DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-039

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	07/26/2023

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 Complaint IN00412775. Complaint IN00412775 - Federal/state deficiencies related to the allegations are cited at F580, F684, F689, and F692. Survey dates: July 25 & 26, 2023 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 112 Residential: 39 Total: 151 Census Payor Type: Medicare: 13 Medicaid: 85 Other: 14 Total: 112 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 7/31/23.	F 0000	The facility kindly asks for a desk review.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s)			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Trina Dean	Regional VP of Clinical	08/15/2023

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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	when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical			

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	configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).			
	Based on record review and interview, the facility failed to notify a resident's Responsible Party and Physician of a change in condition related to refusals of medications, decreased dietary and fluid intake, and weight changes, for 2 of 4 residents reviewed for notification of change. (Residents B and D) Findings include: 1. Resident B's record was reviewed on 7/25/23 at 9:41 a.m. The diagnoses included, but were not limited to, seizures, diabetes, dementia, and Alzheimer's disease. The Physician's Medication Orders included the following medications: Amlodipine (calcium channel blocker) 10 mg (milligrams) daily at 9 a.m. Aspirin 81 mg daily at 9 a.m. Lactobacillus (supplement), 1 tablet daily at 9 a.m. Levothyroxin (hypothyroid) 112 micrograms daily at 9 a.m. Rivastigmine Transdermal Patch (dementia) apply daily at 9 a.m. after removal of previous days patch Vitamin D3 (supplement), 125 micrograms daily at 9 a.m. Vortioxetine (antidepressant), 20 mg daily at 9 a.m. Bisacodyl (laxative), 5 mg twice a day at 9 a.m. and 9 p.m. Hydralazine (hypertension), 50 mg twice a day at 9 a.m. and 9 p.m. Lacosamide (anticonvulsant), 50 mg twice a day at 9 a.m. and 9 p.m.	F 0580	**Dyer Nursing and Rehab COMPLAINT SURVEY: 07/26/23** 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 paper compliance for this survey. **F580 Notify of changes (Injuries/Decline/Room, Etc.)** **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's family/physician notified of the weight loss. **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**	08/08/2023

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	Levetiracetam (anticonvulsant), 7.5 milliliters every 12 hours at 9 a.m. and 9 p.m. Memantine (dementia), 10 mg twice a day at 9 a.m. and 5 p.m. Mirtazapine (antidepressant), 15 mg twice a day at 9 a.m. and 9 p.m. Carbidopa-Levodopa (Parkinson's disease) 25-100 mg four times a day at 9 a.m., 1 p.m., 5 p.m., and 9 p.m. The Medication Administration Record (MAR), dated 7/2023 indicated the amlodipine, aspirin, lactobacillus, levothyroxin, vitamin D3, vortioxetine, bisacodyl, hydralazine, lacosamide, levetiracetam, memantine, mirtazapine, and carbidopa-levodopa at 9 a.m. had not been given and were marked as refused on July 4, 6, and 8, 2023. The rivastigmine patch had not been given at 9 a.m. on July 7 and 8, 2023 and was marked as refused. The carbidopa-levodopa, had not been given at 9 a.m. and 1 p.m. on July 4, 7, and 8, 2023 and was marked as refused. The Physician and the Responsible Party had not been notified the medication had not been administered as ordered. During an interview on 7/25/23 at 1:55 p.m., the RN Consultant, indicated she would look for information the Responsible Party and Physician was notified of the medications not given. The resident was admitted into the facility on 6/5/23. A Nutritional Care Plan, dated 6/15/23, indicated		**place or what systemic changes will be made to ensure that the deficient practice does not recur:** Nurses were in-serviced on timely physician and family notification when a resident refuses medication, when there is a weight loss/discrepancy and when there is a decrease in food/fluid intake. **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 2 times weekly, for 4 months, to ensure the timely notification to physicians and families related to the change in residents' food/fluid intake, significant weight changes and medication refusals. 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. **Date by which systemic corrections will be completed: 08/08/2023**	

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the Physician and Family would be notified of significant weight changes.

The Hospital Transfer Papers, dated 6/5/23, indicated the residents weight was 180 pounds.

The Facility Clinical Admission Assessment, dated 6/5/23 at 1:37 p.m., lacked documentation of a weight obtained on admission.

The weight form in the record, dated 6/7/23 at 11:20 a.m., indicated the weight was 180 pounds.

A Hospital return Admission Clinical Assessment, dated 6/10/23 at 6:32 p.m., indicated the weight was obtained by a mechanical lift on 6/7/23 at 11:29 a.m. and was 180 pounds.

The Hospital Transfer Form, dated 6/10/23, indicated the weight was 163 pounds.

The resident was weighed at the facility on 6/20/23 and was 138 pounds and a second charting indicated 178.8 pounds.

On 6/26/23, the weight from 6/7/23 and the 178.8 pounds from 6/20/23 were crossed out and was coded as, "technical error". The weight of 138 pounds remained active.

The Physician and Responsible party had not been notified of the weight loss/discrepancy.

During an interview on 7/25/23 at 1:55 p.m., the RN Consultant indicated an admission weight had not been completed and the documented weight was from the Hospital. The first facility weight was on 6/20/23 and it was 138. The policy had had not been followed.

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A Registered Dietician's Progress Note, dated 7/6/23 at 1:27 p.m., indicated estimated nutritional needs were 1575-1750 calories and 1575-1750 milliliters of fluids per day.

The nutritional intakes from July 1 through July 8, 2023 were:
On 7/1/23, breakfast 25-50%, lunch 25-50%, and supper 51-75%.
On 7/2/23, breakfast 0-25%, lunch 75-100%, and supper was refused.
On 7/3/23, all meals were refused.
On 7/4/23, breakfast 75-100%, lunch 0-25%, and supper 50-75%.
On 7/5/23, breakfast 25-50%, lunch 25-50%, and supper 75-100%.
On 7/6/23, all meals were 0-25%.
On 7/7/23, breakfast was refused, no lunch intake, and supper was 25-50%.
On 7/8/23, breakfast and lunch was 0-25% and there was no intake marked for supper.

The fluid intakes from July 1 through July 8, 2023 were:
On 7/1/23 - 720 milliliters (ml).
On 7/2/23 - 480 ml.
On 7/3/34 - no fluid intake
On 7/4/23 - 1060 ml.
On 7/5/23 - 830 ml.
On 7/6/23 - 360 ml.
On 7/7/23 - 120 ml.
On 7/8/23 - 480 ml.

The Nurse Practitioner had been notified of the decrease in oral intake on 6/21/23. There was documentation that indicated the Responsible Party had not been notified of the decrease and refusals of food and fluid intakes.

During an interview with a Responsible Family

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	Member on 7/26/23, they indicated they had not been notified of a weight discrepancy or weight loss. They had not been notified of her decline in diet and fluid intakes, nor had they been notified of the refusals of the medications. They indicated they spoke to the Director of Nursing on July 5, 2023 about their concerns about her weight, but the facility had not contacted them. 2. Resident D's record was reviewed on 7/25/23 at 4:23 p.m. The diagnoses included, but were not limited to, vascular dementia. A Nutritional Care Plan, dated 07/13/2023, indicated the family and the Physician would be notified of significant weight changes. A Registered Dietician's Progress Note, dated 7/13/23 at 8:08 p.m., indicated a weight on 7/12/23 of 130 pounds, a weight on 4/5/23 was 154.2 pounds, and on 1/4/23 was 146 pounds. There was a 15.7% weight loss in the past 90 days and a 11.8% weight loss in the past 180 days. There was no documentation that indicated the family and Physician had been notified of the significant weight loss. During an interview on 7/26/23 at 11:51 a.m., the Administrator indicated all Dietary recommendations and assessments were shown to the Nurse Practitioner weekly. The record had not indicated the family had been notified of the weight loss. A Weight Management policy, received from the Administrator as current and dated 3/21/21, indicated the Physician and the resident or Resident Representative would be notified of any significant unexpected and/or unplanned weight			

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	changes. The Nurse would document the notification in the medical record. A Medication Administration policy, dated 10/25/2014 and received by the RN Consultant as current, indicated medication refusals must be reported to the Physician and the notification was to be documented in the record. An undated Change of Condition policy, received as current on 7/26/23 at 11:46 a.m. from the RN Consultant, indicate the Physician and the Resident's Representative would be notified of a significant change in the resident's status or a need to alter treatment. This Federal tag relates to Complaint IN00412775. 3.1-5(a) 3.1-5(a)(2) 3.1-5(a)(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 record review and interview, the facility failed to ensure appropriate emergency care was provided, related to an emergency transfer (911) not obtained for an Emergency Room transfer for a resident with a significant change of condition, related to a low oxygen saturation and a decrease	F 0684	**Dyer Nursing and Rehab Survey: 07/26/2023** Please accept the following as the facility's credible allegation of compliance. This plan of correction does not constitute an	08/08/2023

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	in the level of consciousness. Thorough assessments had not been completed on the resident related to lung, abdomen, and neurological assessments prior to the transfer, for 1 of 3 residents reviewed for an Emergency Room transfer. (Resident B) Finding includes: Resident B's record was reviewed on 7/25/23 at 9:41 a.m. The diagnoses included, but were not limited to, seizures, diabetes, dementia, and Alzheimer's disease. A Nurse's Note, dated 7/8/23 at 7:58 p.m., indicated the resident had a change in condition. She was not eating and was holding medication in her mouth. Temperature was 97.5, blood pressure 146/73, pulse 57, and respirations were 18. The oxygen concentration was 67%. Oxygen was applied and the oxygen saturations increased to 83%. A rebreather mask was then applied and the oxygen level came up to 90%. The resident had a do not resuscitate order and the Power of Attorney (POA) was notified of the changes and asked if he would like her transferred to the hospital or have her remain at the facility. The POA made the decision to have her transferred to the hospital. The Nurse Practitioner was notified and an order to transfer the resident to the Emergency Room was received. The transport service arrived at 7:55 p.m. and transported the resident at 8:08 p.m. The Change of Condition Evaluation, dated 7/8/23 at 11:15 p.m., indicated the change in condition were decreased or unable to eat and/or drink adequate amounts and low oxygen saturation. The change of condition started on 7/8/23 in the afternoon. The symptoms had worsened and the		admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. The Facility respectfully requests paper compliance for this survey. **F684 Quality of Care** **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 **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 who have an emergency health deterioration should be transported to the hospital via 911. Staff were re-educated to perform frequent respiratory, neurological and abdominal assessments frequently after 911 is called, while staff waits for EMS to arrive. **How the corrective action(s)**	

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	oxygen level had dropped. The resident had respiratory distress as evidenced by a low oxygen level during the first encounter. She has had a poor appetite and is refusing food and medication. The mental changes were altered level of consciousness. A decreased level of consciousness, a sudden change in level or responsiveness. At 7:30 p.m., the oxygen saturation was 67%. The Clinician was notified on 7/8/23 at 7:30 p.m. and orders were obtained to send the resident to the Emergency Room. Respiratory changes was marked as other respiratory changes. An abdominal evaluation was completed due to the change, decreased appetite and fluid intake was checked. There were no other assessments of the lungs (shortness of breath, description of breathing, cough, or lung sounds). There were no other assessments of the abdomen (pain, distention, bowel sounds). There were no other neurological assessments (level of alertness, drowsy, unresponsive, difficult to arouse). The Change of Condition Evaluation, General Background Information, indicated the resident was administered oxygen per a nasal cannula and a rebreather mask which increased the oxygen level from 83 to 90%. The oxygen saturation was not re-evaluated after the 90% was reached. The Medical Transportation Record, dated 7/8/23, indicated dispatch was notified on 7/8/23 at 7:33 p.m., arrived at the facility at 7:58 p.m., left the facility at 8:18 p.m. and arrived at the hospital at		**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 weekly, for 4 months, who have had an emergency health deterioration, to ensure that 911 was called and frequent respiratory, neurological and abdominal assessments were performed. 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: 08/08/2023**	

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8:26 p.m. The chief complaint was listed as altered consciousness, normal respirations. Blood pressure at 8:01 p.m. was 90/46, strong and regular pulse, respirations were 40 and regular, and the oxygen saturation level was 84%. The lung sounds were normal and clear. When they entered the room, the resident was on a non-rebreather that was not inflated (should hold one third of exhaled air to assist in rebreathing carbon dioxide to stimulate breathing). The oxygen saturation was 84% on 10 liters of oxygen and the breathing was shallow. An ambu bag was used at 15 liters of oxygen and the oxygen saturation increased. The resident was then transferred to the Hospital Emergency Room.

The Hospital Emergency Triage Notes, indicated per the Medical Transportation Company, they were called for a altered mental status. When they arrived at the facility the resident was in respiratory distress and required the assistance of ambu breathing (delivers positive pressure ventilation). The pulse was weak and she was responsive to pain.

The Emergency Room oxygen saturation was 98%. The Physician indicated the resident was in acute distress, had and ill appearance, the mucous membranes were dry, the eyes were fixed and dilated, tachycardia was present. The respirations were shallow with a rate of 10. The clinical impression included acute respiratory failure with hypoxia, acute renal failure, and severe sepsis. The resident was intubated.

The Medical Transport Company was interviewed on 7/25/23 at 2:18 p.m. They indicated the call for transport came in at 7:30 p.m. on 7/8/23 and they arrived at 7:56 p.m. The facility called it in as an emergency, however, they are not a 911/quick

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response company. They are a request for transport, not a 911 service for emergencies.

The resident's Spouse was interviewed on 7/26/23 at 9:29 a.m. and indicated he received the phone call about 7:30 p.m. on 7/8/23 and when he arrived at the facility the ambulance had not arrived yet. The resident had an oxygen mask on. She was not responsive. When the transport company arrived, they were upset that 911 had not been notified instead of them. They quickly checked her breathing and said it was labored and shallow and that she was in distress.

Nurse 1 was interviewed on 7/26/23 at 9:39 a.m., she indicated she arrived at work at 7 p.m. and was told by staff the resident was not doing well, had not been eating and had been declining for a week. She indicated 911 dispatch had not been notified as the resident was stable and responding. She does not remember checking breath sounds. She indicated when she gave the transport company the papers, she was told by them that 911 should have been contacted not them.

CNA 2 was interviewed on 7/26/23 at 12:10 p.m. and indicated the resident had not been eating well for over a month and she would not take her medications. That evening, she had reported the change of condition to the Nurse and she went in to assess her and had no concerns. After supper the resident, "looked bad", the Nurse went in to check on her. She had a do not resuscitate order so the Nurse called the Spouse to find out what he wanted and he wanted her sent to the Emergency Room. The resident was not in distress. There was no struggle to breathe. She was not gasping for air. The "EMT" (Emergency Medicine Tech) arrived and stated the resident

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	was in distress and 911 should have been notified. This Federal tag relates to Complaint IN00412775. 3.1-37			
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 assistive devices were utilized as documented to prevent injury from falls, for 1 of 3 residents reviewed for accidents. (Resident E) Finding includes: Resident E was observed on 7/25/23 at 12:26 p.m., lying in his bed. An extra mattress was leaning against the wall opposite the head of the bed. At 12:29 p.m., CNA 3 entered the room and provided incontinent care. She then left the room. The extra mattress remained leaning against the wall. On 7/25/23 at 5:06 p.m., the resident was lying in bed on his right side. The extra mattress remained leaning against the wall. Resident E's record was reviewed on 7/25/23 at 5:10 p.m. The diagnoses included, but were not limited to, stroke.	F 0689	**Dyer Nursing and Rehab Complaint Survey: 07/26/2023** 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 paper compliance for this survey. **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;** Floor mat was immediately put in	08/08/2023

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	An Admission Minimum Data Set assessment, dated 6/29/23, indicated a severely impaired cognitive status, required extensive assistance for transfer and toileting, his balance was not steady with staff assistance, and had no prior falls. A Care Plan, dated 6/28/23, indicated a risk for falls related to hypotension, poor balance, unsteady gait. The interventions included, interventions on the at-risk plan would be followed. A Fall Risk Evaluation, dated 6/24/23, indicated a high risk for falls. A Nurse's Progress Note, dated 7/20/23 at 11:26 p.m., indicated he was found on the floor in his room. There was a cut to the bridge of his nose and forehead. The Nurse Practitioner was notified and orders were received to send to the Emergency Room. A SBAR (situation-background assessment recommendation) form, dated 7/20/23, indicated the resident had bleeding due to a fall. There was a laceration present and the resident needed sutures. Orders were received to send the resident to the Emergency room. A new intervention order for a mat to be placed on the floor was received. The Administrator and RN Consultant were questioned about the mattress not in place on 7/26/23 at 11:09 a.m. No further information was received. This Federal tag relates to Complaint IN00412775. 3.1-45(a)(2)		place for Resident E. **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 at risk for falls 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 in-serviced on ensuring fall interventions are in place as ordered. **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;** The DON /designee will audit 5 residents, for 4 months, with fall interventions weekly, to include alternating shifts and weekends, to ensure fall interventions are in place as ordered. The DON /designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

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			Date of Completion: 08/08/2023	
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 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 residents maintained acceptable parameters of nutritional and hydration status related to decreased food and fluid consumption, significant weight loss, weight discrepancies, weights not obtained, supplement intake not documented, and assessments not completed for a resident with decreased food and fluid intakes (Resident B). They also failed to ensure supplements as ordered were provided to a resident with a significant	F 0692	**Dyer Nursing and Rehab Complaint Survey: 07/26/2023** 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	08/08/2023

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	weight loss. (Resident D). Findings include: 1. Resident B's record was reviewed on 7/25/23 at 9:41 a.m. The diagnoses included, but were not limited to, seizures, diabetes, dementia, and Alzheimer's disease. The admission date was 6/5/23. An Admission Minimum Data Set (MDS) assessment, dated 6/14/23 indicated a severely impaired cognitive status, required extensive to total care with activities of daily living, extensive assistance with eating, a weight of 180 pounds, had no significant weight gain or loss, and was on a mechanical soft diet. A Nutrition Care Plan, dated 6/15/23, indicated she was at risk for an impaired nutritional status. the interventions included, the Physician and family would be notified of significant weight changes, meal assistance would be provided as needed, diet and supplements would be provided as ordered, and the Registered Dietician (RD) would evaluate and make diet change recommendations as needed. The Hospital Transfer Papers, dated 6/5/23, indicated the residents weight was 180 pounds. The Facility Clinical Admission Assessment, dated 6/5/23 at 1:37 p.m., lacked documentation of a weight obtained on admission. The Weight Record, dated 6/7/23 at 11:20 a.m. indicated the weight was 180 pounds. A Hospital stay occurred from 6/7/23 to 6/10/23. Upon return from the Hospital, the Admission		paper compliance for this survey. **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 D was assessed and no adverse effects were noted related to not receiving nutritional shakes on meal tray. **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;** Nursing staff were in-serviced on obtaining weights, at least within 24 hours of admission and weekly thereafter for 4 weeks. If there is a 3 pound or greater change from the previous weight, that a reweight is taken immediately. Dietary staff was in-serviced to ensure all food items, including health shakes, are on the resident's meal trays according to	

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	Clinical Assessment, dated 6/10/23 at 6:32 p.m., indicated a weight had been obtained on 6/7/23 at 11:29 a.m.. A mechanical lift was used and the weight obtained was 180 pounds. The Hospital Transfer Form, dated 6/10/23, indicated the weight was 163 pounds. The Weight Record indicated the resident was not weighed at the facility until 6/20/23 at 10:51 a.m. and the weight was 138 pounds. Another entry for 6/20/23 at 10:51 a.m. indicated the weight was 178.8 pounds. The weight on 6/26/23 at 2:09 p.m. was 139.8. The weights of 180 pounds on 6/7/23 and 178.8 pounds on 6/20/23 had a line drawn through them on 6/26/23 at 2:08 p.m. and documented "Technical Error". The weight obtained on 7/3/23 at 9:32 a.m. was 138.8. During an interview on 7/23/23 at 1:55 p.m., the RN Consultant, indicated an admission weight had not been obtained and the weight on 6/7/23 was taken from the Hospital transfer papers and not obtained at the facility. She did not think the weight of 180 pounds was correct at the hospital. The facility should have caught the weight discrepancies and obtained a weight and/or reweight. The weight should have been obtained in the first 24 hours after admission. The policy had not been followed. The Hospital paper she had was from the admission at the hospital, dated 6/7/23 and the weight was 161. She thought the weight on 6/20/23 was incorrect also. There were no weekly weights to compare. She had interviewed the Assistant Director of Nursing, who indicated she had been subtracting the 20-21		the meal ticket. Nursing staff was in-serviced to ensure all items are on the meal tray, including health shakes, prior to delivering the tray to the resident. **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 new admission weights, weekly weights, and monthly weights weekly, for 4 months, to include alternating shifts and weekends, to ensure weights and re-weights are obtained, documented in the medical record and that responsible party/MD have been notified of significant weight changes. Administrator/Designee will randomly observe 10 meal trays weekly, for 4 months, to include alternating shifts and weekends, to ensure that all meal items, including health shakes, are present on the meal tray prior to tray being delivered to the resident. 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	

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	pounds of the wheelchair the resident had sat in when weighed and had not realized the CNA who had weighed the resident had already subtracted the weight of the chair. No one had questioned the weight loss and the facility was unsure how much the resident actually weighed and if there was a weight loss. The Weight Management policy, dated 3/21/21, and received from the Administrator as current, indicated residents would be weighed upon admission or within 24 hours of the admission and then at least weekly for four weeks. A re-weight would be obtained for any weight changes of three pounds from the previous weight. The re-weights would be obtained immediately and would be visualized by a license nurse. The RD was unable to assess the resident on 6/8/23 due to admission into the Hospital. On 6/15/23 at 10:56 a.m., the RD Progress Note indicated a puree diet was ordered with a 4 ounce house shake twice a day. The estimated calorie needs were 1725 calories per day and fluid needs were 1725 milliliters (ml). Remeron (antidepressant) was ordered to assist with appetite stimulation and house shakes were added for nutritional support. A Physician's Order, dated 6/11/23, indicated a regular puree diet with 4 ounces health shake with meals. A RD's Progress Note, dated 7/6/23 at 1:27 p.m., indicated it was a weight clarification note. A puree diet was ordered with 4 ounces of house shake to be given twice a day (order for three times a day with meals). The weight on 7/3/23 was 138.8 and on 6/26/23 was 138. The body mass		quarterly at the QA meeting. Monitoring will be on going. **Date by which systemic corrections will be completed: 08/08/2023**	

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index was in normal limits at 23.8. The estimated nutritional needs were 1575 to 1750 calories and 1575 to 1750 ml's of fluid daily. The hospital weights were 158 and 160 pounds and the resident's weighs were stable since she returned to the facility. The Spouse was in the hallway and voiced concern about the weight and intake. Discussed increasing the 4 ounce house shake supplement to three times a day and continue to do weekly weights.

The nutritional intakes from July 1 through July 8, 2023 were:
On 7/1/23, breakfast 25-50%, lunch 25-50%, and supper 51-75%.
On 7/2/23, breakfast 0-25%, lunch 75-100%, and supper was refused.
On 7/3/23, all meals were refused.
On 7/4/23, breakfast 75-100%, lunch 0-25%, and supper 50-75%.
On 7/5/23, breakfast 25-50%, lunch 25-50%, and supper 75-100%.
On 7/6/23, all meals were 0-25%.
On 7/7/23, breakfast was refused, no lunch intake, and supper was 25-50%.
On 7/8/23, breakfast and lunch was 0-25% and there was no intake marked for supper.

There was no documentation of the percent of intake of the 4 ounces of the house shakes received with her meals.

The fluid intakes from July 1 through July 8, 2023 were:
On 7/1/23 - 720 milliliters (ml).
On 7/2/23 - 480 ml.
On 7/3/34 - no fluid intake
On 7/4/23 - 1060 ml.
On 7/5/23 - 830 ml.
On 7/6/23 - 360 ml.

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On 7/7/23 - 120 ml.
On 7/8/23 - 480 ml.

There were no assessments with the decrease of food and fluid intake.

A Nurse's Progress Note, dated 7/8/23 at 7:58 p.m., indicated the resident had been having a poor appetite and had been refusing food and medication.

The Change of Condition Evaluation Form, dated 7/8/23 at 11:15 p.m., indicated the food and/or fluid intake had decreased or was unable to eat and/or drink adequate amounts and she has had a decrease in her food and fluid intake.

The resident was transferred to the Hospital Emergency Room (ER) on 7/8/23 due to decreased level of consciousness and low oxygen saturations. The Hospital Physician's Notes, indicated she was ill appearing and the mucous membranes were dry. The sodium level was 179 (136-144), potassium 5.9 (3.7-5.2), chloride 133 (96-106), protein 9 (6-8.3), creatinine 11.5 (0.8-1.2), BUN 264 (6-20) and the GFR (glomerular filtration rate - kidneys) was 3 (over 60).

The Hospitalist Admission Note, dated 7/8/23 at 8:28 p.m., indicated the admission diagnoses included severe protein calorie malnutrition, "...Patient has likely not been eating or drinking for the last 7 days..." and acute renal failure with severely abnormal creatinine and BUN. "...suspect acute tubular necrosis due to prolonged prerenal state from severe dehydration..."

A Confidential Family interview, indicated when the resident was visited, either there was no meal tray in the room or the tray had been sitting

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untouched in the room and the staff would not come and assist her.

A Confidential Family interview, indicated they had a meeting with the Director of Nursing DON) on 7/5/23 after she had face-timed with the resident and observed the resident's face as having a sunken in appearance. She appeared to have lost a lot of weight in her face. The DON had informed them that nothing had "flagged" with her weight and the resident was eating. She had informed them the BMI was in a good range. They were upset because the weight loss was caused by her not eating and was not a healthy loss.

A Confidential Family interview, indicated they had also met with the DON on 7/5/23 and discussed their concerns with the resident not eating. Weight loss was noticeable. The facility had not informed them she was not eating or drinking.

During an interview on 7/26/23 at 9:39 a.m., Nurse 1 indicated the resident had not been eating and had been declining for a week.

During an interview on 7/26/23 at 12:10 p.m., CNA 2 indicated the resident had not been eating well for over a month. They assisted her with the meals. She would clench her teeth and refuse to open her mouth and swallow.

2. Observations on 7/25/23 indicated:

At 9:12 a.m., Resident D was in bed with her eyes closed. There was an uncovered and untouched breakfast tray on the over the bed table, which included a box of lactaid free milk, lemonade, and a bowl of frosted flakes. The dietary card on the tray indicated a 4 ounce health shake and a glass

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of prune juice was to be served with all meals. Neither were on the tray. CNA 3 entered the room and encouraged the resident to wake up and eat the breakfast. She indicated the resident could feed herself.

At 12:50 p.m., the lunch tray was on the over the bed table and covered. Therapy was in the room. There was a box of lactaid free milk on the tray and glass of prune juice observed on the tray. No health shake was on the tray.

At 1:02 p.m., she was sitting on the side of the bed eating her lunch of ground meat, potatoes, and a roll. There was no health shake present.

During an interview on 7/25/23 at 1:06 p.m., Nurse 4 indicated the 4 ounce health shakes come from the dietary department on the tray and the 8 ounce supplement was provided by Nursing.

During an interview on 7/25/23 at 1:10 p.m., Cook 5 with the Dietary Consultant indicated they were out of the supplements and the shipment had just been received. The Dietary Consultant indicated there were supplements available.

Nurse 4 indicated on 7/25/23 at 1:30 p.m., the resident did not eat a lot in the morning so she would go to the kitchen and get the 4 ounces of the health shake and give it to her with breakfast and she drank 100% of it. The lunch time shake should have been on the tray.

The Dietary Consultant indicated on 7/25/23 at 4:30 p.m., there were health shakes available, they had just not been thawed out.

Resident D's record was reviewed on 7/25/23 at 4:23 p.m. The diagnoses included, but were not

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limited to, vascular dementia.

A Quarterly MDS assessment, dated 7/13/23, indicated a severely impaired cognitive status, supervision needed with eating, weight of 130 pounds, a significant weight loss without being on a prescribed weight loss regimen, and a mechanically altered diet.

A Nutritional Care Plan, dated 7/13/23, indicated supplements would be provided as ordered.

A Physician's Order, dated 5/22/23, indicated super cereal (high calorie supplement) was to be served at breakfast and 4 ounces of the house supplement was to be served with meals three times a day.

An RD (Registered Dietician) Progress Note, dated 6/8/23 at 6:07 p.m., indicated a mechanical soft diet with house shakes three times a day were ordered. The weights were 133.4 pounds on 6/7/23, 133.6 on 5/29/23, 136.8 on 5/25/23, 147 on 5/22/23, 134.4 on 5/18/23, 146 on 5/16/23, and 152 on 3/7/23. She had fair to good oral intake. The accuracy of the weight on 5/22/23 was questioned and had a stable weight since 5/18/23.

An RD Progress Note, dated 6/22/23 at 2:08 p.m., indicated the weights had been stable since 5/29/23 and the weekly weights were no longer needed.

An RD Progress Note, dated 7/13/23 at 8:08 p.m., indicated a weight on 7/12/23 of 130 pounds, a weight on 4/5/23 was 154.2 pounds, and on 1/4/23 was 146 pounds. There was a 15.7% weight loss in the past 90 days and a 11.8% weight loss in the past 180 days. She had fair to good oral intakes per the food consumption records, and was at risk

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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
	for malnutrition due to dementia and history of weight loss. Weekly weights were recommended. A food and drink policy, dated 3/21/21 and received as current from the RN Consultant, indicated the facility would provide food to meet the individual needs and drinks/other liquids consistent with the resident needs and preferences and sufficient to maintain resident hydration. This Federal tag relates to Complaint IN00412775. 3.1-46(a)(1) 3.1-46(a)(2) 3.1-46(b)			