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	09/26/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00443290 and IN00443701. Complaint IN00443290 - Federal/state deficiencies related to the allegations are cited at F684. Complaint IN00443701 - Federal/state deficiencies related to the allegations are cited at F697, F744, and F842. Survey dates: September 25 and 26, 2024 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 122 Residential: 36 Total: 158 Census Payor Type: Medicare: 7 Medicaid: 92 Other: 23 Total: 122 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 10/1/24.	F 0000		
F 0684 SS=D Bldg. 00	483.25 Quality of Care Based on observation, record review, and interview, the facility failed to ensure a resident	F 0684	**What corrective action(s) will be accomplished for those**	10/18/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Administrator	10/14/2024

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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	received the necessary care and services related to medications not administered as ordered by the Physician, for 2 of 15 residents reviewed for quality of care. (Residents F and G) Findings include: 1. During a random observation on 9/26/24 at 8:18 a.m., QMA 1 was preparing Resident F's morning medication. She indicated the Vitamin D was not in the medication cart and the medication had been ordered from the Pharmacy on 9/23/24. Resident F's record was reviewed on 9/26/24 at 1:09 p.m. The diagnoses included, but were not limited to, anemia and chronic kidney disease stage three. The Admission Physician's Orders, dated 8/13/24, included Vitamin D2 (supplement), 10 micrograms (mcg) (400 Units) every morning and medications were to be initiated upon arrival from the pharmacy. The Medication Administration Record (MAR), dated 8/2024, indicated the Vitamin D2 10 mcg had been administered at 9:00 a.m. on 8/14/24 through 8/31/24. The MAR, dated 9/2024, indicated the Vitamin D2 10 mcg had been administered at 9:00 a.m. on 9/1/24 through 9/22/24 and 9/24 through 9/26/24. The MAR lacked initials that indicated the medication had been administered on 9/23/24. A Pharmacy Audit Report, received on 9/26/24 at 12:15 p.m. from the Nurse Consultant, indicated the Vitamin D2 had been ordered from the pharmacy on 8/12/24 and was not delivered to the facility until 8/16/24, 30 tablets were delivered.		**residents found to have been affected by the deficient practice;** Resident F Senna has been discontinued. Resident G Vitamin D has been discontinued. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All facility residents have the potential to be affected by the 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 has been educated on the requirement to ensure medications are re-ordered timely; to notify the MD and family of a missed or delayed medication; and not to sign out a medication as administered when unavailable, rather use the appropriate code to document why the medication was not administered. **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 residents per week to ensure that all medications are available for	

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	The Pharmacy Audit Report, indicated the Vitamin D2 had been re-ordered on 9/23/24, which was 38 days after it was received. During an interview on 9/26/24 at 12:15 p.m., the Nurse Consultant acknowledged the medication had been documented as administered after the 30 day supply was administered. During an interview on 9/26/24 at 2:25 p.m., the Director of Nursing (DON) indicated the pharmacy had informed the facility on 9/27/24 that the Vitamin D2 was on back order. 2. During a Medication Administration Observation on 9/25/24 at 8:43 a.m., QMA 2 prepared Resident G's morning medications and indicated the morning dose of senna (stool softener) 8.6 milligrams (mg) was not found in the medication cart. QMA 2 indicated the last time it had been ordered was on 7/31/24 and it was delivered on 8/1/24. During an interview on 9/26/24 at 11:39 a.m., the Assistant Director of Nursing indicated medications were to be ordered when seven days of the medication remained. The Pharmacy Audit Report, received from the Nurse Consultant on 9/26/24 at 12:15 p.m., indicated the senna had been ordered on 7/29/24 and 30 tablets were received on 8/1/24. Resident G's record was reviewed on 9/26/24 at 1:47 p.m. The diagnoses included, but were not limited to, Parkinson's disease. A Physician's Order, dated 8/11/23, indicated		administration. The results of the aforementioned audits will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the audits will continue.	

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	senna 8.6 mg, one tablet was to be administered one time a day. The MAR, dated 8/2024, indicated the senna had been administered daily at 9:00 a.m. from 8/1/24 through 8/24/24. The senna was marked as refused on 8/25/24 and was given 8/26/24 through 8/31/24. The MAR, dated 9/2024, indicated the senna had been administered daily at 9:00 a.m. on 9/1/24 through 9/25/24. During an interview on 9/26/24 at 2:35 p.m., the Nurse Consultant acknowledged if the senna was ordered with seven tablets left and the facility received 30 tablets on 8/1/24, the date the medication would have depleted was approximately on 9/4/24. The nurses and QMA's were documenting the medication had been given when the medication would not have been available. A facility medication administration policy, dated 2/17/20, indicated medications were to be administered in accordance with Physician's orders. A policy for re-ordering medications had not yet been provided by the facility at the time of the exit on 9/26/24 at 3 p.m. This citation relates to Complaint IN00443290. 3.1-48(a)(6)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management Based on record review and interview, the facility	F 0697		10/18/2024

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	failed to ensure a resident with pain was monitored and assessed, medication effectiveness was evaluated and non-pharmacological interventions were attempted prior to giving pain medication for 1 of 2 residents reviewed for injury of unknown origin. (Resident D) Finding includes: An IDOH (Indiana Department of Health) Facility Reported Incident, dated 8/19/24, indicated Resident D was noted to have pain in the left knee. The nurse assessed the area and observed swelling and left thigh/knee pain. The MD was notified and orders received to obtain an X-ray. The X-ray results indicated a comminuted, displaced left femoral (upper leg) fracture. The resident's record was reviewed on 9/25/24 at 1:30 p.m. Diagnoses included, but were not limited to, cardiomegaly, osteoarthritis of both knees and repeated falls. A Significant Change Minimum Data Set assessment, dated 8/30/24, indicated the resident had significant cognitive impairment, and was dependent for toileting and transfer assistance. She received scheduled and prn (as needed) pain medication and showed signs of pain during the assessment period. A Physician's Order, dated 11/1/23, indicated to monitor the resident's pain scale every shift. A Physician's Order, dated 1/4/24, indicated: may provide non-phamacological interventions prior to administering prn pain and antipsychotic medications. Code for Prior intervention on the MAR. Interventions included 1-Reposition, 2-Ice/Cold Compress, 3-Diversional Activity,		**The facility respectfully requests a desk review for this citation.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D remains in the facility. Her pain is well managed. **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 alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses and QMAs have been educated on the requirement to ensure that a nurse must complete a physical assessment of a resident that is experiencing an increase in pain. This assessment must include, type of pain, location of pain and any physical changes/abnormalities; Attempts at non-pharmacological interventions prior to administration of PRN (as needed) pain medication, and effectiveness of the medication. All must be documented in the medical record.	

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	4-Snack/Drink, 5-Elevation, 6-Toileting, 7-1:1, 8-Quiet Environment, 9-Offer Rest/Sleep, 10-Other. A Physician's Order, dated 7/17/24, indicated to give Norco (opioid pain medication) 5 milligram (mg)/325 mg every 6 hours as needed for pain. The Controlled Drug Receipt/Record/Disposition Form for August 2024 indicated the resident received prn Norco between 8/13 and 8/19 on the following dates and time: 8/13/24 2:30 am 8/14/24 12:00 a.m. 8/14/24 10:00 a.m. 8/15/24 2:39 a.m. 8/16/24 12:00 a.m. 8/16/24 6:00 a.m. 8/16/24 12:30 p.m. 8/17/24 7:15 a.m. 8/17/24 11:25 p.m. 8/18/24 8:00 p.m. 8/19/24 3:00 a.m. The Controlled Drug Receipt/Record/Disposition Form did not include a pain assessment, prior non-phamacological interventions attempted or if the medication was effective. The August 2024 electronic Medication Administration Record (MAR) indicted the resident was administered prn Norco between 8/13 and 8/19 on the following dates and indicated the pain scale prior to administering the medication and if it was effective: 8/16/24 12:10 a.m.: pain scale 8 (on a 10 point scale), ineffective. 8/17/24 7:16 p.m.: pain scale 5, effective. 8/17/24 11:45 p.m.: pain scale 5, ineffective. The August 2024 MAR indicated the resident's		**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 residents per week that are receiving PRN pain medication to ensure assessment and appropriate coinciding documentation is present. The results of the aforementioned audits will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the audits will continue.	

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	pain was evaluated every shift 8/13-8/19. The pain was 0 every shift with the exception of the following: 8/14/24 evening - blank 8/19/24 days - pain scale 2 The August 2024 MAR indicated there were no specific non-pharmacological pain interventions attempted prior to any medication given between 8/13-8/19. All shifts were checkmarked, but did not indicate with a number code if any interventions had been attempted. A Nurses Note, dated 8/16/24 at 5:44 a.m., indicated Resident D was awake during the night sounding out, talking out and crying out most of the night. The resident was observed rubbing knees and leg which, was medicated for accordingly. An Order Administration Note, dated 8/16/24 at 12:10 a.m., indicated the resident was grabbing onto knees indicating pain. A follow up at 12:41 indicated medication was ineffective. An Order Administration Note, dated 8/17/24 at 7:16 a.m., indicated resident complained of knee pain, interventions x 3 were attempted with minimal relief. Pain med given. An Order Administration Note, dated 8/17/24 at 10:07 p.m., indicated the resident had been medicated for pain and it was effective. The note did not indicate when med was given or where pain was. An Order Administration Note, dated 8/18/24 at 12:58 a.m., indicated the resident had been given pain medication and it was ineffective. The note did not indicate when the med was given or where			

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	the pain was located. A Nurses Note, dated 8/18/24 at 11:35 p.m., indicated the writer observed swelling on the resident's left thigh, painful to touch. Family and Nurse Practitioner (NP) were notified. An NP order for left hip and pelvic X-rays was received. The X-ray results indicated a comminuted, displaced left femoral fracture. The resident was sent to the hospital on 8/19/24 for surgical repair. A Care Plan, revised on 12/4/23, indicated the resident was at risk for complications secondary to arthritis. Interventions included to give analgesics ordered by the Physician and monitor for effectiveness and side effects. During an interview on 9/26/24 at 9:55 a.m., CNA 1 indicated she took care of the resident regularly and she complained of knee pain regularly. About a month ago, before she went to the hospital, she had been complaining of worsening pain. On 8/15, she had notified the nurse the resident was complaining of pain and crying, she told the QMA to give her a pain pill. During an interview on 9/26/24 at 10:45 a.m., the DON was made aware of the concerns of lack of assessment and monitoring of effectiveness and lack of non-pharmacological interventions utilized. There was no additional information provided. This citation relates to Complaint IN00443701. 3.1-37(a)			
F 0744 SS=D Bldg. 00	483.40(b)(3) Treatment/Service for Dementia			

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	Based on record review and interview, the facility failed to ensure a resident's behavior plan of care was implemented related to a resident with dementia who was exhibiting challenging and aggressive behaviors, for 1 of 2 residents reviewed for abuse. (Resident E) Finding includes: An IDOH (Indiana Department of Health) Facility Reported Incident, dated 8/19/24, indicated a CNA had reported that while caring for Resident E during a combative episode, the nurse was rough with the resident. The resident was unable to describe any incident occurred. There was no apparent sign of abuse or deviation in psychosocial well being noted. The follow up report, dated 8/26/24, indicated there were two CNAs in the room during the incident. One had been bending over and unable to see exactly what happened. The other CNA stated that she thought LPN 1 shoved the resident at some point during the event and his hands swiped the resident's ears. The LPN denies being rough with the resident and was trying to assist with care, it was possible his hands bumped the resident's ear as he continued to swing his arms. The nurse had been terminated for failing to deescalate the situation. The record for Resident E was reviewed on 9/26/24 at 11:07 a.m. Diagnoses included, but were not limited to, Alzheimer's dementia, depression and peripheral vascular disease. He resided on the locked memory care unit. The Quarterly Minimum Data Set assessment, dated 8/5/25, indicated the resident had significant cognitive impairment and required moderate	F 0744	**The facility respectfully requests a desk review for this citation.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** No harm came to 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 facility residents that exhibit combative behaviors have the potential to be affected by the 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 has been educated to ensure that care plan interventions are followed when providing care for residents with dementia and behaviors. **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;** Administrator/Designee will review behavior documentation 3 times per week to ensure care plan interventions are followed during	10/18/2024

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	assistance for toileting. He displayed behaviors directed at others such as hitting or kicking for 1-3 days during the assessment period. A Nurse's Note, dated 8/19/24, indicated the CNA informed the nurse that while changing the resident, he became combative. A nurse came in the room to assist, and allegedly became a little rough with the resident. Assessment of the resident noted bilateral ears were reddened, no complaint of pain was voiced. A Witness Statement by CNA 3, dated 8/22/24, indicated on 8/19, she was changing the resident with another CNA. The resident became combative and started swinging at her. The nurse came in behind the resident and hit his ear with his hand. The resident fell over onto the bedside table. CNA 3 finished care and reported it immediately. CNA 3 was unavailable for interview. A Behavior Care Plan, revised on 7/29/24, indicated the resident had the potential to demonstrate physical behaviors related to dementia, depression and history of harm to others. Interventions included, but were not limited to, provide physical and verbal cues to alleviate anxiety, give positive feedback. Staff will intervene before agitation escalates. If the response was aggressive, staff were to walk calmly away and reapproach later. During a telephone interview on 9/26/24 at 1:32 p.m., CNA 2 indicated on 8/19/24, she and CNA 3 were changing the resident's brief. The resident was being combative. LPN 1 came into the room, they had not asked for assistance. LPN 1 started "tapping" both of the resident's ears with his		care for residents with combative behaviors. The results of the aforementioned audits will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the audits will continue.	

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	hands saying it would calm him down, but it didn't. "We eventually got him changed, I bent down to pick up items from the floor and the resident fell onto the bed, I thought the nurse pushed him, but did not witness that." CNA 3 left immediately to report the incident. During an interview on 9/26/24 at 1:44 p.m., the Administrator indicated the resident was complicated, with dementia and behaviors. She felt the nurse was gently tapping the sides of his face to calm the resident down. The LPN 1 was terminated because as the nurse, he failed to deescalate the situation. All staff was reeducated on dementia patients with challenging behaviors after the incident. This citation relates to Complaint IN00443701. 3.1-37			
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information Based on record review and interview, the facility failed to ensure medical records were thoroughly and accurately documented related to pain medication administration for 1 of 2 residents reviewed for injury of unknown origin. (Resident D) Finding includes: Resident D's record was reviewed on 9/25/24 at 1:30 p.m. Diagnoses included, but were not limited to, cardiomegaly, osteoarthritis of both knees and repeated falls. A Significant Change Minimum Data Set assessment, dated 8/30/24, indicated the resident	F 0842	**The facility respectfully requests a desk review for this citation.** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D remains in the facility. Her pain is well managed. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be**	10/18/2024

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

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	has significant cognitive impairment, and was dependent for toileting and transfer assistance. She received scheduled and prn (as needed) pain medication and showed signs of pain during the assessment period. A Physician's Order, dated 7/17/24, indicated to give Norco (opioid pain medication) 5 milligram (mg)/325 mg every 6 hours as needed for pain. The Controlled Drug Receipt/Record/Disposition Form for August 2024 indicated the resident received prn Norco between 8/13 and 8/19 on the following dates and times: 8/13/24 2:30 am 8/14/24 12:00 a.m. 8/14/24 10:00 a.m. 8/15/24 2:39 a.m. 8/16/24 12:00 a.m. 8/16/24 6:00 a.m. 8/16/24 12:30 p.m. 8/17/24 7:15 a.m. 8/17/24 11:25 p.m. 8/18/24 8:00 p.m. 8/19/24 3:00 a.m. The August 2024 electronic Medication Administration Record (MAR) indicted the resident was administered prn Norco between 8/13 and 8/19 on the following dates and times: 8/16/24 12:10 a.m. 8/17/24 7:16 p.m. 8/17/24 11:45 p.m. The August 2024 MAR indicated the resident's pain was evaluated every shift 8/13-8/19. The pain was 0 every shift with the exception of the following: 8/14/24 evening - blank 8/19/24 days - pain scale 2		**taken;** All residents have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Nurses and QMAs have been educated on the requirements for documentation as well as scope of practice related to PRN controlled medications in the medication administration record, the narcotic control sheet, and the progress notes. **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 residents per week that are receiving PRN pain medication to ensure required signatures and documentation are present. The results of the aforementioned audits will be reviewed by the QAPI committee monthly for no less than 4 months to ensure continued compliance. If the threshold falls below 95% the audits will continue.	

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	09/26/2024

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

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A Nurses Note, dated 8/16/24 at 5:44 a.m., indicated Resident D was awake during the night, sounding out, talking out and crying out most of the night. She was observed rubbing her knees and leg, which was medicated for accordingly.

An Order Administration Note, dated 8/16/24 at 12:10 a.m., indicated the resident was grabbing on to her knees indicating pain. A follow up at 12:41 a.m., indicated medication was ineffective.

An Order Administration Note, dated 8/17/24 at 7:16 a.m., indicated the resident complained of knee pain, interventions x 3 were attempted with minimal relief. Pain med given.

An Order Administration Note, dated 8/17/24 at 10:07 p.m., indicated the resident had been medicated for pain and it was effective. The note did not indicate when the medication was given or where the pain was located.

An Order Administration Note, dated 8/18/24 at 12:58 a.m., indicated the resident had been given pain medication and it was ineffective. The note did not indicate when the medication was given or where the pain was located.

During an interview on 9/26/24 at 10:45 a.m., the Director of Nursing indicated prn Norco should be signed off on both the Controlled Drug Receipt/Record/Disposition Form and the MAR for each administration.

This citation relates to Complaint IN00443701.

3.1-50(a)(1)
3.1-50(a)(2)