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	11/22/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey and the Investigation of Complaints IN00392424, IN00392575, and IN00392985. This visit included a State Residential Licensure Survey. Complaint IN00392424 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F692, F758, and F921. Complaint IN00392575 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697 and F921. Complaint IN00392985 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: November 14, 15, 16, 17, 18, 21, and 22, 2022. Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 117 Residential: 37 Total: 154 Census Payor Type: Medicare: 17 Medicaid: 77 Other: 23 Total: 117	F 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	12/14/2022

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	These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 11/29/22.			
F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to ensure residents had Physician's Orders for medications and an assessment to self-administer their own medications for 2 of 2 residents reviewed for self-administration of medication. (Residents 32 and 38) Findings include: 1. On 11/18/22 at 8:50 a.m., Resident 32 asked QMA 1 for her Nystatin (an anti-fungal) powder. The QMA took the powder to the resident and left it in the room. The record for Resident 32 was reviewed on 11/22/22 at 9:21 a.m. Diagnoses included, but were not limited to, type 2 diabetes and functional quadriplegia. The 10/22/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact. The resident did not have a Care Plan for self-administration of medications nor did she have an Self-Administration of medication assessment.	F 0554	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/2022** 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. **F554 Resident Self Admin Meds-Clinically Appropriate** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A self-administration assessment was completed for Residents 32 and MD order received for self administration of medication. A self- administration assessment was competed for Resident 38 and MD order received for self administration of medication. **How the facility will identify other residents having the potential to be affected by the**	12/12/2022

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	A Physician's Order, dated 7/8/22, indicated the resident was to receive Nystatin powder 100,000 unit/gram, apply to affected areas daily as needed. There was no order indicating the medicated powder could be left at the bedside or the resident could apply it. Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the medication should not have been left at the bedside and the resident would be assessed for self administering the powder. 2. On 11/14/22 at 10:13 a.m., Resident 38 was observed sitting up in his bed. At that time there were 2 bottles of Over The Counter (OTC) medications of Prevagen and Super Beta Prostate on the over bed table. He indicated his family had brought the medications to him and he does take them every day by himself. On 11/16/22 at 9:23 a.m., the resident was observed lying in bed dressed in a shirt. At that time the 2 OTC bottles of Prevagen and Super Beta Prostate were observed on the dresser. On 11/16/22 at 11:30 a.m. and 11/17/22 at 10:00 a.m., the resident was not in the room and the 2 bottles of OTC medications remained on top of the dresser. The record for Resident 38 was reviewed on 11/15/22 at 2:20 p.m. The resident was admitted on 4/1/22. Diagnoses included, but were not limited to, dementia without behaviors, high blood pressure, atrial fibrillation, heart failure, and cognitive communication. The Quarterly Minimum Data Set (MDS) assessment, dated 10/16/22, indicated the resident was moderately impaired for decision making.		**same deficient practice and what corrective action will be taken;** All facility residents with medication orders 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 educated on not leaving medications at resident bedside unless there is an order for self-administration in place. Staff were also educated on ensuring medications are stored properly. **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;** Facility Angel's will audit 15 residents 3 days per week to ensure no medication is improperly stored at the bedside. 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 quarterly at the QA meeting. Monitoring will be on going.	

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	There was no Care Plan for the resident to self administer his own medications. Physician's Orders, dated 10/10/22, indicated Prevagen give 1 capsule daily in the morning self-administer. Family will provide. There was no Physician's Order for the OTC medication of Super Beta Prostate supplement. There was no self administration of medication assessment available for review. Interview with the Nurse Consultant on 11/21/22 at 12:45 p.m., indicated a self administration of medication assessment was just completed that day. 3.1-11(a)		**Date by which systemic corrections will be completed: 12/12/2022**	
F 0623 SS=B Bldg. 00	483.15(c)(3)-(6)(8) Notice Requirements Before Transfer/Discharge §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section.			

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	§483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and			

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	submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate			

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	relocation of the residents, as required at § 483.70(l). Based on record review and interview, the facility failed to ensure a resident and/or their Responsible Party were notified in writing related to a transfer to the hospital for 5 of 6 residents reviewed for hospitalization. (Residents 1, 73, 110, 72, and 77) Findings include: 1. The record for Resident 1 was reviewed on 11/17/22 at 3:41 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness and paralysis) affecting his right dominant side following a stroke and altered mental status. The Quarterly Minimum Data Set (MDS) assessment, dated 10/26/22, indicated the resident was moderately impaired for daily decision making. Nurses' Notes, dated 8/23/22 at 10:22 p.m., indicated the CNA reported to the nurse the resident had dark colored emesis. The nurse observed the resident with coffee ground emesis. The Physician was notified and orders were obtained to send the resident to the emergency room for evaluation. 911 was called for transport. The resident was admitted to the hospital with the diagnosis of septic shock and returned to the facility on 8/29/22. There was no documentation indicating the resident's Responsible Party had been notified in writing of the transfer. Interview with the Administrator on 11/21/22 at 2:15 p.m., indicated no transfer notice was given	F 0623	**Dyer Nursing & Rehabilitation Annual Survey: 11-22-22** 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. **F623 Notice Requirements Before Transfer/Discharge** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Facility notice of transfer discharge including the bed hold policies were mailed to the responsible parties for Residents 1, 73, and 77. Residents 72, 110 are 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 that are transferred or discharged 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**	12/12/2022

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	because the resident was sent out 911. 2. The record for Resident 73 was reviewed on 11/17/22 at 1:42 p.m. Diagnoses included, but were not limited to, congestive heart failure and palliative care. The 11/14/22 Significant Change Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making. Nurses' Notes, dated 10/10/22 at 12:35 p.m., indicated the resident was unresponsive. His blood pressure was unreadable and his blood sugar was 165. The Nurse Practitioner was present and orders were given to send the resident to the emergency room for evaluation. The resident returned to the facility on 10/12/22. There was no documentation indicating the resident's Responsible Party had been notified in writing of the transfer. Interview with the Administrator on 11/21/22 at 2:15 p.m., indicated no transfer notice was given because the resident was sent out 911. 3. The record for Resident 110 was reviewed on 11/16/22 at 9:44 a.m. Diagnoses included, but were not limited to, myocardial infarction and atrial fibrillation (irregular heartbeat). The Admission Minimum Data Set (MDS) assessment, dated 11/3/22, indicated the resident had modified independence for daily decision making. Nurses' Notes, dated 10/22/22 at 5:27 p.m., indicated the resident was semi-unresponsive and he was unable to speak or respond. His eyes were		**ensure that the deficient practice does not recur;** Staff were re-educated on providing the notice of transfer discharge including the bed hold policy to the resident/ resident responsible party upon transfer and discharge from facility. Social Service staff was educated to mail (Via USPS) a copy of the notice of discharge including the bed hold packet to the resident's responsible party and ensure it is uploaded into the residents' medical 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 into place;** Administrator/Designee will audit weekly to ensure the notice of transfer discharge including bed hold polices are provided to resident responsible parties upon transfer/discharge. The 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:**	

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	open but his body was rigid. 911 was called and the resident was transported to the hospital. He returned to the facility on 10/28/22. There was no documentation indicating the resident's Responsible Party had been notified in writing of the transfer. Interview with the Administrator on 11/21/22 at 2:15 p.m., indicated no transfer notice was given because the resident was sent out 911. 4. The record for Resident 72 was reviewed on 11/16/22 at 2:14 p.m. Diagnosis included, but were not limited to, stroke, anemia, thyroid disorder, depression, and dysphagia (swallowing difficulties). The Significant Change in Status Minimum Data Set (MDS) assessment, dated 11/1/22, indicated the resident was severely cognitively impaired for daily decision making. Nurses' Notes, dated 10/19/22 at 6:06 a.m., indicated the resident was lying in her room with her eyes closed, when spoken to the resident made babbling noises but did not open her eyes. The residents arms were noted to have jerking movements. Vitals were assessed and she was not noted to be in respiratory distress. The Physician was notified at 5:55 a.m. and gave an order to send the resident to the hospital. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the hospital.		**12/12/2022**	

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	Interview with the Director of Nursing on 11/22/22 at 11:19 a.m., indicated there was no documentation related to the State transfer form being sent with the resident or to the resident's Responsible Party. 5. The record for Resident 77 was reviewed on 11/16/22 at 9:37 a.m. Diagnoses included, but were not limited to, sepsis, high blood pressure, non-Alzheimer's dementia, respiratory failure, and diabetes mellitus. The Quarterly Minimum Data Set (MDS) assessment, dated 11/6/22, indicated the resident was cognitively intact for daily decision making. Nurses' Notes, dated 10/24/2022 at 10:52 a.m., indicated the resident was lethargic and not responsive, vital signs were taken and orders were received from the Nurse Practitioner to send the resident to the hospital for evaluation. Nurses' Notes, dated 10/24/2022 at 11:00 a.m., indicated the resident was transferred to the hospital for evaluation. There was no documentation to indicate the State approved transfer form was completed and sent with the resident. There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the hospital. Interview with the Director of Nursing on 11/22/22 at 11:19 a.m., indicated there was no documentation related to the State transfer form being sent with the resident or to the resident's			

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	Responsible Party. 3.1-12(a)(6) 3.1-12(A)(ii) 3.1-12(A)(iii)			
F 0657 SS=D Bldg. 00	483.21(b)(2)(i)-(iii) Care Plan Timing and Revision §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. Based on record review and interview, the facility failed to ensure residents were invited to their Care Plan conferences for 2 of 2 residents	F 0657	**Dyer Nursing & Rehabilitation** **ANNUAL SURVEY: 11/22/22**	12/12/2022

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	reviewed for care planning. (Residents 38 and D) Findings include: 1. During an interview with Resident 38 on 11/14/22 at 10:19 a.m., he indicated he does not recall being invited to attend a care conference. The record for Resident 38 was reviewed on 11/15/22 at 2:20 p.m. The resident was admitted on 4/1/22. Diagnoses included, but were not limited to, dementia without behaviors, high blood pressure, atrial fibrillation, heart failure, and cognitive communication. The Quarterly Minimum Data Set (MDS) assessment, dated 10/16/22, indicated the resident was moderately impaired for decision making. There was no documentation of a care conference for the resident since admission. Interview with the Nurse Consultant on 11/21/22 at 12:45 p.m., indicated the resident had a care conference held today. 2. During an interview with Resident D on 11/14/22 at 10:50 a.m., she indicated she did not know anything about a care conference. The record for Resident D was reviewed on 11/16/22 at 2:10 p.m. Diagnoses included, but were not limited to, major depressive disorder, morbid (severe) obesity due to excess calories, and fibromyalgia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/18/22, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 plus person physical		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. **F657 Care Plan Timing and Revision** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** Resident 38- care plan conference held 11/16/22, resident was invited to attend. Resident D- care plan conference held 11/21/22, resident was invited to attend. **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 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:** Management staff educated on having care conference meetings timely and inviting the resident/responsible party to	

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	assist for bed mobility, dressing, toilet use, personal hygiene, and bathing. The last documented care conference was 7/26/22. Interview with the Administrator on 11/21/22 at 12:45 p.m., indicated the resident had a care conference held today. 3.1-35(d)(2)(B)		attend. **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;** Administration/designee will audit 10 residents monthly to ensure care conferences are held timely. 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 quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 12/12/2022**	
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 received help with Activities of Daily Living (ADLs) related to repositioning in bed, hair washed, and showers, for 2 of 9 residents reviewed for ADLs. (Residents D and B)	F 0677	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	12/05/2022

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	Findings include: 1. During an interview with Resident D on 11/14/22 at 10:45 a.m., she indicated her hair was greasy and had not been washed in a very long time. Her bathing preference was a bed bath, which she received 2 times a week. On 11/16/22 at 11:15 a.m., the resident was observed lying in bed. The right side of the bed was against the wall. At that time, CNA 1 was observed standing next to the bed holding a bed pan in one hand. The resident indicated she had to have a bowel movement. The CNA instructed the resident to turn onto her right side so she could place the bed pan under her. The resident was very obese, and was unable to turn by herself onto her side. The CNA placed both of her hands on the resident's left hip and physically pushed her over to the other side. The resident was heard telling the CNA she was hurting her while pushing her over. The resident already had the bowel movement so the CNA provided incontinence care. The CNA did not stop to get or ask for help from any other staff member. Interview with CNA 1 at that time, indicated the resident was supposed to be a 2 person physical assist with bed mobility, however, when she had to go to the bathroom there was no time to get anyone to help. On 11/17/22 at 11:20 a.m., the resident was observed in bed. At that time, her hair was disheveled and greasy. Interview with the resident at that time, indicated she did not want to have hair washed at that time. The record for Resident D was reviewed on		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F677 ADL Care Provided for Dependent Residents** **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. Resident D- shower offered. CNA 1 educated on proper position of residents D. **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 assistance with ADL care including general grooming, hair washing, regular showers, and transfers as per resident's plan of care. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality**	

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	11/16/22 at 2:10 p.m. Diagnoses included, but were not limited to, major depressive disorder, morbid (severe) obesity due to excess calories, and fibromyalgia. The Quarterly Minimum Data Set (MDS) assessment, dated 10/18/22, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 plus person physical assist for bed mobility, dressing, toilet use, personal hygiene, and bathing. A Care Plan, dated 5/22/22, indicated the resident displayed rejection of care and refused bed baths. The approaches were staff would provide education on the risks and consequences of their refusal of care. A Care Plan, dated 5/22/22, indicated the resident required assistance with ADLs. The shower sheets for 11/2022 indicated there was no documentation the resident received a bed bath. The computer Point of Care charting indicated the resident received a complete bed bath on 11/9/22. She received a partial bed bath on 11/8, 11/10, 11/13 and 11/15/22. There was no documentation the resident had her hair washed. Interview with the West Assistant Director of Nursing (ADON) on 11/16/22 at 2:45 p.m., indicated the CNA should have asked for help in turning the resident over to provide incontinence care. The resident required a 2 plus person assist for repositioning in bed.		**assurance programs will be put into place;** DON/designee will randomly observe 10 residents weekly with a focus on dependent residents to ensure assistance with ADL care including grooming, hair washed, facial hair removed, showers offered, and transfers are provided per plan of care. Nurse manager/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: 12/12/2022**	

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	Interview with the West Shower CNA 1 on 11/17/22 at 11:20 a.m., indicated she just became the shower aide in the last 2 weeks. When she took over as the shower aide, she initiated all new shower sheets for all the residents. Resident D was an evening bed bath, so she would not give the resident a bed bath during the day, and the evening CNA would be responsible for that. Interview with the Administrator on 11/21/22 at 12:45 p.m., indicated she had just spoken to the Central Supply Supervisor and they were going to order a different type of device so the resident's hair could be washed during her bed baths. Interview with the Nurse Consultant on 11/21/22 at 12:45 p.m., indicated there was no documentation of the resident refusing to have her hair washed during the complete bed baths.2. Resident B's closed record was reviewed on 11/16/22 at 9:47 a.m. The resident was admitted into the facility on 8/29/22 and expired on 10/12/22. Diagnoses included, but were not limited to, heart disease, high blood pressure, non-Alzheimer's dementia, depression, and renal insufficiency. The Quarterly Minimum Data Set (MDS) assessment, dated 9/21/22, indicated the resident was severely cognitively impaired for daily decision making. The September and October Bath and Skin Report Sheets indicated the resident received showers on the following days: - 9/1/22 - 10/4/22 - 10/7/22 - 10/11/22			

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	Interview with the Director of Nursing on 11/22/22 at 11:19 a.m., indicated she was unable to provide any more documentation related to at least twice a week showers being given for the resident. This Federal tag relates to Complaint IN00392424. 3.1-38(a)(2)(B) 3.1-38(b)(2) 3.1-38(b)(3)			
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 observation, record review, and interview, the facility failed to ensure areas of bruising were assessed and monitored for 1 of 4 residents reviewed for skin conditions, non-pressure related. (Resident E) Finding includes: On 11/14/22 at 9:59 a.m., Resident E was observed sitting in a chair inside her room. At that time the resident's entire forehead, nose, around both eyes and her cheek bones were red and purple color. The record for Resident E was reviewed on 11/16/22 at 9:45 a.m. The resident was admitted to the facility on 8/22/22. Diagnoses included, but were not limited to, depression, fractured right	F 0684	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** 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. **F684 Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident E- Bruises were	12/12/2022

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	femur, dementia with other behavioral disturbances, repeated falls, weakness, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 10/6/22, indicated the resident was not cognitively intact and had no mood or behaviors. The resident needed extensive assist with 2 person physical assist for transfers. The resident had no falls since the last assessment. Nurses' Notes, dated 11/09/22 at 2:20 a.m., indicated the resident was observed lying on the floor next to the floor mat. A hematoma was noted to the left forehead. The resident was also noted with a moderate amount of blood from her nose. The resident was transferred to the emergency room for treatment. Nurses' Notes, dated 11/09/22 at 10:13 a.m., indicated the resident returned to the facility from the hospital. She was diagnosed with a contusion/closed fracture of left orbital. There was a hematoma to the left side of her face, with red and purple bruising to the left eye and the left side of her forehead. Physician's Orders, dated 11/11/22, indicated monitor bruising daily to left forehead/cheek/eye. Monitor left forehead hematoma daily. Monitor all bruising every shift. The 11/2022 Medication Administration Record (MAR) indicated there was no documentation for monitoring all bruising every shift on 11/12/22 and 11/13/22 for the day shift and 11/12/22 and 11/14/22 for the evening shift. The 11/2022 MAR indicated there was no documentation for monitoring the hematoma to		assessed and new orders were received to monitor bruises. **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;** Nurses were re-educated on assessing and documenting changes in skin condition (pressure/non-pressure), notifying physician, and obtaining orders for treatment/monitoring. Assistive clinical staff were educated on notifying the nurse of any change in skin condition. **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 the MAR weekly to ensure that all residents ,requiring monitoring of bruising, are receiving the monitoring and that staff are documenting this on the MAR for 3 months. Director of Nursing/designee will present a summary of the audits to the Quality Assurance	

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	the left forehead on 11/12/22 and 11/13/22 for the day shift and 11/11/22 and 11/14/22 for the evening shift. The 11/2022 MAR indicated there was no documentation for monitoring the left forehead/cheek/eye bruising on 11/12/22 and 11/13/22 for the day shift and 11/11/22 and 11/14/22 for the evening shift. Interview with the Nurse Consultant on 11/21/22 at 12:45 p.m., indicated the bruises were to be monitored as ordered by the Physician. 3.1-37(a)		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: 12/12/2022**	
F 0688 SS=D Bldg. 00	483.25(c)(1)-(3) Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. Based on observation, record review, and interview, the facility failed to ensure splints were	F 0688	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22**	12/12/2022

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	applied as ordered and range of motion was completed for 3 of 3 residents reviewed for limited range of motion (ROM). (Residents 1, 30, and 90) Findings include: 1. On 11/14/22 at 10:00 a.m., Resident 1 was observed in his room seated in a broda chair. The resident's right hand had a splint in place. On 11/15/22 at 10:24 a.m., the resident's right hand was closed in a first and no anti-contracture device was in use. On 11/16/22 at 11:04 a.m. and 1:31 p.m., the resident was wearing a right hand splint. On 11/17/22 at 10:17 a.m., 11:44 a.m., and 3:50 p.m., the resident was not wearing the splint to his right hand. On 11/18/22 at 8:20 a.m., the splint was not in use. On 11/21/22 at 9:40 a.m. and 11:58 a.m., the splint was not in use. The record for Resident 1 was reviewed on 11/17/22 at 3:41 p.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis (muscle weakness and paralysis) affecting his right dominant side following a stroke and altered mental status. The Quarterly Minimum Data Set (MDS) assessment, dated 10/26/22, indicated the resident was moderately impaired for daily decision making. The resident had a functional limitation in range of motion (ROM) on one side of his upper and lower extremities.		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. **F688 Increase/Prevent Decrease in ROM/Mobility** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 1- no longer resides in the facility. Resident 90-resident was re-evaluated by therapy to determine ROM programming. Resident 30- resident 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 with splints 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;** Nursing staff were educated on ensuring splints are in place per	

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	A Care Plan, dated 7/22/22, indicated the resident had a history of a stroke with right sided hemiparesis. Interventions included, but were not limited to, monitor and record any increased stiffness in joints and follow physical and occupational therapy guidelines. The November 2022 Physician's Order Summary (POS), indicated the resident had no order for the hand splint. There was no documentation on the October or November Medication and/or Treatment records indicating the splint was applied. Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the order for the splint needed to be clarified. A new Physician's Order, dated 11/21/22, indicated the resident was to wear the splint to his right hand, apply in the morning and remove at bedtime, may remove for hygiene. 2. The record for Resident 30 was reviewed on 11/16/22 at 2:56 p.m. Diagnoses included, but were not limited to, Parkinson's and stiffness of unspecified joint. The 10/6/22 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively impaired for daily decision making and required extensive assistance with bed mobility and transfers. The resident had a functional limitation in range of motion (ROM) on one side of his lower extremities. The Physical Therapy discharge summary, dated 10/5/22, indicated a restorative nursing program was recommended for passive ROM.		physician orders. Nursing staff educated on ensuring Restorative programming is being followed based on therapy recommendations. **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 4 residents with splints weekly to ensure splint are in place as physician orders. DON/Designee will audit 10 residents weekly to ensure restorative programing is being completed per therapy recommendation. Nurse manager/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: 12/12/2022**	

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The Occupational Therapy discharge summary, dated 10/5/22, indicated a restorative nursing program was recommended for active and passive ROM to maintain his current level of performance and prevent decline.

There was no documentation indicating the resident had received ROM as recommended by therapy.

Interview with the Administrator on 11/22/22 at 10:44 a.m., indicated there was no documentation where the resident had received ROM per his therapy discharge recommendations.

3. Interview with Resident 90 on 11/14/22 at 10:25 a.m., indicated she had been discharged from therapy and referred to restorative. She had been seen by restorative only once.

The record for Resident 90 was reviewed on 11/16/22 at 10:44 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease (COPD), heart failure, and stiffness of unspecified joint.

The Quarterly Minimum Data Set (MDS) assessment, dated 10/28/22, indicated the resident was moderately impaired for daily decision making and she required extensive assistance with bed mobility and transfers. She had no functional limitation in range of motion (ROM).

The Physical Therapy discharge summary, dated 10/27/22, indicated the resident had reached her maximum potential. A restorative nursing program was recommended to facilitate maintaining her current level of performance and to prevent decline. The following restorative nursing

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	program had been developed and instruction provided with the Interdisciplinary Team for bed mobility and passive ROM. The Occupational Therapy discharge summary, dated 10/27/22, indicated the resident had a good prognosis to maintain her current level of function with consistent staff follow through. Restorative nursing was recommended for active and passive ROM. Social Service notes, dated 11/14/22 at 1:44 p.m., indicated the resident inquired about restorative therapy and when she would start services. The writer spoke with the restorative aide about the resident's services. The aide informed the writer that once the nurse determined her schedule she would inform the resident. Social Service notes, dated 11/21/22 at 9:47 a.m., indicated the resident expressed concerns about the therapy she was receiving from the restorative department. She expressed that she did not feel that she was receiving enough therapy to complete her goal of going home. The Plan of Care response section indicated the resident received active ROM on the following dates and times: -11/15/22 at 12:55 p.m. and 3:37 p.m. -11/17/22 at 10:43 a.m. and 3:51 p.m. -11/19/22 at 9:41 a.m. -11/20/22 at 9:33 a.m. Interview with the Administrator on 11/22/22 at 10:46 a.m., indicated the resident should have			

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	been added to the restorative case load in a more timely manner. 3.1-42(a)(2)			
F 0689 SS=D Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure fall interventions were in place for residents with a history of falls with and without injury related to a floor mattress and non-slip socks for 3 of 4 residents reviewed for falls. (Residents E, F, and C) Findings include: 1. On 11/14/22 at 9:59 a.m., Resident E was observed sitting in a chair inside her room. At that time the resident's entire forehead, nose, around both eyes and her cheek bones were red and purple color. On 11/15/22 at 10:06 a.m., the resident was observed in bed. At that time, the floor mattress was standing up on end and not on the floor beside the bed. At 10:08 a.m. the Restorative Nurse walked into the room and swabbed the resident for COVID-19. She left the room and left the mattress standing on end. At 10:21 a.m., the	F 0689	**Dyer Nursing & Rehabilitation Annual Survey: 11-22-22** **F 689 Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident C- Staff ensured that the floor mat was in place. Resident E- Staff ensured that the floor mat was in place. Resident F- Staff ensured that non-skid socks were in place. **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;**	12/12/2022

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	155220	A. BUILDING 00 B. WING	11/22/2022

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	mattress was still standing on end and not on the floor beside the resident. At 10:45 a.m., LPN 1 entered the room and placed the mattress on the floor beside the bed. On 11/16/22 at 1:30 p.m., the resident was observed in bed. She was awake and sitting up. The floor mattress was observed standing on end and not on the floor beside the resident's bed. At 1:40 p.m., Agency CNA 1 walked into the room and put the mattress down beside the bed. The record for Resident E was reviewed on 11/16/22 at 9:45 a.m. The resident was admitted to the facility on 8/22/22. Diagnoses included, but were not limited to, depression, fractured right femur, dementia with other behavioral disturbances, repeated falls, weakness, and high blood pressure. The Quarterly Minimum Data Set (MDS) assessment, dated 10/6/22, indicated the resident was not cognitively intact and had no mood or behaviors. The resident needed extensive assist with 2 person physical assist for transfers. The resident had no falls since the last assessment. A Care Plan, dated 8/23/22, indicated the resident was at risk for falling related to impaired mobility. The approaches were to place a floor mattress next to the bed. Nurses' Notes, dated 9/9/22 at 10:32 a.m., indicated the resident was found on the floor in her room. She was observed with the left leg extended and the right leg bent. At that time, she complained of pain to the right hip. The resident was transferred to the emergency room. Nurses' Notes, dated 9/9/22 at 2:58 p.m., indicated		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;** Licensed staff were in-serviced on ensuring all resident with history of fall have appropriate fall interventions in place. **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 10 residents weekly to ensure fall interventions are in place for 3 months. After 3 months, DON/ designee will audit, for 3 more months, weekly 5 residents to ensure fall interventions are in place. The Director of Nursing/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: 12/12/2022**	

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	they received a call from the hospital and the resident would be admitted with a fractured right hip. Nurses' Notes, dated 11/09/22 at 2:20 a.m., indicated the resident was observed lying on floor next to the floor mat. A hematoma was noted to the left forehead. The resident was also noted with a moderate amount of blood from her nose. The resident was transferred to the emergency room for treatment. Nurses' Notes, dated 11/09/22 at 10:13 a.m., indicated the resident returned to the facility from the hospital. She was diagnosed with a contusion\closed fracture of left orbital. There was a hematoma to the left side of her face, with red and purple bruising to the left eye and the left side of her forehead. Physician's Orders, dated 11/9/22, indicated mattress at bedside. Interview with the Nurse Consultant on 11/21/22 at 12:45 p.m., indicated the floor mattress was to be on the floor next to the bed while the resident was in bed. 2. On 11/15/22 at 10:28 a.m., Resident F was observed lying on one half of the bed and her feet were dangling over the side of the bed on the floor mat. The resident was not wearing any socks on her feet. On 11/16/22 at 9:23 a.m., 11:10 a.m., and 1:30 p.m., the resident was observed sitting in a reclined broda chair. At those times, she was wearing plain socks that were not non-slip. On 11/17/22 at 9:30 a.m., 10:15 a.m., and 11:00 a.m.,			

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	the resident was observed sitting in a reclined broda chair. At those times, she was wearing plain socks that were not non-slip. The record for Resident F was reviewed on 11/17/22 at 10:20 a.m. The resident was admitted to the facility on 9/6/22. Diagnoses included, but were not limited to, insomnia, anxiety disorder, repeated falls, dementia in other diseases classified elsewhere, unspecified severity, with agitation, and major depressive disorder. The Admission Minimum Data Set (MDS)) assessment, dated 9/12/22, indicated the resident was not cognitively intact. The resident needed extensive assist with 1 person physical assist for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. She had a history of falls prior to admission in the last month. In the last 7 days the resident received an antipsychotic medication 6 times, an antidepressant medication 6 times, a hypnotic medication 6 times. A Care Plan, dated 9/16/22, indicated the resident was at risk for falling related to dementia, impaired mobility, poor cognition, and safety awareness. The approaches were to provide proper, well-maintained footwear. A Fall Event, dated 9/28/22 at 11:37 a.m., indicated the resident had a fall out of the wheelchair. A small lump was noted to the top of the ride side of the head. Nurses' Notes, dated 9/28/22 at 11:47 a.m., indicated the resident was sitting at the Nurses' Station in a wheelchair. She stood up and lost her balance and fell sideways, hitting her head on the floor. There was a small lump to the ride top side of the head. .			

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	Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the resident was to be wearing a type of non-slip socks at all times.3. Resident C's record was reviewed on 11/17/22 at 11:39 a.m. Diagnosis included, but were not limited to, heart failure, high blood pressure, non-Alzheimer's dementia, anxiety disorder, depression, and dysphagia (difficulty swallowing). A Significant Change Minimum Data Set (MDS) assessment, dated 10/4/22, indicated the resident was moderately cognitively impaired for daily decision making. The resident required extensive assistance with a two person assist for bed mobility, transfers, dressing, toilet use, bathing and personal hygiene. Nurses' Notes, dated 8/12/2022 at 2:31 a.m., indicated the resident was observed face down on the side of the bed closest to the window. The resident was assisted back to bed via a hoyer lift, a head to toe assessment was conducted, and a skin tear to the right knee was noted. The resident stated he was trying to get up to get water. The floor mat was not in place, he had no socks or shoes on, and was wearing a gown. The Physician and the resident's family were notified. Nurses' Notes, dated 10/17/2022 at 2:00 a.m., indicated the resident was observed lying on the floor beside the bed on his back. The resident stated he was trying to get up and turn on the news. The Physician and the resident's family were notified. The Fall Investigation for the fall on 10/17/22 at 2:00 a.m., indicated the resident had attempted to get out of bed to turn on the news. He was			

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	ambulating in the room at the time of the fall and was wearing regular socks. There was not a bed mattress in place on the floor. The fall resulted in an abrasion to the resident's head and a skin tear to his right leg. A Care Plan, dated 5/25/22, indicated the resident was a risk for falling related to limited mobility, diagnoses, and medication profile. Interventions included, but were not limited to, placement of a floor mattress. Interview with the Director of Nursing on 11/22/22 at 11:19 a.m., indicated she had no further information. This Federal tag relates to Complaint IN00392985. 3.1-45(a)(2)			
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			

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	indwelling catheter or subsequently receives one is assessed for removal of the catheter 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 interview and record review, the facility failed to ensure a resident with a urinary catheter received the necessary treatment and services related to completing catheter care as ordered for 2 of 2 residents reviewed for urinary catheters. (Residents J and 84) Findings include: 1. Interview with Resident J on 11/14/22 at 1:48 p.m., indicated the resident did not always receive catheter care every shift. The record for Resident J was reviewed on 11/16/22 at 2:01 p.m. Diagnoses included, but were not limited to, high blood pressure, paraplegia, chronic lung disease, diabetes mellitus, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/22, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistant with bed	F 0690	**Dyer Nursing and Rehab** **Annual Survey: 11/22/22** 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 J – catheter care was provided. Resident 84- catheter care was provided. **How the facility will identify**	12/12/2022

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	mobility, dressing, toilet use, and personal hygiene. She had an indwelling catheter and an ostomy. A Care Plan, dated 4/27/22, indicated the resident required an indwelling catheter. Interventions included, but were not limited to, provide catheter care as ordered and as needed, and provide assistance for catheter care. A Physician's Order, dated 9/8/22, indicated catheter care every shift. The September Medication Administration Record (MAR) indicated the resident did not have catheter care performed on the following dates and shifts: - Day shift: 9/9/22, 9/10/22, 9/11/22, 9/12/22, 9/13/22, 9/14/22, 9/15/22, 9/16/22, 9/22/22, 9/23/22, 9/27/22, 9/28/22, 9/29/22, and 9/30/22 - Evening shift: 9/26/22 and 9/29/22 - Night shift: 9/24/22, 9/25/22, 9/27/22, and 9/29/22 The October Medication Administration Record (MAR) indicated the resident did not have catheter care performed on the following dates and shifts: - Day shift: 10/7/22 - Night shift: 10/5/22, 10/7/22, and 10/9/22 Interview with the Regional Nurse Consultant on 11/21/22 at 10:10 a.m., indicated she had no further information. 2. The record for Resident 84 was reviewed on 11/16/22 at 1:40 p.m. Diagnoses included, but were not limited to, cancer, heart failure, high blood pressure, paraplegia, bipolar disorder and depression.		**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 catheter care is provided. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** 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. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	

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	The Quarterly Minimum Data Set (MDS) assessment, dated 10/26/22, indicated the resident was cognitively intact for daily decision making. The resident required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. He had an indwelling catheter. A Physician's Order, dated 10/20/22, indicated to clean the suprapubic catheter site daily and as needed. A Care Plan, dated 12/1/21, indicated the resident required a suprapubic catheter related to neuromuscular dysfunction of bladder and obstructive uropathy. The Medication Administration Record (MAR) for October 2022 indicated suprapubic catheter care every shift was not completed on the following dates and shifts: - Day shift: 10/20/22, 10/21/22, 10/23/22, 10/24/22, 10/25/22, 10/26/22, 10/27/22, 10/28/22, 10/29/22, 10/31/22 - Evening shift: 10/20/22, 10/26/22 - Night shift: 10/20/22, 10/21/22, 10/24/22, 10/26/22, 10/28/22 Interview with the Director of Nursing on 11/22/22 at 11:19 a.m., indicated she had no further information to provide. 3.1-41(a)(2)		Monitoring will be on going. **Date by which systemic corrections will be completed: 12/12/2022**	
F 0692 SS=D 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			

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	resident's comprehensive assessment, the 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 observation, record review, and interview, the facility failed to ensure reweights were obtained, food consumption logs were completed and supplements were provided for residents with a history of weight loss for 2 of 4 residents reviewed for nutrition. (Residents H and B) Findings include: 1. The record for Resident H was reviewed on 11/16/22 at 2:06 p.m. Diagnoses included, but were not limited to, hemiplegia (muscle weakness), stroke, dysphagia (difficulty swallowing), and type 2 diabetes. The Quarterly Minimum Data Set (MDS) assessment, dated 8/9/22, indicated the resident was cognitively intact and required extensive assistance with eating. The resident had no weight issues and received a mechanically altered diet.	F 0692	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** 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 B- no longer resides in the facility. Resident H - re-weight received per RD recommendation. **How the facility will identify other residents having the**	12/12/2022

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	A Care Plan, reviewed on 11/10/22, indicated the resident required a mechanically altered diet. Interventions included, but were not limited to, obtain/record weight per facility protocol. Notify the Physician and family of any significant weight change. A Care Plan, reviewed on 11/10/22, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, observe and record intake of food and fluids. A Registered Dietitian (RD) progress note, dated 11/13/22 at 3:10 p.m., indicated the resident presented with a 26.0% weight loss over the past 30 days, 32.8% weight loss over the past 90 days, and 36.4% weight loss over the past 180 days. Question the accuracy of the resident's weight. Ready care shakes and supercereal in place for nutritional support as well as double portions at breakfast. Recommend one can of Ensure daily and add weekly weights to verify the resident's weight. On 10/6/22, the resident weighed 189 pounds. On 11/11/22, the resident weighed 140 pounds. No re-weight had been completed. The food consumption log for the month of October 2022, indicated the following meals were not documented: -No breakfast or lunch documented on 10/21, 10/24, 10/28, and 10/30/22. -No dinner documented on 10/27 and 10/29/22. The food consumption log for the month of November 2022, indicated the following meals were not documented: -No dinner was documented on 11/7 and 11/13/22.		**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;** Nursing staff was in-serviced on providing supplements per MD order and following RD recommendations. Nursing staff were in-serviced on documenting meal intake in Point of Care. **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 meal intake documentation for 10 residents in Point of Care weekly to ensure documentation compliance. Nurse Managers will audit Medication Administration Record for 5 residents weekly to ensure nutritional supplement consumption was provided and documented. 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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	Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated a reweight should have been obtained and the food consumption sheets completed. Follow up interview with the Nurse Consultant at 3:02 p.m., indicated the resident was reweighed and he weighed 180 pounds. 2. Resident B's closed record was reviewed on 11/16/22 at 9:47 a.m. The resident was admitted into the facility on 8/29/22 and expired on 10/12/22. Diagnoses included, but were not limited to, heart disease, high blood pressure, non-Alzheimer's dementia, depression, and renal insufficiency. The Quarterly Minimum Data Set (MDS) assessment, dated 9/21/22, indicated the resident was severely cognitively impaired for daily decision making. The resident required extensive assistance with bed mobility, dressing, eating, and personal hygiene. A Registered Dietician note, dated 9/15/22 at 6:31 p.m., indicated the resident had weight loss over the past week (6.9% weight loss) and since admission into the facility (10.8% weight loss). The resident had poor oral intake per the food consumption records. The recommendations included an increase of the 4 ounce ready care shake to three times a day, supercereal at breakfast, and a weekly weight the following week. The Weekly Weights for the resident were completed on the following dates: - 9/1/22: 100.8 pounds (lbs) - 9/7/22: 96.6 lbs - 9/14/22: 89.9 lbs - 9/21/22: 91.8 lbs		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: 12/12/2022**	

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	155220	A. BUILDING 00 B. WING	11/22/2022

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	- 9/29/22: 89.2 lbs - 10/6/22: 89.2 lbs A Physician's Order, dated 9/16/22, indicated 4 ounce ready care shake three times a day at 9:00 a.m., 2:00 p.m., and 8:00 p.m. The September Medication Administration Record (MAR) indicated the resident did not receive the ready care shake on the following dates and times: - 9:00 a.m.: 9/16/22, 9/17/22, 9/18/22, 9/19/22, 920/22, 9/21/22, 9/22/22, 9/23/22, 9/24/22, 9/25/22, 9/26/22, 9/27/22, 9/28/22, 9/29/22, and 9/30/22 - 2:00 p.m.: 9/16/22, 9/17/22, 9/18/22, 9/19/22, 920/22, 9/21/22, 9/22/22, 9/23/22, 9/24/22, 9/25/22, 9/26/22, 9/27/22, 9/28/22, 9/29/22, and 9/30/22 - 8:00 p.m.: 9/16/22, 9/17/22, 9/18/22, 9/20/22, 9/23/22, and 9/28/22 Interview with the Director of Nursing on 11/22/22 at 11:19 a.m., indicated she had no further information. This Federal tag relates to Complaint IN00392424. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (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 facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's			

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	clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and interview, the facility failed to ensure gastrostomy tube placement was checked prior to administering medications and the water flush and medications were instilled via gravity for 1 of 1 gastrostomy tube medication administrations. (Resident 24) Finding includes: On 11/18/22 at 11:27 a.m., LPN 2 was observed preparing medications for Resident 24. The resident was going to receive Oyster Shell Calcium 500 milligrams (mg), Prevacid (a medication for gastroesophageal reflux) 30 mg, and Sucralfate (an antacid) 1 gram by the way of her gastrostomy tube (G Tube). At 11:45 a.m., the LPN entered the resident's room. Prior to giving the medications, the LPN placed her stethoscope on the resident's abdomen and she listened to the resident's bowel sounds for placement of the tube. She did not instill an air bolus or check for residual. The LPN then proceeded to administer a water flush prior to giving the medications, she used the plunger of the syringe and pushed the water through the tube instead of letting the water instill via gravity.	F 0693	**Dyer Nursing and Rehab** **Annual Survey: 11/22/22** 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. **F693 Tube Feeding Management/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 24 was immediately assessed and noted with no adverse reactions related to not checking the g-tube for placement prior to the administration of medications and not giving the medication and water flushes via gravity. LPN 2- was re-in serviced	12/12/2022

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	The LPN administered each med separately with a water flush in between and after the medications had been given. She used the plunger of the syringe to instill the medications and the water flushes. The medications and water flushes were not instilled via gravity. The record for Resident 24 was reviewed on 11/21/22 at 3:24 p.m. Diagnoses included, but were not limited to, stroke, dysphagia (difficulty swallowing), and gastrostomy. The 10/20/22 Admission Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired and required a feeding tube. A Care Plan, dated 10/14/22, indicated the resident was dependent on a tube feeding for total nutrition and hydration support due to swallowing difficulty and refusal to eat related to dementia and Alzheimer's. Interventions included, but were not limited to, verify feeding tube placement and patency every shift. Check for residual per Physician Orders and report noted abnormalities to the Physician. Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the water flushes and medications should have been instilled by gravity and tube placement checked either by air bolus or residual. 3.1-44(a)(2)		regarding medication administration via g-tube. **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 with g-tubes 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;** Clinical staff were re-educated on proper medication administration technique for residents with g-tubes including medications should be instilled via gravity and placement must be checked by either air bolus or residual prior to the administration of medication. **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 manager will randomly audit/observe 2 nurse's administer medications via feeding tube 2 times per week to ensure proper medication administration technique. 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 by which systemic corrections will be completed: 12/12/2022**	
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on record review and interview, the facility failed to ensure a resident with complaints of pain received scheduled medication to relieve the pain for 1 of 3 residents reviewed for pain. (Resident J) Finding includes: Interview with Resident J on 11/14/22 at 1:53 p.m., indicated she did not always receive her pain medications. The record for Resident J was reviewed on 11/16/22 at 2:01 p.m. Diagnoses included, but were not limited to, high blood pressure, paraplegia, chronic lung disease, diabetes mellitus, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/22, indicated the resident was cognitively intact for daily decision making.	F 0697	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** 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. **F697 Pain Management** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Pain medication was administered as per orders for resident J. **How the facility will identify**	12/12/2022

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	The resident required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. She had an indwelling catheter and an ostomy. She received a scheduled pain medication regimen. A Care Plan, dated 4/7/22, indicated the resident had complaints of chronic pain related to intractable back pain and wounds. Interventions included, but were not limited to, administer medications and monitor and record effectiveness. A Physician's Order, dated 11/9/22, indicated hydrocodone-acetaminophen 10-325 milligram (mg), 1 tablet every six hours. The September and October 2022 Medication Administration Record (MAR) indicated the resident did not receive the hydrocodone-acetaminophen tablet on the following dates and times: - 9/9/22 at 12:00 a.m. and 6:00 a.m. - 9/29/22 at 6:00 a.m. - 10/27/22 at 12:00 a.m. and 6:00 a.m. Interview with the Regional Nurse Consultant on 11/21/22 at 10:10 a.m., indicated she had no further information to provide. This Federal tag relates to Complaint IN00392575. 3.1-37(a)		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents that require pain management 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 administering medications as per orders. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will randomly audit 5 residents' medication administration record 2 times per week to ensure mediations are provided as per 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**	

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			corrections will be completed: 12/12/2022	
F 0757 SS=D Bldg. 00	483.45(d)(1)-(6) Drug Regimen is Free from Unnecessary Drugs §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. Based on record review and interview, the facility failed to ensure insulin was administered as ordered related to sliding scale insulin for 2 of 5 residents reviewed for unnecessary medications. (Residents G and J) Findings include: 1. The record for Resident G was reviewed on 11/17/22 at 1:30 p.m. The resident was admitted to	F 0757	**Dyer Nursing & Rehabilitation Annual Survey: 11-22-22** **F 757 Unnecessary Medications Plan of Correction** Submission of this Plan of Correction by Dyer Nursing and Rehabilitation Center is not a legal	12/12/2022

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	the facility on 8/24/22. Diagnoses included, but were not limited to, metabolic encephalopathy, stroke, high blood pressure, type 2 diabetes, repeated falls, major depressive disorder, syncope, specified dementia, unspecified severity, with other behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22 indicated the resident was not cognitively intact. In the last 7 days the resident received insulin 7 times and an antipsychotic medication 7 times. A Care Plan, dated 11/9/22, indicated the resident received insulin related to diabetes mellitus. The approaches were to administer insulin per doctor's order. Physician's Orders, dated 11/8/22, indicated Insulin Aspart U-100 per sliding scale as follows: If Blood Sugar was 71 to 180, give 0 Units. If Blood Sugar was 181 to 230, give 4 Units. If Blood Sugar was 231 to 280, give 7 Units. If Blood Sugar was 281 to 330, give 10 Units. If Blood Sugar was 331 to 350, give 13 Units. If Blood Sugar was greater than 350, give 13 Units. If Blood Sugar was greater than 350, call Medical Doctor. The 9/2022 Medication Administration Record (MAR) indicated the following: - There was no documentation (was blank) on 9/15 at 8:00 a.m. and 12:00 p.m. - There was no documentation of the blood sugar and 10 units were administered on 9/3 and 9/11 at 12:00 p.m. - There was no documentation of how many units of Insulin was administered on 9/11 at 5:00 p.m., and the blood sugar was 379. - There was no documentation (was blank) on		admission that a deficiency exists or that this Statement of Deficiencies was correctly cited. In addition, preparation and submission of this POC does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the survey agency. **How will corrective action will be accomplished for those residents found to have been affected by the deficient practice?** Residents G and J did not suffer any adverse effects related to the documentation not being completed for insulin administration. **How will the facility will identify other residents having the potential to be affected by the same deficient practice?** All residents with insulin orders have the potential to be affected by the alleged deficiency. **What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur?** Director of Nursing or designee re-educated staff nurses on the	

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	9/18/22 at 5:00 p.m. - There was no documentation of how many units of Insulin was administered on 9/23 at 5:00 p.m., and the blood sugar was 230. The 10/2022 MAR indicated the following: - There was no documentation (was blank) on 10/8 and 10/9/22 at 12:00 p.m. - There was no documentation of how many units of Insulin was administered on 10/9/22 at 8:00 a.m., and the blood sugar was 242. - There was no documentation of how many units of Insulin was administered on 10/17/22 at 12:00 p.m., and the blood sugar was 277. - There was no documentation (was blank) on 10/24 at 12:00 p.m. Interview with the Nurse Consultant 11/21/22 at 12:45 p.m., indicated the insulin was either not signed out on the MAR, missing units administered or missing the blood sugar.2. The record for Resident J was reviewed on 11/16/22 at 2:01 p.m. Diagnoses included, but were not limited to, high blood pressure, paraplegia, chronic lung disease, diabetes mellitus, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 9/8/22, indicated insulin lispro, 100 unit/milliliter, administer three times a day per sliding scale as follows: If blood sugar is less than 70, call Physician. If blood sugar is 150 to 200, give 2 units. If blood sugar is 201 to 250, give 4 units. If blood sugar is 251 to 300, give 6 units. If blood sugar is 301 to 350, give 8 units. If blood sugar is greater than 250, call Physician.		facility Insulin Administration policy, specifically on administering insulin as ordered and signing the Insulin Administration Record immediately post administration. This documentation includes the documentation of what the blood sugar was and how many units of insulin was administered. **How will the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur?** DON/designee will audit twice weekly 7 residents with blood glucose monitoring orders and insulin administration orders to ensure that the nurse documents and records in the MAR both the blood glucose results and the amount of insulin administered for 3 months. After 3 months, DON/designee will audit, for 3 more months, weekly 7 residents to ensure blood glucose results and insulin administration is recorded in the MAR. 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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	The September 2022 Medication Administration Record (MAR) indicated the following: - There was no documentation of how many units of insulin were administered with a blood sugar of 151 on 9/11/22 at 8:00 p.m. - There was no documentation (was blank) on 9/14/22 at 7:00 a.m. - There was no documentation of how many units of insulin were administered with a blood sugar of 159 on 9/17/22 at 11:00 a.m. - There was no documentation of how many units of insulin were administered with a blood sugar of 167 on 9/21/22 at 8:00 p.m. - There was no documentation of how many units of insulin were administered with a blood sugar of 154 on 9/28/22 at 8:00 p.m. - There was no documentation (was blank) on 9/29/22 at 7:00 a.m. Interview with the Regional Nurse Consultant on 11/21/22 at 10:10 a.m., indicated she had no further information to provide. 3.1-48(a)(6)		quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 12/12/2022**	
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1)-(5) Free from Unnec Psychotropic Meds/PRN Use §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a			

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	resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. Based on observation, record review, and interview, the facility failed to ensure residents did not receive unnecessary medications without adequate indications for use and prn (as needed) anti-anxiety medication were only administered	F 0758	**Dyer Nursing & Rehabilitation Annual Survey: 11-22-22** Please accept the following as the facility's credible allegation of compliance. This plan of	12/12/2022

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	after non-pharmaceutical interventions were attempted for 2 of 5 residents reviewed for unnecessary medications. (Residents G and F) Findings include: 1. On 11/16/22 at 9:34 a.m., Resident G was observed sitting in a wheelchair in the memory care dining room. At that time, his head was low and his eyes were closed. At 11:15 a.m., the resident remained with his eyes closed. At 1:30 p.m., the resident was observed sitting in his wheelchair with his back facing the room door. At that time, his head was low and his eyes were closed. The record for Resident G was reviewed on 11/17/22 at 1:30 p.m. The resident was admitted to the facility on 8/24/22. Diagnoses included, but were not limited to, metabolic encephalopathy, stroke, high blood pressure, type 2 diabetes, repeated falls, major depressive disorder, syncope, and specified dementia, unspecified severity, with other behavioral disturbance. The Quarterly Minimum Data Set (MDS) assessment, dated 10/4/22 indicated the resident was not cognitively intact. In the last 7 days the resident received insulin 7 times and an antipsychotic medication 7 times. A Care Plan, dated 8/25/22, indicated the resident was at risk for adverse consequences related to receiving antipsychotic medication for treatment of dementia with behavioral disturbance. A Hospital Note, dated 8/25/22, indicated the resident was receiving Seroquel 25 milligrams (mg) as needed for agitation. A History and Physical Note from the hospital indicated the resident was		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F758 Free from unnecessary psychotropic meds/PRN use** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident G - Diagnosis/indication of use for Seroquel was received and updated in the medical record. Also, MD notified and order received for the resident to be seen by psych services. Resident F- No adverse reaction to prn Haldol and Lorazepam given without prior intervention. **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 receiving psychotropic medications 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 educated on ensuring there is an appropriate diagnosis/indication for use of psychotropic medications and	

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	not taking Seroquel at home prior to hospitalization. Physician's Orders, dated 8/25/22, indicated Seroquel (an antipsychotic medication) 25 mg at night time. The medication was discontinued on 8/31/22. Physician's Orders, dated 8/31/22, indicated Seroquel 25 mg 1 tab three times a day. The medication was discontinued on 11/16/22. Physician's Orders, dated 11/16/22, indicated Seroquel 25 mg twice a day for insomnia. There were no psychiatric Physician Progress Notes from time of admission to current regarding the Seroquel medication. The resident was not being seen by the outside behavioral health consultant. Interview with the resident's spouse on 11/17/22 at 3:11 p.m., indicated the resident had been sleeping all the time and that concerned her. The resident was not on an antipsychotic medication while at home when she was taking care of him. Interview with the Nurse Consultant 11/21/22 at 2:15 p.m., indicated the resident had not been seen by the behavioral health consultants since admission 2. The record for Resident F was reviewed on 11/17/22 at 10:20 a.m. The resident was admitted to the facility on 9/6/22. Diagnoses included, but were not limited to, insomnia, anxiety disorder, repeated falls, dementia in other diseases classified elsewhere, unspecified severity, with agitation, and major depressive disorder.		notification to psychiatrist for any indication of use needed. Also, any resident who admits to the facility on psychotropic medications be referred to psych services. Staff were educated on attempting non-pharmacological interventions and recording these attempts in the EMR prior to giving a prn psychotropic medication. **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 5 residents receiving prn psychotropics weekly to ensure prior interventions were attempted. Social Services Director/Designee will randomly audit 5 residents receiving psychotropic medications weekly to ensure there is an appopriate diagnosis/indication for use is in place. 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 quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:**	

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The Admission Minimum Data Set (MDS) assessment, dated 9/12/22, indicated the resident was not cognitively intact. The resident needed extensive assistance with 1 person physical assist for bed mobility, transfers, dressing, eating, toilet use, and personal hygiene. She had a history of falls prior to admission in the last month. In the last 7 days the resident received an antipsychotic medication 6 times, an antidepressant medication 6 times, and a hypnotic medication 6 times.

A Care Plan, dated 9/16/22, indicated the resident received an anti-anxiety medication related to dementia with behaviors. The approaches were to quantitatively and objectively document the resident's behavior/mood.

Physician's Orders, dated 9/6/22, indicated Lorazepam (an anti-anxiety medication) 0.5 milliliters (ml) every 6 hours as needed (prn).

Physician's Orders, dated 9/7/22, indicated Haloperidol 0.25 milligrams (mg) under the tongue prn (as needed) every 4 hours.

The Medication Administration Record (MAR) for 10/2022 indicated the prn Haloperidol was administered on 10/25/22 and 10/29/22 at 12:30 p.m. for agitation, and on 10/30/22 at 8:00 p.m. for agitation.

The MAR for 10/2022 indicated the prn Lorazepam was administered on 10/29/22 and 10/30/22 at 4:00 p.m. for agitation.

There was no documentation in the Nurses' Notes of any interventions attempted prior to administering the prn medications on 10/25/22, 10/29/22 or 10/30/22.

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	The resident was moved to the memory care unit on 11/2/22. Interview with the Nurse Consultant on 11/21/22 at 12:45 p.m., indicated there was no documentation of interventions attempted prior to administration of the prn Haloperidol and prn Lorazepam. This Federal tag relates to Complaint IN00392424 3.1-48(a)(4)			
F 0761 SS=D Bldg. 00	483.45(g)(h)(1)(2) Label/Store Drugs and Biologicals §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit			

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	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medication carts were locked when out of view on 1 of 3 units throughout the facility. (The West Unit) Finding includes: On 11/17/22 at 4:27 p.m., RN 1 entered Resident 90's room to administer her medications. The medication cart was left unlocked and the cart was out of the RN's view when she was in the resident's room. At 4:44 p.m., the RN remained in the resident's room and the cart was still unlocked and out of her view. Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the medication cart should have been locked prior to entering the resident's room. A facility policy, titled "Storage of Medications" was provided by the Administrative Consultant on 11/22/22 at 3:04 p.m. The policy indicated medication rooms, carts, emergency kits/boxes, and medication supplies were to be locked when not attended by persons with authorized access. 3.1-25(m)	F 0761	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** 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. **F761 Label/Storage Drugs & Biologicals** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Medications were immediately secured when notified. RN 1 educated on locking medication cart when not in view. **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;** Nurses were educated ensuring	12/12/2022

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			medication carts are locked when out of view of nurse. **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;** Facility angels will round 5 times per week x 3 months to ensure medication carts are locked when not in view of a nurse. Nurse manager/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: 12/12/2022**	
F 0800 SS=D Bldg. 00	483.60 Provided Diet Meets Needs of Each Resident §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Based on observation, record review, and interview, the facility failed to provide a resident with a nourishing and well-balanced diet and failed to provide special dietary needs for 1 of 3 residents reviewed for nutritional services.	F 0800	**Dyer Nursing and Rehab Annual Survey: 11/22/2022** Please accept the following as the facility's credible allegation of	12/12/2022

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	(Resident J) Finding includes: During an interview on 11/14/22 at 1:28 p.m., Resident J indicated she had an allergy to corn and corn products, but the facility staff were still serving her corn products. She indicated she often just ate less during her meals because of it. During an observation of a lunch meal on 11/21/22 at 12:42 p.m., the resident received her lunch which consisted of barbeque meat loaf, mashed potatoes with brown gravy, seasoned corn, cornbread, juice, and a S'Mores bar dessert. The resident's meal card was still on the tray, which indicated for lunch meals the resident was to receive double protein and juice with lunch. The resident was not to be served: corn, cornbread, soda, juice drinks, barbeque sauce, jelly, crackers, applesauce, syrup, any desserts, or grits. The residents allergies were listed as corn. The meal card indicated the resident was not to receive any corn products at all. The record for Resident J was reviewed on 11/16/22 at 2:01 p.m. Diagnoses included, but were not limited to, high blood pressure, paraplegia, chronic lung disease, diabetes mellitus, and depression. The Quarterly Minimum Data Set (MDS) assessment, dated 10/23/22, indicated the resident was cognitively intact for daily decision making. A Physician's Order, dated 11/9/22, indicated a mechanical soft, no added salt, no concentrated sweets diet with special instructions for super cereal at breakfast, double protein at all meals, ground meats, and no corn or corn products.		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. **F800 Diet** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident J had no adverse reaction to being served corn. **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 residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Dietary staff were educated on ensuring the diet order/restrictions are being followed. **What quality assurance plans will be implemented to monitor facility performance to ensure**	

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	Interview with the Administrator on 11/21/22 at 2:00 p.m., indicated she had no further information to provide. 3.1-46		**corrections are achieved and permanent?** Dietary manager/designee will audit 3 meals weekly on alternating shifts x 3 months to ensure the diet tickets are being followed as written. 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. **By what date the systemic changes will be completed: 12/12/2022**	
F 0804 SS=E Bldg. 00	483.60(d)(1)(2) Nutritive Value/Appear, Palatable/Prefer Temp §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and			

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	appetizing temperature. Based on observation and interview, the facility failed to ensure food served to resident rooms was received hot for 1 of 2 units observed. This had the potential to affect the 56 residents who resided on that unit and received food from the kitchen. (East Unit) Finding includes: Interview with Resident J, who resided on the East Unit, on 11/14/22 at 1:43 p.m., indicated the food was not warm for a lot of the meals she had been served. On 11/21/22 at 12:34 p.m., the last tray from the East Unit food tray cart was removed. It was delivered with the plastic dome lid covering the plate. At that time, the Dietary Manager removed the plastic dome lid and used a food thermometer to obtain the following food temperatures: - Barbeque meatloaf: 127 degrees - Mashed potatoes with brown gravy: 125 degrees - Seasoned corn: 113 degrees Interview with the Dietary Manager at that time, indicated she would like the temperature to be a little warmer, approximately 135 degrees or warmer. 3.1-21(a)(2)	F 0804	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** **F 804 Food Temperatures** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Temperatures have been taken and meals have been served at the proper temperature. There have been no complaints related to cold food served. **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 residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Facility staff educated on passing meals/trays in a timely manner to avoid food getting cold.	12/12/2022

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			Facility staff also educate on reheating resident food if requested. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Administrator/designee will audit 3 meals per week on various shifts x 6 months to ensure meals are being served in a timely manner and at the proper temperature. A summary of the audits will be presented to the Quality Assurance Committee monthly x 6 months. **By what date the systemic changes will be completed: 12/12/2022**	
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			

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	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 and interview, the facility failed to serve and prepare food under sanitary conditions related to dirty food equipment, steam tables, wire racks, standing fans, and standing mixer for 1 of 1 kitchens observed. This had the potential to affect the 116 residents who received food from the kitchen. (The Main Kitchen) Findings include: During the Brief Kitchen Sanitation Tour on 11/14/22 at 9:18 a.m. with the Dietary Food Manager, the following was observed: a. There was a moderate amount of dirt and dust on the storage racks that housed clean pots and pans. b. There was a heavy accumulation of burned food and crumbs on the stove top. c. There was a heavy accumulation of food spillage and grease on the inside of both convection ovens and on the inside of the glass doors. There was grease noted on the sides of the ovens.	F 0812	**Dyer Nursing & Rehabilitation** **Annual Survey: 11-22-22** **F 812 Food and Nutritional Services** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Storage racks cleaned Burned food and crumbs removed from stove top Convection ovens cleaned and glass doors cleaned. Ovens, griddle and stove cleaned	12/12/2022

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	d. There was a heavy accumulation of grease on the sides of the griddle, stove, and both ovens. e. The handles to the ovens were sticky to touch. e. There was a heavy accumulation of dirt and dust on the standing fan blades blowing directly at the steam table. f. There was a heavy accumulation of food spillage on the bottom of the steam table. g. There was a heavy accumulation of dirt, dried food spillage, and grease on a portable steam table. Interview with the Dietary Manager at that time, indicated the steam table was not in use and not functional. h. There was a torn, dirty, and food stained piece of plastic over the stand mixer. There was a moderate amount of food crumbs on the stand and around the bowl. Interview with the Dietary Food Manager on 11/21/22 at 10:45 a.m., indicated all of the above was in need of cleaning or repair. 3.1-21(i)(3)		Standing fan cleaned Steam table cleaned Stand mixer cleaned **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the same alleged deficient practice **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Dietary staff have been in-serviced regarding, proper Cleaning and sanitation of equipment, and drying techniques. All alleged concerns have been added to routine dietary cleaning schedule. **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;** Administrator or designee to audit sanitation of kitchen area 3 times	

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			a week for 6 months. 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. **Date by which systemic corrections will be completed: 12-12-22**	
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			

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	conducted according to §483.70(e) and following accepted national standards; §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.			

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	Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §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 ensuring hand hygiene was completed before and after glove removal. The facility also failed to ensure lancets were disposed of properly for 2 of 2 glucometers observed, personal protective equipment (PPE) was worn correctly during COVID-19 testing, masks were worn correctly, wash basins were stored correctly, and multi-use equipment was disinfected for random observations for infection control. (Residents 58, 90, 102, 82, 85, 41, and G) Findings include: 1. On 11/17/22 at 4:08 p.m., RN 1 was preparing to check Resident 58's blood sugar. The RN washed her hands and donned a pair of gloves. She wiped the glucometer with a sani wipe, removed her gloves, did not hand sanitize, and donned a new pair of gloves. The RN then proceeded to punch the resident's pills from the punch card into the medication cup. When done, she removed the gloves and used hand sanitizer. The RN then proceeded to enter the resident's room to check her blood sugar. She sanitized her hands prior to donning her gloves, the resident's finger was cleansed with an alcohol wipe, then pricked with the lancet, and a blood sample was	F 0880	**Dyer Nursing & Rehabilitation Root Cause Analysis** According to the 2567: Based on observations, interviews, and record review that the facility failed to properly follow infection control and prevention policies related to COVID-19. POC 880 Infection Prevention & Control A discussion was held with the Administrator, Director of Nursing, Infection Preventionist, Medical Director and members of the IDT during an emergency QA meeting. The discussion detailed the areas the facility was cited on according to the 2567. The Medical Director was in agreement with the plan of correction related to infection control and Prevention. The Medical Director was made aware of the education and auditing put in place by the facility. Education was provided to facility staff on Infection Prevention and Control related to PPE related to COVID testing, Personal Protective Equipment, disinfecting	12/12/2022

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	obtained. The RN removed her gloves, the lancet was wrapped up in one of the gloves and discarded in the trash can on the side of the medication cart. At 4:27 p.m., the RN entered Resident 90's room to check her blood sugar. When done, the RN placed the lancet in one of her gloved hands. She proceeded to remove both gloves and disposed of them in the resident's trash can next to her bed. Interview with RN 1 at 4:46 p.m., indicated she should have disposed of both lancets in the sharps container rather than in the trash can. Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the lancets were to be disposed of in the sharps container and staff had recently been inserviced. 2. On 11/15/22 at 10:24 a.m., two gray wash basins were stacked together and on the floor next to the toilet in Room 155. Two residents shared the bathroom. 3. On 11/15/22 at 10:12 a.m., there was a wash basin on the floor in the bathroom of Room 167. The wash basin was not contained. One resident used the bathroom. 4. On 11/15/22 at 10:15 a.m., there was a wash basin on the floor, not contained, in the bathroom of Room 168. Two residents shared the bathroom. During the Environmental tour on 11/16/22 at 10:05 a.m., the wash basins remained on the bathroom floor in Rooms 167 and 168. Interview with the Nurse Consultant on 11/22/22 at 2:55 p.m., indicated the wash basins should not		multi equipment in between resident use and proper disposal of lancets The facility administrator, Director of Nursing, and Infection Preventionist reviewed the 2657, Infection Control and Prevention policies, and CMS guidelines and completed a root cause analysis. It was determined that a possible element leading to non-compliance may have included need for additional education with practices related to infection prevention and control processes. In addition, the need to have a clear(er) picture of guidance and when it changes as there are many agencies providing guidance to Nursing Homes: CDC/ CMS/ PH / Counties/ to aid in reinforce facility infection control procedures. The Infection Preventionist and Director of Nursing, in conjunction with the Medical Director, and senior leadership/Governing Body concurrence, shall complete the following: Provide on-going education related to Infection Prevention and Control **System Changes**: The facility shall complete the following actions: Educate staff on items below: • Preventing the Spread of COVID-19 • Proper PPE use during COVID testing • Disinfecting equipment in	

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	have been stored on the floor. 5. During a random observation on 11/16/22 at 9:50 a.m., Nurse Practitioner (NP) 1 entered the memory care dining room and began to assess Resident G. At that time, she listened to the resident's chest with her stethoscope and checked his oxygen saturation by placing a pulse oximeter she pulled out of her coat pocket on his finger. After the resident's assessment, she walked over to Resident 41 and checked his oxygen saturation with the same pulse oximeter that had not been disinfected in between residents. NP 1 did not perform hand hygiene in between the residents. The NP was then summoned back into the memory care dining room to assess Resident 91. She removed the pulse oximeter from her coat pocket and placed it on Resident 91's finger and removed her stethoscope from her coat pocket and listened to the resident's chest. The pulse oximeter had not been disinfected in between residents. 6. During a random observation on 11/16/22 at 1:30 p.m., Agency CNA 1 was observed sitting in the dining room on his cell phone with his face mask below his mouth and nose. LPN 1 was in the nursing office on the unit and not in view of the CNA. At that time, there were 2 residents in the dining room sitting near the Agency CNA. At 1:35 p.m., a visitor brought some dirty clothes and gave them to the CNA, who then stood up and pulled up his mask over his mouth but not his nose and walked out of the dining room and out of the unit with a glove on one of his hands. He returned to the memory care unit with his face mask over his mouth only and not his nose. He then walked into Resident E's room at 1:40 p.m., and placed the floor mattress on the side of the resident's bed. His face mask was still observed below his nose. He left the room and did not perform hand hygiene, then walked down the hall		between resident use • Proper disposal of lancets • Hand Hygiene • Proper PPE use Completed as of 11/16/2022 see attachment **Monitoring:** Monitoring of approaches to ensure infections are controlled will include: • The Infection Preventionist, Director of Nursing and other nursing leadership will conduct audits throughout the facility to ensure staff are adhering to the Infection Control policy and procedures related but not limited to PPE related to COVID testing, Personal Protective Equipment, disinfecting multi equipment in between resident use and proper disposal of lancets. Education will be provided immediately to persons who are not following the Infection and prevention/control practices. Such monitoring will be completed daily for 6 weeks. Completed as of: Started 11/16/2022 and will continue. See attachment **Quality Assurance and Performance Improvement (QAPI):** · The facility though the QAPI program will review, update and make changes as needed for sustaining substantial compliance for no less than 6 months.	

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	into another resident's room. He returned to the dining room and pulled out his cell phone with his face mask still below his nose. The same 2 residents remained in the dining room. 7. During a random observation on 11/17/22 at 9:50 a.m., the Restorative Nurse moved the treatment cart into the memory care dining room. At that time, she was preparing to swab residents for COVID-19. The Restorative Nurse was wearing a regular surgical face mask. She was not wearing any gloves, protective eyewear, or a gown. She swabbed Resident 102 and placed the specimen in the package and placed it on the treatment cart. She did not perform hand hygiene. She attempted to swab Resident 82, but she refused. She walked over to Resident 85 and swabbed him, again only wearing a surgical face mask. She obtained the specimen and placed it in the package and set it on the treatment cart. She did not perform hand hygiene. After swabbing those residents, she placed a face mask over each of their noses and mouths with her bare hands and did not perform hand hygiene in between residents. The current and updated 2/8/22, "COVID-19 Infection Control Guidance in Long-term Care Facilities", indicated hand hygiene (use of alcohol-based hand rub (ABHR)) was preferred. Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care. The updated 4/4/22 CDC guidance for "Guidance for SARS-CoV-2 Point-of-Care and Rapid Testing," indicated "For personnel collecting specimens or working within 6 feet of patients suspected to be infected with SARS-CoV-2, maintain proper infection control and use		Started 11/16/22 and ongoing **Dyer Nursing & Rehabilitation** **Annual Survey: 11/22/22** 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. **F880 Infection Prevention and Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 58 no adverse reaction Resident 90 no adverse reaction Resident 102 no adverse reaction to staff testing with improper PPE Resident 82 no adverse reaction to staff testing with improper PPE Resident 85 no adverse reaction Resident 41 no adverse reaction related to oximeter not being sanitized in between use Resident G no adverse reaction RN 1 educated on proper disposal of lancets Wash basins removed from rooms 155, 167, 168 Nurse Practitioner educated on disinfecting multi use equipment in between resident use.	

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	recommended personal protective equipment [PPE], which could include an N95 or higher-level respirator [or face mask if a respirator is not available], eye protection, gloves, and a lab coat or gown." Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the appropriate Personal Protective Equipment to swab a person for COVID-19 was an N95 face mask, protective eyewear, and gloves. She indicated staff should be wearing their face masks over their mouth and nose and multi-use equipment was to be sanitized in between residents. 3.1-18(b)		Agency CNA 1 educated on wearing PPE properly Restorative Nurse educated on proper PPE to be worn when COVID testing **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;** Staff were educated on proper PPE, sanitizing equipment in between resident use, hand hygiene after resident contact, proper PPR to wear when testing for COVID, proper disposal of lancets and proper storage of wash basins **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 conduct surveillance observations 3 x week for 6 months to ensure improvement of infection control practices. The DON/designee will present a summary of the audits to the	

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			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: 12/12/2022**	
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pneumococcal Immunizations §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's			

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	representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.			
	Based on interview and record review, the facility failed to ensure residents and/or responsible parties were offered the opportunity to receive or decline an influenza and pneumococcal immunization and provided education on the benefits and potential side effects of the	F 0883	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** Please accept the following as the facility's credible allegation of compliance. This plan of	12/12/2022

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	immunizations for 2 of 5 residents reviewed for immunizations. (Residents D and 72) Findings include: 1. The record for Resident D was reviewed on 11/17/22 at 1:30 p.m. Diagnoses included, but were not limited to, metabolic encephalopathy, respiratory syncytial virus, respiratory failure, high blood pressure, chronic obstructive pulmonary disease, and dementia. There was no documentation the resident was offered the influenza or pneumococcal immunizations or provided education regarding them. 2. The record for Resident 72 was reviewed on 11/16/22 at 2:14 p.m. The resident was admitted on 9/23/22. Diagnoses included, but were not limited to, stroke, high blood pressure, coronary artery disease, depression, and dysphagia. There was no documentation the resident was offered the influenza or pneumococcal immunizations or provided education regarding them. Interview with the Director of Nursing on 11/22/22 at 11:15 a.m., indicated there was no documentation related to the facility offering or providing education on the influenza or pneumococcal vaccinations to those residents.		correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **F 883 Immunization** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents D and 72 were offered the influenza and pneumococcal vaccinations **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;** An audit was completed to ensure all residents have been offered the flu and pneumonia vaccine. Nursing staff were educated on offering the flu/pneumonia vaccine to residents upon admission and annually. **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; DON/designee will audit 10 residents monthly to ensure they are up to date with flu, pneumonia and COVID vaccines. 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. **Date by which systemic corrections will be completed: 12/12/2022**	
F 0921 SS=E Bldg. 00	483.90(i) Safe/Functional/Sanitary/Comfortable Environ §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure the residents' environment as well as the kitchen area was clean and in good repair related to dirty floors, marred doors, lime build up, dirty heating unit covers, dirty baseboards, food build up on the baseboards, lime build up on pipes, dirty floor tile, and dirty transportation carts in 1 of 1 kitchen areas and on 3 of 4 units. (The Main Kitchen and East, West, and Memory Care Units) Findings include:	F 0921	**Dyer Nursing & Rehabilitation Annual Survey: 11/22/22** 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. **F921**	12/12/2022

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	1. During the Environmental tour with the Director of Maintenance and the Director of Housekeeping on 11/16/22 at 10:00 a.m., the following was observed: East Unit a. The privacy curtain in Room 122 was stained. b. Only one side of the window blind in Room 136 pulled up. The front of the heating unit was loose and was coming off. One resident resided in this room. West Unit a. An accumulation of lime build up was observed on the bathroom faucet in Room 151. The floor tile in the bathroom was dirty and a black substance was on the floor tile behind toilet. The door frame to the room was marred and the plastic cover was peeling along the edges. Two residents resided in the room and shared the bathroom. b. The floor tile in the bathroom of Room 152 was marred and stained. Two residents resided in the room and shared the bathroom. c. The floor tile in Room 153 was dirty with a dull finish. The edge of the bathroom door was marred. The floor tile in the bathroom was discolored and the caulk around the base of the toilet was discolored. The baseboard behind the toilet was peeling away from the wall. Two residents resided in the room and shared the bathroom. d. The floor tile in Room 155 was dirty with a dull		**Safe/Functional/Sanitary/Comfortable Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** **East Unit** **Room 122- privacy curtain cleaned** **Room 136- window blind fixed. Front of heating unit fixed.** **West Unit** **Room 151- lime build up cleaned. Floor tile cleaned. Door frame repaired** **Room 152- floor tile cleaned** **Room 153- floor tile cleaned, bathroom door repaired, caulk around toilet re-done, baseboard repaired** **Room 155- floor tile cleaned, heating unit cleaned** **Memory Care Unit** **Room 167-wheelchair arm replaced** **Kitchen** **White PVC pipes cleaned, lime build up cleaned, base boards cleaned, garbage can cleaned, rubber bumpers cleaned, wheels cleaned and/or replaced, white PVC under food prep sink cleaned. Food prep sink area cleaned, plastic strip on ice machine replaced, food crumbs cleaned** **How the facility will identify other residents having the potential to be affected by the**	

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	finish. There was dried spillage on the front of the heating unit. Two residents resided in the room. Memory Care Unit a. The arm of the wheelchair in Room 167 was ripped and torn. One resident resided in the room. Interview with the Maintenance and Housekeeping Directors at the time, indicated all of the above were in need of cleaning and/or repair. 2. During the Brief Kitchen Sanitation Tour on 11/14/22 at 9:18 a.m. with the Dietary Food Manager, the following was observed: a. The white PVC pipes under the dish machine were dirty with dried food spillage. b. There was a moderate amount of lime build up on floor under the dish machine and under the food prep table. c. There was a moderate amount of adhered dirt and grime along the base board in the entire kitchen. d. The outside of all the garbage cans were dirty with dried food substance. e. The rubber bumper on the outside of 6 transportation carts were dirty with dried food spillage. The wheels on all of those carts were greasy with adhered dirt. f. The white PVC pipes under a food prep sink were dirty. The food prep sink was not in working order and had been that way for a very long time. Inside the sink was dried food spillage and there was lime build up underneath on the floor.		**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;** Staff were re-educated on the procedure of notifying maintenance/environmental services of any necessary repairs/cleaning needed. **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;** Environmental services supervisor/Maintenance department/ will audit 10 rooms per week on alternating units for Environmental/cleaning issues and maintenance issues. Any identified issues will be corrected. Dietary Manager/designee will audit the kitchen 3 days a week for cleanliness and possible items that need to be repaired. 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	

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	g. The plastic strip in the ice machine was peeling away and broken. h. There was a heavy accumulation of food crumbs and debris under the tables and and along the wall. Interview with the Dietary Manager on 11/21/22 at 10:45 a.m., indicated all of the above was in need of cleaning or repair. This Federal tag relates to Complaints IN00392424 and IN00392575. 3.1-19(f)		done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 12/12/2022**	
R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. This visit included a Recertification and State Licensure Survey and the Investigation of Complaints IN00392424, IN00392575, and IN00392985. Complaint IN00392424 - Substantiated. Federal/State deficiencies related to the allegations are cited at F677, F692, F758, and F921. Complaint IN00392575 - Substantiated. Federal/State deficiencies related to the allegations are cited at F697 and F921. Complaint IN00392985 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689. Survey dates: November 14, 15, 16, 17, 18, 21, and	R 0000	The facility kindly requests a desk review.	

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	22, 2022. Facility number: 000125 Residential Census: 37 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 11/29/22.			
R 0215 Bldg. 00	410 IAC 16.2-5-2(b) Evaluation - Deficiency (b) The preadmission evaluation (interview) shall provide the baseline information for the initial evaluation. Subsequent evaluations shall compare the resident ' s current status to his or her status on admission and shall be used to assure that the care the resident requires is within the range of personal care and supervision provided by a residential care facility. Based on record review and interview, the facility failed to complete a Pre-Admission Evaluation for 1 of 7 residents reviewed. (Resident 3) Finding includes: Resident 3's record was reviewed on 11/21/22 at 11:13 a.m. Diagnoses included, but were not limited to, hyperlipidemia and hypertension. The resident was admitted to the facility on 11/1/22. There was a lack of documentation that a Pre-Admission Evaluation had been completed prior to the resident being admitted to the facility. Interview with the Administrator on 11/22/22 at 11:20 a.m., indicated she was unable to provide any further documentation.	R 0215	**Dyer Nursing & Rehabilitation-Sheffield** **Annual Survey: 11/22/2022** **R 215 Pre- Admission Evaluation** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will**	12/12/2022

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			be accomplished for those residents found to have been affected by the deficient practice? Resident 3- resident remains in the facility, unable to complete a pre-admission evaluation. Service plan updated. **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 residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Sheffield Manor licensed nursing staff/designee educated on completing pre- admission evaluations of potential residents. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** Administrator/designee will review	

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			all residents that admit to the facility x 3 months to ensure a pre-admission evaluation screening has been completed. A summary will be presented to the Quality Assurance committee monthly x 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. **By what date the systemic changes will be completed: 12/12/22**	
R 0216 Bldg. 00	410 IAC 16.2-5-2(c)(1-4)(d) Evaluation - Noncompliance (c) The scope and content of the evaluation shall be delineated in the facility policy manual, but at a minimum the needs assessment shall include an evaluation of the following: (1) The resident ' s physical, cognitive, and mental status. (2) The resident ' s independence in the activities of daily living. (3) The resident ' s weight taken on admission and semiannually thereafter. (4) If applicable, the resident ' s ability to self-administer medications. (d) The evaluation shall be documented in writing and kept in the facility. Based on record review and interview, the facility failed to ensure a medication self-administration evaluation was completed for 1 of 7 residents	R 0216	**Dyer Nursing & Rehabilitation-Sheffield** **Annual Survey: 11/22/22**	12/12/2022

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	reviewed. (Resident 4) Finding includes: Resident 4's record was reviewed on 11/21/22 at 1:56 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation and type 2 diabetes mellitus. The resident was admitted to the facility on 7/17/20. The Medication Administration Record (MAR), dated 11/2022, indicated the resident self-administered the following medications: prednisolone acetate eye drops, Spiriva (tiotropium bromide) inhaler, and brimonidine eye drops. The most recent Service Plan, dated 6/30/22, indicated staff was to administer medications to the resident and he did not self-administer any medications. The Physician's Order Summary, dated 11/2022, lacked any orders for the self-administration of medications. There was a lack of any self-administration of medications assessment. Interview with the Administrator on 11/22/22 at 11:20 a.m., indicated she was unable to provide any documentation of a self-administration assessment.		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. **R 216 Evaluation** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 4- A self-administration assessment was completed and resident determined to be able to self-administer medication. Service plan updated. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents with medication orders 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 educated on completing a self-administration observation prior to resident having medications in the apartment. Staff educated on writing an order	

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			for resident to self-administer medications when appropriate. **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 Supervisor/Designee will audit 5 residents per month x 3 months to ensure residents are properly assessed to determine if they are appropriate for self-administering medications. The Nurse Supervisor/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: 12-12-22**	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation and interview, the facility failed to serve and prepare food under sanitary conditions related to dirty food equipment, steam tables, wire racks, standing fans, and standing	R 0273	**Dyer Nursing & Rehabilitation-Sheffield** **Annual Survey: 11-22-22**	12/12/2022

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	mixer for 1 of 1 kitchens observed. This had the potential to affect all 37 residents who received food from the kitchen. (The Main Kitchen) Findings include: During the Brief Kitchen Sanitation Tour on 11/14/22 at 9:18 a.m., with the Dietary Food Manager indicated the following: a. There was a moderate amount of dirt and dust on the storage racks that housed clean pots and pans. b. There was a heavy accumulation of burned food and crumbs on the stove top. c. There was a heavy accumulation of food spillage and grease on the inside of both convection ovens and on the inside of the glass doors. There was grease noted on the sides of the ovens. d. There was a heavy accumulation of grease on the sides of the griddle, stove, and both ovens. e. The handles to the ovens were sticky to touch. e. There was a heavy accumulation of dirt and dust on the standing fan blades blowing directly at the steam table. f. There was a heavy accumulation of food spillage on the bottom of the steam table. g. There was a heavy accumulation of dirt, dried food spillage, and grease on a portable steam table. Interview with the Dietary Manager at that time, indicated the steam table was not in use and not		**R 273 Food and Nutritional Services** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Storage racks were cleaned Stove top cleaned and burned food and crumbs removed Convection ovens and glass doors cleaned. Accumulation of food and grease removed. Ovens, oven handles, griddle and stove cleaned. Accumulation of grease removed. Standing fan and blades were cleaned Steam table was cleaned. Accumulation of food spillage, dirt and grease were removed. Stand mixer cleaned and stand mixer cover replaced. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	

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	functional. h. There was a torn, dirty, and food stained piece of plastic over the stand mixer. There was a moderate amount of food crumbs on the stand and around the bowl. Interview with the Dietary Food Manager on 11/21/22 at 10:45 a.m., indicated all of the above was in need of cleaning or repair.		**taken;** All facility 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;** Dietary staff have been in-serviced regarding, proper cleaning and sanitation of dietary equipment. All alleged concerns have been added to routine dietary cleaning schedule. **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;** Administrator or designee to audit kitchen sanitation 3 times a week for 6 months. 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.	

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			Monitoring will be on going. **Date by which systemic corrections will be completed: 12-12-22**	
R 0409 Bldg. 00	410 IAC 16.2-5-12(d) Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had a required health assessment and statement for 1 of 7 residents reviewed for annual health statements. (Resident 3) Finding includes: Resident 3's record was reviewed on 11/21/22 at 11:13 a.m. Diagnoses included, but were not limited to, hyperlipidemia and hypertension. The resident was admitted to the facility on 11/1/22. The record lacked a health statement to indicate the resident was free of communicable diseases. Interview with the Administrator on 11/22/22 at 11:20 a.m., indicated she was unable to provide any documentation of an annual health statement.	R 0409	**Dyer Nursing & Rehabilitation-Residential** **Annual Survey 11/22/22** 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. **R 409 Health Statement** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident 3- annual health statement received without any adverse findings.	12/12/2022

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			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 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;** Licensed nurses were educated on obtaining an annual health statement upon admission and yearly thereafter. **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 Supervisor/designee will audit all new admissions x 3 months to ensure the annual health statement is received. The nurse supervisor/designee will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the	

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			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: 12-12-22**	
R 0410 Bldg. 00	410 IAC 16.2-5-12(e)(f)(g) Infection Control - Noncompliance (e) In addition, a tuberculin skin test shall be completed within three (3) months prior to admission or upon admission and read at forty-eight (48) to seventy-two (72) hours. The result shall be recorded in millimeters of induration with the date given, date read, and by whom administered and read. (f) For residents who have not had a documented negative tuberculin skin test result during the preceding twelve (12) months, the baseline tuberculin skin testing should employ the two-step method. If the first step is negative, a second test should be performed within one (1) to three (3) weeks after the first test. The frequency of repeat testing will depend on the risk of infection with tuberculosis. (g) All residents who have a positive reaction to the tuberculin skin test shall be required to have a chest x-ray and other physical and laboratory examinations in order to complete a diagnosis. Based on record review and interview, the facility failed to ensure residents had a documented Mantoux test (test for tuberculosis) completed	R 0410	**Dyer Nursing & Rehabilitation Annual Survey: 11-22-22**	12/12/2022

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	upon admission and yearly for 2 of 7 residents reviewed for Mantoux testing. (Residents 3 and 4) Findings include: 1. Resident 3's record was reviewed on 11/21/22 at 11:13 a.m. Diagnoses included, but were not limited to, hyperlipidemia and hypertension. The resident was admitted to the facility on 11/1/22. There was a lack of documentation to indicate the resident had received a Mantoux test prior to or upon admission. 2. Resident 4's record was reviwed on 11/21/22 at 1:56 p.m. Diagnoses included, but were not limited to, hypertension, atrial fibrillation and type 2 diabetes mellitus. The resident was admitted to the facility on 7/17/20. There was a lack of documentation to indicate the resident had received an annual Mantoux test. Interview with the Administrator on 11/22/22 at 11:20 a.m., indicated she was unable to provide any documentation of completed Mantoux testing.		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. **R 410 Infection Control** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** R3 was given an initial Mantoux test series without any adverse findings. R4 was given the annual Mantoux test without any adverse findings. **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 residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?**	

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			Sheffield Manor licensed nursing staff educated on administering TB test upon admission and annually thereafter. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/designee will review all admissions x 3 months to ensure TB test was administered. DON/designee will review 5 residents monthly with order for annual TB test to ensure the test was administered. 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. **By what date the systemic changes will be completed: 12-12-22**	