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	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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F 0000 Bldg. 00	This visit was for Investigation of Complaints IN00365165, IN00367643, IN00367975, IN00368066, IN00368649, IN00369641, IN00371602, and IN00371776. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00365165 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F812, and F880. Complaint IN00367643 - Unsubstantiated due to lack of evidence Complaint IN00367975 - Unsubstantiated due to lack of evidence Complaint IN00368066 - Substantiated. Federal/State deficiencies related to the allegations are cited at F692. Complaint IN00368649 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F690, and F695. Complaint IN00369641 - Substantiated. Federal/State deficiencies related to the allegations are cited at F695. Complaint IN00371602 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677. Complaint IN00371776 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F692, F745, and F880. Survey dates: January 30, and 31, and February 1	F 0000	The facility respectfully requests a desk review	

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

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	and 2, 2022 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 124 Residential: 35 Total: 159 Census Payor Type: Medicare: 44 Medicaid: 56 Other: 24 Total: 124 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/7/22.			
F 0677 SS=D 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; Based on observation, record review and interview, the facility failed to ensure dependent residents were assisted out of bed for 1 of 4 residents reviewed for activities of daily living (ADLs). (Resident G) Finding includes: On 1/30/22 At 11:50 a.m., Resident G was observed in bed dressed in a hospital gown. Interview with the resident indicated he had been	F 0677	**Dyer Nursing and Rehab** 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**	02/11/2022

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	in bed and was not asked if he wanted to get up. The resident indicated he was in bed all day on Saturday 1/29/22 as well. On 1/30/22 at 1:00 p.m., the resident remained in bed and was still dressed in a hospital gown. The resident was still in bed at 1:30 p.m. The record for Resident G was reviewed on 1/31/22 at 11:10 a.m. Diagnoses included, but were not limited to, major depressive disorder, PTSD, high blood pressure, and weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/21, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 person physical assist with bed mobility and transfers. The resident was an extensive assist with a 1 person physical assist for dressing. A Care Plan, dated 6/17/21, indicated the resident preferred to be up at 6 a.m. and for all meals. A Care Plan, dated 12/13/19, indicated the resident will display rejection of care for showers. The approaches were staff to allow the resident to make decisions regarding the scheduling of their care, for example showers, therapy, wakening hours and bedtime hours. A Care Plan, dated 10/6/19, indicated the resident was limited in functional status in regards to the ability to transfer self. The resident required weight bearing assist and used a hoyer lift. The Point of Care responses for transfers and getting out of bed indicated the resident was out of bed on 1/1, 1/6, 1/14, 1/19, 1/24, 1/25, 1/26, and		**Dependent Residents** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G was assisted with all needed ADL's, which included being assisted from bed as per care plan. **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 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 assisting residents out of bed per preference and care plan. **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;** DON Designee will Audit 15 random residents 3 times weekly with a focus on dependent resident's requiring ADL	

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	1/28/22. The activity did not occur on 1/10, 1/11, 1/13, 1/20, 1/23, 1/22, 1/27, and 1/31/22. Interview with the Assistant Director of Nursing on 2/1/22 at 2:03 p.m., indicated the resident does refuse sometimes to get up, but that should be documented. The resident should have been assisted out of bed, it that was what he wanted. This Federal tag relates to Complaints IN00365165, IN00368649, IN00371602, and IN00371776 3.1-38(a)(2)(B)		assistance to ensure they are being assisted from bed per their preferences and 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: 2/11/22**	
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 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			

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	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 urinary catheters, urinary output was monitored, and catheter care was completed for 3 of 3 residents reviewed for urinary catheter use. (Residents Q, J, and E) Findings include: 1. On 1/31/22 at 1:38 p.m., Resident Q was observed in her room in bed sleeping. The resident did not have a urinary catheter in use. The record for Resident Q was reviewed on 2/1/22 at 11:28 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, COVID-19, pneumonia, and altered mental status. The Admission Minimum Data Set (MDS) assessment, dated 11/24/21, indicated the resident was cognitively impaired for daily decision making and required extensive assistance for toilet use. She did not have a urinary catheter and she was always incontinent of urine.	F 0690	**Dyer Nursing and Rehab Complaint 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 residents found to have been affected by the deficient practice;** Residents Q foley cath order clarified, foley catheter care was completed. Resident J foley care was completed. Resident E is no longer in the facility.	02/11/2022

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	There was no Care Plan related to having a urinary catheter. Nurses' Notes, dated 1/15/22 at 4:02 p.m., indicated the resident returned to the facility via transport service with 2 attendants. All assessments were completed and all orders were entered. She was alert and oriented to person with confusion, needed 1-2 assist with all ADLs and was incontinent of bowel and bladder. The resident had a 16 french foley (urinary) catheter in use that was draining amber urine. There was no Physician's Order for the foley catheter and catheter care. A Physician's Order, dated 1/21/22, indicated the resident was to have a foley catheter (no size listed) and catheter care every shift. The January 2022 Treatment Administration Record (TAR), indicated catheter care had not been signed out as being completed for the following dates: Day shift: 1/22, 1/23, 1/24, 1/26, and 1/29/22 Evening shift: 1/21, 1/24, 1/29, and 1/30/22 Night shift: 1/24, 1/25, 1/29, 1/30, and 1/31/22 Nurses' Notes, dated 1/31/22 at 7:38 a.m., indicated orders were received from the Physician to discontinue the foley catheter. Interview with the Assistant Director of Nursing on 2/1/22 at 2:30 p.m., indicated there was a delay in obtaining a Physician's Order for the foley catheter and catheter care was not consistently documented as being completed. She also indicated there was no diagnosis to support the		**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. The facility has completed an audit and has identified all residents that have a foley catheter. **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 documentation is completed, specifically urinary output and catheter care, 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;** DON/Designee will randomly audit 5 residents with foley catheters weekly to ensure that documentation is being completed related to urinary output and catheter care. 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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	use of the catheter. 2. On 1/31/21 at 10:45 a.m., Resident J was observed in bed. The resident had a foley catheter hanging on the side of the bed draining yellow urine. The record for Resident J was reviewed on 1/31/22 at 12:06 p.m. The resident was admitted to the facility on 1/18/22. Diagnoses included, but were not limited to, pressure ulcers, high blood pressure, type 2 diabetes, anemia, and benign prostatic hyperplasia. The Admission Minimum Data set (MDS) assessment, dated 1/24/22, indicated the resident was cognitively intact, and was an extensive assist with a 2 person physical assist for bed mobility. The Resident has a foley catheter and was always continent of bowel and bladder. He had unhealed pressure ulcers from Stage 2 to 4, unstageable and deep tissue injuries. A Care Plan, dated 1/19/22, indicated the resident required an indwelling urinary catheter related to pressure ulcers. The approaches were to document urinary output every shift and record the amount, type, color, and odor. Physician's Orders, dated 1/18/22, indicated catheter care every shift for 16 FR (French) indwelling foley catheter due to sacral wound. Change urinary bag as needed. The Treatment Administration Record (TAR) for 1/2022 indicated foley catheter care had not signed out as completed and all shifts/days were blank. There was no documentation of any urinary output since admission.		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: 2/11/22**	

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	Interview with CNA 3 on 1/31/22 at 2:50 p.m., indicated she emptied the resident's foley catheter once or twice a shift depending on how full it was. She emptied the urine in a clear container and informed the nurse how much was in the foley catheter. She had not documented any urine output in the computer. Interview with the Director of Nursing on 2/1/22 at 2:05 p.m., indicated catheter care was to be done every shift and urinary output was to be monitored, documented, and recorded only if there was a Physician's Order. Interview with the Nurse Consultant on 2/1/22 at 3:10 p.m., indicated the urine output was to be monitored per the facility's policy for all residents with indwelling foley catheters. The current and revised 9/2005 "Urinary Catheter Care" policy, provided by the Nurse Consultant on 2/1/22 at 3:10 p.m., indicated maintain an accurate record of the resident's daily output per facility policy and procedure.3. Resident E's closed record was reviewed on 1/31/22 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and anemia. The Significant Change MDS assessment, dated 9/28/21, indicated the resident required an extensive assist of one with personal hygiene and toilet use. A Care Plan indicated the resident required an indwelling urinary catheter. The nursing interventions included, "...measure and record intake and output per facility protocol...provide assistance for catheter care...provide catheter care as ordered and as needed..."			

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	A Physician's Order, dated 8/2021, indicated to complete catheter care every shift. The Medication Administration Record (MAR), dated 10/2021, indicated the catheter care had not been signed out as completed on the following shifts: -Day shift on 10/3/21, 10/4/21, 10/8/21, 10/12/21, 10/15/21, 10/16/21, 10/18/21, 10/19/21, 10/20/21, and 10/30/21. -Evening shift on 10/5/21, 10/9/21, 10/11/21, 10/12/21, 10/13/21, 10/25/21, 10/27/21, and 10/31/21. -Night shift on 10/13/21 and 10/31/21. The urine output documentation, dated 10/2021 through 11/2021, indicated the output had only been recorded on 10/6/21, 10/9/21, and 10/25/21. Interview with the Director of Nursing (DON) on 2/1/22 at 1:56 p.m., indicated the care should have been signed off on the MAR when it was completed. The urine output would only be documented if the resident had a Physician's Order to measure intake and output (I&O). This Federal tag relates to Complaint IN00368649. 3.1-41(a)(1) 3.1-41(a)(2)			
F 0692 SS=G 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			

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	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 consistently monitor food and fluid intake for at risk residents which resulted in hospitalization for dehydration for 2 of 3 residents reviewed for a change in condition. (Residents D and H) Findings include: 1. The closed record for Resident D was reviewed on 2/1/22 at 8:53 a.m. Diagnoses included, but were not limited to, vascular dementia without behavior disturbance, dysphagia (difficulty swallowing), major depressive disorder, and muscle weakness. The resident was admitted to the facility on 10/28/21. The Admission Minimum Data Set (MDS) assessment, dated 11/3/21, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She needed extensive assistance with eating and received a mechanically altered diet.	F 0692	**Dyer nursing and Rehab Complaint 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. **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 D is no longer at the facility. Resident H is no longer at the facility. **How the facility will identify other residents having the potential to be affected by the**	02/11/2022

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	The Care Plan, dated 11/2/21, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, notify Physician and Responsible Party with any change in condition, observe for and record intake of food and fluids, and provide assistance at the level the resident required. The resident received a mechanical soft diet 11/1 through 11/17/21. A Physician's Order, dated 11/18/21, indicated the resident was to receive a pureed diet with thin liquids and super cereal at breakfast. A Speech Therapy note, dated 11/17/21 at 1:00 p.m., indicated a diet downgrade recommendation to puree consistency as the resident was pocketing food. Nursing and dietary were notified of the change. A Registered Dietitian (RD) Progress Note, dated 11/18/21 at 3:08 p.m., indicated the resident's weights were reviewed and she had lost approximately 4.6 pounds over the past 9 days. Collaborated with speech therapy, resident was recently downgraded to puree textures. Resident with poor oral intake per food consumption records, typically less than 50% of most meals. Super cereal at breakfast was recommended and to continue with weekly weights. Nurses' Notes, dated 11/24/21 at 8:54 a.m., indicated the resident had a poor appetite that morning for breakfast and was resting in bed at the time. The next entry in the progress notes was completed by the Physician on 11/25/21 at 9:06		**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;** CNA's, nurses and all staff that assist with resident meal tray pass were in-serviced on the following: recording of meal consumption intake, fluid intake and Matrix POC. **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;** DON/Designee will review the Matrix resident meal consumption 3 x week each week to monitor for meal intake/fluid intake trends including a decrease in meal intake. The DON/designee will communicate meal intake reductions to the dietician and MD/NP for review and intervention. 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	

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	p.m., and indicated the resident was confused and suffered from severe dementia. He also indicated she needed to be assisted with feeding and to encourage oral intake. The Food and Fluid Intake Sheets for the month of November 2021, indicated no meal intake was documented for 11/11, 11/14, 11/20, 11/21, and no breakfast or lunch on 11/22/21. The resident did not consume any breakfast or lunch on 11/25/21 and there was no documentation for dinner. The resident's average food consumption was 1-25% on days documentation was completed. There was no fluid intake documented for 11/11, 11/14, 11/20 and 11/21/21. On 11/18/21 at 9:22 a.m., the resident consumed 236 milliliters (ml) of fluid. At 1:10 p.m., the resident consumed 240 ml of fluid. The next documented entry related to the resident's fluid intake was on 11/23/21 at 9:55 a.m. which was 120 ml. At 12:45 p.m., she also consumed 120 ml. On 11/24/21 at 8:54 a.m., she consumed 100 ml of fluid. On 11/25/21 at 9:08 a.m. and 1:14 p.m., she consumed 120 ml. Nurses' Notes, dated 11/26/21 at 2:50 a.m., indicated the resident was resting in bed with no acute distress noted. The next documented entry at 2:25 p.m., indicated during rounds, the resident appeared lethargic and was nonresponsive to tactile or verbal stimuli. Her blood pressure was 92/62, her pulse was 92, and her respirations were 20. Temperature was 98.1 and her oxygen saturation was 87% on room air. Oxygen was immediately applied. The Physician was in the facility and orders were obtained to send the resident to the emergency room via 911. The Emergency Room Progress Note, dated 11/26/21 at 3:20 p.m., indicated the resident was		quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 2/11/22**	

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	being evaluated for altered mental status. The resident was possibly last normal 7 days ago but exact date was unclear. The resident was unable to provide any history at that time. History and review of symptoms was limited secondary to altered mental status. History was obtained from EMS personnel and nursing staff. Upon arrival to the emergency room, the resident's blood pressure was 78/51, pulse 90, and respirations were 28. Emergency room laboratory results indicated the resident's white blood cell count was elevated at 18.5, her blood urea nitrogen (BUN) level was elevated at 119 (normal 6-24, an elevated BUN is also indicative of dehydration or malfunctioning kidneys), and her Creatinine (a kidney function test) was elevated at 7.1 (normal level 0.59 to 1.04). The resident's sodium level was elevated at 164 (normal 135-145, elevated sodium levels can be caused by dehydration). The resident was admitted to the hospital with the diagnoses of acute kidney injury, dehydration, hypernatremia (high sodium levels), and leukocytosis (elevated white count). Preadmission laboratory results, dated 9/15/21, indicated the resident's BUN was normal at 18 and her Creatinine was normal at 1.2. Interview with the Nurse Consultant on 2/1/22 at 3:32 p.m., indicated the resident's food and fluid intake should have been monitored more closely. 2. The closed record for Resident H was reviewed on 1/31/22 at 4:50 p.m. The resident was admitted on 11/24/21 and discharged to the hospital on 1/5/22. Diagnoses included, but were not limited to, stroke, high blood pressure, type 2 diabetes, convulsions, aphasia, altered mental status, slurred speech, and major depressive disorder.			

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The Admission Minimum Data Set (MDS) assessment, dated 11/30/21, indicated the resident was alert and oriented and needed extensive assist with a 2 person physical assist for bed mobility. The resident needed extensive assist with a 1 person assist for dressing and personal hygiene, and was totally dependent on staff for toilet use and bathing.

A Care Plan, dated 11/25/21, indicated the resident received a diuretic medication and was at risk for dehydration. The approaches were to observe the cardiovascular system and fluid status to determine effectiveness of diuretic therapy for example edema, mental confusion, shortness of breath, abnormal breath sounds, or abnormal heart sounds, observe for and report symptom of dehydration such as dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation, fever, or infection.

A Care Plan, dated 11/25/21, indicated the resident was limited in functional status in regards to eating and drinking independently. The approaches were to observe and record intake of food and fluids and refer to OT/ST as needed.

A NP (Nurse Practitioner) Note, dated 11/26/21, indicated the resident was being seen for a new admission. She presented to the ER (emergency room) with stroke-like symptoms and the MRI demonstrated those findings. The resident was nonverbal and was admitted to the acute rehab at the hospital and then discharged to the facility for further rehab. The assessment and plan for the resident for the seizure disorder was to monitor weekly weights, fluid intake, and provide a low

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	sodium diet. Lab work from the resident's hospital admission of 11/9/21 indicated labs were drawn on 11/24/21 right before the resident was admitted to the facility. Her WBC count (White Blood Cell) was 10.54 (normal 4.5-11), BUN (Blood Urea Nitrogen, measures the function of the kidneys) was 21 (normal 6-24) and CR (Creatinine, measures the function of the kidneys) was 1.02 (normal 0.7-1.3). The resident weighed 156 on 11/24/21, 148 pounds on 11/30 and 12/2, and 150 on 12/7/21. There was no recorded weight for 1/2022. Meal consumption logs for 12/2021 indicated on 12/28 and 12/29 the resident consumed 76-100% of dinner. On 12/29, the resident consumed 76-100% of lunch. On 12/30 the resident consumed 26-50% of dinner. On 12/31/21 the resident consumed 1-25% for breakfast and lunch and 26-50% for dinner. Meal consumption logs for 1/2022 indicated 1/1-1/3 for all meals, the resident consumed 1-25%. There was no documentation on 1/4/22 of any meal and on 1/5 the resident consumed 1-25% for breakfast. The only fluid intake documented was on 12/28/21 which indicated the resident consumed 240 milliliters of fluid. There was no other documentation of any other oral intake. Physician Orders, dated 11/24/21, indicated furosemide (a diuretic medication) 40 milligrams (mg) daily. There was no therapy ordered for the resident such as PT, OT, or ST.			

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A RD (Registered Dietitian) Note, dated 11/28/21 at 1:16 p.m., indicated labs and weight were addressed. The resident was not at risk for malnutrition and recommend a no concentrated and no added salt diet and textures per Physician or speech therapy.

The last RD Note was on 12/9/21 at 3:08 p.m., which indicated the resident's weights were stable and to discontinue weekly weights and follow up with monthly weights.

A Physician Note, dated 12/17/21 at 3:33 p.m., indicated the resident was seen and had no new complaints. Vital signs were stable and she was seen by dietary. She would like to participate in PT.

A Nurses' Note, dated 1/3/22, indicated the resident received a PCR COVID-19 test.

The next entry in Nurses' Notes was on 1/5/22 at 1:30 p.m., which indicated "Writer called 911 to report change in resident's status. Writer spoke with daughter and made her aware of resident's change in condition. Resident has a change in AMS [altered mental status] resident loss of appetite today, tolerated medications this AM without any difficulty, however resident is very lethargic now. Afebrile, VS [vital signs] abnormal. Resident will be sent out to the hospital to eval [evaluate] and treat. DON [Director of Nursing] is aware."

Nurses' Notes, dated 1/5/22 at 1:51 p.m., indicated the Physician was made aware of the resident's change in condition.

Nurses' Notes, dated 1/5/22 at 1:52 p.m., indicated

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	the EMT's were present at the resident's bedside. The resident was transferred to the hospital and admitted with acute renal failure and acute encephalopathy. A Physician's Note, dated 1/5/22 at 11:22 p.m., (Recorded as Late Entry on 1/22/22 at 11:24 a.m.) indicated the resident was discharged to the hospital. The resident has been lethargic and had not been doing well and apparently had been dehydrated and not making urine. Discussed with staff will transfer to nearby hospital. Hospital Emergency Room Notes, dated 1/5/22 at 2:40 p.m., indicated the resident had altered mental status and was last seen normal at 8:30 a.m. at the nursing home. "Apparently she was found unresponsive at some point and she cannot talk or open her eyes but can move her eyelids a little bit. She looks clinically dehydrated." Her vital signs were blood pressure 100/63, pulse 115 and oxygen saturation at 92%. Her weight was 137 pounds. Laboratory tests were obtained on 1/5/22 in the hospital and the resident's WBC was 22.5 (a high value), BUN was 103 (a high value) and CR was 5.9 (a high value). The resident was admitted with acute renal failure and acute encephalopathy. A Nephrology consult, dated 1/5/22 at 6:55 p.m., indicated the plan was for aggressive fluids, foley catheter and renal ultrasound. Hospital labs, dated 1/13/22, indicated the resident's BUN was now 17 and the CR was 1.4. There was no documentation from 1/1-1/5/22 regarding the resident's mental status or an assessment of her eating and drinking.			

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	Interview with the Nurse Consultant on 2/1/22 at 3:10 p.m., indicated there was no documentation from 1/1-1/5/22 regarding the resident's condition of not eating or drinking. The resident's fluid intake was not monitored, nor was her mental status. This Federal tag relates to Complaints IN00368066 and IN00371776. 3.1-46(b)			
F 0695 SS=D Bldg. 00	483.25(i) Respiratory/Tracheostomy Care and 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 record review and interview the facility failed to ensure tracheostomy (a surgically created opening in the neck/trachea) care was completed for 1 of 1 residents reviewed for tracheostomy care. (Resident E) Finding includes: Resident E's closed record was reviewed on 1/31/22 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and anemia. The Significant Change MDS assessment, dated	F 0695	**Dyer Nursing and Rehab** 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/Tracheostomy care and Suctioning**	02/11/2022

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	9/28/21, indicated the resident required an extensive assist of one with personal hygiene and received tracheostomy care. A Care Plan indicated the resident had a tracheostomy and was at risk for adverse consequences. The nursing interventions included the completion of tracheostomy care. A Physician's Order, dated 8/2021, indicated to complete tracheostomy care every shift. The Medication Administration Record (MAR), dated 10/2021, indicated the tracheostomy care had not been signed out as completed on the following shifts: -Day shift on 10/3/21, 10/4/21, 10/6/21, 10/8/21, 10/12/21, 10/14/21, 10/15/21, 10/18/21, 10/19/21, 10/20/21, and 10/22/21. -Evening shift on 10/9/21, 10/11/21, 10/12/21, 10/14/21, 10/27/21, 10/28/21, 10/29/21, and 10/30/21. -Night shift on 10/11/21, 10/17/21, and 10/30/21. Interview with the Director of Nursing (DON) on 2/1/22 at 1:56 p.m., indicated the care should have been signed off on the MAR when it was completed. This Federal tag relates to Complaints IN00368649 and IN00369641. 3.1-47(a)(6)		**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E is no longer in the facility. **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 a tracheostomy, have the potential to be affected by the same alleged deficient practice. The facility has completed an audit and has identified all residents with a tracheostomy. **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 performing tracheostomy care according to the physician orders and documentation of care provided in the clinical record. **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 in place;** DON/designee will audit all residents with a tracheostomy 2x each week reviewing both the	

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			MAR and progress notes to ensure that care is being performed according to the physician orders. 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: 2/11/22**	
F 0745 SS=D Bldg. 00	483.40(d) Provision of Medically Related Social Service §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. Based on record review and interview, the facility failed to provide medically related social services related to ensuring family requests for therapy were communicated to the appropriate department for authorization for 1 of 3 residents reviewed for therapy services. (Resident H) Finding includes: The closed record for Resident H was reviewed on 1/31/22 at 4:50 p.m. The resident was admitted on 11/24/21 discharged to the hospital on 1/5/22. Diagnoses included, but were not limited to,	F 0745	**Dyer Nursing & Rehabilitation** 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. **F 745 Provision of Medically Related Social Service** **What corrective action(s) will**	02/11/2022

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	stroke, high blood pressure, type 2 diabetes, convulsions, aphasia, altered mental status, slurred speech, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 11/30/21, indicated the resident was alert and oriented and needed extensive assist with a 2 person physical assist for bed mobility. The resident needed extensive assist with a 1 person assist for dressing and personal hygiene, and was totally dependent on staff for toilet use and bathing. A NP (Nurse Practitioner) Note, dated 11/26/21, indicated the resident was being seen for a new admission. She presented to the ER (emergency room) with stroke-like symptoms and the MRI demonstrated those findings. The resident was non-verbal and was admitted to the acute rehab at the hospital and then discharged to the facility for further rehab. The assessment and plan for the resident for her seizure disorder was to monitor weekly weights, fluid intake, and provide a low sodium diet. There were no Physician's Orders for any type of therapy. Social Service (SS) Notes, dated 11/28/21 at 12:32 p.m., indicated the resident was a new admission. She was alert and oriented and was unsure of her stay at that time. SS to remain available as needed. An SS Note, dated 12/8/2021 at 5:15 p.m., indicated the writer spoke with the resident's daughter, who had requested an update on the resident's therapy sessions. The writer informed her the resident was currently residing at the		**be accomplished for those residents found to have been affected by the deficient practice;** Resident H no longer resides in the facility. **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;** Social service and Admission staff were educated on communicating family/resident requests regarding therapy services and other related requests. Admission staff was educated related to all incoming admission will receive a therapy screen. **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 document family/resident requests on a log and present that log to the Administrator during morning meetings 5 days a week to ensure requests are being	

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	facility with a payer source of Medicaid and she was not currently receiving therapy. The SS asked if the resident had secondary insurance or Medicare. The daughter believed the resident had Medicare and would go to the resident's apartment located at an assisted living facility to retrieve the insurance card. The daughter was to send the card in and the insurance would be contacted to see if resident had benefits that would allow her to participate in therapy. SS to remain available as needed. An SS Note, dated 12/29/21 at 9:10 a.m., indicated the writer returned the resident's daughter's call and received voicemail. SS left a message with a call back number. SS to remain available as needed. The next and last SS Note was on 12/30/21 at 11:47 a.m., which indicated writer spoke to the resident's daughter concerning resident receiving therapy. SS informed her the Medicare insurance information was received the day prior and was sent to admissions to run for verification. The daughter verbalized understanding. A Physician Note, dated 12/17/21 at 3:33 p.m., indicated the resident was seen and had no new complaints. Vital signs were stable and she was seen by dietary. She would like to participate in PT. The Hospital Face Sheet, dated 11/9/21, indicated the resident's Medicare Advantage insurance number was located under payor source and was scanned in under the resident's documents in the clinical record. The Acute Rehabilitation Facility Discharge Summary Note, dated 11/23/21, indicated physical		addressed and followed up on. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 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: 2/11/22**	

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	therapy, speech therapy and occupational therapy were all recommended to be continued at the SNF facility. Interview with the Admissions Coordinator on 2/1/22 at 11:25 a.m., indicated the resident was admitted under Medicaid. The case manager at the hospital and the Physician for the Acute Rehabilitation facility spoke with the insurance company and a peer to peer review was denied. The resident had Medicare Advantage insurance and not the traditional Medicare insurance. The hospital Physician was agreeable to having the resident stay at the hospital for 1 more week if the insurance company would accept that. The case manager had spoken with her on 11/24/21 and they agreed to accept the resident under the secondary insurance of Medicaid as the primary was not approving. The Admission Coordinator indicated the case manager at the hospital informed the resident's daughter of the situation and she was aware of the information and the daughter was in agreement. At the time of admission, when the resident arrived to the facility she had given the therapy department the payor source for the resident and since she was Medicaid, therapy did not pick her up at all during her stay. The family was made aware the resident would not be receiving therapy at the time of admission. Interview with Social Service on 2/1/22 at 11:38 a.m., indicated she had notified the assisted living facility for the insurance information and the director had sent it to her. She gave all the information to admissions to verify and explained the daughter wanted her to have therapy, and that was where her duties stopped. She indicated the daughter kept calling and leaving messages regarding therapy and when was it going to start.			

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	She was unaware the insurance information was in the hospital admission paper work under resident documents. Interview with the Admissions Coordinator and the Administrator on 2/1/22 at 11:50 a.m., indicated there was no communication between SS and her department indicating the resident's family wanted to see if the resident qualified for therapy under her Medicare Advantage insurance. The Medicare Advantage insurance number was already in the clinical record from the hospital information at the time of admission. The Admissions Coordinator stated, "If the family wanted the facility to run authorization for therapy again, that would not have been a problem, however, I was never informed of that request." Interview with the Social Service Director on 2/1/22 at 1:55 p.m., indicated she unaware of the situation with the resident and the family's request for therapy. This Federal tag relates to Complaint IN00371776. 3.1-34(a)			
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.			

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	(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 serve food under sanitary conditions related to passing uncovered beverages down the hallway to residents in their rooms for 2 of 3 units observed for dining service. This had the potential to affect 66 residents who resided on the West and Dementia care units. (The West and Dementia care units) Findings include: 1. During an observation on the West unit on 1/30/22 at 11:55 a.m., a dietary employee was pushing a tall transportation cart full of lunch trays down to the unit. The trays themselves were not covered and the beverages on the cart were also not covered. At 11:57 a.m. a CNA was observed removing 5 cups of coffee from a crate on top of the West unit nurses' station. The coffee cups had no lids on them and she carried all five cups of coffee down the hallway to resident rooms. At 12:05 p.m. an enclosed food cart was delivered to the West unit. There were trays on top of the cart with no lids on the juices. Two staff members removed the trays and passed them to the	F 0812	**Dyer Nursing and Rehab Complaint 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** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Food and beverages were covered before transporting in hallway the remainder of the survey. **How will facility identify other residents who have the potential to be affected by the**	02/11/2022

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	residents in their rooms without covering the drinks. At 12:10 p.m., the staff on West unit were observed passing trays with no lids on the juice or coffee cups down the hallway to resident rooms. 2. During an observation of the Dementia Care unit, on 1/30/22 at 12:07 p.m., indicated a CNA was observed passing trays to residents in their rooms. She was removing the trays from a tall transportation cart that was not covered. The beverages on the trays were uncovered. Interview with the CNA at that time, indicated the cart came down to the unit uncovered. Interview with the Administrator on 2/1/22 at 2:05 p.m., indicated dietary carts were to come down to the units with all the food and beverages covered. Lids should have been on the beverages and the tall transportation carts should have been covered with plastic. This Federal tag relates to Complaint IN00365165. 3.1-21(i)(3)		**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 aides were educated on ensuring food and beverages are covered before transporting in the hallway. Facility staff educated on ensuring food and beverages are covered when transporting in the hallway. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Dietary manager/designee will audit 3 meals weekly on alternating shifts 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.	

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			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: 2/11/22**	
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: §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;			

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	§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. §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.			

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	§483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not wearing personal protective equipment (PPE) correctly when entering a transmission based precaution (TBP) isolation room, wearing gloves in the hallway, not completing hand hygiene prior to donning PPE, incorrect mask use by staff and visitors, lack of eye protection during resident contact, and not monitoring residents who were in TBP for COVID-19 or suspected COVID-19 for 1 of 3 residents reviewed for infection control and for 1 of 2 treatments observed. This had the potential to affect 124 residents who resided in the facility. (Residents K, R, S, J, U, and T) Findings include: 1. During a random observation on 1/31/22 at 11:03 a.m., CNA 1 was observed in the hallway charting at the kiosk. He had his N95 mask pulled down below his chin. Interview with the Assistant Director of Nursing on 2/1/22 at 2:30 p.m., indicated the CNA's mask should not have been below his chin. 2. On 1/31/22 at 11:03 a.m., Resident K was observed in his room in bed. He had a kerlix gauze dressing to his left foot which had fresh blood present. At 11:10 a.m., the resident was repositioned in bed by CNA 1. The CNA indicated the resident's dressing was not like that	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:** Staff were immediately re-educated about ensuring that visitors are wearing face masks correctly while in residents' room especially when there are other residents present. TNA was immediately re-educated related to putting on the proper PPE when entering a transmission-based precaution room. CNA was immediately re-educated related to not wearing gloves in the hallway. Staff was immediately educated about performing hand hygiene prior to donning gloves and gowns and after doffing gloves and gowns.	02/11/2022

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	earlier and the blood was fresh. At 11:28 a.m., the treatment nurse indicated the resident was seen by the Wound Care Physician that morning and he had debrided an area on the top of the resident's foot. She donned a gown and a disposable glove to the right hand prior to entering the room. She did not perform hand hygiene prior to donning the personal protective equipment (PPE). She retrieved items from the treatment cart prior to entering the room. When entering the room, she donned the glove to the left hand without completing hand hygiene. The treatment nurse applied a pressure dressing to the resident's left foot. She removed her gloves and proceeded to the bathroom. The resident had dried blood to his left lateral knee at that time and the treatment nurse indicated she was going to clean that area as well. She donned cleaned gloves and cleansed the area with wound cleanser. She removed her gloves, donned new gloves without completing hand hygiene, and proceeded to finish cleaning the knee area. She applied a dry dressing when she was done. At 1:34 p.m., some break through bleeding was observed on the resident's left foot dressing. Interview with the treatment nurse at 3:18 p.m. indicated she had not been back to the unit to check on the resident's foot, but she had called the unit and they indicated his dressing was dry. At 3:20 p.m., the treatment nurse observed the resident's dressing and she indicated she would notify the Wound Care Physician. At 3:42 p.m., the treatment nurse indicated she was going to change the resident's dressing to his left foot. She donned a gown and gloves and entered the resident's room. Again, hand hygiene was not completed prior to donning PPE. Prior to		Staff was immediately re-educated on wearing the proper eye protection and masks and keeping masks covering nose and mouth while in resident care areas. Staff were immediately re-educated related to the importance of assessing residents that are in transmission-based precaution rooms every shift. CNA was immediately re-educated on not carrying clean linens against her body/uniform. **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:** Extended Care Clinical Nurse Consultant with Infection Preventionist Certification re-educated the facility Administrator, Director of Nursing and Assistant Director of Nursing related to visitors wearing masks at all times when in residents rooms especially when other	

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	removing the dressing, she applied another pair of gloves over the ones she was already wearing. The resident's dressing was removed. The treatment nurse removed her gloves and applied a new pair of gloves without completing hand hygiene. Calcium alginate pads were applied to the top of the resident's foot and it was wrapped in kerlix gauze with an ace wrap covering the gauze. After completing the treatment, the nurse removed her gown and gloves in the bathroom and washed her hands. Interview with the Assistant Director of Nursing on 2/1/22 at 2:30 p.m., indicated hand hygiene was to be completed prior to and after glove removal. 3. On 1/31/22 at 3:18 p.m., two visitors were observed walking down the main hallway. They were both wearing face shields and masks, however, one of the visitors had her mask below her nose. The Director of Nursing saw the two visitors and the visitor was not educated to pull up her mask. 4. On 1/31/22 at 2:20 p.m., Agency CNA 2 was observed at the West Unit nurses' station. He donned a pair of disposable gloves at the nurses' station and he proceeded down the hallway and entered a resident's room to provide incontinence care. He did not perform hand hygiene prior to donning the gloves. Interview with the Nurse Consultant on 2/1/22 at 2:30 p.m., indicated the CNA should have performed hand hygiene prior to applying the gloves and gloves were not to be worn in the hallway. 5. On 1/31/22 at 2:25 p.m., Agency CNA 1 was observed going in and out of resident rooms on		residents are present, wearing PPE when entering TBP rooms, performing hand hygiene before donning and doffing gown and gloves, not wearing gloves in the hallway, wearing the correct eye protection and face masks and keeping masks covering mouth and nose while in resident care areas, transporting clean linens and allowing it to touch the body/uniform and assessing unvaccinated residents in TBP every shift. Staff were immediately re-educated about ensuring that visitors are wearing face masks correctly while in residents' room especially when there are other residents present. Clinical Staff were re-educated related to putting on the proper PPE when entering a transmission-based precaution room. Clinical Staff were re-educated related to not wearing gloves in the hallway. Clinical Staff were re- educated about performing hand hygiene prior to donning and doffing gown and gloves. Clinical Staff were re-educated on wearing the proper eye protection and masks while in resident care areas and keeping the masks	

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	the West Unit. She was not wearing a face shield and she had a pair of safety glasses hanging from her scrub top. The CNA had been within 6 feet of each resident. At 2:36 p.m., the MDS Coordinator informed the CNA she needed to wear a face shield when she was in the residents' rooms. Interview with the Nurse Consultant on 2/1/22 at 2:30 p.m., indicated the CNA should have either worn her safety glasses or a face shield when in resident rooms. 6. During a random observation on 2/1/22 at 10:24 a.m., two visitors were in the Memory Care Unit lounge with a female resident. Neither the visitors nor the resident were wearing face masks. Another resident was seated in a chair in the corner at that time. His mask was pulled down below his chin. Interview with the Administrator on 2/1/22 at 2:30 p.m., indicated they were having trouble with some visitors wearing masks and they needed to be reminded. 7. During a random observation on 1/30/22 at 11:35 a.m., the screener at the door allowed 4 visitors to enter. She took their temperature after they had signed in and stated "Do you know where you are going?" they all said "yes" and walked down the hallway. There was no instruction given to them as far as personal protective equipment (PPE) and ensuring they all wore their face masks while visiting the resident. At 12:30 p.m., a visitor for Resident R was observed seated in a chair by the resident's bed with her face mask around her neck. The resident was not wearing a face mask. The resident's		covering the mouth and nose. Clinical Staff were re-educated on assessing unvaccinated residents that are in transmission-based precaution rooms at least every shift. Clinical Staff were re-educated on not carrying clean linens against her body/uniform **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 surveillance observation audits 3 times weekly to ensure improvement of infection control practices. · Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Dates when corrective**	

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	roommate was observed in his bed with no mask over his face. At 12:34 p.m., CNA 5 walked into the resident's room and picked up his lunch tray. The CNA did not instruct the visitor to put on her face mask over her mouth and nose. At 12:50 p.m., the visitor was still sitting in the chair with no face mask over her mouth and nose. On 1/31/22 at 1:29 p.m., the same visitor was seated in a chair by the resident's bed. Her face mask was pulled down beneath her chin. The resident was not wearing a face mask and the resident's roommate was observed in his bed. 8. On 1/30/22 at 1:25 p.m., a visitor entered Resident S's room wearing a face mask over his nose and mouth. After entering the room, the visitor sat in the resident's bed and removed his face mask. The resident was not wearing a face mask, nor was her roommate who resided in the first bed. Interview with the Administrator on 2/1/22 at 2:05 p.m., indicated the staff were to be monitoring visitors to ensure face masks were being worn while visiting the residents. They also were aware they needed to provide privacy during the visits and signs were posted throughout the facility for visitors to wear their face masks during the visits. The current and revised 11/22/21 "IDOH COVID-19 Regulatory Visitation and Activities Guidance for Long-term Care" policy indicated "Indoor Visitation during an Outbreak (this section only pertains to SNF/NFs facilities required to conduct outbreak testing): When a new case of COVID-19 among residents or staff is identified, a facility should conduct an investigation and begin outbreak testing. - It is safer for visitors to not enter during the		**action will be completed: 2/11/22**	

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	outbreak investigation, but they must still be allowed in the facility if the resident wishes to have visitors. The visitors should be made aware of the potential risks and the need to adhere to the core principles of COVID-19 infection prevention. If the visitor chooses to visit, they should wear a face covering (regardless of vaccination status) and visits should be in the resident room. Visitors: If community transmission is substantial to high for the facility, all residents and visitors (regardless of vaccination status) must wear masks and physically distance at all times." 9. During a random observation on 1/30/22 at 11:40 a.m., on East unit, the Wound Nurse and RN 1 were observed talking to one another outside Resident J's room. At that time the Wound Nurse was dressed in full PPE with a gown, gloves, N95 face mask, and face shield on and RN 1 was standing next to her with his face mask below his chin. He pulled up his surgical face mask and walked into the COVID unit with no eye protection on. The Wound Nurse was observed to walk inside the resident's room with all of the PPE on. She positioned the over bed table and touched other items in the room with her gloved hands. She walked out of the room to the treatment cart which was located right outside the room and picked up other items from the cart to change the resident's bandages. The Wound Nurse did not doff any of the PPE and with the same gloved hands walked back into the room and closed the door. 10. During a random observation on 1/30/22 at 11:45 a.m., there were 4 clean linen carts located in the halls on the East unit. All of the covers were lifted up and the clean linen was exposed. 11. During a random observation on 1/30/22 at			

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	11:55 a.m., Agency LPN 1 was observed wearing a face shield that was not fitted snug to her face or forehead. There was a large gap down the center. The LPN was observed walking in and out of resident rooms on the West unit. At 12:03 p.m., Agency LPN 1 was still observed wearing the wrong face shield. The Agency LPN indicated she was unaware it was the wrong kind of eye protection. Review of the CDC current county positivity rates, indicated the local county was high risk for transmission of COVID-19. The current and updated 11/22/21 "IDOH COVID-19 Infection Control Guidance in Long-term Care Facilities" policy, indicated "All healthcare professionals must wear eye protection for resident care when community transmission is substantial or high. Eye protection should be close to face with no gaps at top, bottom, or sides of eyes." 12. During a random observation on 1/30/22 at 12:01 p.m., CNA 5 was observed to don an isolation gown and clean gloves to both hands to enter Resident U's room. The CNA did not perform hand hygiene prior to donning the gown and gloves. The resident was in contact isolation for C-diff. 13. During a random observation on 1/30/22 at 12:15 p.m., CNA 4 was observed walking down the hall with a lunch tray. She stopped at Resident J's room. The resident had signs on his door that indicated he was in droplet/contact isolation. The CNA was observed to don an isolation gown and clean gloves to both hands. She did not perform hand hygiene before donning the PPE.			

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During a random observation on 1/30/22 at 12:52 p.m., CNA 3 was observed to answer Resident T's call light. She walked out of that room carrying a dirty lunch meal tray and walked into Resident J's room. There was a sign on Resident J's door that indicated he was in droplet/contact isolation. The CNA did not don any PPE prior to entering the room. She picked up his dirty lunch tray and waked out of the room. She did not perform hand hygiene after leaving either room.

Interview with the CNA at that time indicated she was aware she did not don PPE before entering the room, she stated "I was in a hurry to pick up the lunch trays.

The current and updated 11/22/21 "IDOH COVID-19 Infection Control Guidance in Long-term Care Facilities" policy indicated "Hand hygiene [use of alcohol-based hand rub (ABHR) is preferred]:
· Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care. ABHR >60% are preferred unless hands are visibly soiled or when handwashing is advocated by CDC guidance."

14. During a random observation on 1/31/22 at 11:39 a.m., CNA 6 was observed walking down the hallway carrying clean linens she just removed from the linen cart up against her body.

Interview with the Director of Nursing on 2/1/22 at 2:05 p.m., indicated staff were to be performing hand hygiene before donning PPE to enter a resident's room who was in isolation. Staff were to be wearing the correct eye protection and gowns and gloves were to be doffed before

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	155220	A. BUILDING 00 B. WING	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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	leaving a TBP room. Linens were to be carried away from the body. 15. 2. On 1/30/21 at 11:45 a.m., Resident J was observed in bed. There was sign posted on his door that indicated the resident was in droplet/contact isolation. The record for Resident J was reviewed on 1/31/22 at 12:06 p.m. The resident was admitted to the facility on 1/18/22. Diagnoses included, but were not limited to, pressure ulcers, high blood pressure, type 2 diabetes, anemia, and benign prostatic hyperplasia. The Admission Minimum Data set (MDS) assessment, dated 1/24/22 indicated the resident was cognitively intact, and was an extensive assist with a 2 person physical assist for bed mobility. The Resident has a foley catheter and was always continent of bowel and bladder. He had unhealed pressure ulcers from Stage 2 to 4, unstageable and deep tissue injuries. A Care Plan, dated 1/19/22, indicated the resident has the need for droplet and contact isolation due to recent hospital admission. Physician's Orders, dated 1/18/22, indicated droplet isolation related to new admission. The COVID-19 symptom assessment was completed on 1/18/22 at 10:58 p.m., 1/28/22 at 3:06 a.m., 1/30/22 at 3:53 a.m., and 1/31/22 at 10:54 a.m. Vital signs were documented on every shift, however, there was no assessment completed of the resident's lungs and breathing status. Interview with the Assistant Director of Nursing on 2/1/22 at 3:15 p.m., indicated nurses were to be			

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	completing the COVID-19 screening assessments every shift for all residents in transmission based precautions. The resident was in TBP due to being a new admission and unvaccinated for COVID-19. The Indiana Department of Health current and updated 1/4/22 "Long-term Care COVID-19 Clinical Guidance" policy indicated, "Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter. · Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection." This Federal tag relates to Complaints IN00365165 and IN00371776 3.1-18(b)			