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	04/05/2024

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 IN00430737, IN00430826, IN00431391, and IN00431447. This visit resulted in a Partially Extended Survey - Substandard Quality of Care - Immediate Jeopardy. Complaint IN00430737 - Federal/State deficiencies related to the allegations are cited at F689. Complaint IN00430826 - Federal/State deficiencies related to the allegations are cited at F686 and F842. Complaint IN00431391 - Federal/State deficiencies related to the allegations are cited at F686. Complaint IN00431447 - Federal/State deficiencies related to the allegations are cited at F686. Survey dates: April 1, 3, 4, and 5, 2023 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 108 Residential: 38 Total: 146 Census Payor Type: Medicare: 11 Medicaid: 82 Other: 15 Total: 108 These deficiencies reflect State Findings cited in	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Administrator	04/19/2024

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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	accordance with 410 IAC 16.2-3.1. Quality review completed on 4/9/24.			
F 0689 SS=G 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 adequate supervision was provided to Resident B during a sit to stand mechanical lift transfer. Resident B required two staff assistance with transfers and was transferred with one CNA and not placed in the correct position on the bed and slid out of the sit to stand transfer sling with her right arm caught in the sling, onto the floor. This resulted in a fracture of the right humeral neck (shoulder). The facility also failed to ensure a fall prevention intervention was in place, related to a call light not with in reach for 2 of 3 residents reviewed for falls. (Residents B and F) Findings include: 1. During an interview on 4/1/24 at 8:52 a.m., Resident B was lying in bed with the head of the bed elevated. She indicated she was lowered to the floor after she slid out of a sling when she was being transferred to bed. She indicated there was only one staff member who assisted her with the transfer.	F 0689	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B has been transferred with the Hoyer lift and 2 staff members without incident. Resident F received a longer call light and is in reach of the resident. The care plan has been updated to reflect the intervention, “dycem to wheelchair” that was put in place for the fall on 3/26/24. How the facility will identify other residents having the potential to be affected by the same deficient practice; All residents requiring mechanical lifts have the potential to be affected. All facility residents have the potential to be affected by the same deficient practice. What measures will be put into	04/22/2024

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	Resident B's record was reviewed on 4/3/24 at 8:48 a.m. The diagnoses included, but were not limited to, stroke with right side paralysis and obesity. An Annual Minimum Data Set (MDS) assessment, dated 2/23/24, indicated an intact cognitive status, had clear speech, made self understood and understood other.. No behaviors were present, had an impairment of the upper and lower extremity on one side, had not ambulated, had one fall with no major injuries since the last assessment, and was dependent on staff for sit-to-stand position changes and transfers. A Care Plan, dated 12/11/23, indicated Resident B was at risk to experience falls related to a history of a stroke and right-sided paralysis. The interventions indicated the staff were to ensure the resident's needs were anticipated, the call light would be within reach, and she would be encouraged to use the call light when assistance was needed. The staff would ensure the resident was wearing non-skid footwear when ambulating and when she was in the wheelchair. Physical Therapy (PT) would evaluate the resident as ordered by the Physician and as needed. A) A, "Post Fall Observation", dated 2/3/24 at 8:45 a.m., indicated two CNA's were using the sit-to-stand mechanical lift to transfer the resident and the resident fell while CNA 6 and CNA 7 was transferring her with the sit-to-stand mechanical lift. The resident was wearing non-skid footwear at the time of the fall. The Nurse indicated a 2.0 centimeter length by 2.0 centimeter width was found on the back of the head. Neurological assessment was without abnormal findings. The Nurse Practitioner (NP) was notified and messages had been left on the family's voicemail.		place or what systemic changes will be made to ensure that the deficient practice does not recur; All nursing staff have been educated on the requirement for mechanical lifts to be always completed with 2 caregivers. Nursing staff have been in serviced on ensuring fall prevention interventions such as call lights are in place. The DON/designee will randomly audit 6 residents who require a transfer with a mechanical lift on varying days and shifts weekly to ensure two staff members are present. The DON / designee will randomly audit 10 residents rooms on varying days and shifts weekly to ensure fall prevention interventions such as call lights are in place. The DON /designee will submit the findings of the aforementioned audits to the QAPI committee for review monthly for no less than 6 months to ensure continued compliance. If the threshold falls below 95%, the audits will continue.	

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	A Nurse's Progress Note, dated 2/3/24 at 8:50 a.m., indicated Resident B experienced a witnessed fall and was observe lying in a supine (lying on the back) position on the floor of the shower room with one end of the sit-to-stand belt around the residents back and the other end connected to the mechanical lift. The resident indicated she had bumped her head and received a 2.0 cm by 2.0 cm hematoma (a solid swelling of clotted blood within the tissues) on the back of the head. The Neurological assessment was performed without abnormal findings. The NP and Director of Nursing (DON) were notified. There were several messages left for the Power of Attorney to return a call to the facility. A Care Plan, dated 2/3/24, indicated Resident B experienced a fall. The new intervention implemented to prevent further falls was to have a PT consult conducted to evaluate the resident's strength and mobility and to evaluate the resident's needs for safe transfers with appropriate mechanical lift equipment. The plan of care did not include documentation to show immediate and effective interventions were implemented to prevent further falls. A Fall Interdisciplinary Team(IDT) Progress Note, dated 2/5/24 at 9:38 a.m., indicated the resident experienced a fall during a transfer with the sit-to-stand mechanical lift. The resident started to slide. The root cause was the resident is a hemiplegic. The new intervention added, indicated therapy was to evaluate for full mechanical lift (Hoyer) usage for transfers. An Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 2/6/24, indicated the sit-to-stand mechanical lift for transfers was to			

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	continue to be used. The resident had not wanted the full mechanical (Hoyer) lift to be used. The note indicated OT services would be provided for strengthening exercises, wheelchair management, and self-care management. During an interview, on 4/3/24 at 10:57 a.m., the Therapy Supervisor indicated therapy staff recommended the staff use a full mechanical (Hoyer) lift for transfers after the resident fell on 2/3/24. The Therapy Supervisor indicated the resident refused the recommendation to use the full mechanical (Hoyer) lift and said she would just not get out of bed if it was used. B) A Nurse's Progress Note, dated 3/12/24 at 8:51 p.m., indicated the CNA (Past Employee CNA 4) reported a witnessed fall and had slid from the sit-to-stand mechanical lift sling to the floor during a transfer from the wheelchair to the bed with the assistance of one staff. The note indicated the nurse observed the resident sitting on the floor of the bedroom and the resident reported pain to the right shoulder. No injuries were noted and the range of motion was within normal limits. The NP and family members were notified. A, "Post Fall Observation", dated 3/12/24 at 11:35 p.m., indicated Past Employee CNA 4 had transferred the resident without the assistance of a second staff person using the mechanical sit-to-stand lift. The resident resident reported that Past Employee 4 guided her body to a sitting position on the floor during the fall. Non-skid footwear was not in use at the time of the fall and she experienced right shoulder pain that increased with range of motion. The NP and the resident's family member were notified.			

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	A Nurse's Note, dated 3/13/24 at 12 a.m., indicated the resident complained of right shoulder pain that radiated to the right hand. The pain was rated at a 7 out of 10. Pain medication was administered (as needed acetaminophen 325 milligrams, two tablets). The resident reported the pain started after her fall. The resident has a history of pain to the right shoulder and reported the pain was worse than what she usually experienced. There was no bruising or swelling observed on the right shoulder. The area was very tender with palpation . The NP was notified and an order was received to obtain an X-ray for the right shoulder, arm, elbow, and wrist as soon as possible. A voicemail was left with the Responsible Party. A Nurse's Note, dated 3/13/24 at 2 p.m., indicated the X-ray results were positive for a fracture. The NP, DON, and family member was notified and the resident was transferred to the Hospital Emergency Room for treatment. The X-ray results, dated 3/13/24, indicated a right humeral neck fracture with displacement of fracture fragments. A Nurse's Progress Note, dated 3/13/24 at 10 p.m., indicated the resident returned to the facility with an immobilizer and soft cast with elastic bandage to the the right shoulder. An Interdisciplinary Team (IDT) Note, dated 3/14/24 at 9:47 a.m., indicated the resident slid out of the sling down to the floor while being transferred from the wheelchair to the bed. The intervention was to use the full mechanical lift (Hoyer) for all transfers. The note indicated the root cause of the fall was the resident slid out of the sling of the sit-to-stand mechanical lift while being transferred.			

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The fall plan of care, dated 2/3/24, was revised and updated on 3/14/24 and the intervention to use a full mechanical lift (Hoyer) for all transfers.

The Administrator provided an undated, unsigned, typed statement on 4/3/24 and indicated it was from Past Employee CNA 4. The statement indicated Past Employee CNA 4 had transferred Resident B without assistance from another staff member, with the mechanical sit-to-stand lift. She had seated the resident on the bed and before she could remove the transfer sling, the resident slid to the floor. She received assistance from another CNA, Nurse, and full mechanical lift (Hoyer) to transfer the resident back into the bed. The statement did not include sufficient documentation to show the CNA was aware two staff should have been present during the sit-to-stand mechanical lift transfer.

The Job Specific Orientation Check List for Past Employee CNA 4, indicated orientation had been completed on 11/11/23 for use of the Hoyer and the sit-to-stand mechanical lift.

During an interview on 4/3/24 at 11:55 a.m., the Nurse Consultant indicated the instructions on how to transfer the resident were located on the Resident's Dashboard in the computer under special instructions. She was unable to "pull-up" the past transfer intervention, though knew it was listed as a sit-to-stand mechanical lift and it required two staff to assist.

During an interview on 4/3/24 at 1:02 p.m., the Administrator indicated the investigation found the resident still had the sling hooked up to the lift when she slid out and the resident's right arm was caught in the sling due to the paralysis. She

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	indicated the resident had not been placed on the bed correctly and had slid out. Two staff members were supposed to assist with transfers when using any type of mechanical lift. Past Employee CNA 4 had not said why she had not obtained assistance to help with the transfer. A Facility Transfer and Mechanical lift policy, dated 9/1/20, and received from the Administrator as current, indicated a mechanical lifting device was to be used for any resident who required two-person assistance, or who could not transfer comfortably and /or safely by normal transfer technique. The -transferring needs of the resident would be assessed on an ongoing basis and would be designated into a categories, which included, sit to stand lift with two caregivers. 2. Resident F was observed lying in bed with her head of the bed elevated on 4/1/24 at 9:05 a.m. The resident was interviewed at the time of the observation and indicated she was unsure how to call the staff if she needed assistance. Resident F was observed lying in bed with her head of the bed elevated on 4/1/24 at 10:25 a.m. and at 10:43 a.m. with the call light draped over the side table to the right of the bed and out of the resident's reach. During an interview on 4/1/24 at 10:43 a.m., the DON indicated the call light was not in reach of the resident and placed the call light on the resident's bed. Resident F's record was reviewed on 4/3/24 at 9:42 a.m. The diagnoses included but were not limited to, diabetes mellitus and dementia. Nursing Progress Notes, dated 3/26/24, indicated			

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	the resident was found on the floor, assessed, no injuries noted, family and NP (Nurse Practitioner) were notified. A Care Plan, dated 3/11/24, indicated the resident required assistance with bed mobility and transfers. A Care Plan, dated 3/11/24, indicated a risk for falls with actual falls on 11/2/23, 12/28/23, and 2/12/24. The interventions included, but not limited to, ensure the resident's call light was within reach and encourage to use it for assistance as needed. There were no care plan updates or interventions added after the fall on 3/26/24. A fall prevention policy, dated 9/1/20 and received as current from the Administrator, indicated the call light would be placed within the resident's reach at all times. This citation relates to Complaint IN00430737. 3.1-45(a)(2)			
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.			

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	§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 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			

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	(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 completed in a timely manner, related to a change in condition assessment not charted at the time of the change and then had late entries entered 9 days after the event, for 1 of 10 residents reviewed for medical records. (Resident C) Finding includes: Resident C's record was reviewed on 4/3/24 at 11:48 a.m. The diagnoses included, but were not limited to, stroke, subarachnoid hemorrhage, non traumatic, respiratory failure, bipolar, aphasia, vascular implants and grafts, spina-bifida with shunts, and history of breast cancer (9/23/22). A Nurse's Progress Note, dated 3/27/24 at 3:54 p.m. for 3/18/24 at 4:01 p.m., written by LPN 1, indicated the resident was exiting the facility and being transferred to the Emergency Room by three Paramedics. The resident's Power of Attorney was made aware. The Nurse Practitioner was notified	F 0842	What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident C no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice; 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; All licensed nurses have been educated on the requirement to ensure residents with change in condition have appropriate and timely documentation. The DON/designee will audit 5	04/22/2024

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	of the transfer. A Change of Condition assessment form, dated 3/27/24 at 3:54 p.m. for 3/18/24 at 3:30 p.m., written by LPN 1, indicated Resident C had abnormal vital signs and a loss of consciousness. The resident's blood pressure was 96/64, pulse was 108 beats per minute, respirations were 16 per minute, and temperature was 97.6 degrees. The oxygen saturation was 87%. The resident was unresponsive. A Nurse's Progress Note, dated 3/27/24 at 3:54 p.m., for 3/18/244 at 3:30 p.m., written by LPN 1, indicated a blood pressure of 96/64, a pulse of 108 per minute, respirations of 16 per minute, and temperature of 97.9 degrees. The oxygen saturation was at 87%. The NP was notified and an order was received for a transfer to the Emergency Room for an evaluation and treatment. The Responsible Party was notified. During an interview, on 4/4/24 at 11:23 a.m., LPN 1 indicated there had been a lot of things that happened that day and it had been shift change and she had thought the Evening Shift Nurse should have charted the change of condition, though the change of condition occurred on the day shift. This citation relates to Complaint IN00430826. 3.1-50(a)(1)		residents with condition changes weekly to ensure residents records and condition change assessments are completed timely. The results of the aforementioned audits with be submitted to the QAPI Committee for review monthly for no less than 4 months. If the results fall below 95%, the audits will continue.	