STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 00 B. WING	09/21/2023

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 the Investigation of Complaints IN00416460 and IN00417422. Complaint IN00416460 - Federal/State deficiencies related to the allegations are cited at F812. Complaint IN00417422 - Federal/State deficiencies related to the allegations are cited at F684. Survey dates: September 20 and 21, 2023 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF: 10 SNF/NF: 90 Residential: 38 Total: 138 Census Payor Type: Medicare: 10 Medicaid: 73 Other: 17 Total: 100 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/25/23.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to			

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

Amy Suzanne Maurice | Administrator | 10/06/2023

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

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	facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review and interview, the facility failed to ensure a resident was assessed and monitored prior to being sent to the hospital for a change in condition and hospice orders were followed as written for 1 of 3 residents reviewed for a change in condition and 1 of 1 residents reviewed for hospice. (Resident B) Finding includes: The closed record for Resident B was reviewed on 9/20/23 at 12:16 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness and/or paralysis on one side of the body) following a stroke affecting the left non-dominant side, palliative care, dysphagia (difficulty swallowing), type 2 diabetes, protein calorie malnutrition, and depression. The Significant Change Minimum Data Set (MDS) assessment, dated 5/17/23, indicated the resident was cognitively impaired for daily decision making and she was totally dependent for bed mobility and needed extensive assistance with transfers and eating. Nurses' Notes, dated 5/11/23 at 8:45 p.m., indicated the resident returned to the facility from the hospital and was admitted to hospice. Orders were received to discontinue all medication orders, blood draws, and diagnostic orders. There was no documentation of an assessment	F 0684	**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. The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B- no longer resides in the facility. Facility contacted NICL Lab's Strategic Program Manager and requested that education be provided to all phlebotomists to collect laboratory specimens as per orders. If there is any indication that labs are to be discontinued the phlebotomist must confirm orders with nurse prior to specimen collection. **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;**	10/06/2023

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	prior to the resident going to the hospital and no change in condition assessment had been completed. The Hospital Discharge Summary, dated 5/11/23, indicated the resident arrived to the hospital on 5/11/23 at 3:16 a.m. in respiratory distress. The work up revealed severe sepsis with lactic acidosis, acute kidney injury, dehydration, and hyponatremia (low sodium level). The resident was given an intravenous (IV) fluid bolus and a dose of broad spectrum antibiotics. Palliative care was consulted and the family made the decision to transition the resident to hospice. Hospice Orders, dated 5/11/23, indicated to discontinue all blood draws and diagnostic testing. The resident had blood draws for a complete blood count (CBC) and a comprehensive metabolic panel (CMP) completed on 5/12, 5/13, and 5/15/23. Interview with the Administrator on 9/21/23 at 2:00 p.m., indicated documentation should have been completed prior to the resident being sent to the hospital. Interview with Nurse Consultant 1 on 9/21/23 at 3:30 p.m., indicated the facility's Nurse Practitioner (NP) had ordered the labs on 5/11/23 while the resident was in the hospital. An order was sent to the lab on 5/12/23 to discontinue the standing orders for the CBC and CMP but they were still drawn on 5/13 and 5/15/23. This Federal tag relates to Complaint IN00417422. 3.1-37(a)		All residents with a change in condition have the potential to be affected by the same alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses were re-educated on documentation required upon change in condition requiring transfer to the hospital including; Assessment of the change in condition MD notification Any orders received /Any interventions initiated Responsible party/family notification Nurses were educated on; Ensuring that all labs are collected as per orders. Ensuring orders to discontinue labs are followed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Nurse managers will audit clinical documentation 2 times per week to ensure change in condition documentation for resident requiring hospitalization is completed. Nurse Manager/Designee will audit 2 residents with “No lab draw” orders weekly to ensure no labs	

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			have been ordered/collected as per orders. The DON/designee will present a summary of the audits to the QAPI committee monthly for no less than 6 mos. Thereafter if the committee feels continued monitoring is necessary audits will continue to ensure substancial compliance.	
F 0812 SS=F Bldg. 00	483.60(i)(1)(2) Food Procurement,Store/Prepare/Serve-Sanitary §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation, record review, and interview, the facility failed to ensure food temperatures were monitored for each meal. This had the potential to affect the 100 residents who	F 0812	**Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute**	10/06/2023

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	received their food from the kitchen. (The Main Kitchen) Finding includes: On 9/20/23 at 10:02 a.m., a kitchen sanitation tour was completed with the Dietary Food Manager (DFM). The food temperature binder was reviewed at that time. The food temperature logs for August and September 2023 were lacking documentation for the following dates and meals: - No documentation of lunch temperatures on 8/21/23. - No documentation of breakfast or lunch temperatures on 8/23/23 and 9/5/23. - No documentation of dinner temperatures on 9/1/23. - No documentation of any food temperatures on 9/2 and 9/3/23. The food temperatures that were documented from 9/5 through 9/20/23, were documented at the start of the meal service. Interview with the DFM at that time, indicated food temperatures were to be documented for each meal. The facility policy titled, "Safe Food Handling" was provided by the Administrator on 9/21/23 at 1:21 p.m. The policy indicated, "Cooks will monitor proper temperatures of TCS foods and record and start of meal service, middle of meal service and the completion of meal service." This Federal tag relates to Complaint IN00416460. 3.1-21(i)(3)		**an admission of guilt or liability by the facility and is submitted only in response to th1e regulatory requirement. The facility respectfully requests a desk review.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Food temperatures were immediately obtained, monitored, and documented in logs. **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 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;** Dietary managers/cooks were re-educated on: Appropriate food temperature levels/range Monitoring food temperatures per protocol Documenting food temperature per protocol **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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			assurance programs will be put into place; Administrator/Designee will audit food temperature logs 2 times per week at different meals to ensure food temperatures are maintained and documented in the Dietary temperature logs per protocol. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	