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	03/25/2021

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DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

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F 0000 Bldg. 00	This visit was for Investigation of Nursing Home Complaints IN00340893, IN00343183, IN00343626, IN00343747, IN00344105, and IN00347980. This visit included a COVID-19 Focused Infection Control Survey. This visit also included the Investigation of Residential Complaint IN00348906 and a Residential COVID-19 Quality Assurance Walk Through. Complaint IN00340893: Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F693. Complaint IN00343183: Substantiated. Federal/state deficiencies related to the allegations are cited at F580 and F692. Complaint IN00343626: Substantiated. Federal/state deficiencies related to the allegations are cited at F561 and F677. Complaint IN00343747: Substantiated. Federal/state deficiencies related to the allegations are cited at F692. Complaint IN00344105: Substantiated. Federal/state deficiencies related to the allegations are cited at F580, F684 and F689. Complaint IN00347980: Substantiated. No deficiencies related to the allegations were cited. Complaint IN00348906: Substantiated. State Residential Findings related to the allegations are cited at R0350. Survey dates: March 22, 23, 24, and 25, 2021.	F 0000	Please accept the following as the facility's plan of correction. 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 would like to request a desk review.	

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

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	Facility number: 000125 Provider number: 155220 AIM number: 1002566740 Census Bed Type: SNF/NF: 72 SNF: 21 Residential: 35 Total: 128 Census Payor Type: Medicare: 21 Medicaid: 51 Other: 21 Total: 93 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 3/29/21.			
F 0561 SS=D Bldg. 00	483.10(f)(1)-(3)(8) Self-Determination §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.			

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	§483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. Based on record review and interview, the facility failed to honor resident choices related a resident's preference to be showered over being given bed baths for 1 of 3 residents reviewed for preferences. (Resident E) Finding includes: The closed record for Resident E was reviewed on 3/24/21 at 12:28 p.m. Diagnoses included, but were not limited to, major depression, diabetes, obesity, and hypertension. The Admission Minimum Data Set (MDS) assessment, dated 10/23/20, indicated the resident was alert and oriented and she was totally dependent with bathing. The New Admission Preference documentation, dated 10/19/20, indicated the resident preferred showers over bed baths by 10:00 a.m., every Tuesday and Friday. The 11/2020 Shower Sheet indicated the resident received bed baths on 11/3, 11/6, 11/10, 11/13,	F 0561	**F 561** **Self Determination** Please accept the following at the facility's plan of correction. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement. **What corrective action which will be accomplished for those residents found to have been affected by the deficient practice.** Resident E's no longer resides in facility. No corrective actions can be made. **How the facility will identify other residents having the potential to be affected by the same deficient practice.**	04/02/2021

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	11/16, and 11/27/20. She received showers on 11/18, 11/23, and 11/28/20. Interview with the Director of Nursing on 3/25/20 at 11:10 a.m., indicated the resident's preferences should have been honored. This Federal tag relates to Complaint IN00343626. 3.1-3(u)(1)		All facility residents have to potential to be affected by the same deficient practice. All residents' preferences for showers/bathing have been reviewed. **What measures will the facility take or systems the facility will alter to ensure that the problem will be corrected and will not recur.** Nursing staff in-serviced on following residents' preferences for showers/bathing including: · time of shower/bath including morning or afternoon and · bed bath/ shower/ tub bath · any other preference that the facility can meet **How will the corrective action be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** The Director of Nursing/designee will monitor 5 residents shower sheets weekly for 6 months to ensure that showers/bathing are offered per residents' preferences. A summary of the POC audits will	

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			be presented to the Q/A Committee for 6 months. After 6 months, it will be determined by the Q/A Committee if further monitoring is required. **Date of Completion: April 2, 2021**	
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) 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			

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	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 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 ensure the Physician was promptly notified of a change in condition related to complaints of dizziness for 1 of 5 residents reviewed for notification of change. (Resident D) Finding includes: A confidential interview on 3/23/21 at 2:40 p.m., with a concerned family member indicated it was extremely hard to get a hold of anyone at the facility while a loved one was in the COVID-19 unit. The family got a hold of LPN 1 on	F 0580	**F 580** **Notify of Changes** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident D is no longer at the facility. No corrective actions can be made. . **How the facility will identify**	04/02/2021

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	11/21/20 at 1:30 p.m., at which time the LPN had indicated the resident had a fainting spell coming out of the bathroom after having a bowel movement and his blood pressure was low. The LPN was very defensive when questioned about the episode. The family member indicated the Nurse Practitioner (NP) had informed them that neither she nor the Physician were notified of the fainting spells. The closed record for Resident D was reviewed on 3/24/21 at 9:20 a.m. The resident was admitted to the facility on 11/19/20 and discharged on 11/25/20. Diagnoses included, but were not limited to, COVID-19, pneumonia, decreased white blood cell count, bacteremia, thrombocytopenia, iron deficiency anemia, unsteadiness on feet and weakness. A Nurses' Note, dated 11/19/20 at 7:01 p.m., indicated the resident arrived via ambulance from the hospital. The resident was alert times 3 and able to make his needs known. The resident needed supervision with transfers and he was continent of bowel and bladder. A Nurse Practitioner (NP) Note, dated 11/20/20 at 7:44 p.m., indicated the resident was seen for a new admission. Diagnoses: COVID-19, pneumonia, anemia. thrombocytopenia, fatigue, weakness. high risk for readmit. The resident denies syncopal episode and has no fever. Nurses' Notes, dated 11/21/20 at 11:12 a.m., indicated the resident was a new admit and 15 minute checks continued. The resident was in respiratory isolation due to COVID. Oxygen at 6 liters per nasal cannula, with no shortness of breath or temperature noted. The resident had a dry nonproductive cough and his lung sounds		**other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who have changes in condition have the potential to be affected by the same deficient practice. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** Licensed nurses were in serviced on: · The policy titled "Notification of Resident Change in Condition". · Documentation of notifications of any changes in condition. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will review 5 resident charts, including review of events and progress notes weekly for 6 months to ensure that the physician is notified of any changes in condition. The DON /designee will present a summary of the audits to the Quality Assurance committee	

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	were clear. There was no documentation regarding any episodes of dizziness or fainting spells in the Nurses' notes. A Physiatrist (Physical Medicine and Rehabilitation Physician) Progress Note, dated 11/23/20, indicated "the patient had a couple of syncopal episodes/presyncopal episodes over the weekend. He is a bit dizzy today. No headaches. No cough, chest pain, shortness of breath, fevers, or chills. Improving shortness of breath per patient. Plan: Patient continues to have dizziness and syncopal episodes despite stable vitals, potentially orthostatic related. We will monitor vitals closely." An NP Note, recorded as a late entry on 11/25/20 at 10:27 p.m., indicated "also per staff over the weekend he had 2 syncopal episodes in the bathroom. He stated he felt like he " passed out" but denies falling. Staff was there and did not report fall." There was no documentation to indicate the NP or the Physician were notified of the resident's dizziness or syncopal episodes. Interview with the Director of Nursing on 3/24/21 at 3:30 p.m., indicated the LPN 1 does not remember him having syncope or passing out. There was no documentation of any fainting or syncope episodes or of the NP or Physician being notified. Interview with LPN 1 on 3/25/21 at 11:05 a.m., indicated she was informed by therapy the resident was dizzy so she went into the room and assessed the resident, took his vital signs, and		monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. **Date of Completion: April 2, 2021**	

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	charted that information, however, there was no information in her notes of the dizziness or if the Physician was notified. This Federal tag relates to Complaints IN00343183 and IN00344105. 3.1-5(a)(2)			
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 assistance with showers for 1 of 3 residents reviewed for activities of daily living. (Resident L) Finding includes: The record for Resident L was reviewed on 3/23/21 at 10:02 a.m. Diagnoses included, but were not limited to, history of cervical fracture, osteoarthritis, abnormal gait, blindness in one eye, dementia and a history of falling. The Annual Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident was moderately impaired for decision making. She needed extensive assist with 1 person assist for bed mobility and was totally dependent on staff for bathing. A shower preference sheet indicated the resident preferred showers in the morning. The resident's	F 0677	**F 677** **ADL Care Provided for Dependent Residents** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Dependent resident L is provided with assistance twice weekly. Showers are being documented. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All facility residents who are dependent on staff for ADL care have the potential to be affected	04/02/2021

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	shower days were Wednesdays and Saturdays. The showers sheets from 1/2021-3/2021 indicated the resident did not receive a shower at least two times a week. The resident did not receive a shower on 1/9, 1/23, 1/30, 2/6, and 2/27/21. There was no Care Plan to indicate the resident refused care or showers. Interview with the Director of Nursing on 3/24/21 at 4:00 p.m., indicated the resident was to receive a shower at least 2 times a week. This Federal tag relates to Complaint IN00343626 3.1-38(a)(2)(A)		by the same deficient practice. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?** Nursing staff were in serviced on: · Documentation on the residents showers/baths at least twice weekly. · Providing residents with assistance per resident preference. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will review 5 residents requiring assistance weekly for 6 months to ensure that showers/baths were completed per residents' preference and documented on the shower sheet. The DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date of Completion: April 2, 2021**	

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F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to monitor non-pressure skin conditions related to scratches and scabs for 2 of 3 residents reviewed for non-pressure skin conditions. (Residents Q and R) Findings include: 1. The record for Resident Q was reviewed on 3/23/21 at 10:32 a.m. Diagnoses included, but were not limited to, alcohol abuse, chronic kidney disease, adult failure to thrive, heart failure and cognitive deficit. The Admission Minimum Data Set (MDS), dated 2/1/21, indicated the resident was severely cognitively impaired and required an extensive 1 person physical assist with bed mobility. A Physician's Order, dated 3/2/21, indicated monitor scab to right plantar lower foot daily. The 3/2021 Treatment Administration Record (TAR) indicated the monitoring of the scab to the right plantar lower foot was only documented as	F 0684	**F 684** **Quality of Care** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident R is no longer in the facility. No corrective actions can be made. The scab to the right plantar lower foot for Resident Q is being monitored daily. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents who have wounds.	04/02/2021

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	being monitored on 3/2, 3/5, 3/12, 3/19, and 3/23/21. Interview with the Director of Nursing (DON) on 3/25/21 at 11:10 a.m., indicated the resident's scab should have been monitored daily as ordered. 2. On 3/24/21 at 4:20 p.m., LPN 2 was observed performing a skin assessment for Resident R. At that time, she indicated the resident had scratches which had scabbed over. The record for Resident R was reviewed on 3/23/21 at 1:15 p.m. Diagnoses included, but were not limited to, hemiplegia, thyroid disorder, traumatic seizures, falls, hypertension, and anxiety. The Admission Minimum Data Set (MDS) assessment, dated 3/18/21, indicated the resident was moderately cognitively impaired and required an extensive 1 person physical assist with bed mobility and an extensive 2 person physical assist with transfers. A Physician's order, dated 3/12/21, indicated monitor scratches to left knee and right great toe every shift until healed. The Full Clinical/Body Observation, dated 3/12/21 indicated the resident had 2 scratches on her right great toe and left knee. The 3/2021 Treatment Administration Record (TAR) indicated the scratches to the left knee and right great toe were not documented as being monitored on 3/21 day shift, 3/16, 3/17, 3/20 and 3/22 evening shift, and 3/15-3/17, 3/21 and 3/22/21 night shift.		Review completed list of residents with non-pressure areas to ensure that orders are in place and non-pressure areas are being monitored. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Licensed nursing staff were educated to ensure the monitoring of non-pressure areas. Training included: · Following Physician orders · Documentation of non-pressure are in the clinical record · Monitoring for improvement or decline **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/designee will randomly audit weekly 5 residents identified to have non-pressure areas, such as bruising/rashes/scabs/etc. weekly to ensure that skin areas are being monitored as ordered for 6 months. The DON/designee will present a summary of the audits will be presented to QA committee	

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	Interview with the Director of Nursing (DON) on 3/25/21 at 11:10 a.m., indicated the resident's scratches should have been monitored as ordered. This Federal tag relates to Complaint IN00344105. 3.1-37(a)		monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing. **Date of Completion: April 2, 2021**	
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 related to non-skid floor strips for a resident with a history of falls for 1 of 3 residents reviewed for falls. (Resident L) Finding includes: On 3/23/21 at 9:50 a.m., Resident L was observed in bed. The foot of her bed was in a very high position with the head of her bed in a low position. The resident was dressed in a hospital gown and wearing plain socks. There	F 0689	**F 689** **Free of Accident Hazards/Supervision/Devices** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident L was assessed and her fall interventions were updated. **How the facility will identify other residents having the potential to be affected by the**	04/02/2021

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	were no non-skid floor strips in the bathroom. On 3/23/21 at 12:30 p.m. the resident was observed in bed wearing a hospital gown and plain socks. There were no non-skid floor strips in the bathroom. On 3/24/21 at 12:15 p.m., the resident was observed in bed wearing a hospital gown. There were no non-skid floor strips in the bathroom. The record for Resident L was reviewed on 3/23/21 at 10:02 a.m. Diagnoses included, but were not limited to, history of cervical fracture, osteoarthritis, abnormal gait, blindness in one eye, dementia and a history of falling. The Annual Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident moderately impaired for decision making. She needed extensive assist with 1 person assist for bed mobility and was totally dependent on staff for bathing. The resident had no falls since the last assessment. The Care Plan, dated 2/21/20, indicated the resident was at risk for falling related to impaired balance, history for falls, medication profile, and general muscle weakness. The nursing approaches were to place anti-skid strips in bathroom. Physician's Orders, dated 9/9/20, indicated nursing interventions: anti-skid strips to bath. A Fall Event, dated 3/8/21 at 12:56 p.m., indicated the resident fell while ambulating. Nurses' Notes, dated 3/08/21 at 12:46 p.m.,		**same deficient practice and what corrective action will be taken;** All residents who have orders for fall interventions have the potential to be affected by the same alleged deficient practice. An audit of all fall interventions was completed. **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 fall interventions and to ensure 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 with fall interventions weekly to ensure fall interventions are in place as ordered for 6 months. 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. **Date of Completion: April 2,**	

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	indicated summoned to the room by CNA. The resident was observed sitting on her buttocks on the floor next to the bed. No injuries noted. A fall investigation, dated 3/8/21, indicated the resident stated "I was trying to get to the bathroom." Interview with the Director of Nursing on 3/24/21 at 4:00 p.m., indicated the resident had changed rooms and the non-skid floor strips were not placed down and they should have been. This Federal tag relates to Complaint IN00340893 and IN00344105. 3.1-45(a)(2)		**2021**	
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;			

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	§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 fortified foods were served as ordered and food consumption and supplements were monitored for residents with a history of weight loss for 3 of 5 residents reviewed for nutrition. (Residents D, L, and M) Findings include: 1. The closed record for Resident D was reviewed on 3/24/21 at 9:20 a.m. The resident was admitted to the facility on 11/19/20 and discharged on 11/25/20. Diagnoses included, but were not limited to, COVID-19, pneumonia, decreased white blood cell count, bacteremia, thrombocytopenia, iron deficiency anemia, unsteadiness on feet and weakness. The resident resided in the COVID-19 unit after admission. Physician's Orders, dated 11/20/20, indicated document fluid intakes every shift and meal consumption for breakfast, lunch and dinner. There were no meal consumptions documented on 11/19 and 11/20 for dinner, 11/21, 11/22, and 11/23/20 for all 3 meals There were no fluid intakes documented on 11/19, 11/21, 11/22, and 11/23/20. Interview with the Director of Nursing on 3/24/21 at 3:30 p.m., indicated the resident's meals and fluid intakes were not complete and	F 0692	**F 692** **Nutrition/Hydration Status Maintenance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident D no longer resides in the facility. No corrective actions can be made. Resident L's diet was reviewed by the RD, recommendations were made and new orders received. Resident M's diet was reviewed by the RD, recommendations were made and new orders received. **How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?** The deficient practice has the potential to affect all facility residents. **What corrective measures will the facility take or will alter to ensure that the problem will not recur?** Nursing staff educated on: · Monitoring residents' consumption of meals including	04/02/2021

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	documented during his stay. 2. On 3/23/21 at 12:30 p.m., the resident was observed in bed. A CNA was observed standing at the bedside and feeding the resident. She was served fish, cornbread, rice and a dessert. There was a health shake on the resident's tray. The resident needed assistance with eating. There were no fortified mashed potatoes observed on the resident's meal tray. On 3/24/21 at 12:15 p.m., the resident was observed lying in bed on her left side, with her eyes closed. CNA 2 took the resident's meal tray into the room, removed the lid and placed it on the over bed table in front of the resident and left the room. The resident was not awakened or repositioned to feed herself. The resident was served a health shake, applesauce, meat sauce over noodles and mixed vegetables. The resident was not served fortified mashed potatoes. At 12:47 p.m., the resident remained in the same position and no staff had been in the room to assist or help the resident eat. The resident had not even touched her food and the health shake remained unopened. The record for Resident L was reviewed on 3/23/21 at 10:02 a.m. Diagnoses included, but were not limited to, history of cervical fracture, osteoarthritis, abnormal gait, blindness in one eye, dementia and a history of falling. The Annual Minimum Data Set (MDS) assessment, dated 2/23/21, indicated the resident was moderately impaired for decision making. She needed extensive assist with 1 person assist for bed mobility and was totally dependent on staff for bathing. The resident's weight was 83		fortified foods and supplements. Dietary staff educated on: · Following meal ticket orders and the provision of fortified foods and dietary supplements. A list of residents with orders for fortified foods was complied. A list of residents with orders for supplements was complied. Nursing orders for meal consumption were reviewed **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** DON/ designee will audit 15 residents' meal consumption records and supplement records weekly x 6 months to ensure documentation is in place. Administrator/ designee will audit 15 resident trays weekly x6 months to ensure fortified foods are in place. The DON/designee will present a summary of the audits will be presented 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	

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	pounds with no current weight loss. A Care Plan, dated 2/21/20, indicated the resident was limited in functional status in regards to eating and drinking independently. The resident required supervision and assist to perform eating/drinking. The goal indicated the resident would receive assistance with all meals through the next review. The nursing approaches were to assure the resident was in good body alignment while eating/ drinking, and provide assistance at the level the resident required. The resident's weight on 12/3/20 was 129 pounds and her current weight on 3/21/21 was 87 pounds. A Registered Dietitian (RD) note, dated 3/17/21 at 2:11 p.m., indicated the resident had a Body Mass Index of 15 (underweight), and continued to show a significant wt loss times 90 days. The resident received super cereal at breakfast, ready care shake at lunch and dinner, fortified mashed potatoes at lunch, and a house supplement 90 milliliters (ml) three times a day between meals for nutritional support. Physician's Orders, dated 10/9/20, indicated regular diet with no added salt (NAS), ready care shake with breakfast and lunch, super cereal at breakfast, and fortified mashed potatoes at lunch. Document all meals in the point of care. Physician's Orders, dated 2/12/21, indicated house supplement 90 ml three times a day. The meal consumption logs for 2/2021 and 3/2021 were as follows: - No documentation of dinner on 2/1-2/7, 2/15,		the QA meeting. Monitoring will be on going. **Date of Completion: April 2, 2021**	

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	2/17, 2/22, 2/24, 3/1, 3/5, 3/6, 3/9, 3/11, 3/12, 3/14, 3/16, 3/21, and 3/23/21. - No documentation of lunch on 2/16, 2/26, and 3/7/21. - No documentation of breakfast on 2/16/21. There was no documentation of the health shake intakes on the Medication Administration Record or in the supplement section in the clinical record for 2/2021 and 3/2021. Interview with the Director of Nursing (DON) on 3/24/21 at 4:00 p.m., indicated the meal consumption logs were not complete for all three meals and the resident should have received the fortified mashed potatoes for lunch. Interview with the DON on 3/25/21 at 8:45 a.m., indicated the facility had no policy regarding the documentation of the intake of the health shakes and there was no way to indicate how much the resident consumed every time she was served a health shake. 3. On 3/23/21 at 12:35 p.m., Resident M was observed in bed. The lights were turned off over his bed and he was dressed in a hospital gown. The resident's eyes were closed. His lunch tray was observed untouched with the lid still in place on the over bed table. He was served ground fish, rice, black beans, cornbread and a dessert. There was no fortified mashed potatoes noted on the plate. At 12:45 p.m., a CNA walked into the resident's room and picked up his tray and walked out. She did not assist or feed him or offer any other food. On 3/24/21 at 12:30 p.m., the resident was			

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	served his lunch tray. He received meat sauce over noodles, mixed vegetables, and applesauce. He was not served fortified mashed potatoes. The record for Resident M was reviewed on 3/23/21 at 1:05 p.m. The resident was admitted on 10/14/20. Diagnoses included, but were not limited to, dysphagia, stroke, and dementia. A Significant Change Minimum Data Set (MDS) assessment, dated 2/3/21, indicated the resident was not alert and oriented and needed supervision with set up for eating. The resident weighed 137 pounds with no current weight loss noted. The Care Plan, dated 11/18/20, indicated the resident required a mechanically altered diet and was currently under hospice care for end stage disease. The nursing approaches were to offer available substitutes if resident had problems with the food being served and provide assistance with meals prn (as needed). Physician's Orders, dated 12/5/20, indicated serve a mechanical soft diet with ground meat, and thin liquids. Provide super cereal at breakfast, and fortified mashed potatoes at lunch. The resident's current weight on 3/9/21 was 128 pounds. The resident weighed 145 pounds on admission on 10/14/20. A Registered Dietitian's Note, dated 3/11/21 at 8:19 p.m., indicated the resident was on hospice and was currently receiving a mechanical soft diet with ground meat. He was receiving super cereal at breakfast and fortified mashed potatoes at lunch. The resident presented with 6.6% weight loss over past 30 days.			

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	The meal consumption logs for 2/2021 and 3/2021 were as follows: - No documentation of breakfast on 2/11, 2/16, 3/7, 3/8, 3/11, 3/18, and 3/20/21. - No documentation of lunch on 2/11, 2/16, 3/4, 3/7, 3/8, 3/11, 3/18, and 3/20/21. - No documentation of dinner on 2/1, 2/2, 2/5, 2/7, 2/11-2/13, 2/16, 2/19, 2/27-2/28, 3/1, 3/4, 3/7, 3/9, 3/16, 3/20, 3/21, and 3/23/21. Interview with the Director of Nursing on 3/24/21 at 3:30 p.m., indicated the resident should have received the fortified mashed potatoes for lunch and the meal consumption logs were incomplete. This Federal tag relates to Complaints IN00343183 and IN00343747. 3.1-46(a)(1)			
F 0693 SS=D Bldg. 00	483.25(g)(4)(5) Tube Feeding Mgmt/Restore Eating Skills §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and			

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	§483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on record review and interview, the facility failed to ensure a resident received adequate hydration and nutrition through enteral feedings related to water flushes not being administered as ordered by the Physician for 1 of 5 residents reviewed for nutrition. (Resident C) Finding includes: The closed record for Resident C was reviewed on 3/24/21 at 1:48 p.m. The resident was admitted to the facility on 3/3/20 and discharged on 4/15/20. Diagnoses included, but were not limited to, tracheostomy, stroke, chronic respiratory failure, anemia, and acute kidney failure. The Admission Minimum Data Set (MDS) assessment, dated 3/9/20, indicated the resident had short and long term memory problems and was severely impaired for decision making. The resident was dependent on staff for all of her activities of daily living and had a feeding tube. Physician's Orders, dated 3/3/20, indicated the resident was NPO (nothing by mouth). The resident was to receive an enteral feeding of Jevity 1.2 at 55 cubic centimeters (cc) continuously with a water flush of 200 cc every 6 hours.	F 0693	**F 693** **Tube Feeding Management/Restore Eating Skills** **What corrective action(s) will be accomplished for those residents found to be affected by the alleged deficient practice;** Resident C is no longer at facility. No corrective actions can be made. How will the facility identify other residents who have the potential to be affected by the same alleged deficient practice? All facility residents with orders for tube feedings flushes have the potential to be affected by the same deficient practice. Residents with orders for tube feeding flushes were audited. No concerns were noted. **What corrective measures will the facility take or will the facility alter to ensure that the problem will not occur?**	04/02/2021

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	Physician's Orders, dated 4/7/20, indicated general water flush of 150 cc times 5, daily with bolus feeding. The Medication Administration Record (MAR), dated 3/2020, indicated the water flushes were not signed out as being administered 3/3-3/18/20. The water flushes were not signed out as being administered on 3/21 at 12 p.m., and 6 p.m., 3/22 at 12 p.m., 3/23 at 12 p.m., 3/24-3/27 at 6 p.m., and 3/31 at 6 p.m. The MAR, dated 4/2020, indicated the water flushes were not signed out as being administered on 4/1 at 6 p.m., 4/6 at 12 p.m. The 150 cc water flush was not signed out as being administered on 4/10 at 3 and 8 p.m., and on 4/13/20 at 3 p.m. Interview with the Director of Nursing on 3/24/21 at 3:30 p.m., indicated the water flushes were not signed out as being administered and there was no documentation of the water flushes being administered until 3/19/20. This Federal tag relates to Complaint IN00340893. 3.1-44(a)(2)		Licensed nurses and Q.M.A's were in serviced on: · Ensuring residents receive adequate hydration/nutrition related to water flushes. · Following Physician orders related to enteral feeding and water flushes. · Documentation of the administration of tube feeding flushes for residents with tube feedings. · Documented of tube feeding flushes on the medication administration record as ordered. **What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?** The DON/designee will review 5 residents with orders for tube feeding flushes weekly for 6 months to ensure that the water flushes are documented on the medication administration record as ordered. The DON/designee will present a summary of the audits to the QA committee monthly for 6 months. Thereafter, if determined by the QA committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing.	

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R 0000 Bldg. 00	This visit was for the Investigation of Residential Complaint IN00348906. This visit included a Residential COVID-19 Quality Assurance Walk Through. This visit also included the Investigation of Nursing Home Complaints IN00340893, IN00343183, IN00343626, IN00343747, IN00344105, and IN00347980 and a Nursing Home COVID-19 Focused Infection Control Survey. Complaint IN00348906: Substantiated. State Residential Findings related to the allegations are cited at R0350. Complaint IN00340893: Substantiated. Federal/state deficiencies related to the allegations are cited at F689 and F693. Complaint IN00343183: Substantiated. Federal/state deficiencies related to the allegations are cited at F580 and F692. Complaint IN00343626: Substantiated. Federal/state deficiencies related to the allegations are cited at F561 and F677 Complaint IN00343747: Substantiated. Federal/state deficiencies related to the allegations are cited at F692. Complaint IN00344105: Substantiated. Federal/state deficiencies related to the	R 0000	Please accept the following as the facility's plan of correction. 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 would like to request a desk review.	

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	allegations are cited at F580, F684 and F689. Complaint IN00347980: Substantiated. No deficiencies related to the allegations were cited. Survey dates: March 22, 23, 24, and 25, 2021. Facility number: 000125 Residential Census: 35 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 3/29/21.			
R 0350 Bldg. 00	410 IAC 16.2-5-8.1(b)(1-2) Clinical Records - Noncomformance (b) Clinical records must be retained after discharge: (1) for a minimum period of one (1) year in the facility and five (5) years total; or (2) for a minor, until twenty-one (21) years of age. Based on record review and interview, the facility failed to ensure clinical records were maintained after discharge for 1 of 2 closed records reviewed. (Resident T) Finding includes: The closed record for Resident T was reviewed on 3/24/21 at 3:15 p.m. Diagnoses included, but were not limited to, Parkinson's, hypertension, obsessive compulsive disorder, schizophrenia, and bipolar disorder. The resident was admitted to the facility on 1/5/21 and discharged on 1/13/21. Nurses' Notes, dated 1/13/21 at 9:30 a.m.,	R 0350	**R 350** **Clinical Records Nonconformance** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident T no longer resides in the facility. The facility has reached out to Resident T and Resident T's emergency contact and requested the original copy of	04/02/2021

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	155220	A. BUILDING 00 B. WING	03/25/2021

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	indicated the resident's personal belongings and medications were given to him upon discharge as ordered. The resident's January 2021 Medication Administration Record (MAR) was not available for review. Interview with the Health Services Coordinator on 3/25/21 at 9:30 a.m., indicated the resident's January MAR could not be found. She indicated it may have been sent with the resident. Interview with the Administrator on 3/25/21 at 1:30 p.m., indicated the resident's Power of Attorney (POA) was contacted and the original MAR was sent with the resident. The Administrator indicated a copy should have been made for the resident and the facility should have kept the original form. This State Residential Finding relates to Complaint IN00348906.		medication administration record. The original has not been returned to 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 deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Licensed nurses were in-serviced on: Medication Administration Record will be available for review. **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 Sheffield director will audit 5 resident's MARs weekly for 6 months to ensure they remain part of residents' medical charts. The Nursing Director/designee will present a summary of the audits to the Quality Assurance	

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			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 ongoing. **Date of Completion: April 2, 2021**	