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	05/18/2021

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 IN00352309, IN00352983, IN00353272, IN00353570 and IN00353618. Complaint IN00352309 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F684. Complaint IN00352983 - Substantiated. Federal/ State deficiencies related to the allegations are cited at F694. Complaint IN00353272 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00353570 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00353618 - Substantiated. No deficiencies related to the allegations are cited. Survey dates: May 17 & 18, 2021 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census bed type: SNF: 14 SNF/NF: 79 Residential: 40 Total: 133 Census payor type: Medicare: 22 Medicaid: 50 Other: 21	F 0000	Please accept the following as the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility would like to request a desk review.	

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

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

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	Total: 93 These deficiencies reflect State findings in accordance with 410 IAC 16.2-3.1. Quality review completed on 5/24/21.			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to 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 received treatment and care in accordance with professional standards of practice related to medication not given as ordered by the Physician for 1 of 3 residents reviewed for quality of care. (Resident D) Finding includes: Resident D's closed record was reviewed on 5/17/21 at 3:51 p.m. The diagnoses included, but were not limited to, respiratory failure. A Physician's Order, dated 4/20/21, indicated Preparation H ointment, a thin layer was to be applied rectally every shift. The Medication Administration Record (MAR) and Treatment Administration Record (TAR), dated 4/2021, lacked documentation of the order for the Preparation H ointment. The Preparation H	F 0684	**F 684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident no longer resides at the facility. Resident D had no adverse outcomes related to not receiving Preparation H. . **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 medication orders have the potential to be	05/26/2021

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	ointment had not been administered per the Physician's Orders. During an interview on 5/18/21 at 11:53 a.m., the East Unit Manager indicated the Preparation H ointment was not on the MAR or the TAR and was unable to determine if it was administered as ordered by the Physician. The order was written, then a Medication Record was to be printed out. The Medication Record, "must not have been printed". This Federal tag relates to Complaint IN00352309. 3.1-37(a)		affected by the same deficient practice. Medication orders for the past 30 days have been reviewed to ensure MD orders are being followed. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** Licensed nurses were in serviced on: ·Administration of medication according to the current physician's orders. ·Ensuring all new orders for any medications are printed and placed in the MAR/TAR as appropriate. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/Designee will run the new order report for all residents 3 x each week to ensure all new orders were placed into the MAR/TAR and administered as ordered for 6 months. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter,	

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			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 of Completion: May 26, 2021**	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review and interview, the facility failed to ensure the Physician's Orders were followed for a tubing change and dressing change for a resident's PICC (peripherally inserted central catheter) line for 1 of 3 residents reviewed for PICC lines. (Resident J) Finding includes: During an observation on 5/17/21 at 9 a.m., Resident J was lying in bed. There was a PICC line located in the right forearm. The clear dressing had not been dated. The Infection Control Nurse acknowledged the dressing on the PICC line was not dated. Resident J's record was reviewed on 5/17/21 at 1:14 p.m. The diagnoses included, but were not limited unstageable (full thickness tissue loss, covered by slough and/or eschar) and infected sacral pressure ulcer.	F 0694	**F 694 Parenteral/IV Fluids** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident J remains in the facility. The PICC line dressing and tubing was immediately changed. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility	05/26/2021

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	A Care Plan, dated 4/12/21, indicated the resident was receiving an intravenous medication through the PICC line. The interventions included the dressing was to be changed per the Physician's Order. A Physician's Order, dated 4/10/21, indicated Zosyn (antibiotic) 3.375 milligrams in 50 milliliters of normal saline was to be given through the PICC line every 6 hours. A Physician's Order, dated 4/10/21, indicated the tubing on the PICC line was to be changed every 24 hours. A Physician's Order, dated 4/17/21, indicated the dressing on the PICC line in the right upper arm was to be changed weekly and as needed. The Medication Administration Record (MAR), dated 4/2021, indicated by a lack of initials, the weekly dressing change of the PICC line had not been completed from 4/17/21 through 4/30/21. The PICC tubing change had not been completed from 4/10/21 through 4/27/21. The MAR, dated 5/2021, indicated by a lack of initials, the weekly dressing change of the PICC line had not been completed from 5/1/21 through 5/17/21. On 5/18/21 at 10:05 a.m., the East Unit Manager indicated the dressing changes were not marked as being completed and the tubing change had not been completed as ordered by the Physician. This Federal tag relates to Complaints IN00352983. 3.1-47(a)(20)		residents with orders for PICC lines. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** All residents with PICC/IV/Central line orders were reviewed for proper dressing changes and tubing. Licensed nursing staff were educated on PICC/IV/Central line tubing and dressing changes. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will review 3 residents weekly x 6 months to ensure PICC/IV/Central line dressing and tubing are changed as ordered. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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