabetes mellitus.</p> <p>A Physician's Order dated 4/22/14, indicated the resident was to receive Novolog (a type of insulin) by the way of a sliding scale four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m., and 8:00 p.m. The resident was to receive the following dose of insulin based on her blood sugar:</p> <p>151-200=4 units 201-250=8 units 251-300=12 units 301-350=16 units 351-400=20 units Call MD (Medical Doctor) if blood sugar</p>	F000329	<p>F-329 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 24 is as follows: The care plan and current orders were reviewed to identify any necessary changes to the current interventions listed. The resident had no negative outcomes related to the insulin not being signed out to show it was given as ordered. 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 have the potential to be affected by the same alleged deficient practice. The care plans and orders of the diabetic residents were reviewed for any necessary changes. Care</p>	06/06/2014

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	<p>below 60 or above 400</p> <p>Review of the May 2014 Diabetic flow sheet indicated the following:</p> <p>5/2/14 at 6:00 a.m., blood sugar 200 no insulin signed out as given.</p> <p>5/9/14 at 6:00 a.m., blood sugar 288 no insulin signed out as given.</p> <p>5/12/14 at 4:00 p.m., blood sugar 183 no insulin signed out as given.</p> <p>5/13/14 at 8:00 p.m., blood sugar 338 no insulin signed out as given.</p> <p>5/16/14 at 8:00 p.m. no blood sugar documented.</p> <p>Review of the 5/2014 Medication Administration Record (MAR), indicated to "see flow sheet" for the sliding scale insulin administration.</p> <p>Interview with the West Unit Manager on 5/19/14 at 10:35 a.m., indicated the resident's insulin should have been documented as given on the diabetic flow sheet.</p> <p>3.1-48(a)(3)</p>		<p>plans were updated as needed.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</p> <p>In-serviced held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Reading the insulin orders to identify when blood sugars should be taken and what coverage should be administered 2. Recording the blood sugars on the glucose record form 3. Recording the amount of insulin administered based on the physician orders How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place; Weekly, the Unit Manager/designee will audit 15 diabetic residents insulin and glucose flow sheets to ensure the blood sugars are being recorded and the proper insulin coverage is being provided according to the physician orders. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for six months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.</p>		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation and interview, the facility failed to ensure food was served under sanitary conditions related to staff handling resident's food with bare hands in 2 of 3 dining rooms observed. (The Main Dining Room and the East Unit Assisted Dining Room)</p> <p>Findings include:</p> <p>On 5/13/14 at 12:13 p.m., an observation was made in the East unit assisted dining room. CNA #5 removed bread from the paper wrapper with her bare hands and placed it on a resident's tray.</p> <p>Interview with the CNA at 12:30 p.m., indicated she had used her bare hands to assist the resident with the bread.</p> <p>On 5/13/14, the following observations were made in the Main dining room</p>	F000371	<p>F-371 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; There were no negative outcomes related to the staff opening and preparing the bread with their hands. 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 have the</p>	06/06/2014			

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	<p>during lunch:</p> <p>At 12:10 p.m., 12:15 p.m. and 12:18 p.m., CNA #1 was observed removing separate resident's bread from the paper wrappers with her bare hands. At those times, she was observed to use her bare hands to spread the butter on the bread.</p> <p>At 12:19 p.m., LPN #2 was observed removing a resident's bread from the paper wrapper with her bare hands, and then put butter onto the bread with bare hands.</p> <p>At 12:22 p.m., CNA #2 was observed removing a resident's bread from the paper wrapper with her bare hands, and then put butter onto the bread with bare hands.</p> <p>Interview with the Dietary Manager and CNA #1 on 5/13/14 at 12:25 p.m., indicated staff should not touch resident's food with bare hands. The Dietary Manager indicated they should wear clean gloves. She indicated to LPN #1 and CNA #2 at that time that they should wear clean gloves when touching the residents food.</p> <p>3.1-21(i)(3)</p>		<p>potential to be affected by the same alleged deficient practice. An in-service was immediately completed with facility staff who assist in the dining rooms to re-educate them about not touching any of the resident's food with their bare hands. Rounds were made during the meals following to ensure compliance was maintained.</p> <p>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service was held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Proper measures of protection in preventing food borne illness 2. Using the utensils to set up/prepare the food when needed to prevent touching the food with their bare hands 3. If not possible to use the utensils to prepare the food, wearing gloves to prevent touching the food with their bare hands Return demonstration was required of the staff to show proper buttering of the bread to prevent their bare hands touching the bread. Residents were informed of the new way the staff will be buttering their bread at the Residents Food Council meeting held on May 28, 2014. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>		

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F000431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and</p>		<p>programs will be put into place; Director of nursing/designee will complete observations twice weekly of all three meals to ensure the staff is following proper procedures to prevent their bare hands touching any of the residents food items. If any staff member is observed making contact with the food with their bare hands it will be discarded immediately and they will be shown the proper technique immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three 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.</p>		

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	<p>cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, record review and interview, the facility failed to ensure medications were stored in a locked compartment during 2 of 7 observations of medication administration. (Residents #7, #30, #221, and #225)</p> <p>Findings include:</p> <p>1. On 5/20/14 at 6:22 a.m., 1 of 3 medication carts located on the West Unit was in the hallway located next to Room 158. On top of the medication cart was a bottle of Robitussin cough syrup for Resident #221, a vial of Novolog insulin for Resident #30, and 3 bottles of Megace (an appetite stimulant) for Resident #225. LPN #1, who was</p>	F000431	<p>F-431</p> <p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 221 is as follows: The Robitussin cough syrup was properly stored in the medication cart. The corrective action for</p>	06/06/2014

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	<p>assigned to the medication cart, was seated at the Nurses' station at this time.</p> <p>Interview with LPN #1 at the time, indicated that she was called away from her cart. She indicated the medications should not have been left on top of the cart unattended.</p> <p>2. On 5/20/14 at 6:49 a.m., RN #1 was observed preparing Resident #7's medications. The resident was not in her room at the time and the RN proceeded down the hall to give the resident her medications. The RN did not lock the medication cart and the medication cart was not in the RN's view.</p> <p>Review of the facility policy titled "Storage and Expiration of Medications, Biologicals, Syringes and Needles" provided by the Director of Nursing on 5/20/14 at 7:45 a.m. and identified as current, indicated the following: General Storage Procedures: Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors."</p> <p>Interview with the Director of Nursing (DoN) on 5/20/14 at 7:00 a.m., indicated</p>		<p>resident 30 is as follows: The vial of Novolog insulin was properly stored in the medication cart. The corrective action for resident 225 is as follows: The bottles of Megace was properly stored in the medication cart. The corrective action for resident 7 is as follows: The medication cart was locked upon the nurse's return after delivering the medications. 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 have the potential to be affected by the same alleged deficient practice. Rounds were made of the other medications carts to ensure they were no medications not properly stored and the carts were locked if not in use. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service was held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Proper storage of medications 2. What items can be on top of a medication cart 3. Locking the medication cart when not in use or in eye view How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance</p>		

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F000441 SS=E	<p>the medications should have been stored either in the medication room or the medication cart. She also indicated the medication cart was to be locked when not in view.</p> <p>3.1-25(m)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and</p>		<p>programs will be put into place; Director of nursing/designee will complete observations weekly on all three shifts of each medication cart to ensure the medications carts are locked when not in use or eye view, and all medications are properly stored. Any areas of non-compliance will be corrected immediately with the nurse assigned to that medication cart. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three 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.</p>		

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	<p>corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, record review and interview, the facility failed to ensure therapy staff were informed of what type of isolation a resident was in for 1 of 1 residents reviewed who were in isolation. The facility also failed to ensure wash basins and bed pans were stored properly on 2 of 2 units throughout the facility. (Resident #225 and the West and East units)</p> <p>Findings include:</p> <p>1. On 5/13/14 at 8:15 a.m., an isolation set up was observed outside of Resident #225's room. A sign was also on the door indicating for visitors to check with</p>	F000441	<p>F-441</p> <p>Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 225 is as follows: Therapy was re-educated regarding the type of isolation for</p>	06/06/2014

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	<p>staff prior to entering the resident's room.</p> <p>Interview with the West Unit Manager on 5/13/14 at 8:20 a.m., indicated the resident was in contact isolation due to ESBL (Extended spectrum beta-lactamase infection) and VRE (Vancomycin resistant enterococci) in his urine and respiratory isolation due to MRSA (Methicillin-resistant Staphylococcus aureus) in his nares.</p> <p>On 5/14/14 at 8:30 a.m., Resident #225 was observed in the hall with COTA #1. When asked what type of isolation the resident was in, the COTA indicated contact for ESBL and VRE to urine and stool. The COTA was not aware the resident was also in respiratory isolation for MRSA to his nares. She indicated she was only filling in today.</p> <p>The record for Resident #225 was reviewed on 5/14/14 at 12:09 p.m. The resident's diagnoses included, but were not limited to, urinary tract infection and infection resistant to penicillin.</p> <p>A Physician's Order dated 5/4/14 indicated, contact isolation for VRE in urine and respiratory isolation due to MRSA of nares.</p> <p>A Plan of care was initiated on 5/5/14</p>		<p>the resident and the appropriate precautions. The care plan and the orders were reviewed for accuracy. The pink fracture bed pan in room 105 was removed and placed in the trash container. A new bed pan was provided. The wash basin in room 107 was removed and placed in the trash container. A new wash basin was provided. The wash basin and bed pan in room 170 were removed and the placed in the trash container. A new wash basin and bed pan was provided. The sippy cup observed in room 169 was removed from the back of the toilet, washed and given back to the family (it was the visiting grandchild's sippy cup). The wash basins observed in the bathroom were removed and placed in the trash container. New wash basins were provided to both residents in the room. The toilet seat was cleaned and placed in a plastic bag and stored in the bedside cabinet. 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 have the potential to be affected by the same alleged deficient practice. Room rounds were completed to ensure resident's personal items were properly bagged and/or stored. What measures will be put into place or what systemic changes will be made to</p>		

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	<p>indicating the resident had been placed in contact/respiratory isolation to prevent the spread of infection to self/others related to VRE urine and MRSA to nares.</p> <p>Interview with the Director of Nursing on 5/19/14 at 10:15 a.m., indicated Therapy staff were informed daily in morning meeting of what type of isolation the residents were in. She indicated the COTA should have been aware of what type of isolation the resident was in.</p>		<p>ensure that the deficient practice does not recur; In-service was held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. Appropriate storage of urinals/bed pans/wash basins 2. After cleaning out the bed pans, they should be placed in a plastic bag and stored in the bedside cabinet 3. Wash basin are not to be left on the floor in the bathroom or on the back of the toilet. They should also be cleaned after use, wiped dry and stored in the bedside cabinet. 4. No resident or family items should be stored on the back of the toilet 5. Isolation signs, set up and reporting to the nurse prior to entering an isolation room to identify the type of pathogen and location 6. Appropriate personal protection wear when entering an isolation room depending on the type of isolation 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; Weekly 25 room inspections will be completed by department managers to ensure proper storage of resident personal items. If found, the item will be stored per proper procedure immediately. The Administrator/designee will interview the therapy staff weekly to ensure they know who is on isolation and the type of isolation.</p>		

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F000465 SS=D	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 ensure the resident's environment was clean and in good repair related to marred closet doors, loose and broken molding, spillage on room walls, discolored floor tile, and rusted toilet paper and electrical outlets for 2 of 2 Units. (The East and West Units)</p> <p>Findings include:</p> <p>1. On 5/19/14 at 11:30 a.m., during the Environmental Tour the following was observed on the East Unit:</p> <p>A. In room 114 the floor mat next to the bed had multiple holes in it and was torn in several places. There were two</p>	F000465	<p>The Administrator/designee will update any therapy staff that is unaware of the current isolation status. A summary of the audits will be presented to the Quality Assurance committee monthly by Administrator/designee for three 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.</p> <p>F-465 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective actions were as follows: A new floor mat was provided next to the bed in room 114 R 220's wheel chair arm rest was repaired. The</p>	06/06/2014

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	<p>residents who resided in the room.</p> <p>B. Resident #220's wheelchair arm was loose and wobbly. The resident herself indicated that it drove her nuts. Further observation in room 16 indicated the molding on the door frame was loose and broken. The resident's room door would not close all the way due to the broken molding. There were two residents who resided in the room.</p> <p>C. The bathroom fixtures such as the electrical outlets and the toilet paper holders were rusty in rooms 121, 123, 124, and 125. There were two residents who resided in those rooms.</p> <p>D. The molding on the door frame was loose and broken in room 107. There were two residents who resided in the room.</p> <p>E. There was paint peeling away from the wall by the closet door in room 118. The door molding was loose and chipped. There were two residents who resided in the room. Room 118</p> <p>F. The bathroom sink caulking was cracked in room 125. The wall was also marred behind chair. There were two residents who resided in the room.</p>		<p>molding on the door frame of room 16 was repaired. The rusty electrical outlets and toilet paper holders were replaced in rooms 121, 123, 124, 125 The molding of the door frame in room 107 was repaired. The wall was painted by the closet door in room 118 as well as the loose door molding repaired. The bathroom sink caulk of room 125 was repaired as well as the marred wall painted. The chipped paint under the soap dispenser and the marred closet door was repaired in room 122. The wall besides the bed in room 108 was cleaned. The loose door molding around the bathroom door and the marred base board were repaired. The marred closet door in room 109 was repaired. The discoloration of the floor tile in room 158 was removed 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 have the potential to be affected by the same alleged deficient practice. Rounds were made by the maintenance staff to identify similar issues in need of repair. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service to be held on May 30, 2014 by Director of</p>				

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	<p>G. There was chipped paint noted under the soap dispenser in room 122. The closet door was also marred. There were two residents who resided in the room.</p> <p>H. There was a large amount of brown spillage noted on the wall beside the bed in room 108. The base board was marred and the door molding was loose fitting and broken around the bathroom door. There were two residents who resided in the room.</p> <p>I. The closed doors were marred in room 109. There were two residents who resided in the room.</p> <p>2. On 5/19/14 at 11:45 a.m., during the Environmental Tour the following was observed on the West Unit:</p> <p>A. The floor tile was discolored by the resident's bed in room 158. There were two resident's who resided in the room.</p> <p>Interview with the Maintenance Director on 5/19/14 at 12:00 p.m., indicated all of the above was in need of cleaning and or repair.</p> <p>3.1-19(f)</p>		<p>Nursing/designee regarding the following: 1. Completing Work Orders for any issues the staff observe during their rounds or while providing care. 2. The location of blank Work Orders and where to put them after completion. 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; The facility managers have been assigned a group of residents and their associated rooms. Weekly the managers will complete 25 room inspections to identify any environmental issues in need of repair. The manager will complete a Work Order and place it in the appropriate location. A summary of the audits will be presented to the Quality Assurance committee monthly by Maintenance Supervisor/designee for three 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. at the QA meeting. Monitoring will be on going.</p>		

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F000498 SS=D	<p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. Based on observation, interview and record review, the facility failed to ensure a Certified Nursing Assistant (CNA) performed within the scope of practice related to a CNA applying prescription topical powder to a resident during catheter care. (Resident #223)</p> <p>Findings include:</p> <p>The record for Resident #223 was reviewed on 5/14/14 at 2:27 p.m. The resident was admitted to the facility on 4/23/14 following gallbladder surgery. Resident diagnoses included, but were not limited to, altered mental status and urinary retention. The resident had a Foley catheter for urinary management.</p> <p>On 5/16/14 at 1:30 p.m., an observation of the resident's catheter care was made with CNA #1 and an assistant CNA. After cleansing and drying the resident's</p>	F000498	<p>F-498 Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 223 is as follows: The Nystop powder was removed from the bed side cabinet. The resident did not have any negative outcomes from the Certified Nursing Assistant applying the treatment. The resident was assessed and Nystop discontinued. How the facility will identify other</p>	06/06/2014
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	<p>groin and peri area, CNA #1 removed a bottle of powder from the resident's dresser drawer. She applied the powder to the groin area. She indicated the resident had no redness to that area because she applied powder all the time. She indicated the powder was called Nystop (a prescription anti-fungal medication). The bottle was observed and labeled Nystop.</p> <p>The May 2014 Treatment Administration Record indicated Nystop was to be applied two times a day under the breasts and abdominal folds, it did not indicate it was to be applied to the groin area.</p> <p>Interview on 5/16/14 at 2:00 p.m. with RN #1 indicated CNA's should not apply prescription topical medications, nurses were required to do that. She also indicated the powder was not ordered to be applied the groin area.</p> <p>3.1-14(i)</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. Rounds were made of the bedside cabinets to identify any other treatment products that should be kept in the treatment cart. Any products that were found were immediately removed and stored in the treatment cart. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-serviced was held on May 30, 2014 by Director of Nursing/designee regarding the following: 1. What treatments may be applied by a C.N.A. 2. Appropriate items that may be stored at the bed side 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; The facility managers have been assigned a group of residents and their associated rooms. Weekly the manager will complete 25 room inspections to ensure only appropriate items are stored at the bedside. Any inappropriate item observed at the bed side will be removed by the manager immediately and</p>		

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R000000	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-5.	R000000	stored in the appropriate location such as the treatment cart. A summary of the audits will be presented to the Quality Assurance committee monthly by Director of Nursing/designee for three 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.		
R000349	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 maintain clinical records that were complete and	R000349	R349 Dyer Nursing and Rehabilitation Center respectfully requests a	06/06/2014	

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	<p>accurately documented related to the indication for the use of an antipsychotic medication, documentation related to a hospital transfer and follow up documentation after a medication was initiated for 4 of 7 sampled residents. (Residents #2, #4, #5, and #6)</p> <p>Findings include:</p> <p>1. The record for Resident #4 was reviewed on 5/19/14 at 3:05 p.m. The resident's diagnosis included, but was not limited to, dementia.</p> <p>Documentation in the Nursing Progress Notes dated 3/12/14 (no time) indicated, staff had reported the resident was on the call light all night asking if it was time to get up yet. The next documented entry on 3/14/14 at 12:15 p.m., indicated the resident's Physician's office was contacted to see if an order could be obtained for something to help the resident rest at night due to her being very anxious, on the call light all night and not sleeping. A new order was received on 3/20/14 (six days later), for Alprazolam (an antianxiety medication) 0.25 milligrams (mg) give a half tablet to equal 0.125 mg at night for restlessness and anxiety. Documentation on 3/20/14 at 11:00 a.m., indicated the resident continued to put on the call light</p>		<p>desk review in place of a follow-up visit. Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The corrective action for resident 4 is as follows: The physician was contacted by the Resident Care Coordinator and the current clinical condition reviewed. The Seroquel will be reduced x 3 days then discontinued. The corrective action for resident 6 is as follows: The resident no longer resides in the facility The corrective action for resident 5 is as follows: The resident remains off the Bumex. There were no negative outcomes related to the lack of documentation when the resident initiated the medication and when the medication was discontinued. The corrective action for resident 2 is as follows: The resident had no negative outcomes related to the lack of documentation, and although not documented, did not have any observed or reported side effects. How the facility will identify other residents having the potential to be affected by the same deficient practice and</p>				

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	<p>throughout the night and was not sleeping.</p> <p>An entry in the Nursing Progress Notes dated 3/23/14 at 3:00 p.m., indicated the midnight shift reported the resident did not sleep through the night and she was using the call light frequently. The resident was also reported as being agitated on the evening shift.</p> <p>Documentation in the Nursing Progress Notes on 3/24/14 at 10:00 a.m., indicated the resident was still awake half of the night and on the call light asking if it was time to get up. The next documented entry in the Nursing Progress Notes was on 4/22/14, 29 days later, indicating an order was received from the resident's Physician to discontinue the Alprazolam and start Lorazepam (an antianxiety medication) 0.5 mg at night for anxiety and insomnia. The next documented entry in the Nursing Progress Notes was on 5/2/14, 10 days later, indicating a new order was received from the Medical Director to start Seroquel (an antipsychotic medication) 25 mg at night for agitation, paranoia, anxiety, and sleep. Documentation on 5/3 and 5/4/14, indicated the resident had slept better. Documentation on 5/6/14 at 11:30 a.m., in the Nursing Progress Notes, indicated the midnight shift reported the resident</p>		<p>what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. The clinical records were reviewed to determine if any other residents have recently had any meds initiated or discontinued for monitoring of adverse effects. The medications were reviewed to ensure any other residents on psychotropic have appropriate supportive documentation. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; In-service was held on May 30, 2014 by Resident Care Coordinator/designee with Sheffield Manor staff regarding the following: 1. Documenting daily for 3 days whenever a new medication is initiated or a medication has been discontinued and observe for adverse reactions 2. Documenting the behaviors and interventions attempted to reduce such behaviors in the clinical record prior to initiating a psychotropic 3. Documenting in the clinical record the reason why a resident was sent out to the hospital and the clinical observations 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; Twice weekly, the</p>				

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	<p>had not slept the past two nights. The Medical Director was notified and orders were received to increase the resident's Seroquel to twice a day.</p> <p>Documentation in the Nursing Progress Notes on 5/7/14 at 2:00 p.m., indicated the resident did not sleep well and was on the call light every hour. On 5/8/14 at 10:00 a.m., documentation in the Nursing progress notes indicated the resident seemed lethargic and the writer felt the lethargy was due to the morning dose of Seroquel. The Physician was going to be contacted to see if the resident's Seroquel could be given at night. A Physician's Order was obtained on 5/9/14 for Seroquel 50 mg at night for anxiety, insomnia, paranoia and agitation.</p> <p>Entries in the Nursing progress notes on 5/10 and 5/13/14 at 11:00 a.m., indicated staff reported the resident was on the call light all night asking if it was time to get up.</p> <p>On 5/16/14 at 3:00 p.m., the Medical Director was informed the resident was not sleeping at night. An order was received to increase the resident's Lorazepam to 1 mg at night.</p> <p>Documentation in the Nursing Progress Notes dated 5/19/14 (no time), indicated</p>		Resident Care Coordinator will audit the clinical records of any residents who require documentation to ensure completion. Resident Care Coordinator will follow-up with the nursing staff for any missing entries. A summary of the observations will be presented to the Quality Assurance committee monthly by Resident Care Coordinator/designee for three 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.				

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	<p>staff had reported the resident was on the call light all night on 5/17 and 5/18/14. The resident had slept from 11:00 p.m. to 1:00 a.m. The resident was on the call light from 1:30 a.m. until 6:00 a.m. On 5/19/14, the resident slept from 11:00 p.m. until 12:30 a.m. then she was pushing the call light every hour until 6:00 a.m. when she was gotten up. The Physician was to be notified the resident was still not resting at night.</p> <p>Interview with the Care Coordinator on 5/20/14 at 11:00 a.m., indicated there was no documentation to indicate the use for the Seroquel. She also indicated the resident had received the antianxiety and antipsychotic medications but had not received a hypnotic medication for her insomnia.</p> <p>2. The closed record for Resident #6 was reviewed on 5/20/14 at 9:59 a.m. The resident's diagnosis included, but was not limited to, chronic obstructive pulmonary disease.</p> <p>An entry in the Nursing Progress Notes dated 12/21/13, indicated the resident's Physician was notified of STAT (immediate) chest x-ray results. No new orders were received at this time and the resident was going to be monitored.</p>				

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	<p>The next entry in the Nursing Progress Notes was on 4/8/14, which indicated the resident was readmitted to the facility from the health care side.</p> <p>Interview with the Care Coordinator on 5/20/14 at 11:15 a.m., indicated the resident was sent to the Emergency Room for respiratory distress on 1/23/14. The Care Coordinator indicated this was documented on the 24 hour report sheet but not in the resident's clinical record.</p>			