

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  12/20/2013
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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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F000000	<p>This visit was for the Investigation of Complaints IN00140945 and IN00141418.</p> <p>Complaint IN00140945-Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Complaint IN00141418-Substantiated. Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey dates: December 19 &amp; 20, 2013</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Survey team: Janet Adams, RN, TC Heather Hite, RN</p> <p>Census bed type: SNF/NF: 139 Residential: 47 Total: 186</p> <p>Census payor type: Medicare: 29 Medicaid: 74</p>	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	<p>Other: 83 Total: 186</p> <p>Sample: 11</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 27, 2013, by Janelyn Kulik, RN.</p>				

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F000323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview the facility failed to ensure safety devices were in place to prevent accidents related to bed not left in the lowest position, alarms not in place, floor mats not in place, and wheelchair locks not in place for 3 of 4 residents reviewed for falls in the sample of 11. This resulted in a fracture for one resident (Resident #B) and a head laceration requiring staples (Resident #G). (Residents #B, #G, &amp; #L) (CNA #1) (CNA #2)</p> <p>Findings include:</p> <p>1. On 12/19/13 at 10:30 a.m., Resident #G was observed sitting in a high back chair in her room. The resident was awake and did not responded to verbal questions.</p> <p>The record for Resident #G was reviewed on 12/19/13 at 12:50 p.m. The resident's diagnoses included, but were not limited to, Alzheimer's Disease, joint contractures, cardiac</p>	F000323	<p>Please</p> <p>accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute</p> <p>an admission of guilt or liability by the facility and is submitted only in</p> <p>response to the regulatory requirement.</p> <p>F-323</p> <p>What corrective action(s) will be accomplished for those residents</p>	01/10/2014			

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	<p>pacemaker, congestive heart failure, high blood pressure, pain, cardiomegaly (enlarged heart), and anxiety state.</p> <p>The 11/20/13 Minimum Data Set (MDS ) quarterly assessment indicated the resident's cognitive skills for decision making were moderately impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight bearing support) of 2+ staff members for bed mobility and transfer. The MDS assessment also indicated the resident had impairment in range of motion to her right and left upper and lower extremities and had no falls since her last admit, reentry or assessment.</p> <p>Review of the 11/19/13 quarterly Fall Risk assessment indicated the resident's score was (10). This score indicated the resident was at high risk for falls.</p> <p>The residents' current care plans were reviewed. A care plan initiated on 11/28/13 indicated the resident was at risk for falls. The care plan was last reviewed with a target goal date of 2/25/14. Care plan interventions included for the</p>		<p>found to have been affected by the deficient practice;</p> <p>Resident G care card and care plan were reviewed and updated. Bed was checked for proper function.</p> <p>Resident B care card and care plan were reviewed and updated. Alarm was put in place and check for proper function.</p> <p>Resident L care card and care plan were</p>				

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	<p>resident's bed to be kept in the low position with the brakes locked. This intervention was initiated on 11/28/11.</p> <p>The 12/2/13 Nursing Progress Notes were reviewed. An entry made on 12/2/13 at 1:50 p.m. indicated staff responded to the resident being on the floor. Blood was noted to the right side of the resident's forehead. Ice and pressure were applied to the area. Neurological checks (checks to evaluate the resident's neurological status) were started and the resident was awake and alert. The Physician was notified. A Physician's order was written to send the resident to the hospital for an evaluation and treatment.</p> <p>An Observation Report note was initiated on 12/2/13 at 1:59 p.m.. The note was completed by a LPN. The note indicated a CNA informed the LPN to come to the resident's room as the resident was found laying on the floor . The resident was found laying on her right side with a moderate amount of bright red blood coming from the forehead area. A laceration measuring 2 cm (centimeters) x .8 cm was noted. The ambulance service was contacted to transfer the resident to the hospital.</p>		<p>reviewed and updated. Auto lock brakes were applied</p> <p>to the new wheel chair.</p> <p>How the facility will identify other residents having the potential to be affected by the same deficient practice</p> <p>and what corrective action will be taken;</p> <p>All</p> <p>facility residents have the potential to be affected by the same alleged</p> <p>deficient practice. Residents fall care</p> <p>plans were reviewed for current and appropriate interventions and then compared</p> <p>to the care cards in the room for accuracy. Any differences observed between</p>				

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	<p>The 12/2/13 hospital Emergency Room records were reviewed. The Emergency Department Provider Notes indicated the resident was seen in the Emergency Room at 2: 12 p.m. with a laceration to the right side of the head after a fall. A Physical Examination indicated the resident had a 3 cm (centimeter) laceration. The wound was closed with (3) staples. The resident's Emergency Room diagnoses were head injury, laceration of the head, and fall from bed.</p> <p>The facility investigation into the resident's fall/ injury was reviewed on 12/2/13 at 2:00 p.m. Interviews from the involved staff members were obtained. An interview obtained from CNA#1 (the CNA assigned to care for the resident at the time of the fall) indicated she and CNA #2 transferred Resident #G into bed and both CNA's left the resident's room. CNA #1 returned to the resident's room about 5-6 minutes later and upon walking into the room found the resident on the floor.</p> <p>CNA #2's interview indicated she assisted CNA #1 with putting Resident #G into bed with the Hoyer lift (a mechanical device used to transfer residents). The interview</p>		<p>the care card and the card plan were immediately corrected.</p> <p>What measures will be put into place</p> <p>or what systemic changes will be made to ensure that the deficient practice</p> <p>does not recur;</p> <p>In-service</p> <p>held on 1/3/14 by Director of Nursing/designee regarding the following:</p> <p>Upon the start of the shift, staff</p> <p>members should observe each resident assigned to their run and review the care</p> <p>card to ensure all coded interventions are in place and working properly. If any</p>		

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	<p>indicated the CNA did not lower the bed and both CNA #2 and CNA#1 walked out of the room with the resident's bed not in the low position.</p> <p>Corrective Action notices were completed for both the above CNA's. CNA #1 was suspended related to the resident's bed not being place in the lowest position and the resident sustained a fall from the bed. CNA #2 received a formal warning related to the above.</p> <p>When interviewed on 12/19/13 at 4:20 p.m., the Director of Nursing indicated the resident's 12/2/13 fall was investigated and several staff members were interviewed. The Director of Nursing indicated two CNA's transferred the resident from the chair into her bed. The staff members were CNA#1 and CNA #2. CNA #1 was assigned to care for the resident on the day of the fall. CNA #2 assisted CNA#1 in transferring the resident into bed prior to the resident's fall. The staff members left the resident's room with the bed not in the lowest position. CNA #1 returned to the resident's room approximately 5-6 minutes later and observed the resident on the floor. The Director of Nursing indicated the CNA #1 was educated and</p>		<p>intervention is not in place,</p> <p>notify nursing/restorative or the appropriate staff member to obtain the necessary intervention(s). Emergency boxes with extra interventions, batteries are located in the medication room on each unit. If you observe any items on the care card that are not current or have changed such as thickened liquid, fluid restriction, assistance needed, geri sleeves, glasses, dentures, hearing aids, etc. notify nursing as soon as possible so the appropriate corrections can be made to the care card.After caring for a resident, prior to leaving, ensure the bed is in the low position if they are in bed. Ensure all necessary interventions are also in place prior to leaving, including but not limited to: chair/bed alarm attached and on, floor mat next to bed if in bed, bolsters, call light in reach,</p>		

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	suspended related to the event and CNA #2 was counseled. The Director of Nursing indicated the resident's bed should have been in the lowest position as per her plan of care to prevent injury and accidents.		wedge cushion, dycem, auto lock brakes,  etc.If a resident has a bathroom door  alarm, ensure the alarm is engaged prior to leaving the room. 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; Director of  Nursing/designee will audit 10 residents on each unit weekly, and observe that  all interventions coded on the care card are in place. Any interventions  observed not in place, will be corrected immediately by nursing staff. A summary  of the audits will be presented to the Quality Assurance committee monthly by  Director of Nursing/designee for three months.  Thereafter, if determined by the Quality Assurance committee, auditing  and monitoring will be done	

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			quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	<p>2. The record for Resident #B was reviewed on 12/20/13 at 9:35 a.m. Resident #B is a DNR (Do Not Resuscitate) status. The resident's diagnoses included, but were not limited to, post traumatic hip fracture, subdural hemorrhage, osteoporosis, muscle weakness, cerebral vascular disease, Alzheimer's disease, polyneuropathy, and a history of falls.</p> <p>The fall investigation provided by the DoN (Director of Nursing) on 12/19/13 for Resident #B's reportable fall on 12/12/13 indicated, "12/13/13 Fall Reviewed: Res (Resident) stood up from wheelchair and leaned to the right and fell. Fall not witnessed but heard. MD in facility, res (resident) assessed &amp; sent to ER (Emergency Room). Spoke [with] CNA &amp; CNA counseled R/T (related to) alarm not in place to alert staff. Will review ..." The written investigation interview with CNA #3, who had worked the 6 am - 2 pm shift on 12/12/13, indicated</p>			

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	<p>she had gotten Resident #B up in her broda chair with chair alarm for breakfast, had to adjust alarm several times throughout the shift &amp; the alarm was in place before the end of the shift. A corrective action notice was included in the investigation and indicated, "This CNA did not ensure that all intervention were in place, which resulted in a fall with injury." The written investigation interview with CNA #4 who worked the 3 - 11p.m. shift on 12/12/13, indicated she arrived on the unit around 2:23 p.m. from the other unit, had filled her cart and was receiving report from a staff nurse when she was told one of her residents had fallen. The interview further indicated she "then came to the nurse station were {sic} resident fell and noticed no chair alarm. Went to her room grabbed alarm and placed on her chair."</p> <p>A Restorative fall intervention checklist dated 12/12/13, provided by the DoN on 12/20/13, indicated fall interventions were in place, including a chair alarm, as ordered for Resident #B at 11:00 a.m.</p> <p>The hospital Emergency Room physician examination notes dated 12/12/13 indicated "status post fall with intertrochanteric fracture of right</p>						

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	<p>hip" and a recommendation for surgical repair.</p> <p>The quarterly Minimum Data Set (MDS) assessment, dated 11/1/13, indicated Resident #B had severe cognitive impairment and required extensive assist (resident involved in activity with staff providing weight bearing support) of two staff for transfers.</p> <p>Progress notes for Resident #B indicated additional falls documented on 10/19/13 (2 different times) and 11/15/13.</p> <p>The event report for the first fall on 10/19/13 at 6:45 p.m. indicated, "Resident fell out of chair in hallway on buttocks trying to stand up, hit head on wheelchair." The event report for fall #2 on 10/19/13 at 8:00 p.m. indicated "Resident slid out of bed onto buttocks." The event report for 11/15/13 at 12:55 a.m., indicated Resident #B "got out of bed (bolsters in place) wearing regular socks walked across floor carrying a brief, washcloth and empty can of cleaning foam. Was found sitting on floor outside of room ... states she had gotten tired and lowered herself down the wall ... Res incontinent of BM (bowel movement). 10 minutes prior</p>						

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	<p>she was toileted and had large BM and moderate amt. (amount) urine." There were two scratches noted to her mid back.</p> <p>Care plans for Resident #B indicated "3/15/13 Resident at risk for falling R/T Visual and cognitive impairment." The following fall prevention interventions were to be put into place:                      3/15/13: Provide proper, well-maintained footwear; keep call light in reach, bed in lowest position and provide incontinent care after each episode.                      3/22/13 added: Bolsters to bed                      4/9/13 added: High back reclining wheelchair                      10/20/13 added: Wheelchair alarm, 2 person assist for transfers, Dycem (a pad placed on the chair to prevent sliding or slipping), and padded wheelchair arms.                      11/15/13 added: Bed alarm R/T fall, thin floor mat next to bed while in bed, and non skid slipper socks while in bed and at bedtime.</p> <p>An interview was conducted with the DoN on 12/20/13 at 10:45 a.m. She indicated, based on the investigation of Resident #B's fall on 12/12/13, the chair pad alarm was not on the wheelchair at the time of the fall, nor</p>			

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	<p>was it found in the area. She further indicated the protocol to ensure proper interventions were in place was for Restorative to do daily rounds and each CNA was also to check. The DoN also indicated Resident #B had a history of trying to remove her chair alarm and was sometimes able to be directed when the alarm went off. In a continuation of the interview at 1:54 p.m., the DoN indicated the Dycem was not addressed during the fall investigation and she did not know if it had been in place on the wheelchair.</p> <p>In an interview with the Restorative Program Director (RPD) on 12/20/13 at 1:15 p.m., she indicated Resident #B was part of the Restorative program since she was discharged from therapy (after her fall on 11/15/13) and had been much more energetic. The intervention for Restorative staff to ambulate Resident #B daily along with her range of motion exercises was put into place to attempt to help occupy the resident. The RPD indicated she had seen Resident #B ambulating and she did well. The RPD further indicated daily rounds by Restorative staff were completed on all residents with any fall prevention in place and a master flow sheet is used. The</p>			

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	<p>information comes from morning meetings and Physician's orders. If an intervention is not in place or not in working order, the staff replaces the item and records the information on the flowsheet. The staff also notifies the nursing staff and the RPD. The RPD indicated that the Restorative staff have notified her of missing or non-working items on a regular basis and she herself then checks the status of the intervention, rechecks the physician's orders, events and care plans, and makes the nursing staff aware.</p> <p>3. During Orientation Tour on 12/19/13 at 8:58 a.m. Resident #L was observed in bed. No staff members or visitors were in the room at the time. The resident was in bed. The resident's bed was in the low position. There was a blue mattress on the floor near the lower half of the bed. The mattress was approximately 3 feet away from the resident's bed.</p> <p>On 12/19/13 at 12:05 p.m., the resident was observed in bed. The resident was eating his lunch. A blue floor mat was observed on the floor approximately 2- 2/12/ feet away from the resident's bed. There were</p>			

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NAME OF PROVIDER OR SUPPLIER  DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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	<p>no staff members or visitors in the resident's room at this time.</p> <p>On 12/19/13 at 12:15 p.m., the resident was observed in bed. The blue floor mat remained in the same position. There were no staff members or visitors in the resident's room.</p> <p>On 12/19/13 at 12:35 p.m., the resident was observed in bed. The resident's meal tray was not in the room at this time. The blue floor mat remained in the same position. There were no staff members or visitors in the resident's room.</p> <p>On 12/19/13 at 1:30 p.m., the resident was observed in bed. A Hoyer lift machine (a mechanical device used to transfer residents) was observed in the doorway of the resident's room. CNA #5 walked into the doorway and removed the Hoyer lift from the room. The blue floor mat was not next to the resident's bed at this time. The CNA took the Hoyer lift out to the hallway and did not return to the resident's room.</p> <p>On 12/19/13 between 1:30 p.m. and 1:35 p.m., several staff members were observed in the hallway near the resident's room. No staff members</p>			

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	<p>entered the resident's room.</p> <p>On 12/19/13 at 1:45 p.m., the resident was observed in bed. The blue floor mat was not next to the resident's bed. There were no staff members or visitors in the resident's room at this time.</p> <p>On 12/20/13 at 7:40 a.m., Resident #L was observed sitting in wheel chair in the unit Dining Room. There were no auto locks on the resident's wheel chair.</p> <p>On 12/20/13 at 8:20 a.m., the resident was observed sitting in his wheel chair in his room. There were no auto locks on the resident's wheel chair. There were no staff members or visitors in the room.</p> <p>The record for Resident #L was reviewed on 12/20/13 at 8:00 a.m. The resident's diagnoses included, but were not limited to, senile dementia, depressive disorder, history of falls, anxiety state, and hearing loss.</p> <p>A Fall Risk assessment completed on 12/5/13 indicated the resident's score was (20). The assessment indicated the resident had three or more falls in the last three months and had</p>				

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	<p>balance problems while standing and walking. A score greater then (10) indicated the resident was at risk for falls.</p> <p>The resident's care plan were reviewed. A care plan initiated on 3/30/13 indicated the resident had a history of falls related to his medication regime and disease process. The care plan was last reviewed on 10/29/13. Care plan interventions included for the resident to have a floor mat at the bedside and wheel chair auto locks.</p> <p>The 9/19/13 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (3). This score indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance (resident involved in activity with staff providing weight bearing support) of two persons for bed mobility and transfers.</p> <p>Review of the 12/2013 Nursing Progress Notes indicated an entry was made on 12/5/13 at 5:30 p.m. This entry indicated the Nurse was called to the resident's room by the</p>				

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	<p>CNA and found the resident sitting on the floor next to his bed mat. The resident stated he was trying to put himself back to bed. The resident denied pain, discomfort, or hitting his head.</p> <p>An entry made on 12/4/13 at 2:33 p.m. indicated at 12:30 p.m., the resident was noted getting out of his chair and laying himself on the bedside mat.</p> <p>The 10/2013 Nursing Progress Notes were reviewed. An entry dated 10/29/13 at 6:20 p.m., indicated the resident was found sitting on the floor in his room next to the wheel chair. The resident reported he was trying to transfer himself to bed from the wheel chair. No injuries were noted.</p> <p>When interviewed on 12/20/13 at 8:20 a.m., the Director of Nursing indicated the wheel chair the resident was currently in did not have auto locks in place. The Director of Nursing indicated this was not the wheel chair the resident had in the past.</p> <p>When interviewed on 12/20/13 at 8:25 a.m., CNA #5 indicated she was assigned to care for the resident this shift The CNA also indicated the</p>			

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	<p>resident's hall was her normal run (assignment). The CNA was interviewed in the resident's room and the resident was in the wheel chair. The CNA identified the wheel chair as the resident's wheel chair that she had been getting him into all week on her run.</p> <p>When interviewed on 12/20/13 at 10:45 a.m., the Director of Nursing indicated the resident had been placed on Hospice care a few weeks ago and the resident's wheel chair was switched by Hospice. The Director of Nursing indicated the current wheel chair did not have auto locks in place as per the resident's plan of care.</p> <p>This Federal tag relates to Complaints IN00140945 and IN00141418.</p> <p>3.1-45(a)(2)</p>				

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