

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  01/27/2015
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F000000	<p>This visit was for the Investigation of Complaint IN00163380.</p> <p>Complaint IN00163380- Substantiated. Federal/State deficiencies related to the allegations are cited at F 246 and F 314.</p> <p>Survey date: January 27, 2015</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Survey team: Janet Adams, RN-TC</p> <p>Census bed type: SNF/NF: 139 Residential: 47 Total: 186</p> <p>Census payor type: Medicare: 51 Medicaid: 71 Other: 17 Total: 139</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	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.	

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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F000246 SS=D	<p>Quality review completed on January 28, 2015, by Janelyn Kulik, RN.</p> <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. Based on observation, record review, and interview, the facility failed to ensure the residents needs were accommodated related to call lights not in reach for 1 of 3 residents reviewed for call lights in place in the sample of 3 (Resident #F)</p> <p>Finding includes:</p> <p>On 1/27/15 at 9:10 a.m., Resident #F was observed sitting in her room in a wheel chair. The wheel chair was in front of the dresser next to her bed. The resident's call light cord was hanging from the wall outlet and draped over the dresser with the push pad near the ground. The call light pad was not in the resident's reach. The resident yelled out several times. The Housekeeping Supervisor was walking down the hall at this time and entered the resident's room. The</p>	F000246	<p>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. <b>F-246</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>Resident #F's call light was placed within reach.</p>	02/05/2015

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	<p>Housekeeping Supervisor stated "(Resident's name) Why are you yelling?"</p> <p>On 1/27/15 at 9:18 a.m., RN #1 walked down the resident's hall and into the resident's room. The RN then exited the room and walked back down the hall to her Medication Cart by the Nurses' Station.</p> <p>On 1/27/15 at 9:45 a.m., the resident remained in the wheel chair in her room. No staff members or visitors were present in the room. The resident's call light remained in the same place and out of her reach. The resident was yelling out at this time.</p> <p>On 1/27/15 at 10:00 a.m., the resident remained in the wheel chair in her room. The resident had a blanket pulled over her head. No staff members or visitors were present in the room. The resident's call light remained in the same place and out of her reach.</p> <p>On 1/27/14 at 10:30 a.m., the resident remained in the wheel chair in her room. A staff member was in the resident's room and told the resident she had apple juice for her her. The staff member placed the cup on the resident's table and exited the room. The resident's call light remained in the same place and out of her</p>		<p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-serviced held on 1/29/15 by Director of Nursing/designee with the staff regarding the following:</p> <p>1.Ensuring the residents needs are accommodated by placing the call light within reach.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>	

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	<p>reach.</p> <p>On 1/27/15 at 12:55 p.m., LPN #2 wheeled the resident into her room from the hallway. The resident's call light remained out of reach. The LPN exited the room without placing the resident's call light in her reach.</p> <p>The record for Resident #F was reviewed on 1/27/15 at 10:45 a.m. The resident's diagnoses included, but were not limited to, legal blindness, loss of hearing, diabetes mellitus, Vitamin B deficiency, urinary tract infection, muscle weakness, and sinusitis.</p> <p>Review of the 11/15/14 Minimum Data Set (MDS) quarterly assessment indicated the residents' BIMS (Brief Interview for Mental Status) score was (12). A score of (12) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required extensive assistance(resident involved in activity with staff providing weight bearing support) of one staff member for transfers, dressing, and eating.</p> <p>The resident's current Care Plans were reviewed. The Care Plans were last reviewed on 11/10/14. A Care Plan initiated on 6/21/2013 indicated the</p>		<p><b>i.e., what quality assurance programs will be put into place;</b></p> <p>Director of Nursing/designee will audit 15 resident rooms weekly to ensure the call light is in place.</p> <p>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> <p><b>Date by which systemic corrections will be completed: February 5, 2015</b></p>				

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F000314 SS=D	<p>resident had severely impaired vision related to diabetes mellitus. Care Plan interventions included to keep the resident's call light in reach and assure the floor was free of foreign objects.</p> <p>When interviewed on 1/27/15 at 2:05 p.m. , the Director of Nursing indicated the resident's call light should have been in reach as per the resident's plan of care.</p> <p>3.1-3(v)(1)</p> <p>This Federal tag relates to Complaint IN00163380.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to ensure a resident with pressure ulcers received the</p>	F000314	Please accept the following as the facility's credible allegation of compliance. This plan of	02/05/2015	

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	<p>necessary treatment and services to promote healing and prevent new sores from developing related to not having a pressure reduction chair cushion in place for 1 of 3 residents reviewed for pressure ulcers in the sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>On 1/27/15 at 10:10 a.m. CNA's # 1 &amp; 2 were observed placing a Hoyer lift (a mechanical lift) sling under the resident. The CNA's turned the resident to her side. The resident had a dressing on her mid spine and on her sacral/buttock area. The CNA's placed the sling under the resident and used the Hoyer lift to transfer Resident #C from her bed into a high back wheel chair in her room. There was no seat cushion on the wheelchair.</p> <p>On 1/27/15 at 12:57 p.m., the resident was observed sitting in the wheel chair in the hallway across from the Nurses' Station. The Hoyer lift sling was in place under the resident. The Unit Manager assessed the resident and felt under the sling. There was no pressure reduction cushion on the seat of the wheel chair.</p> <p>The record for Resident #C was reviewed on 1/27/15 at 12:50 p.m. The resident's diagnoses included, but were not limited to, renal failure, Alzheimer's disease,</p>		<p>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. <b>F-314</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The corrective action for Resident #C is as follows: The wheelchair cushion for Resident #C was placed in the chair.</p> <p><b>How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;</b></p> <p>All facility residents have the potential to be affected by the same alleged deficient practice. An audit of all facility residents in wheelchairs that require pressure</p>	

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	<p>congestive heart failure, high blood pressure, diabetes mellitus, osteoarthritis, and chronic airway obstruction. The resident was sent to the hospital on 1/14/15 and returned to the facility on 1/21/15.</p> <p>Two Skin Integrity Condition reports were initiated on 1/22/15. The first report indicated the resident had a Deep Tissue Injury (purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear) pressure wound on sacrum extending to the right and left buttock areas and the onset date of the wound was 1/21/15. The wound measured 6 cm (centimeters) x 9 cm with the depth undetermined. The wound bed was clean and pink in color. A scant amount of serous (bloody) exudate was present. Skin treatment interventions included for the resident to have pressure relieving devices for her bed and chair in place.</p> <p>The second Skin Integrity Condition report indicated the resident had a Stage II (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed) pressure ulcer to the mid spine and the onset date of the ulcer was 1/21/15. The ulcer measured 4 cm x 2.5 cm x &lt;.1 cm. The wound bed was</p>		<p>relieving devices was completed to identify those without pressure reduction wheelchair cushions.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>In-serviced held on 1/29/15 by Director of Nursing/designee with the staff regarding the following:</p> <p>1.All residents with pressure ulcers should receive a pressure reduction wheelchair cushion to promote healing and prevent new sores from developing.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;</b></p> <p>Director of Nursing/designee will audit 15 residents weekly to ensure a pressure reduction wheelchair cushion is in place.</p>	

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	<p>clean and red in color. A scant amount of serous (bloody) exudate was present. Skin treatment interventions included for the resident to have pressure relieving devices for her bed and chair in place.</p> <p>The resident's current Care Plans were reviewed. A Care Plan initiated on 1/22/15 indicated the resident had current pressure ulcers and wound healing could be hindered by muscle weakness and the resident's limited mobility. Care Plan approaches included for the resident to utilize a pressure reduction cushion when she was up in the chair.</p> <p>When interviewed on 1/27/15 at 2:05 p.m. , the Director of Nursing indicated the resident should have had a pressure reduction cushion in her chair.</p> <p>This Federal tag relates to Complaint IN00163380.</p> <p>3.1-40(a)(2)</p>		<p>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> <p><b>Date by which systemic corrections will be completed: February 5, 2015</b></p>		