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	09/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00379319, IN00380478, IN00389260, IN00390448, and IN00390827. Complaint IN00379319 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00380478 - Substantiated. No deficiencies related to the allegations are cited. Complaint IN00389260 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684 and F759. Complaint IN00390448 - Substantiated. Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00390827 - Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiencies are cited. Survey dates: September 27, 28, and 29, 2022 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 119 Residential: 38 Total: 157 Census Payor Type: Medicare: 21	F 0000	We respectfully ask for a desk review.	

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

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

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	Medicaid: 78 Other: 20 Total: 119 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 9/30/22.			
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 treatments and care were provided in accordance with professional standards of practice, related to interventions not being initiated and assessments not completed after a resident choked on food, and administering a medication to a resident after the medication had been discontinued, for 2 of 10 residents reviewed for quality of care. (Residents B and F) Findings include: 1. Resident B's record was reviewed on 9/27/22 at 1:09 p.m. The diagnoses included, but were not limited to, dementia. A Quarterly Minimum Data Set assessment, dated 5/11/22, indicated no chewing or swallowing problems and received a mechanically soft diet.	F 0684	Dyer Nursing and Rehabilitation 601 Sheffield Ave Dyer, IN 46311 **Plan of Correction** *This Plan of Correction represents the Center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in*	10/07/2022

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A Care Plan, dated 12/16/21 and revised on 5/26/22, indicated a mechanical soft diet was required. The interventions included, encourage dietary intake.

A Physician's Order, dated 12/6/21, indicated a regular mechanical soft diet with thin liquids.

A Nurse's Progress Note, dated 7/31/22 at 12:10 p.m., indicated the resident was eating lunch and not chewing the food. She was swallowing whole pieces of food and had choked on undigested food. Back thrusts were initiated and the food was expelled. There was no respiratory distress and she was able to consume fluids and ice cream without difficulty.

The next Nurse's Progress Note was dated 8/1/22 at 5:51 p.m., which indicated a laboratory test result had been received and a message had been left for the Physician.

There were no further assessments for signs and symptoms of aspiration and no interventions had been initiated to prevent further risk for choking or the resident not chewing the food. The Physician and family had not been notified of the choking and the status of diet consumption of not chewing her food.

During an interview on 9/27/22 at 3:31 p.m., LPN 3 indicated the Physician and family had not been notified, no interventions had been initiated to prevent further choking risks and there had been no follow up assessments for risk of aspiration.

2. Resident F's record was reviewed on 9/28/22 at 1:09 p.m. The diagnoses included, but were not limited to, stroke, vascular dementia and

the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.

F684- Quality of Care
Corrective action taken for residents found to have been affected by the deficient practice
1. Resident B is no longer in the facility. Employee was in-serviced regarding follow-up of any observation of a resident while eating related to mechanical or behavioral difficulty.
2. Resident F was assessed for any adverse effects and no adverse effects were noted. The sertraline order was corrected, MD and Family were notified. Licensed Nurse was re inserviced related to entering orders into the EMR and adding order to the MAR.

How the center will identify other residents having the potential to be affected by the same deficient practice
All residents have the potential related to the alleged deficient practice.

What changes will be put into place to ensure that the problem will be corrected and will not reoccur.
1. Licensed Nurses and staff

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	depression. A Physician's Order, dated 9/20/22, indicated sertraline (antidepressant) 25 milligrams was to be given daily. A Physician's Order, dated 9/21/22, indicated the sertraline had been discontinued. The Medication Administration Record, dated 9/2022, indicated the sertraline had not been discontinued and the sertraline had been administered on September 22, 23, 27, and 28, 2022. The Medication Administration Record indicated the sertraline had not been given on September 24, 25, and 26, 2022. The Medication Cart was observed with LPN 4 on 9/28/22 at 2 p.m., the sertraline was not located in the Medication Cart. LPN 4 indicated the sertraline needed to be re-ordered from the Pharmacy. During an interview on 9/28/22 at 4:09 p.m., the RN Corporate Consultant, indicated the Nurse had the incorrect medication order, the Physician was notified, and the sertraline should not have been discontinued. This Federal tag relates to Complaints IN00379319, IN00389260, and IN00390448. 3.1-37		that supervise resident during meals were educated regarding the regarding follow-up of any observation of a resident while eating related to mechanical or behavioral difficulty. a. Notification to SLP b. Notification to Physician/Dentist c. Notification to responsible Party d. Notification of behavioral difficulty to Social Service 2. Licensed Nurses were educated regarding physician medication orders including a. Entering orders into the EMR MATRIX b. Printing new orders and placing in the Medication Administration Record (MAR) c. Removing discontinued orders from the MAR The Director of Nursing/designee will conduct observations of 10 residents for mechanical or behavior problems while they are eating, weekly for four months, to determine if any assessments or interventions are required. The Director of Nursing/designee will conduct an audit of 10 medication orders for new admissions/readmissions twice weekly for four months, to ensure correct medications have been discontinued.	

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			Quality Assurance Plan to monitor performance and to make sure corrections are achieved and are permanent. The results of these audits will be reviewed by the QAA Committee to monitor ongoing compliance monthly for 4 months. The Committee may recommend the implementation of further corrective action as needed until it is determined that the corrections are effective and permanent. **Date when corrective action will be completed: 10/07/2022**	
F 0759 SS=D Bldg. 00	483.45(f)(1) Free of Medication Error Rts 5 Prcnt or More §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5% for 2 of 4 residents reviewed during 2 medication pass observations. 2 errors in medications were observed during 32 opportunities for errors in medication administration. This resulted in a medication error rate of 6.25%. (Residents P and N) Findings include: 1. During the medication pass observation on 9/29/22 at 8:45 a.m., QMA 2 prepared Resident P's morning medication, which included sodium	F 0759	Dyer Nursing and Rehabilitation 601 Sheffield Ave Dyer, IN 46311 **Plan of Correction** *This Plan of Correction represents the Center's Allegation of Compliance. The following Plan of Correction is not an admission to any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health.*	10/07/2022

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	chloride (sodium supplement) 1 gm (gram). The label on the medication card indicated sodium chloride 1 gm tablet was to be administered every 8 hours. QMA 2 placed two tablets of sodium chloride into the medication cup and indicated she was ready for the morning medications to be administered. The medication administration was stopped and QMA 2 reviewed the medications in the medication cup. She then indicated there were two sodium chloride tablets in the medication cup and removed the second sodium chloride tablet prior to the medication administration. Resident P's record was reviewed on 9/29/22 at 10:59 a.m. The diagnoses included, but were not limited to stroke. A Physician's Order, dated 9/20/22, indicated sodium chloride, 1000 milligrams (1 gm) was to be given every 8 hours.2. On 9/29/22 at 9:07 a.m., QMA 1 was observed preparing Resident N's medications, which included artificial tears eye drops. QMA 1 administered the resident's pills, donned gloves, and administered 2 eye drops to the resident's right eye. She then administered 2 eye drops to the resident's left eye. The record for Resident N was reviewed on 9/29/22 at 10:00 a.m. Diagnoses included but were not limited to Parkinson's Disease and anemia. The Physician's Order Summary, dated 9/2022, indicated the resident should receive artificial tears, 1 drop to both eyes, three times a day. A facility Medication Administration policy, dated 10/2014, and received from the Administrator as		*Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.* **F759 - Free of Medication Error Rate of 5% or More** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The surveyor was present and corrected the administration with QMA 2 of sodium chloride for Resident P. QMA 1 was re-educated on the correct administration of eyedrops for Resident N, including ensuring the correct dosage is given. The artificial tears had no adverse effect. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents, who receive medications, have the potential to be affected by the same alleged deficient practice. **What measures will be put into**	

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	current, indicated, the 5-rights of medication would be applied for medication administration. The 5-rights included the right dose. This Federal tag relates to Complaint IN00389260. 3.1-25(b)(9) 3.1-48(c)(1)		**place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nurses and QMA's were educated on medication administration including: ·Reading the MAR ·Administration of eye drops and the number of drops to be administered Nurse managers will conduct medication pass observation of 2 QMA's and or nurses each week for 5 random residents to ensure correct medication administration. These observations may include all routes of administration. **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 present a summary of medication pass observations 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: 10/07/2022**	

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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- (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			

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	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 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 a resident's record was accurate and complete, related to a duplicate order for a medication signed as administered on the Medication Administration Record (MAR), for 1 of 12 residents reviewed for medical records accuracy. (Resident F) Finding includes:	F 0842	Dyer Nursing and Rehabilitation 601 Sheffield Ave Dyer, IN 46311 **Plan of Correction** *This Plan of Correction represents the Center's Allegation of Compliance. The following Plan of Correction is not an admission to*	10/07/2022

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	Resident F's record was reviewed on 9/28/22 at 1:09 p.m. The diagnoses included, but were not limited to, stroke, vascular dementia and depression. A Physician's Order, dated 9/20/22, indicated Plavix (clopidogrel) (antiplatelet) 75 mg (milligrams) was to administered daily. The MAR, dated 9/2022, indicated clopidogrel 75 mg, 1 tablet was to be administered daily and Plavix 75 mg, 1 tablet was to be administered daily. The MAR indicated a dose of clopidogrel and Plavix were both given on September 21, 22, and 23, 2022. The Pharmacy Delivery Forms for the clopidogrel 75 mg, dated 8/8/22 and 9/7/22, provided by the RN Corporate Nurse Consultant, indicated the resident had not received the double dose of clopidogrel on September 21, 22, and 23, 2022. During an interview on 9/28/22 at 4:09 p.m., the RN Corporate Nurse Consultant indicated the return hospital orders were reviewed by two Nurses and the order for clopidogrel was duplicated. She acknowledged both clopidogrel and Plavix had been signed out as administered. 3.1-(a)(1) 3.1-(a)(2)		*any of the alleged deficiencies and is submitted at the request of the Indiana Department of Health. Preparation and execution of this response and the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and/or executed solely because it is required by the provision of Federal and State law.* **F842-Resident Records-Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident F was assessed and no adverse effects were noted. Licensed Nurses were educated medication reconciliation and review of Medication Administration Record (MAR) for duplicate orders. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents receiving medications have the potential to be affected by the same alleged deficient practice. **What measures will be put into**	

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			place or what systemic changes will be made to ensure that the deficient practice does not recur; Licensed Nurses were re-educated on completing a medication reconciliation to ensure that duplicate orders are not placed in the Medication Administration Record (MAR). Director of Nursing/Designee will complete audits on all new admissions and hospital readmissions for 4 months to ensure there are no duplicate orders in the Medication Administration Record (MAR). **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Director of Nursing/designee will 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: 10/07/2022**	