STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155840	A. BUILDING 00 B. WING	06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
SYMPHONY OF DYER	1532 CALUMET AVENUE DYER, IN 46311

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00404644, IN00406233, IN00407458, IN00407900, IN00408525, IN00408541, IN00409951, and IN00410943. This visit included a COVID-19 Focused Infection Control Survey. Complaint IN00404644 - No deficiencies related to the allegations are cited. Complaint IN00406233 - No deficiencies related to the allegations are cited. Complaint IN00407458 - Federal/State deficiencies related to the allegations are cited at F692. Complaint IN00407900 - No deficiencies related to the allegations are cited. Complaint IN00408525 - No deficiencies related to the allegations are cited. Complaint IN00408541 - Federal/State deficiencies related to the allegations are cited at F842. Complaint IN00409951 - No deficiencies related to the allegations are cited. Complaint IN00410943 - No deficiencies related to the allegations are cited. Survey dates: June 19, 20, and 21, 2021 Facility number: 013462 Provider number: 155840 AIM number: 201330210 Census Bed Type:	F 0000	Symphony of Dyer Please accept the following as the facility's credible allegation of compliance. 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. This facility respectfully requests a desk review for the given citations in this survey. Please see all attached documentation for your consideration.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Megan Matula	Administrator	07/07/2023

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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	SNF/NF: 6 SNF: 67 Residential: 26 Total: 99 Census Payor Type: Medicare: 22 Medicaid: 6 Other: 45 Total: 73 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 6/22/23.			
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; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet.			

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	Based on observation, record review, and interview, the facility failed to ensure a resident maintained acceptable parameters of nutritional status related to supplements not administered as ordered and meal consumption records not completed for a resident with a history of weight loss for 1 of 3 residents reviewed for nutrition. (Resident D) Finding includes: On 6/20/23 at 12:13 p.m., Resident D received his lunch meal tray in his room. The tray ticket indicated he received a mechanical soft texture diet with double portions and a Magic Cup (a supplement). The tray did not contain a Magic Cup for his lunch time supplement. Interview with CNA 1 at the time indicated the Magic Cup was supposed to arrive with his meal tray at lunch and dinner. Resident D's record was reviewed on 6/19/23 at 9:34 a.m. The diagnoses included, but were not limited to, end stage renal disease, type 2 diabetes mellitus, and heart failure. The Annual Minimum Data Set (MDS), dated 5/21/23, indicated the resident was moderately cognitively impaired and he required extensive assistance with one person physical assist for eating. A Care Plan, revised on 8/17/22, indicated the resident had a nutritional problem or a potential for a nutritional problem. Interventions included, but were not limited to, administer medications as ordered and monitor/document for side effects and effectiveness, provide and serve diet as ordered, and observe intake and record each meal.	F 0692	**POC for F692 – 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 suffered no ill effects from alleged deficient practice. **How will you 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 this alleged deficient practice. · Full house audit of supplements was completed to ensure supplement is listed on residents tray card for supplements provided from kitchen as well as an accurate order in residents MAR. · Full house audit was completed to ensure residents receiving all supplements have been administered as ordered. · Full house audit of all resident's meal consumption logs was completed to help identify nutritional concerns and/or	07/06/2023

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	A Physician's Order, dated 2/17/23 at 5:00 p.m., indicated high calorie frozen dessert (Magic Cup or ice cream) twice daily. The May 2023 Medication Administration Record (MAR) indicated the high calorie frozen dessert was not given as ordered at 12:00 p.m. on 5/3/23, 5/5/23, 5/10/23, 5/12/23, 5/15/23, 5/17/23, 5/19/23, 5/22/23, 5/24/23, 5/26/23, 5/29/23, and 5/31/23. The June 2023 MAR indicated the high calorie frozen dessert was not given as ordered at 12:00 p.m. on 6/5/23, 6/7/23, 6/12/23, and 6/14/23, and at 5:00 p.m. on 6/11/23 and 6/14/23. A Physician's Order, dated 5/2/23 at 12:00 p.m., indicated Nepro (a dietary supplement) 1 can/carton with meals. The May 2023 MAR indicated the Nepro was not administered as ordered on 5/3/23 at 8:00 a.m., and on 5/5/23, 5/10/23, 5/12/23, 5/15/23, 5/17/23, 5/19/23, 5/22/23, 5/24/23, and 5/26/23 at 12:00 p.m. The June 2023 MAR indicated the Nepro was not administered as ordered on 6/5/23, 6/7/23, 6/9/23, 6/12/23, and 6/14/23 at 12:00 p.m., and 6/11/23 and 6/14/23 at 5:30 p.m. The Meal Consumption Logs for May 2023 indicated there was no documentation for the breakfast meal on 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, and 5/30/23. There was no documentation of the lunch meal on 5/25/23, 5/26/23, 5/27/23, 5/28/23, 5/29/23, and 5/30/23. There was no documentation of the dinner meal on 5/25/23, 5/26/23, and 5/30/23. The Meal Consumption Logs for June 2023		address further documentation trends for correction. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · All clinical staff were educated on POC documentation, the importance of tracking meal intakes for all residents, and notifying nurse supervisor/manager for any meal refusals. · All clinical staff were educated to ensure supplements are administered as ordered and items listed on tray tickets are received at each meal and notifying kitchen staff when it is not provided and/or nursing supervisor/manager of refusals. · All dietary staff educated on importance of providing all supplements at each meal that are listed on meal tray tickets. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · DON/Designee will review POC documentation 5x a week to ensure meal consumption logs are	

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	indicated there was no documentation for the breakfast meal on 6/3/23, 6/7/23, 6/9/23, 6/13/23, 6/17/23, 6/18/23, and 6/19/23. There was no documentation for the lunch meal on 6/3/23, 6/7/23, 6/9/23, 6/13/23, 6/17/23, 6/18/23, and 6/19/23. There was no documentation for the dinner meal on 6/3/23, 6/4/23, 6/5/23, 6/7/23, 6/9/23, 6/13/23, 6/14/23, 6/17/23, 6/18/23, and 6/19/23. Interview with the Director of Nursing on 6/20/23 at 9:40 a.m., indicated he had no further information to provide. This Federal tag relates to Complaint IN00407458. 3.1-46(a)(1)		being completed. · Dietary Manager/Designee will audit 15 meal trays weekly on various shifts to ensure supplements are delivered to residents as ordered. · DON/Designee will review 10 supplement orders weekly to ensure supplements are being administered and documented as ordered. · The DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 07/06/2023**	
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 observation, record review, and interview, the facility failed to ensure a resident's clinical record was complete and accurately documented related to treatment order charting not updated for 1 of 3 residents reviewed for non-pressure related skin conditions. (Resident M) Finding includes: On 6/20/23 at 9:45 a.m., Resident M was observed in her room in bed. Her right heel area was wrapped with gauze and her toes were exposed. On 6/21/23 at 9:30 a.m., the resident was again observed in her room in bed. Her right heel area was wrapped with gauze and her toes were exposed. The record for Resident M was reviewed on 6/20/23 at 10:08 a.m. Diagnoses included, but were not limited to, type 2 diabetes mellitus,	F 0842	**POC for F842– Resident Records – Identifiable Information** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** · Resident M suffered no ill effects from alleged deficient practice. · Review of records indicates that the treatment being provided to Resident M's right heal was accurate and appropriate. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.**	07/06/2023

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	acquired absence of the left leg below the knee, and peripheral vascular disease. The Medicare 5 day Minimum Data Set (MDS) assessment, dated 6/11/23, indicated the resident was cognitively intact and she needed extensive assistance with bed mobility and transfers. She also had an infection of the foot. A Care Plan, dated 11/7/22, indicated the resident was at risk for alteration in skin integrity due to risk factors associated with cardiovascular disease, chronic or end stage renal disease, diabetes, pain, poor skin turgor (firmness), and peripheral vascular disease. Interventions included, but were not limited to, reposition/shift weight at frequent intervals and check skin daily. A Physician's Order, dated 6/9/23, indicated betadine (a topical antiseptic) was to be applied to the right heel daily. The area was to be left open to air (LOTA). The Wound Physician Progress Notes, dated 6/15/23, indicated the resident had a full thickness arterial wound of the right heel. The area measured 0.6 centimeters (cm) x 1.3 cm x 0.3 cm. The dressing treatment plan was betadine, apply daily, and gauze roll apply daily. The June 2023 Treatment Administration Record (TAR), indicated the treatment order had not been updated on 6/15/23. The treatment of betadine and LOTA was still signed out as being completed after 6/15/23. Interview with the Wound Nurse on 6/21/23 at 10:35 a.m., indicated the current treatment order had not been updated on the TAR.		· All residents have the potential to be affected by this alleged deficient practice. · Full house audit of physician wound progress notes was completed to ensure treatment orders matched recommendations written in wound physician progress notes. There were no further discrepancies identified. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** · Treatment/wound nurses were educated on reviewing all physician progress notes when written to ensure any new recommendations and/or order changes written in progress notes have accurate correlating orders in treatment administration record. · Clinical staff were educated on reviewing progress notes to ensure any recommendations written by physicians and/or NPs at the time of visit, assessment, and documentation, have correlating order updated if different than current orders. · Credentialed physicians and NPs were educated on either	

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	This Federal tag relates to Complaint IN00408541. 3.1-37(a)		updating orders when there are new recommendations or order changes or verbally dictating order changes to licensed nurses when there are new recommendations and/or order changes. **How will the corrective actions(s) be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** · DON/Designee will review the wound physician progress notes weekly to ensure the orders match physician recommendations and updated order changes. · DON/Designee will review 5 resident charts weekly to ensure physician/NP progress notes have accurate correlating orders updated in MAR/TAR, and/or plan of care is updated when appropriate. · The DON/Designee will present summaries of the audit to the Quality Assurance Committee monthly for six months. Thereafter, if determined by Quality Assurance Committee that further monitoring is needed, audits will continue. **Date of compliance: 07/06/2023**	

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