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	02/20/2024

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

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00426658, IN00427627, and IN00428128. Complaint IN00426658 - Federal/State deficiencies related to the allegations are cited at F684 and F732. Complaint IN00427627 - Federal/State deficiencies related to the allegations are cited at F622. Complaint IN00428128 - Federal/State deficiencies related to the allegations are cited at F732. Unrelated deficiency is cited. Survey dates: February 19 & 20, 2024 Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 110 Residential: 37 Total: 147 Census Payor Type: Medicare: 15 Medicaid: 80 Other: 15 Total: 110 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 2/26/24.	F 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Administrator	03/06/2024

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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F 0554 SS=D Bldg. 00	483.10(c)(7) Resident Self-Admin Meds-Clinically Approp §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. Based on observation, record review, and interview, the facility failed to determine self-administration of medications was appropriate for residents, related to medications left with the residents for self administration and no assessment to indicate the residents were appropriate for self administration of medications, for 2 of 2 residents observed with medications left in the room for administration. (Residents N and K) Findings include: 1) During an observation on 2/19/24 at 9:03 a.m., Resident N was in her room and in bed. with the head of the bed elevated. Located on the table next to the bed. were four stacked plastic medication cups with three to four pills in each one, one cup by itself with one pill, and one cup by itself with five pills in it, and a bottle of turmeric capsules (supplement). She indicated she takes the turmeric. She indicated the cup sitting by itself with the five pills contained the vitamins she takes and it was brought to her this morning, and the others were "extras". She stated she did not need the Nurse to stand by her when she took the medications. During an interview, on 2/19/24 at 9:18 a.m., QMA 1 indicated the morning medications are given to the resident and she would take her vitamins and supplements "when she wants" and she was checked on to ensure the medications were taken.	F 0554	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident N had no adverse outcomes related to medication administration. Resident requested medication be scheduled and agreed not to have at bedside. The Nurse Practitioner was updated, and a medication adjustment was made. Resident K had no adverse outcomes related to medication administration. The MD was notified, and no new orders were received. **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;** Facility residents have the potential to be affected by the same 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 staff were re-educated on	03/06/2024

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	Resident N's record was reviewed on 2/20/24 at 12:55 p.m. The diagnoses included, but were not limited to, diabetes mellitus. An Annual Minimum Data Set assessment, dated 2/2/24, indicated an intact cognitive status. The current Physician's Orders, indicated the following medications were to be administered at 9 a.m.: Ascorbic acid 500 mg (vitamin C), 1 tablet Calcium citrate with D, 1 tablet Multi-vitamin, 1 tablet Hiprex 1 gm (antibiotic) 1 tablet for prophylactic for an urinary tract infection Metformin (anti-diabetic) 500 mg tablet There was no Self-Administration of Medication assessment completed. There was no Care Plan for self-administration of medication, and no Physician's Orders that indicated the resident could self administer the medications. 2) During an observation, on 2/20/24 at 8:23 a.m., Resident K was in bed with the head of the bed elevated. There was a plastic medication cup with five pills in the cup sitting on the over the bed table. She identified the pills as her morning medications, and indicated she had forgotten to take them. The pills were given to her when she had not eaten breakfast yet, and did not like to take the medications on an empty stomach. She had forgotten to take pills after she ate her breakfast. She then took the medications one at a time. Resident K's record was reviewed on 2/20/24. The diagnoses included, but were not limited to, stroke and cognitive communication deficit		proper storage of medications and needed documentation for self -administration of medications. **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;** D.O.N./designee audit 10 resident rooms per week x 4 months to ensure medications are properly stored and needed documentation is in place for self-administration of medications. D.O.N./designee will present a summary of the audits to the Quality Assurance committee monthly for 4 months. If the results of the audit fall below 95%, the audit will continue.	

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	A Quarterly Minimum Data Set assessment, dated 12/18/23, indicated an intact cognitive status and impairment of one side of the upper and lower extremities. The current Physician's Orders, indicated the following medications were to be administered at 9 a.m.: Multivitamin capsule, one capsule. Furosemide (diuretic) 20 mg (milligrams), two tablets. Levetiraceta tablets (anti-seizure), 500 mg, one tablet. Metoprolol 50 mg (hypertension), one tablet. Gabapentin (nerve pain) 300 mg, 1 capsule. The Physician's Orders lacked an order for the turmeric capsules. There was no order or assessment that indicated medication could be kept at the bedside. There was no Self-Administration of Medication assessment completed. There was no Care Plan for self-administration of medication, and no Physician's Orders that indicated the resident could self administer the medications. A Self-Administration of Medication Policy, dated 1/2021, and received as current from the Administrator, indicated the residents would be allowed to self-administer medications if the interdisciplinary team determined that it was safe. Appropriate documentation of the determination was to be completed and care planned. 3.1-11			
F 0622 SS=D Bldg. 00	483.15(c)(1)(i)(ii)(2)(i)-(iii) Transfer and Discharge Requirements §483.15(c) Transfer and discharge-			

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	§483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that			

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	failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including			

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	a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. Based on record review and interview, the facility failed to ensure the requirements for a resident initiated discharge were completed, related to documentation of the intent to discharge, lack of a discharge planning Care Plan, lack of a discussion with the resident or Responsible Party about the discharge, and lack of a Discharge Summary, for 1 of 3 residents reviewed for discharges from the facility. (Resident J) Finding includes: Resident J's closed record was reviewed on 2/20/24 at 11:19 a.m. The diagnoses included, but were not limited to, stroke. The resident was discharged from the facility on 2/13/24. An Admission Minimum Data Set assessment, dated 1/22/24, indicated an intact cognitive status, had no behaviors, required moderate assistance for toileting, dressing of the upper body, bed mobility, transfers and ambulation. She required maximum assistance with showers and dressing of the lower extremities and was dependent for wheelchair mobility. The current Care Plan, dated 1/15/24, indicated assistance was required for all activities of daily living. The Care Plan indicated an impaired cognitive functioning related to dementia. The interventions included the resident and family would be updated with with the resident's capabilities and needs.	F 0622	Resident J was discharged safely to her Assisted Living apartment without any concerns voiced. All residents with discharge planning needs have the potential to be affected by the alleged deficient practice. The IDT has been educated on the requirements for discharge and documentation of discharge planning including discussion with resident and or responsible party, discharge summary, discharge orders and location that resident is discharging to. The Administrator/ Designee will review all planned discharges weekly to ensure appropriate planning and documentation is present in the medical record. The results of the audit will be submitted to the QAPI committee for review for no less than 4 months to ensure continued compliance. If the results of this audit fall below 95%, the audits will continue.	03/06/2024

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	The Baseline Care Plan, dated 1/15/24, indicated she had been admitted for therapy, the discharge goal was to return to the community and no discharge plans were initiated. The last Progress Note in the record was a Nutrition/Dietary Note, dated 2/9/24 at 2:25 p.m. and indicated there were no recommendations. The Physician's Orders lacked an order for the resident to be discharged from the facility. There was no documentation of a discussion of the discharge with the resident and/or Responsible Party, no discharge planning and preparedness for the discharge, no discharge summary completed, and no documentation when the resident discharged, where she went, and status of the resident when she discharged. During an interview, on 2/20/24 at 11:28 a.m., the Social Service Director indicated a discharge planning care plan should have been initiated. The resident had been discharged to the Assisted Living Community at the facility and therefore was a discharge from the Healthcare facility. She acknowledged there was no resident and/or family input on the discharge documented, no discharge paperwork/summary, nor discharge planning completed from the facility. This citation relates to Complaint IN00427627. 3.1-12(a)(3) 3.1-12(a)(5) 3.1-12(a)(6)(B)			
F 0684 SS=D	483.25 Quality of Care			

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Bldg. 00	§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, record review, and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards, related to treatment, assessment, and documentation of a skin condition, for 1 of 3 residents reviewed for quality of care related to skin conditions. (Resident D) Finding includes: During an interview on 2/19/24 at 4 p.m., Resident D was in her room and in bed. She indicated she was given a shower today, she had a rash under her breasts and abdominal folds, and the staff only applied powder to the areas after they bathed her. The area under the left breast was observed and was pink, and had a superficial rash on the inner area of the upper abdomen under the breast. Resident D's record was reviewed on 2/19/24 at 1:51 p.m. The diagnoses included, but were not limited to, diabetes mellitus. A Quarterly Minimum Data Set assessment, dated 1/9/24, indicated an intact cognitive status, no behaviors, was dependent for showers, hygiene, bed mobility, and transfers. Applications of ointments or medications were provided to areas other than the feet.	F 0684	**What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Resident D has been receiving her treatments as ordered, and her care plan and weekly skin assessment are reflective of her current skin condition. **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 same alleged deficient practices. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;**	03/06/2024

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	The current Care Plans, dated 1/2/24, indicated no care plan was initiated for the skin conditions under the bilateral breasts and abdominal folds. A Physician's Order, dated 9/20/23, indicated clobetasol propionate cream (steroid cream) 0.05% was to be applied to the abdominal and breast folds twice a day for MASD (moisture associated skin damage) A Physician's Order, dated 10/10/23, indicated the abdominal folds were to be washed with soap and water, patted dry, clobetasol cream was to be applied, and Interdry AG (moisture wicking fabric) was to be applied on day shift on Monday and Thursdays and as needed due to MASD. A Physician's Order, dated 1/1/24, indicated nystatin (anti-fungal) powder was to be applied to the breast and abdominal folds daily due to a rash. The Medication Administration and Treatment Administration Records, indicated the nystatin treatment and the Interdry treatment had been completed as ordered. The clobetasol cream treatment was not documented as completed on the evening shift of 1/19/24, day shift on 1/28/24, and evening shift on 2/14/24. The Weekly Skin Assessments, dated 1/18/24, 2/1/24, 2/10/24 indicated the skin was intact and there were no skin concerns. The Weekly Skin Assessment, dated 1/26/24, indicated there was bruising of the left arm and an open area to the left gluteal area. The Weekly Skin Assessment, dated 2/12/24, indicated an open area to the left buttock area.		Licensed nursing staff have been re-educated to ensure treatments are completed as ordered and care plans and skin assessments are completed and reflective of the current skin condition. **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;** Weekly for 4 months, the DON/designee will review 10 residents' treatment records to ensure treatments are completed as ordered and care plans and skin assessments are completed and reflective of the current skin condition. Don/designee will present a summary of the audits to the QA committee monthly for 4 months. If the results of this audit fall below 95%, the audits will continue.	

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	There were no assessments of the areas under the breast and abdominal folds in the Progress Notes from 1/15/24 to 2/19/24. During an interview on 2/19/24 at 4:14 p.m., the Wound Nurse indicated it was ultimately her responsibility to ensure the areas under the breast and abdominal folds were care planned and the skin condition was monitored and assessed. This citation relates to Complaint IN00426658. 3.1-37			
F 0732 SS=C Bldg. 00	483.35(g)(1)-(4) Posted Nurse Staffing Information §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format.			

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	(B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. Based on observation, record review, and interview, the facility failed to ensure the posted Nurse Staffing Information was up-to-date and current, related to a lack of facility census documented on the postings. This had the potential to affect all of the residents who resided in the facility for the month of February, 2024. Findings include: During an observation on 2/19/24 at 10 a.m., the Nursing Staff Posting was posted at the front door of the facility. The facility census was not documented on the posting. At the time of the observation, the Administrator indicated the census was usually written on the posting after the morning meeting. The Nursing Staff Schedules and Postings from 1/10/24 to 2/11/24 were reviewed on 2/19/24 at 7 p.m. There was no facility census posted on the postings from 2/5/24 through 2/11/24. The Administrator acknowledged on 2/20/24 at 10 a.m., the facility census had not been documented on the postings.	F 0732	Upon surveyor notification the census was immediately added to the staffing posting. No residents were affected by the alleged deficient practice. DON/Scheduler has been educated to ensure the census is included on the daily staffing posting. The Administrator or Designee will audit the staffing posting 3 times per week, including weekends for one month and weekly for 3 months to ensure the census is included on the posting. The results of the audit will be submitted to the QAPI committee for review for no less than 4 mos to ensure continued compliance. If the compliance rate falls below 95% the audit will continue.	03/06/2024

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