STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		A. BUILDING 00 B. WING	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CEDARHURST OF DYER	1763 CALUMET AVENUE DYER, IN 46311

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R 0000 Bldg. 00	This visit was for a State Residential Licensure Survey. Survey dates: April 3 and 4, 2024 Facility number: 014415 Residential Census: 71 These State Residential Findings are cited in accordance with 410 IAC 16.2-5. Quality review completed on 4/11/24.	R 0000		
R 0036 Bldg. 00	410 IAC 16.2-5-1.2(k)(1-2) Residents' Rights- Deficiency (k) The facility must immediately consult the resident ' s physician and the resident ' s legal representative when the facility has noticed: (1) a significant decline in the resident ' s physical, mental, or psychosocial status; or (2) 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. Based on record review and interview, the facility failed to ensure follow up contact was made with the Physician and/or Nurse Practitioner related to an ear, nose, and throat consultation, and a delay in obtaining a urine sample and urinalysis results, for 2 of 7 records reviewed. (Residents 6 and 5) Findings include: 1. The record for Resident 6 was reviewed on 4/3/24 at 2:26 p.m. Diagnoses included, but were	R 0036	**R036** **Resident Rights:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** DON spoke with POA of Res 6 to request information on the ENT appointment. POA stated the	05/24/2024

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

Jaqueisha Johnson | DON | 05/16/2024

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	not limited to, dementia, diabetes mellitus, and depression. A Nurses' Note, dated 2/28/24 at 8:30 a.m., indicated the resident had a swallow study completed and he had new orders for a diet change to mechanical soft with thin liquids. The resident also needed a referral for a ear, nose, and throat (ENT) consultation. The Nurse Practitioner (NP) was made aware of the referral. A Nurses' Note, dated 3/18/24 at 5:30 p.m., indicated new orders had been received for the resident to have an ENT and gastrointestinal (GI) consult. The resident's Power of Attorney (POA) was made aware and she indicated she would schedule the appointments. During an interview on 4/4/24 at 10:00 a.m., the Director of Nursing indicated the NP should have been contacted again related to the ENT referral. 2. The record for Resident 5 was reviewed on 4/3/24 at 11:03 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia with psychotic disturbance, and hypertension. Nurses' Notes, dated 12/21/23 at 2:45 p.m., indicated the resident was noted with increased confusion and her urine was cloudy and dark. New orders were received to collect a urine sample for a urinalysis and culture and sensitivity. Nursing staff were made aware to collect a urine sample. At 8:45 p.m., the urine in the resident's toilet was dark and fluids were encouraged. There was no documentation indicating the urine sample was collected. A Nurses' Note, dated 12/22/23 at 2:30 p.m.,		appointment had not been scheduled as of 4/5/2024. DON notified NP the appointment had not been scheduled as of 4/5/24. No new orders or referrals were given regarding the appointment. Community gained access to the laboratory's portal on 4/22/24. Portal will be utilized for viewing all lab results. **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 the facility will make to ensure that the deficient practice does not recur;** All nursing staff were in-serviced on physician notification as well as the requirement of additional follow-up notification when there is delay in orders being carried out. All nursing staff were in-serviced on accessing and utilizing the laboratory's portal for results. All staff were in-serviced on Resident Rights.	

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	indicated staff were attempting to get the urine specimen due to mental status changes. The next entry related to the urine sample was dated 12/26/23 at 6:45 a.m., which indicated the urine sample was collected and the lab was made aware. There was no documentation indicating the Physician and/or NP were made aware of the delay in obtaining the urine specimen. The urinalysis results were received by the facility on 12/27/23 and the urine culture results were received on 12/29/23. The NP was not notified of the results until 1/3/24. During an interview on 4/4/24 at 1:30 p.m., the Director of Nursing indicated the NP should have been notified of the delay in obtaining the urine sample and he should have been notified of the results in a more timely manner.		**How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** - DON/Designee will monitor all referrals and lab orders weekly for six weeks and the monthly ongoing to ensure all referrals and lab orders are carried out without delay **By what date the systemic changes will be completed.** May 24,2024	
R 0092 Bldg. 00	410 IAC 16.2-5-1.3(i)(1-2) Administration and Management - Noncompliance (i) The facility must maintain a written fire and disaster preparedness plan to assure continuity of care of residents in cases of emergency as follows: (1) Fire exit drills in facilities shall include the transmission of a fire alarm signal and simulation of emergency fire conditions, except that the movement of nonambulatory residents to safe areas or to the exterior of the building is not required. Drills shall be conducted quarterly on each shift to familiarize all facility personnel with signals and emergency action required under varied conditions. At least twelve (12) drills shall be			

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	held every year. When drills are conducted between 9 p.m. and 6 a.m., a coded announcement may be used instead of audible alarms. (2) At least every six (6) months, a facility shall attempt to hold the fire and disaster drill in conjunction with the local fire department. A record of all training and drills shall be documented with the names and signatures of the personnel present. Based on record review and interview, the facility failed to ensure at least every 6 months, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. This had the potential to affect the 71 residents who resided in the facility. Finding includes: The Fire and Disaster Drills were reviewed on 4/3/24 at 2:30 p.m. There was no documentation the local fire department was invited to participate in at least 1 fire drill every 6 months. During an interview on 4/4/24 at 8:20 a.m., the Maintenance Director indicated he was not sure if they had one, but would look for the information in the computer. During an interview on 4/4/24 at 11:45 a.m., the Administrator indicated the fire department had not participated in the facility's fire drills in 2023.	R 0092	**R092** **Administration and Management**: Noncompliance **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** On 4/19/24, an attempt was made to hold a fire and disaster drill in conjunction with the local fire department. A subsequent invitation will be sent to the local fire dept on 10/19/24. **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**	04/25/2024

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			put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur; A TELS (the building management platform and services) task has been created and scheduled to populate every 6 months. Environmental Services Director (ESD) will complete scheduled tasks every 6 months and will retain proof of invitation sent to local fire department. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** . /b> **By what date the systemic changes will be completed**. April 25, 2024	
R 0217 Bldg. 00	410 IAC 16.2-5-2(e)(1-5) Evaluation - Deficiency (e) Following completion of an evaluation, the facility, using appropriately trained staff members, shall identify and document the services to be provided by the facility, as follows: (1) The services offered to the individual resident shall be appropriate to the: (A) scope;			

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	(B) frequency; (C) need; and (D) preference; of the resident. (2) The services offered shall be reviewed and revised as appropriate and discussed by the resident and facility as needs or desires change. Either the facility or the resident may request a service plan review. (3) The agreed upon service plan shall be signed and dated by the resident, and a copy of the service plan shall be given to the resident upon request. (4) No identification and documentation of services provided is needed if evaluations subsequent to the initial evaluation indicate no need for a change in services. (5) If administration of medications or the provision of residential nursing services, or both, is needed, a licensed nurse shall be involved in identification and documentation of the services to be provided. Based on record review and interview, the facility failed to ensure Service Plans were signed and revised as needed, related to foley catheter care and wound care, for 2 of 7 records reviewed. (Residents 6 and 3) Findings include: 1. The record for Resident 6 was reviewed on 4/3/24 at 2:26 p.m. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and depression. A Service Plan, dated 10/26/23, was not signed by the resident and/or his responsible party. During an interview on 4/4/24 at 1:30 p.m., the Director of Nursing indicated the resident's	R 0217	**R217** **Evaluation:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The service plan for Res 6 was reviewed and signed by POA on 4/5/24. The service plan for Res 3 has been revised to reflect the most recent Physician Order Statement. DON reviewed Service Plan for Res 3 with POA in person on 4/4/24. POA was given a copy of the service plan ON 4/4/24.	05/24/2024

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	Service Plan should have been signed. 2. The record for Resident 3 was reviewed on 4/3/24 at 11:15 a.m. Diagnoses included, but were not limited to, dementia, anemia, diabetes mellitus, and an enlarged prostate. The current 1/2024 Physician Order Statement indicated the resident had a foley catheter. Nurses' Notes, dated 3/22/24 at 6:15 p.m., indicated the Home Health Nurse was at the facility to change the foley catheter. The nurse examined the resident's feet and noted the right great toe with a surface opening at the tip and the left great toe with a closed nickel size black necrotic area on the top. There was no redness, swelling or drainage noted. A dry gauze dressing was applied to left toe after medicated ointment was applied. The nurse indicated she would contact his Physician for further orders going forward. The current Service Plan, dated 9/27/23, indicated the foley catheter and the wounds to the toes were not addressed. During an interview on 4/4/24 at 11:00 a.m., the Director of Nursing indicated the foley catheter and the new wounds on the toes were not addressed on the resident's Service Plan. The resident was admitted with the foley catheter in 2021.		POA returned signed Service Plan on 4/23/24. **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 the facility will make to ensure that the deficient practice does not recur;** DON/Designee will audit 10 residents Service Plans a month for 2 months to ensure Service Plan is signed and revised to reflect current needs and preferences of resident. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Ongoing Service Plan audits to be conducted quarterly in Feb, May, Aug, and Nov.	

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			By what date the systemic changes will be completed. May 24, 2024	
R 0240 Bldg. 00	410 IAC 16.2-5-4(d) Health Services - Deficiency (d) Personal care, and assistance with activities of daily living, shall be provided based upon individual needs and preferences. Based on record review and interview, the facility failed to ensure foley catheter care was completed and wound treatments were completed by a Home Health Agency, for 1 of 7 sampled residents. (Resident 3) Finding includes: The record for Resident 3 was reviewed on 4/3/24 at 11:15 a.m. Diagnoses included, but were not limited to, dementia, anemia, diabetes mellitus, and an enlarged prostate. The current 1/2024 Physician Order Statement, indicated the resident had a foley catheter. There were no orders to perform catheter care. Nurses' Notes, dated 3/22/24 at 6:15 p.m., indicated the Home Health Nurse was at the facility to change the foley catheter. The nurse examined the resident's feet and noted the right great toe with a surface opening at the tip and the left great toe with a closed nickel size black necrotic area on the top. There was no redness, swelling or drainage noted. A dry gauze dressing was applied to left toe after medicated ointment was applied. The nurse indicated she would contact his Physician for further orders going forward.	R 0240	**R240** **Health Services:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Order to perform catheter care for Res 3 is currently active and being carried out as ordered. Orders for treatment to Res 3 toes have been received and referred to home health. Order to assess and treat have been carried out by preferred home health agency. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents with catheter in place have the potential to be affected by the same deficient practice. All current residents with catheter	04/24/2024

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	A Nurses' Note, dated 3/23/24 at 9:45 p.m., indicated the resident was asked several times to take a shower and he refused. The resident was easily agitated and was yelling. He compromised and allowed a dressing change to his feet. The right great toe was noted to have a dry red tip which was smaller then the day before. The left great toe was much improved, and less necrotic in appearance. There was no drainage or odor at the time. The areas were cleansed and the ointment was applied from the home health supplies and redressed. A Nurses' Note, dated 3/24/24 at 2:15 p.m., indicated the resident's feet were assessed and the right great toe was red in color but not opened at this time. The left great toe was still noted with dark discoloration to the tip but not opened. The toes were covered with gauze for protection. During an interview on 4/4/24 at 8:50 a.m., the Director of Nursing indicated there were no orders or documentation to ensure foley catheter care was completed, as the resident could not do it himself. She indicated they were having issues with the communication between the home health agency and the Physician. She was aware the facility staff were not allowed to do treatments for the wounds on the toes.		in place have active order for catheter care to be provided. All current residents requiring wound care/treatments have active orders in place for home health or hospice to assess and manage. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All staff were in-serviced on receiving/obtaining and carrying out catheter care orders. All admissions or re-admissions, with catheters in place, will be required to have orders stating to provide catheter care. All staff were in-serviced regarding receiving/obtaining and carrying out wound care and treatment orders. Home health orders will be obtained upon admission for residents with catheter. Resident's will be referred to their preferred home health agency. Home Health will assess wounds and provide any necessary treatments. **How the corrective action(s) will be monitored to**	

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			ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and DON/Designee to audit all new admissions/readmissions ongoing to ensure orders are in place to provide catheter care. DON/Designee to audit all new admissions/readmissions ongoing to ensure orders for home health to provide wound care and treatments are in place and carried out. **By what date the systemic changes will be completed.** May 24, 2024	
R 0273 Bldg. 00	410 IAC 16.2-5-5.1(f) Food and Nutritional Services - Deficiency (f) All food preparation and serving areas (excluding areas in residents ' units) are maintained in accordance with state and local sanitation and safe food handling standards, including 410 IAC 7-24. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to dirty and greasy food equipment, expired leftovers, food not dated after prepared, and touching food with bare hands for 1 of 1 kitchens. (The Main Kitchen) This had the potential to affect the 71 residents who received food from the kitchen. Findings include:	R 0273	**R273** **Food and Nutritional Services:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** All kitchen appliances, refrigerators/freezers, and equipment were thoroughly	04/24/2024

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	1. During the Kitchen Sanitation Tour on 4/3/24 at 9:40 a.m., the following was observed: a. There was an open beverage tumbler, in which Cook 1 indicated was his, in the food prep area on the counter. b. There was a moderate amount of dried food inside the bottom of the microwave oven. c. The following was observed in the walk in cooler: - 4 small bowls of jello wrapped in saran wrap with no date of when prepared. The bowls were tipped over and dripping onto the next rack. - There was a pan of strawberry jello with a prepared date of 3/25/24. - there was a pan of orange jello with no date of when prepared. - there were 2 bowls of salad with dressing with no date of when prepared. - there was pan of cake with no date of when prepared. - there was pan of frozen sausage links that were not covered. - there was a pitcher of ice tea covered with saran wrap with no date of when prepared. - there was pitcher of egg nog with no date of when prepared. - there was a plastic container of liquid eggs with no date of when opened. - there was a container of banana pudding with no date of when prepared. d. The floor of the freezer had food crumbs and debris noted. e. The deep fryer had a heavy accumulation of dried grease noted on the sides and dried food noted on the back. The sides of the griddle had a		cleaned and restored to sanitary conditions. **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 the facility will make to ensure that the deficient practice does not recur;** All dining staff were in-serviced on cleaning/sanitizing work stations and kitchen equipment, cleaning checklists, and cleaning schedules to be utilized effective immediately and ongoing. All staff were in-serviced on Handling Leftovers Policy & Procedures. All staff were in-serviced on infection control and proper storage of personal items. All staff were in-serviced on Glove and Handwashing Policy & Procedures. **How the corrective**	

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	piece of aluminum foil with a heavy accumulation of grease and the griddle had an accumulation of dried food and grease. The grates on the grill were dirty. f. There were 2 raw and uncovered hamburger patties inside the refrigerated drawer under the griddle and grill. g. There were open bags of frozen french fries and shrimp in a small freezer located by the deep fryer with no date opened. h. There was a container of tuna salad in the reach in cooler with a prepared date of 3/23/24. i. There was a moderate amount of dried food spillage inside the self cleaning oven on the shelves, bottom and door. During an interview at that time, Cook 1 indicated he had been out of cleaning solution so the oven had not been cleaned. 2. During a random observation during the kitchen sanitation tour, Server 1 was observed using her bare hands and removing bread from a package and putting into the toaster. She then removed 1 piece of the toasted bread with her bare hands and was asked to stop and wash her hands. Server 1 was observed picking up a fresh apple with her bare hands and putting into a fruit bowl to serve to a resident. During an interview at that time, Server 1 indicated she was unaware she could not touch food with her bare hands, and she did not perform hand hygiene prior to touching the food.		**action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** DSD/designee will inspect all refrigerators and freezers weekly for 6 weeks and ongoing monthly to ensure all opened foods are properly dated and stored. /b> **By what date the systemic changes will be completed.** May 24, 2024	

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	During an interview on 4/4/24 at 10:45 a.m., the Dietary Food Manager indicated all of the above was in need of cleaning. Dietary staff were to wear gloves when touching food and leftovers were to be thrown out after they had expired. The food should have been dated after it was made or opened. The current and undated "Handling Leftovers" policy, provided by the Administrator on 4/4/24 at 11:45 a.m., indicated leftovers stored in the refrigerator should be wrapped, dated, and labeled with a use by date that was no more than 72 hours from the time of first use. The current and undated "Glove and Hand Washing", policy provided by the Administrator on 4/4/24 at 11:45 a.m., indicated hands were to be washed before donning gloves and after glove removal. Gloves were to be used whenever direct food contact was required.			
R 0302 Bldg. 00	410 IAC 16.2-5-6(c)(6) Pharmaceutical Services - Deficiency (6) Over-the-counter medications must be identified with the following: (A) Resident name. (B) Physician name. (C) Expiration date. (D) Name of drug. (E) Strength. Based on observation and interview, the facility failed to ensure over the counter medications were labeled with the resident's name as well as the Physician's name for 1 of 5 residents observed during medication administration. (Resident 9) Finding includes: On 4/3/24 at 4:43 p.m., QMA 1 was observed	R 0302	**R302** **Pharmaceutical Services:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**; All Over The Counter medications	05/24/2024

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		A. BUILDING 00 B. WING	04/04/2024

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	administering medications to Resident 9. The QMA retrieved an over the counter (OTC) bottle of Calcium with Vitamin D3 600 milligrams (mg) - 800 mg from the medication cart. The resident's room number was written on the lid, however, neither the resident's name nor the Physician's name was written on the bottle. During an interview on 4/4/24 at 2:05 p.m., the Director of Nursing indicated the resident was a newer admission and the bottle of Calcium should have been labeled with her name and the Physician's name instead of just the room number.		for Res 9 have been audited and properly labeled. DON conducted a medication cart audit on 4/6/24. The audit revealed no improperly labeled OTC medications. All labels of OTC medications for all current residents currently contain a label listing the resident's name and their physician's name. Medication to EMAR Cart Audit Policy and Procedures updated 4/22/24. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents receiving OTC medications have the potential to be affected by this same deficient practice. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur**; All nursing staff were in-serviced on Over the Counter medication labeling requirements. All nursing staff were in-serviced	

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			on updated Medication eMAR to Cart Audit Policy & Procedure. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Bi-Weekly audit of the medication cart will be conducted for 6 weeks and monthly thereafter. **By what date the systemic changes will be completed.** May 24, 2024	
R 0349 Bldg. 00	410 IAC 16.2-5-8.1(a)(1-4) Clinical Records - Noncompliance (a) The facility must maintain clinical records on each resident. These records must be maintained under the supervision of an employee of the facility designated with that responsibility. The records must be as follows: (1) Complete. (2) Accurately documented. (3) Readily accessible. (4) Systematically organized. Based on record review and interview, the facility failed to ensure clinical records were complete and accurately documented related to insulin administration for 1 of 7 records reviewed. (Resident 6) Finding includes:	R 0349	**R349** **Clinical Records:** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice**;	04/15/2024

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	The record for Resident 6 was reviewed on 4/3/24 at 2:26 p.m. Diagnoses included, but were not limited to, dementia, diabetes mellitus, and depression. A Physician's Order, dated 3/12/24, indicated the resident was to receive Aspart insulin by the way of a flexpen before meals and at bedtime based on the following sliding scale: 70-139=0 units 140-169=4 units 170-199=6 units 200-249=8 units 250-299=10 units 300-400=12 units The March 2024 Medication Administration Record (MAR) indicated the resident received insulin on 3/13 at 7:30 p.m., 3/14 at 9:16 p.m., 3/15 at 5:45 p.m., 3/16 at 12:00 p.m., 3/17 at 9:37 p.m., 3/22 at 5:16 p.m., 3/23 at 12:18 p.m. and 8:07 p.m., 3/26 at 1:13 p.m., 3/27 at 9:31 p.m., 3/28 at 10:16 p.m., 3/29 at 5:01 p.m. and 8:31 p.m., 3/30 at 10:47 a.m. and 2:03 p.m., and 3/31/24 at 2:03 p.m., 5:13 p.m., and 8:39 p.m. There was no documentation indicating how many units of insulin the resident received for the above dates and times. The April 2024 MAR indicated the resident received insulin on 4/1 at 10:06 p.m. and 4/3/24 at 4:30 p.m. and 8:35 p.m. Again, there was no documentation indicating how many units of insulin the resident received. During an interview on 4/4/24 at 1:30 p.m., the Director of Nursing indicated the amount of insulin the resident received should have been		EMAR for Res 6 was updated on 4/5/24 prompting a question to input/document the number of units of insulin received. On 4/15/24, NP gave orders to DC insulin and sliding scale. This order has been carried out. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken**; All residents with orders to administer insulin based on a sliding scale have the potential to be affected by this same deficient practice. There are currently no residents with sliding scale orders in place. **What measures will be put into place or what systemic changes the facility will make to ensure that the deficient practice does not recur;** All nursing staff have been in-serviced on updated EMAR documentation of administration of insulin per sliding scale. EMAR orders for all insulin to be administered per sliding scale have been associated with a question prompting	

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	documented.		input/document the number of units of insulin administered per sliding scale. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and** Effective immediately and ongoing monthly, pharmacy and/or DON will review orders for all insulin to be administered per sliding scale to ensure question prompting the number of units of insulin administered per sliding scale is associated with the EMAR. **By what date the systemic changes will be completed**. April 15, 2024	