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	06/28/2023

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 the Investigation of Complaints IN00399021, IN00404721, IN00405373, IN00405569, IN00407582, and IN00411260. Complaint IN00399021 - Federal/state deficiencies related to the allegations are cited at F684 and F689. Complaint IN00404721 - Federal/state deficiencies related to the allegations are cited at F677, F684 F686, and F842. Complaint IN00405373 - Federal/state deficiencies related to the allegations are cited at F677 and F921. Complaint IN00405569 - Federal/state deficiencies related to the allegations are cited at F684, F694, and F757. Complaint IN00407582 - No deficiencies related to the allegations are cited. Complaint IN00411260 - Federal/state deficiencies related to the allegations are cited at F684. Unrelated deficiency is cited. Survey dates: June 26, 27, and 28, 2023 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 120 Total: 120	F 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	07/17/2023

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

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	Census Payor Type: Medicare: 20 Medicaid: 88 Other: 12 Total: 120 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/5/23.			
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 showers at least 2 times a week and the timeliness of incontinence care for 3 of 4 residents reviewed for ADLs. (Residents B, D and L) Findings include: 1. The record for Resident B was reviewed on 6/27/23 at 11:05 a.m. Diagnoses included, but were not limited to, stroke, fracture of the right femur, dysphagia, heart failure, high blood pressure, pain, arthritis, atrial fibrillation, major depressive disorder and anemia. The 5/11/23 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making and was totally dependent with bathing.	F 0677	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **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 D and L are no longer in the facility. Resident B was assessed and no	07/17/2023

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	A Care Plan, dated 6/13/23, indicated the resident required assistance with activities of daily living including bathing. The approaches were to assist with bathing as needed. The 4/2023 bath/shower sheets indicated the resident received a bed bath on 4/1, 4/5, 4/18, 4/25 and 4/28/23. The 6/2023 bathing report did not indicate if the resident received a shower or bed bath. The bathing report indicated the self performance and the support needed for the bath or shower. Interview with the Vice President of Operations on 6/28/23 at 11:33 a.m., indicated they have someone working on the situation in point click care regarding the bathing activity and to identify whether the resident had a shower or complete bed bath. Interview with the Nurse Consultant on 6/28/23 at 1:45 p.m., indicated the resident should have received 2 showers or complete bed baths per week.2. The Closed record for Resident D was reviewed on 6/27/23 at 2:16 p.m. The resident was admitted to the facility on 3/24/23. Diagnosis included, but were not limited to, lung cancer, anemia, malnutrition, chronic obstructive pulmonary disease, and respiratory failure. The Admission Minimum Data Set (MDS) assessment, dated 3/31/23, indicated the resident was not cognitively intact. The resident was frequently incontinent and needed extensive assist with 1 person physical assist for toileting. The updated Care Plan, dated 3/27/23, indicated the resident experienced bladder incontinence.		abnormalities were noted related to showers not being provided per plan of care. Resident B had a shower provided. **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 with assistance with ADLs per resident's plan of care including assisting residents with showers and incontinence 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;** DON/Designee will audit 15 residents, 3 times weekly with a focus on dependent resident's requiring ADL assistance to ensure they are being assisted from bed per their preferences and plan of care with showers and incontinence care per their plan of care for 4 months. Director of Nursing/designee will	

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	The approaches were to provide assistance for toileting, to keep the resident clean and dry, and to provide incontinence care after each incontinent episode. The updated Care Plan, dated 3/27/23, indicated the resident had limited functional ability and required instruction with toileting. The approaches were to provide instruction with transfers and toileting, provide assistance with toileting as needed, and to keep the call light within reach. The incontinent responses documented in Matrix (computer tracking program) by the CNA's for the months of March and April 2023, indicated the following: 3/24/23 8:13 p.m. - Incontinent 3/26/23 2:18 p.m. - Incontinent 3/26/23 7:16 p.m. - Incontinent 3/27/23 1:41 p.m. - Incontinent 3/27/23 7:18 p.m. - Incontinent 3/28/23 9:36 p.m. - Incontinent 3/29/23 3:04 a.m. - Incontinent 3/29/23 7:06 p.m. - Incontinent 3/30/23 2:52 a.m. - Incontinent 3/30/23 1:56 p.m. - Incontinent 3/30/23 7:47 p.m. - Incontinent 3/31/23 4:21 a.m. - Incontinent 3/31/23 2:01 p.m. - Incontinent 3/31/23 9:30 p.m. - Incontinent 4/1/23 5:49 a.m. - Incontinent 4/2/23 1:02 a.m. - Incontinent 4/2/23 12:43 p.m. - Incontinent 4/3/23 12:32 a.m. - Incontinent 4/3/23 12:51 p.m. - Incontinent 4/3/23 3:45 p.m. - Incontinent 4/4/23 2:41 a.m. - Incontinent 4/4/23 1:33 p.m. - Incontinent		present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 7.17.23**	

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	4/4/23 6:10 p.m. - Incontinent 4/5/23 2:59 a.m. - Incontinent 4/5/23 4:02 p.m. - Incontinent 4/6/23 2:04 a.m. - Incontinent 4/6/23 11:23 a.m. - Incontinent There was no documentation the resident was checked and changed at least every 2 hours, and on some days was only changed 1 time. Interview with the resident's daughter on 6/26/23 at 3:32 p.m., indicated she felt the CNA's did not want to do their job. She stated "My father would sit in his own filth for several hours." Interview with the Nurse Consultant on 6/27/23 at 2:16 p.m., indicated the documentation of incontinence care was lacking. 3. The record for Resident L was reviewed on 6/26/23 at 9:21 a.m. Diagnosis included, but were not limited to, anemia, high blood pressure, peripheral vascular disease, and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 6/18/23, indicated the resident was moderately impaired for decision making. The resident needed extensive assist with 1 person physical assist for personal hygiene. The Care Plan, dated 6/18/23, indicated the resident required assistance with activities of daily living including toileting and bathing. The approaches were to provide assistance with bathing as needed, offer shower at least 2 times daily, offer full or partial bed bath on non shower days, or with shower refusals. The 6/2023 bathing record did not indicate if the resident received a shower or a bed bath. The			

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	bathing report indicated the self performance and the support provided for the bed bath or shower. Interview with the Vice President of Operations on 6/28/23 at 11:33 a.m. indicated they have someone working on the situation in Point Click Care regarding the bathing activity and to identify whether the resident had a shower or a bed bath. This Federal tag relates to Complaints IN00404721 and IN00405373. 3.1-38(a)(2)(A) 3.1-38(a)(2)(C)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on record review, and interview, the facility failed to ensure transportation services were provided for a Physician's appointment for 1 of 3 residents reviewed for transportation, weekly skin assessments were completed as ordered for 1 of 3 residents reviewed for non-pressure skin conditions, and follow up assessments were completed after a fall with a fracture for 1 of 3 residents reviewed for falls. (Residents E, N, and F) Findings include:	F 0684	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **F684 Quality of Care** **What corrective action(s) will**	07/17/2023

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	1. The record for Resident E was reviewed on 6/26/23 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, kidney stones, urinary tract infection, type 2 diabetes, major depressive disorder, high blood pressure, and anxiety. The resident was admitted to the hospital on 3/12/23 and returned to the facility on 3/22/23, then was admitted again on 5/8/23 and returned to the facility on 5/11/23. The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident was cognitively intact. A Nurses' Note, dated 3/28/23 at 3:50 p.m., indicated the resident was readmitted back from the hospital. The resident had an upcoming appointment on April 3rd for a cystoscopy. There was no documentation in the nursing progress indicating the resident went to her Physician's appointment for the procedure. Interview with the Assistant to the Administrator (AA) on 6/28/23 at 11:45 a.m., indicated the resident's appointment was scheduled at 11 a.m., however, the transportation company had called the facility and canceled the ride. The AA called the Physician's office and explained what happened and was told she could come later in the day. The transportation company was called back and indicated they could pick her up at 12:30 p.m. The resident was picked up and taken to the appointment, however, when she arrived they were not able to do the procedure. Interview with the Administrator on 6/28/23 at 3:30 p.m., indicated they do have other transportation		**be accomplished for those residents found to have been affected by the deficient practice;** Resident N was assessed and no abnormalities were noted related to not having circulation, movement and sensitivity monitored every shift. Facility ensures that Resident E had scheduled transportation for all upcoming scheduled appointments. Resident F no longer resides 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 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 to ensure that all residents that have appointments have transportation scheduled. If transportation does not arrive, staff to follow up with the DON/Designee for alternative transportation arrangements. Licensed Nurses were re-educated on the need to document their skin assessments weekly. Licensed Nurses were	

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	companies to reach out to if the regular transportation company canceled the ride. 2. The record for Resident N was reviewed on 6/28/23 at 10:16 a.m. Diagnoses included, but were not limited to, peg tube, major depressive disorder, anxiety, epilepsy, fractured ankle, and pulmonary edema. The 6/9/23 Annual Minimum Data Set (MDS) assessment, indicated the resident was moderately impaired for decision making. Nurses' Notes, dated 4/4/23 at 6:39 a.m., indicated the CNA on duty reported to the writer the resident had complaints of pain and was yelling out. The resident indicated her shoulder and right ankle hurt. There was a purple discoloration to the right inner ankle. An X-ray was obtained and indicated the resident had a fracture of the right ankle and she was sent to the hospital on 4/4/23 at 2:15 p.m. The resident returned back to the facility on 4/4/23 at 10:27 p.m., with a post mold cast to the right ankle. Physician's Orders, dated 4/4/23, indicated monitor circulation, movement, and sensitivity to the right foot every shift. The Medication Administration Record (MAR) for the month of 4/2023 indicated the monitoring of the right ankle was blank and not signed out as being completed as follows: - Day shift: 4/4, 4/6, 4/7, 4/10, 4/12, 4/14, 4/23-4/26, 4/28 and 4/29/23 - Evening shift: 4/4, 4/21, and 4/24-4/29/23 - Night shift: 4/24-4/2923 Interview with the Nurse Consultant on 6/28/23 at		re-educated to ensure that they complete all circulatory assessments and document findings in PCC. **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 10 random residents weekly to ensure skin assessments are completed, in PCC, per the facility policy for 4 months. DON/Designee will audit missing entry report, daily, in PCC for any holes in circulatory assessments. If any assessments were not completed, DON to follow up with Nursing staff to complete and document missing assessments for 4 months. Administrator/Designee to audit transportation log twice weekly to ensure all transportation has been provided for all resident appointments for 4 months. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:**	

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	1:45 p.m., indicated nursing staff should have completed the assessments of the right ankle every shift.3. The closed record was reviewed for Resident F on 6/26/23 at 10:24 a.m. Diagnoses included but were not limited to, chronic obstructive pulmonary disease, high blood pressure, end stage renal disease, diabetes mellitus, and depression. The Admission Minimum Data Set (MDS) assessment, dated 5/18/23, indicated the resident was cognitively intact and had a skin condition of MASD (Moisture Associated Skin Damage). A Care Plan, dated 6/7/23, indicated the resident had a rash on the right buttock and MASD. The approaches were to monitor the skin for rashes for increased spread or signs of infection. A Wound Round Assessment, dated 6/6/23, indicated the resident had MASD and it was classified as full thickness. A Physician's Order, dated 6/8/23, indicated to perform weekly skin assessments on Thursdays. There were no weekly skin assessments in the resident's clinical record after 6/7/23. Interview with Nurse Consultant on 6/28/23 at 2:50 p.m., indicated there were no skin assessments completed after 6/7/23. This Federal tag relates to Complaints IN00399021, IN00404721, IN00405569, and IN00411260. 3.1-37(a)		**7.17.23**	
F 0686 SS=D	483.25(b)(1)(i)(ii) Treatment/Svcs to Prevent/Heal Pressure			

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Bldg. 00	Ulcer §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. Based on observation, record review, and interview, the facility failed to ensure pressure areas were assessed and monitored related to a blistered area to the resident's heel for 1 of 3 residents reviewed for pressure ulcers. (Resident B) Finding includes: On 6/27/23 at 10:35 a.m., Resident B was being provided incontinence care. At that time, the resident was wearing a heel boot to the left foot. The CNA was asked to remove the heel boot. There were loose bandages observed on the bottom of the heel covered with dried betadine. The heel was black and pink in color. On 6/27/23 at 11:55 a.m., the Wound Nurse was called to the resident's room to perform a skin assessment to the left heel. The Wound Nurse indicated the Wound Physician was in earlier today and the bandages were changed as well as some of the treatments. She removed the heel boot to the left foot and there were bandages	F 0686	Please accept the following as the facility's credible allegation-n of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **F686- Treatments/Svcs to Prevent/Heal Pressure Ulcers** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident B was assessed for any additional skin alterations, and none were noted. **How the facility will identify other residents having the potential to be affected by the**	07/17/2023

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	noted on the bottom of the heel. She removed the bandages and indicated the new order was for the areas to be open to air. She identified the pressure ulcer as a Deep Tissue Injury that was acquired in the facility. The record for Resident B was reviewed on 6/27/23 at 11:05 a.m. Diagnoses included, but were not limited to, stroke, fracture of right femur, dysphagia, heart failure, high blood pressure, pain, arthritis, atrial fibrillation, major depressive disorder and anemia. The 5/11/23 Quarterly Minimum Data Set (MDS), indicated the resident was moderately impaired for decision making. The resident needed limited assist with 1 person physical assist for bed mobility, supervision and set up help for eating, and was totally dependent with bathing. The resident had no history of weight loss. A Care Plan, dated 5/12/23, indicated the resident had a pressure ulcer to the left heel. A Nurses' Note, dated 4/18/23 at 8:57 p.m., and recorded as a late entry on 4/19/23 at 5:57 a.m., indicated the resident was being monitored for a blister to the left heel. The blister was intact and the resident had no complains of pain. A Nurses' Note, dated 4/19/23 at 5:57 a.m., indicated the resident was resting in bed and was being monitored for a blister to the left heel. There was no assessment of the blister or measurements obtained. There was no other documentation regarding the blister to the left heel until 5/4/23. Nurses' Notes, dated 5/8/23 at 12:41 p.m.,		**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 were re-educated on ensuring skin assessments are completed according to facility policy. When a new skin area is found, Licensed Nurse must complete skin risk management and notify the wound nurse immediately when new skin area is found. **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 to review nursing documentation daily and ensure that all new documented skin conditions are followed up on by the wound care nurse and that all required documentation is in PCC for 4 months. Nurse manager/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be	

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(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
	indicated a call was placed to the resident's family for permission for the Wound Physician to treat the resident's open area to the left heel. The first documented entry on the Wound Summary Report was on 5/4/23 regarding the left heel pressure ulcer. The left heel was identified as a Deep Tissue Injury that measured 3 centimeters (cm) by 4 cm. The skin was identified as 30% deep maroon and 70% of hard necrotic tissue. Physician's Orders, dated 5/6/23, indicated Cleanse the left heel with normal saline or wound cleanser, pat dry, and apply skin prep to the wound and leave open to air one time a day. The Wound Physician saw the resident beginning on 5/9/23 on a weekly basis. Interview with the Wound Nurse on 6/27/23 at 1:03 p.m., indicated she was not able to find anything in the resident's clinical record regarding the blister to the left heel back in April 2023. She indicated she was the interim DON at that time and was not doing wound treatments. She would have expected nursing staff to assess, measure and document on the blistered left heel in the chart. She indicated the treatment would have been to monitor the blister and leave open to air. Interview with the Nurse Consultant on 6/28/23 at 11:45 a.m., indicated the left heel was first assessed and measured on 5/4/23 and that was when treatments orders were obtained. The current 1/2017, "Measurement of Alterations in Skin Integrity" policy, provided by the Wound Nurse on 6/27/23 at 1:30 p.m., indicated at first observation of any skin condition, the charge nurse or treatment nurse was responsible to		done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 7.17.23**	

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	155220	A. BUILDING 00 B. WING	06/28/2023

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	measure and/or describe skin condition in the clinical record. All measurements will be recorded in centimeters. All wounds/ulcers (pressure, arterial, diabetic, and venous) will be measured weekly and results recorded in the clinical record. This Federal tag relates to Complaint IN00404721. 3.1-40(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 a resident with a history of falls and fracture related to a floor mattress and bolsters for 1 of 3 residents reviewed for falls with fractures. (Resident B) Finding includes: On 6/26/23 at 1:14 p.m., on 6/27/23 at 9:15 a.m., 10:37 a.m., and 11:55 a.m., Resident B was observed in bed. At those times, the bed was against the wall and there was no floor mat noted on the right side of the bed. There were no bolsters on either side of the resident nor did she have a wing tipped mattress on the bed. The record for Resident B was reviewed on	F 0689	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **F689 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;**	07/17/2023

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	6/27/23 at 11:05 a.m. Diagnoses included, but were not limited to, stroke, fracture of right femur, dysphagia, heart failure, high blood pressure, pain, arthritis, atrial fibrillation, major depressive disorder and anemia. The 5/11/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident needed limited assist with 1 person physical assist for bed mobility, supervision and with set up help for eating, and was totally dependent with bathing. A Care Plan, updated on 2/9/23 at 11:36 a.m., indicated the resident was at risk for falling related to limited mobility, history of a stroke, and general muscle weakness. The approaches were to have a right side halo, a floor mat, and a winged mattress. A fall and fracture investigation, dated 12/10/23, indicated there were 2 CNAs providing care for the resident in the early morning. The resident was rolled over to the side towards the wall and the bed shifted and the resident fell out of bed. Both CNAs indicated they could not stop her from falling. The resident sustained a laceration above the right eye and complained of pain to the her leg. She was sent to the emergency room and diagnosed with a hip fracture. The interventions put into place post fall were to provide a bariatric bed for comfort and an air mattress bolster overlay. Interview with the Nurse Consultant on 6/28/23 at 11:45 a.m.. indicated the resident did not have a floor mat on the side of the bed and she should have had the bolsters on the air mattress. Interview with the Administrator on 6/28/23 at		The Fall Mat and Bolsters for Resident B were immediately put into 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.** All Residents with fall interventions 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;** Staff were re-educated to ensure that all resident fall interventions are in place. Restorative Nurse to audit the event reports and risk managements for falls, for the last 6 months, to ensure that every fall intervention is in place. If the fall intervention is no longer appropriate the care plan will be updated. **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 10 random residents, who have had past falls, 3 times weekly to ensure that current fall interventions are in place for 4 months. Director of Nursing/designee will	

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	11:45 a.m., indicated the bolster overlay for the air mattress was in the laundry and had not been on the resident's bed. This Federal tag relates to Complaint IN00399021. 3.1-45(a)(2)		present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 7.17.23**	
F 0694 SS=D Bldg. 00	483.25(h) Parenteral/IV Fluids § 483.25(h) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident's goals and preferences. Based on observation, record review, and interview, the facility failed to ensure PICC (peripherally inserted central catheter) line bandages were changed one time a week and there were Physician's Orders for the care and monitoring of PICC lines for 3 of 3 residents reviewed for PICC lines. (Residents K, E, and L) Findings include: 1. On 6/26/23 at 1:22 p.m., Resident K was observed in bed. At that time, she was noted with a PICC line in her right upper arm. The date on the bandage was 6/26/23. The record for Resident K was reviewed on 6/26/23 at 1:30 p.m. The resident was admitted to	F 0694	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **F694 Parenteral/IV Fluids** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;**	07/17/2023

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	the facility on 6/10/23 from the hospital. Diagnoses included, but were not limited to, dementia with anxiety, urinary tract infection, sepsis, stroke, chronic kidney disease, high blood pressure, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident was not cognitively intact and had received antibiotic therapy while and while not a resident. There was no Care Plan for the IV (intravenous) antibiotic therapy or for the care of the PICC line. A Nurses' Note, dated 6/10/23 at 11:19 p.m., indicated the resident was admitted to the facility at 7:35 p.m. The resident had a single lumen PICC line to the right upper extremity. Physician's Orders, dated 6/26/23, indicated change transparent dressing to Midline/PICC line weekly and measure the circumference of the arm and the length of the exposed catheter every 7 days and as needed. There were no orders to change the PICC line bandage prior to 6/26/23. Interview with the Nurse Consultant on 6/28/23 at 1:50 p.m., indicated there were no orders for the PICC line bandage to be changed prior to 6/26/23. 2. During an interview on 6/26/23 at 1:15 p.m., Resident E indicated she had not had a PICC line since she was last in the hospital. The record for Resident E was reviewed on 6/26/23 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, kidney stones, urinary tract infection, type 2 diabetes, major		Residents K, E, L were immediately assessed and noted with no adverse reactions related to not having MD orders and care plans for PICC line dressings. Resident K and L did not have any adverse effects related to not having a care plan for the IV antibiotics. **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 PICC Lines and IV antibiotics 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 ensuring that all residents who have PICC lines have orders to change the dressing weekly and care plans for PICC lines and IV antibiotics. **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/observe all residents who have PICC lines weekly to ensure that they have orders to change the dressing and	

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	depressive disorder, high blood pressure, and anxiety. The resident was admitted to the hospital on 3/12/23 and returned on 3/22/23, and then again had a hospital admission on 5/8/23 and returned to the facility on 5/11/23. The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident was cognitively intact. A Nurses' Note, dated 3/22/23 at 11:39 p.m., indicated at 7:30 p.m., the resident arrived back to the facility. The resident had a urinary tract infection, had kidney stones extracted with laser lithotripsy, and bilateral stents placed in the ureters. The resident had a PICC line and was to receive intravenous antibiotic therapy. A Nurses' Note, dated 3/23/23 at 6:25 a.m., indicated the resident had a right single lumen PICC line that was patent with a positive blood return. There were no Physician's Orders for the care of the PICC line as well as saline flushes and bandage changes. There was no Care Plan for the PICC line. There was no documentation in the record of when the PICC line was removed. Interview with Nurse Consultant on 6/28/23 at 1:45 p.m., indicated there were no orders for the PICC line or documentation when it was discontinued. 3. On 6/26/23 at 2:21 p.m., Resident L was observed in bed with her eyes closed. At that time, the resident was noted to have a PICC line in		that the dressing has been changed, and that those care plans are in place for 4 months. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 7.17.23**	

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	her right upper arm. The date on the bandage was 6/26/23. On 6/27/23 at 9:16 a.m., the resident was awake watching television. The bandage on her PICC line was clean and dated 6/26/23. The record for Resident L was reviewed on 6/26/23 at 9:21 a.m. Diagnoses included, but were not limited to, high blood pressure, peripheral vascular disease, and diabetes mellitus. The Admission Minimum Data Set (MDS) assessment, dated 6/18/23. indicated the resident was moderately impaired for decision making. A Physician's Progress Note, dated 6/13/23 at 4:22 p.m., indicated the resident was admitted with a right arm PICC line. There were no orders to change the PICC line bandage prior to 6/26/23. There was no Care Plan for the IV (intravenous) antibiotic therapy or for the care of the PICC line. Interview with Nurse Consultant on 6/28/23 at 1:50 p.m., indicated there were no orders for the PICC line bandage change prior to 6/26/23. This Federal tag relates to Complaint IN00405569. 3.1-47(a)(2)			
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			

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	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 pain medication was administered as ordered by the Physician for 1 of 3 residents reviewed for fractures. (Resident N) Finding includes: The record for Resident N was reviewed on 6/28/23 at 10:16 a.m. Diagnoses included, but were not limited to, peg tube, major depressive disorder, anxiety, epilepsy, fractured ankle, and pulmonary edema. The 6/9/23 Annual Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making and did not have any pain during the assessment period. Nurses' Notes, dated 4/4/23 at 6:39 a.m., indicated the CNA on duty reported to the writer the resident had complaints of pain and was yelling out. The resident indicated her shoulder and right ankle hurt. There was a purple discoloration to the right inner ankle. An X-ray was obtained and indicated the resident had a fracture of the right ankle and she was sent to the hospital on 4/4/23 at 2:15 p.m. The resident returned back to the facility on 4/4/23 at 10:27 p.m. with a post mold cast to the right ankle. Physician's Orders, dated 4/4/23, indicated Tylenol 325 milligrams (mg) 2 tablets every 6 hours for pain. The Medication Administration Record for 4/2023, indicated the medication was not signed out as	F 0697	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **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 N. Pain care plan was initiated for Resident N. **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 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	07/17/2023

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	being administered at 12 a.m. on 4/27-4/30/23, at 6 .a.m. on 4/24, and 4/27-4/30/23, at 12 p.m. on 4/7, 4/14, and 4/24-4/29/23, and at 6 p.m. on 4/21, 4/24, and 4/26-4/29/23. There was no Care Plan for pain. Interview with the Nurse Consultant on 6/28/23 at 3:30 p.m., indicated the pain medication was not signed out as being administered. 3.1-37(a)		administering medications, to include pain 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, for 4 months, with a focus on pain medication, to ensure pain medications are provided as per orders. Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 7.17.23**	
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-			

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	§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 manage medications appropriately related to administering insulin, antibiotics and antihypertensive (blood pressure) medications as ordered for 2 of 3 residents reviewed for unnecessary medications. (Residents K and E) Findings include: 1. The record for Resident K was reviewed on 6/26/23 at 1:30 p.m. The resident was admitted to the facility on 6/10/23 from the hospital. Diagnoses included, but were not limited to, dementia with anxiety, urinary tract infection, sepsis, stroke, chronic kidney disease, high blood pressure, and anemia. The Admission Minimum Data Set (MDS) assessment, dated 6/16/23, indicated the resident was not cognitively intact and had received antibiotic therapy while and while not a resident.	F 0757	Submission of this Plan of Correction by Dyer Nursing and Rehabilitation Center is not a legal 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. The facility respectfully requests a paper compliance for the alleged citation. **F 757 Unnecessary Medications Plan of Correction** **<u>What</u> corrective action will be accomplished for those**	07/17/2023

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	Physician's Orders, dated 6/10/23 and discontinued on 6/13/23, indicated Piperacillin Sod-Tazobactam (Zosyn) (an antibiotic medication) 4-0.5 gram (gm). Use 4.5 gram intravenously every 8 hours for wound infection until 7/12/23 for 29 days. Physician's Orders, dated 6/13/23, indicated Piperacillin Sod-Tazobactam Intravenous Solution Reconstituted 4-0.5 gm. Use 4.5 gram intravenously every 8 hours for wound infection until 7/12/23 for 29 days. Physician's Orders, dated 6/11/23, indicated Amlodipine Besylate oral tablet 5 milligrams (mg), give 1 tablet by mouth one time a day for high blood pressure and hold if systolic blood pressure was less than 130. A Nurses' Note, dated 6/11/23 at 6:16 a.m., indicated the Piperacillin Sod-Tazobactam IV antibiotic was not available at that time. The Medication Administration Record (MAR) for the month of 6/2023, indicated the Piperacillin antibiotic was to be administered at 12 a.m., 8 a.m., and 4 p.m. The antibiotic was not administered and blank on the MAR on 6/11 at 8 a.m. and 6/12 at 4 p.m. The antibiotic was coded with a 9 (see nursing progress notes) on 6/11 at 12 a.m. and 4 p.m. The 6/2023 MAR, indicated the Amlodipine 5 mg was administered at 9:00 a.m. on the following days when the blood pressure was outside the parameters: - 6/12 with a blood pressure of 116/64 - 6/15 with a blood pressure of 114/60 - 6/17 with a blood pressure of 114/70 - 6/18 with a blood pressure of 110/60		**residents found to have been affected by the deficient practice?** Resident K and E did not suffer any adverse effects related to the documentation not being completed for insulin and antibiotic administration. Resident K's BP was assessed and no adverse effects related to Licensed Nurse administering BP medications outside of the Medication parameters. MD notified and BP medication parameters adjusted. **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 insulin, and antibiotic orders as well as BP medication parameters 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 facility Medication Administration policy, specifically on administering insulin and	

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	- 6/19 with a blood pressure of 107/64 - 6/20 with a blood pressure of 114/73 - 6/21 with a blood pressure of 106/59, - 6/23 with a blood pressure of 116/62 - 6/24 with a blood pressure of 120/70 Interview with the Nurse Consultant on 6/28/23 at 1:50 p.m., indicated the antibiotic should have been administered as per Physician's Orders and the Amlodipine should have been held as per the blood pressure parameters. 2. During an interview on 6/26/23 at 1:15 p.m., Resident E indicated she has not had a PICC line since she was last in the hospital. The record for Resident E was reviewed on 6/26/23 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, kidney stones, urinary tract infection, type 2 diabetes, major depressive disorder, high blood pressure, and anxiety. The resident was admitted to the hospital on 3/12/23 and returned on 3/22/23, and then again had a hospital admission on 5/8/23 and returned to the facility on 5/11/23. The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident was cognitively intact. A Nurses' Note, dated 3/22/23 at 11:39 p.m., indicated at 7:30 p.m., the resident arrived back to the facility. The resident had a urinary tract infection, had kidney stones extracted with laser lithotripsy, and bilateral stents placed in the ureters. The resident had a picc line and was to receive intravenous antibiotic therapy.		antibiotics as ordered and signing the EMAR immediately post administration. This documentation includes the documentation of what the blood sugar was and how many units of insulin were administered. Staff also educated regarding following all Medication parameters, including BP medications. **How the corrective actions will be monitored to ensure that the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** DON/designee will audit twice weekly, all insulin and antibiotic administration, to ensure administration has occurred per facility policy for 4 months to ensure compliance. DON/Designee will audit, twice weekly, all residents with BP medication parameters to ensure medication is administered per MD order for 4 months. The Director of Nursing/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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	06/28/2023

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	A Nurses' Note, dated 3/23/23 at 6:25 a.m., indicated the resident had a right single lumen PICC line that was patent with a positive blood return. There was no Care Plan for the PICC line or antibiotic therapy. Physician's Orders, dated 3/23/23, indicated Cefepime (antibiotic) 1 gram (gm) in 0.9 normal saline into the vein every 12 hrs for 18 doses until April 1, 2023. The 3/2023 Medication Administration Record (MAR) indicated the antibiotic was not signed out as being administered at 9 a.m. on 3/28/23. Physician's Orders dated 3/23/23, indicated Lantus Insulin, give 20 units at bedtime and was to be administered at 8 p.m. The 3/2023 MAR indicated the Lantus was not signed as being administered on 3/26, 3/27, 3/29, and 3/30/23. The 4/2023 MAR indicated the Lantus was not signed as being administered on 4/4, 4/5, 4/13, 4/19, and 4/25/23. A Physician's Order, dated 3/23/23, indicated Insulin Lispro to be administer per sliding scale: If Blood Sugar was less than 70, call MD. If Blood Sugar was 71 to 180, give 0 Units. If Blood Sugar was 181 to 230, give 1 Unit. If Blood Sugar was 231 to 280, give 2 Units. If Blood Sugar was 281 to 330, give 3 Units. If Blood Sugar was 331 to 350, give 4 Units. If Blood Sugar was greater than 350, give 4 Units and call the Physician. The insulin was to be administered at 7 a.m., 11		**Date by which systemic corrections will be completed: 7.17.23**	

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	a.m., 4 p.m. and 8 p.m. The 3/2023 MAR indicated the insulin Lispro was not signed as being administered on the following days: 7 a.m. on 3/30/23 11 a.m. on 3/28/23 8 p.m. on 3/29/23 The blood sugar was documented on the following days, however, the amount of the insulin Lispro administered was blank and not recorded: 11 a.m. on 3/24-3/28/23 4 p.m. on 3/24-3/27, 3/29 and 3/31/23 The 4/2023 MAR indicated the insulin Lispro was not signed out as being administered on the following days: 7 a.m. on 4/10 and 4/20/23 4 p.m. on 4/5, 4/13, 4/19, and 4/20/23 8 p.m. on 4/4, 4/13 and 4/19/23 The blood sugar was documented on the following days, however, the amount of the insulin Lispro administered was blank and not recorded: 4 p.m., on 4/1, 4/2, 4/7, 4/8, 4/11, 4/14, 4/15, and 4/16/23 8 p.m., on 4/1, 4/2, 4/3, 4/11, and 4/25/23 The 5/2023 MAR indicated the blood sugar was documented on the following days, however, the amount of the insulin Lispro administered was blank and not recorded: 11 a.m. on 5/1, 5/3, 5/4, and 5/5/23. 4 p.m. on 5/5/23 The 6/2023 MAR indicated the insulin Lispro was not signed as being administered on the following			

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	days: 11 a.m. on 6/4/23 4 p.m., on 6/17/23 Interview with the Nurse Consultant on 6/28/23 at 1:45 p.m., indicated Lantus and Lispro insulins and the antibiotic were not administered as ordered by the Physician. This Federal tag relates to Complaint IN00405569. 3.1-48(a)3)			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-			

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	(i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed			

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	professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on record review and interview, the facility failed to ensure the resident's clinical record was complete related to meal consumption records for 3 of 3 residents reviewed for nutrition. (Residents B, C, and E) Findings include: 1. The record for Resident B was reviewed on 6/27/23 at 11:05 a.m. Diagnoses included, but were not limited to, stroke, fracture of right femur, dysphagia, heart failure, high blood pressure, pain, arthritis, atrial fibrillation, major depressive disorder and anemia. The 5/11/23 Quarterly Minimum Data Set (MDS) assessment indicated the resident was moderately impaired for decision making. The resident needed supervision with set up help for eating and had no history of weight loss. A Care Plan, dated 6/13/23, indicate the resident required assistance with activities of daily living including eating. The approaches were to assist with meal consumption, eating, and drinking as needed. The meal consumption logs indicated the breakfast meal was not documented on 6/20 and 6/24/23. The lunch meal was not documented on 6/17 and 6/20/23 and the dinner meal was not documented on 6/4, 6/9, 6/12, 6/14, 6/15, 6/17, 6/18, 6/19, 6/20, 6/21, 6/23, and 6/24/23. Interview with the Nurse Consultant on 6/28/23 at 11:45 a.m. indicated staff were to document the intake of every meal.	F 0842	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **F 842- Resident Records- Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Residents B, C, E were assessed and no substantial findings noted. **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**	07/17/2023

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	2. The closed record for Resident C was reviewed on 6/27/23 at 2:10 p.m. The resident was admitted to the facility on 1/9/23 and discharged on 2/23/23. Diagnoses included, but were not limited to, acute osteomyelitis of the right ankle and foot, type 2 diabetes mellitus, high blood pressure, dementia, and obesity. The Admission Minimum Data Set (MDS) assessment, dated 1/15/23, indicated the resident was not cognitively intact. The resident needed supervision with 1 person assist for eating and had significant weight loss. A Care Plan, dated 1/10/23, indicated the resident was limited in functional status in regards to eating and drinking independently. The approaches were to assist as needed and encourage intake of food and fluids. The meal consumption logs indicated the breakfast meal was not documented on 1/15, 2/5, and 2/20/23. The lunch meal was not documented on 1/15, 2/5, and 2/20/23 and the dinner meal was not documented on 2/5 and 2/20/23. Interview with the Nurse Consultant on 6/28/23 at 11:45 a.m.. indicated staff were to document the intake of every meal. 3. The record for Resident E was reviewed on 6/26/23 at 2:20 p.m. Diagnoses included, but were not limited to, stroke, dysphagia, kidney stones, urinary tract infection, type 2 diabetes, major depressive disorder, high blood pressure, and anxiety. The Quarterly Minimum Data Set (MDS) assessment, dated 5/26/23, indicated the resident		**ensure that the deficient practice does not recur;** Clinical Staff re-educated about the need to document meal intakes for every meal. **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 to run lookback report, in PCC, 3 times weekly for 4 months to ensure that all resident meal consumptions have been documented. If staff did not document the meal consumption, DON/Designee to follow up with staff to ensure that the information gets inputted into the resident medical record. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 7.17.23**	

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	was cognitively intact. The resident had no oral problems and weighed 113 pounds. The resident needed supervision with set up help for eating. A Care Plan, dated 5/18/23, indicated the resident was at risk for impaired nutritional status. The approaches were to provide assistance with meal intake as needed. The meal consumption logs indicated the breakfast meal was not documented on 6/20 and 6/21/23. The lunch meal was not documented on 6/20 and 6/21/23, and the dinner meal was not documented on 5/28, 5/29, 5/31, 6/2, 6/3, 6/6-6/8, 6/11, 6/12, 6/14, 6/15, and 6/18/23. Interview with the Nurse Consultant on 6/28/23 at 11:45 a.m.. indicated staff were to document the intake of every meal. The current 9/1/20, "Nutritional Monitoring" policy, provided by the Nurse Consultant on 6/28/23 at 2:00 p.m., indicated to record the food intake with an overall percentage consumed by the end of each meal. This Federal tag relates to Complaint IN00404721. 3.1-50(a)(1)			
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 random observation and interview, the facility failed to keep the resident's environment clean and in good repair related to urine odors, dirty and sticky floors, marred walls and door	F 0921	Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	07/17/2023

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	frames, and broken closet doors for 2 of 2 units. (The East and West units) Findings include: 1. During random observations on the East Unit, the following was observed: a. On 6/26/23 at 1:15 p.m.., there was a strong urine odor on the entire East Unit. The hallway floors were stained and dirty. b. On 6/27/23 at 9:15 a.m., there was a strong urine odor down the hallway where rooms 119-124 were located. There was also a strong urine odor in the small dining room. The ceiling vent in that hallway was dusty and dirty. The floors on the entire unit were stained and dirty. c. On 6/27/23 at 10:30 a.m., room 124 was observed with the closet door marred and door knob broken. The walls were marred and gouged as well as the door frames. There were crumbs of dirt and debris observed in between the bed frame and box springs. The floor in the room was dirty and stained. There were 2 residents residing in the room. d. On 6/27/23 at 10:45 a.m., room 123 was observed with dirty and stained floors. The walls and door frames were marred. There were 2 residents in the room. Interview with the Administrator on 6/28/23 at 3:30 p.m., indicated she was aware the floors were stained, their scrubber has been broken and they were trying to get it fixed. 2. During random observations on the West Unit the following was observed:		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The facility respectfully requests a paper compliance for the alleged citation. **F921** **Safe/Functional/Sanitary/Comfortable Environment** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Floors were cleaned in resident rooms Urine odors extinguished Hallways were cleaned and urine odor extinguished Marred door frames and walls repaired Closet door off track repaired **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 re-educated on the procedure of notifying maintenance/environmental	

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	a. On 6/26/23 at 8:35 a.m., there was strong urine odor throughout the entire West Unit. The hallway floors were sticky, stained, and dirty throughout the entire unit. b. On 6/26/23 at 1:48 p.m., room 169 was observed with crumbs and trash on the floor and under the bed. The floor had a large stain in front of the bed. The floor was sticky and the room had a strong urine odor. There were 2 residents who resided in the room. c. On 6/26/23 at 1:28 p.m., room 164 was observed and the closet doors were not on the track and were leaning against the closet. Interview with the Administrator on 6/28/23 at 3:30 p.m., indicated their scrubber had been broken and they were trying to have it replaced under warranty but are having some difficulty. She Indicated they were looking into renting a scrubber. This Federal tag relates to Complaint IN00405373. 3.1-19(f)		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 for 4 months. Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed:** **7.17.23**	