STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review, and interview, the facility failed to ensure non-pressure skin areas and signs and symptoms of constipation were assessed, monitored, and documented for 1 of 3 residents reviewed for non-pressure areas and 1 of 3 residents reviewed for a change in condition. (Residents C and J) Findings include: 1. On 4/13/22 at 11:00 a.m., CNA 1 was observed checking Resident C for incontinence. At that time, she was asked to remove the resident's bed linens so both feet and legs could be observed. The resident had a bandage on her lower right leg and her second toe on the left foot was discolored. The record for Resident C was reviewed on 4/13/22 at 10:15 a.m. The resident was admitted on [DATE] from the hospital. Diagnoses included, but were not limited to, cellulitis of the left lower limb, dementia, high blood pressure, peripheral vascular disease, anemia, and angina. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. She weighed 108 pounds, had no oral problems or weight loss, and received a mechanically altered diet. An initial wound exam, performed by the Wound Physician, dated 2/21/22, indicated the resident had an arterial wound on the left dorsal second toe which measured 2 centimeters (cm) by 1 cm. The wound was a dried fibrous exudate (scab). The treatment of Betadine (a skin disinfectant) was put into place. A current and last Wound Physician note, dated 4/12/22, indicated the left second toe arterial wound had improved and measured 1.5 cm by 1 cm and was 100% dermis tissue. Physician's Orders, dated 3/15/22, indicated to monitor the left dorsal second toe each shift for any changes and report to MD/NP (Medical Doctor/Nurse Practitioner). The Treatment Administration Record (TAR) for 4/2022, indicated the treatment had been signed out one time on 4/7/22 on the day shift. Documentation of the toe being monitored was not completed 4/1-4/6/22 for all three shifts and 4/7 (eves and midnights) to 4/12/22 (all shifts). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Wound Nurse on 4/13/22 at 11:00 a.m., indicated the Wound Physician wanted the toe monitored more frequently because it was still dark and discolored even though there was no treatment in place. Nursing staff were supposed to assess the wound every shift. 2. The record for Resident J was reviewed on 4/12/22 at 10:05 a.m. Diagnoses included, but were not limited to, major depressive disorder, PTSD (post traumatic stress disorder), high blood pressure, and weakness. The Annual Minimum Data Set (MDS) assessment, dated 12/8/21, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 person physical assist with bed mobility and toilet use. The resident was always incontinent of bowel and bladder. There was no Care Plan for constipation. Nurses' Notes, dated 4/1/22 at 6:02 a.m., indicated the resident's abdomen was noted as hard and distended. The resident had 2 bowel movements that shift. The stool was noted as watery and non-formed. Staff had noted this issue and stated it was more distended than the previous day. The assessment was to be passed on to the doctor. The next entry in the Nursing Notes was on 4/2/22 at 6:27 a.m. (24 hours later), which indicated the resident remained with firmness and distention to the abdomen without tenderness on palpation. He had a bowel movement over night and appeared comfortable at that time. Would continue to monitor. The next documented entry in Nurses' Notes was on 4/4/22 at 12:56 p.m., indicating the resident had a rapid COVID-19 test and it was negative. There was no documentation regarding the resident's abdomen. Nurses' Notes, dated 4/5/22 at 5:10 a.m., indicated, called to room per CNA who stated the resident didn't look right. Writer observed the resident to be pale in color and called the resident's name multiple times with no response. The resident was not responding to verbal or tactile stimuli. The resident was repositioned and still did not respond. Vital signs were taken and the resident was a full code, so 911 was initiated. At 5:26 a.m., the resident remained unresponsive upon leaving the facility, but had a pulse and noted breaths. The resident was admitted to the hospital and was still in the hospital at this time. A hospital note, dated 4/5/22, indicated a Cat Scan (CT) of the abdomen was obtained. The impression was a massively dilated colon in particular affecting the transverse and sigmoid colon, with preserved haustral pattern. The rectum is also dilated and fluid filled. Another CT of the abdomen was obtained on 4/6/22 which indicated a massively distended colon but possibly stable or slightly improved. A CT of the abdomen was obtained on 4/9/22 which indicated the colon was still massively dilated with air and a rectal tube was present, however, it was stable from the previous days. Physician's Orders, dated 2/5/21, indicated Colace (a stool softener) 100 milligrams (mg) daily prn (as needed). The Medication Administration Record (MAR) for the months of 3/2022 and 4/2022, indicated the Colace was not administered. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The bowel movement (bm) record indicated the following: 3/22-large and medium bm 3/23-medium bm 3/24-3/26 no bm 3/27-small bm 3/28-3/31-no bm 4/1-medium bm 4/2-small and large bm 4/3-large bm 4/4-no bm 4/5-large bm Interview with the Assistant Director of Nursing on 4/13/22 at 2:30 p.m., indicated she was unaware the resident had abdominal distention prior to his hospitalization and she was also unaware the resident had not had a bm for several days. This Federal tag relates to Complaints IN00376606 and IN00377184. 3.1-37(a)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure Registered Dietitian recommendations related to wound healing were carried out in a timely manner for 1 of 3 residents reviewed for pressure ulcers. (Resident F) Finding includes: The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on [DATE]. Prior to admission, the resident was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. The resident was admitted with one Stage 3 pressure area and 4 unstageable pressure areas. Registered Dietitian (RD) progress notes, dated 3/10/22 at 2:43 p.m., indicated per the 3/5/22 wound care management notes, the resident had areas to the right heel, left heel, sacrum, mid lower back and right ear. The resident received MVI with mineral (multivitamin) to aid in healing. The resident may benefit from adding additional protein for wound healing. The resident was at risk for malnutrition due to diagnoses of cancer, diabetes mellitus, congestive heart failure, and hypertension, inability to swallow regular liquids and impaired skin integrity. Recommend-No Concentrated Sweet, No Added Salt diet and 30 cubic centimeters (cc) of Prostat (a supplement for wound healing) twice a day. Will continue to follow as needed. The resident did not have an order for the Prostat. There was also no documentation indicating if the Physician had been contacted about the RD's recommendations. Interview with the Director of Nursing on 4/14/22 at 2:20 p.m., indicated the Physician should have been contacted about the RD's recommendations. This Federal tag relates to Complaint IN00376606. 3.1-40(a)(2)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to consistently monitor food and fluid intake for at risk residents for 2 of 3 residents reviewed for nutrition. (Residents F and C) Findings include: 1. The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on [DATE]. Prior to admission, the resident was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. She also needed supervision with eating. The resident was admitted with one Stage 3 pressure area and 4 unstageable pressure areas. Registered Dietitian (RD) Progress Notes, dated 3/10/22 at 2:43 p.m., indicated per the 3/5/22 wound care management notes, the resident had areas to the right heel, left heel, sacrum, mid lower back and right ear. The resident received MVI (multivitamin) with minerals to aid in healing. The resident had fair oral intake per food consumption records, 25-75% of most meals were recorded. The resident may benefit from adding additional protein for wound healing. The resident was at risk for malnutrition due to diagnoses of cancer, diabetes mellitus, congestive heart failure, and hypertension, inability to swallow regular liquids and impaired skin integrity. The general nursing interventions, dated 3/4/22, indicated document breakfast, lunch and dinner in the point of care response section. No food consumption was documented on 3/6, 3/10, 3/11, and 3/12/22. No dinner intake was documented on 3/13/22. Interview with the Director of Nursing on 4/14/22 at 2:20 p.m., indicated the resident's meal intake should have been documented. 10770 2. On 4/13/22 at 9:10 a.m., Resident C was observed in bed, eating breakfast. She was feeding herself without any difficulty. The record for Resident C was reviewed on 4/13/22 at 10:15 a.m. The resident was admitted on [DATE] from the hospital. Diagnoses included, but were not limited to, cellulitis of the left lower limb, dementia, high blood pressure, peripheral vascular disease, anemia, and angina. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. She weighed 108 pounds, had no oral problems or weight loss, and received a mechanically altered diet. There was no Care Plan for nutrition. Nurses' Notes, dated 2/17/22 at 9:25 p.m., indicated the resident arrived to the facility per EMS. A Registered Dietitian's (RD) Note, dated 2/24/22 at 10:32 a.m., indicated the resident's weight was 108 pounds with a Body Mass Index of 20. She was noted with pressure injuries to her legs. The resident may benefit from nutritional supplements due to variable oral intake and to aid in healing. The resident was at risk for malnutrition due to diagnoses of dementia, anemia, high blood pressure, variable oral intake and skin impairment. Recommend a MVI (multivitamin) with minerals, 30 cc (cubic centimeters) Prostat (a supplement to promote wound healing) twice a day and a 4 ounce ready care shake twice a day. An admission weight was not obtained until 2/22/22 (5 days after the resident had been admitted). The resident's weight was 108 pounds. The meal consumption log for 2/2022 indicated there was no documentation of any meals on 2/17, 2/18, 2/19, 2/20, and 2/21/22. The first meal documentation was on 2/22/22 for breakfast. Physician's Orders, dated 2/21/22, indicated document breakfast, lunch and dinner in the point of care response section. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated the meal consumption logs were to be completed after every meal. This Federal tag relates to Complaints IN00374097 and IN00376606. 3.1-46(a)(1)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on observation, record review and interview, the facility failed to ensure tracheostomy care was provided as ordered for 2 of 2 tracheostomy residents reviewed. (Residents K and E) Findings include: 1. On 4/12/22 at 2:15 p.m., Resident K was observed in bed, he was awake, alert and oriented, and indicated he had been in the facility since last Thursday. The resident was observed with a tracheostomy and an oxygen mask over the trach, there was no drain sponge noted around the trach. The resident indicated it had fallen off a couple of days ago and no staff person had replaced it. He lived at home with his wife and has had a tracheostomy for the last [AGE] years, so he was very familiar with what needed to be done on a daily basis. He was able to cough up a lot of the sputum on his own, however, there was a suctioning device set up for him to do his own suctioning. The resident indicated trach care had only been completed one time since admission. There was a box of supplies on top of the table and inside the drawer, there were 2 boxes of inner cannulas, many suctioning kits, and 2 spare tracheostomies. The record for Resident K was reviewed on 4/12/22 at 3:00 p.m. Diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), congestive heart failure, type 2 diabetes, chronic respiratory failure, cellulitis right and left lower limbs, high blood pressure, chronic kidney disease, tracheostomy status, and asthma. The Admission Minimum Data Set (MDS) was still in process. A Nurses' Note, dated 4/8/22 at 2:39 p.m., indicated the resident was alert and oriented times 3 and was able to make needs known. The Respiratory Therapist was in the facility and set up the resident for the tracheostomy supplies. A Respiratory Note, dated 4/9/22 at 3:59 p.m., indicated a request to set up equipment for 0.28 trach collar. Compressor and concentrator set up and all supplies reviewed. Current supplies were present for trach collar, suction, nebulizer and trach care. Set up yanker (a device used for suctioning) for resident to use in order to keep mouth clear. Trach care was completed and reviewed all processes with nursing. Resident was a long term trach patient. Physician's Orders, dated 4/7/22, indicated tracheostomy care and suctioning every shift and prn (as needed). Change disposable inner cannula daily. Change trach ties weekly and prn. The Medication Administration Record (MAR), dated 4/2022, indicated the tracheostomy care and suctioning was not signed out as being completed for the day shift on 4/10 and 4/11. The trach care for the evening shift was not signed out as completed on 4/8-4/10/22. Trach care was not signed out as being completed on the midnight shift from 4/8-4/11/22. The 4/2022 MAR for changing the inner cannula daily indicated it had been signed out as being completed 4/8, 4/9, 4/10, and 4/12/22. There were no initials on 4/11/22 to indicate it had been completed. The trach ties were not signed out as being completed on 4/11/22. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with Agency LPN 1 on 4/12/22 at 2:30 p.m., indicated she had been taking care of the resident that day. She did not do trach care, due to not being able to find any trach supplies in the room, however, her initials were in the box for the day shift on all trach related items for 4/12/22. When questioned about signing out treatments that were not completed, the LPN stated I should not have marked it as being done when I had not completed trach care. I could not find any supplies in the room to provide the care. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated tracheostomy care should be completed as ordered. 2. The closed record for Resident E was reviewed on 4/12/22 at 3:30 p.m. The resident was admitted to the facility on [DATE] and discharged to the hospital on 2/21/22. Diagnoses included, but were not limited to, throat and neck cancer, viral pneumonia, high blood pressure, tracheostomy, peg tube, repeated falls, aphasia, dysphagia, and weakness. The 5 day Minimum Data Set (MDS) assessment, dated 2/21/22, indicated the resident was alert and oriented and needed extensive assist with 1 person physical assist for transfers and bed mobility. The resident had a tracheostomy and oxygen while a resident. Nurses' Notes, dated 2/15/22 at 1:44 p.m., indicated the resident arrived to the facility per EMS. He was alert, could make his needs known in Spanish, but understood some English. A tracheostomy was in place and respirations were even and unlabored. Physician's Orders, dated 2/16/22, indicated tracheostomy care and suctioning every shift and change disposable inner cannula daily. The Medication Administration Record (MAR) for 2/2022, indicated the trach care was not signed out as being completed for the day shift on 4/20, evening shift on 4/19, and the midnight shift on 4/18/22. The inner cannula had not been signed out as being changed 4/17 and 4/19/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated tracheostomy care should be completed as ordered. This Federal tag relates to Complaint IN00374097. 3.1-47(a)(4)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to ensure a resident's medications were signed out as being administered for 3 of 4 residents reviewed for unnecessary medications. (Residents C, D, and E) Findings include: 1. The record for Resident C was reviewed on 4/13/22 at 10:15 a.m. The resident was admitted on [DATE] from the hospital. Diagnoses included, but were not limited to, cellulitis of the left lower limb, dementia, high blood pressure, peripheral vascular disease, anemia, and angina. The Quarterly Minimum Data Set (MDS) assessment, dated 3/3/22, indicated the resident was moderately impaired for decision making. She weighed 108 pounds, had no oral problems or weight loss, and received a mechanically altered diet. Physician's Orders, dated 2/17/22, indicated medications as follows: - Levothyroxine (a thyroid medication) 100 micrograms (mcg) daily, scheduled for 6:00 a.m. - Caltrate 600 plus D (Calcium carbonate-vitamin D3) 600 milligrams(mg)-20 mcg daily, scheduled for 9:00 a.m. - Atorvastatin (a cholesterol medication) 40 mg daily, scheduled for 9:00 p.m. The Medication Administration Record (MAR) for 2/2022, indicated the Levothyroxine was not signed out as being administered on 2/18 and 2/19/22. The Caltrate was not signed out as being administered on 2/18/22 and the Atorvastatin was not signed out as being administered on 2/18, 2/20, and 2/22/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated medication should be administered as ordered by the doctor. 2. The record for Resident D was reviewed on 4/13/22 at 9:45 a.m. Diagnoses included, but were not limited to, status post pancreatosplenectomy due to abscess on abdominal wall. The resident was sent out to the hospital on 1/27/22 and returned on 2/8/22 at 2:32 p.m. At that time, he had his pancreas and spleen removed. The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/22, indicated the resident was cognitively intact and had major surgery for removal of the spleen. In the last 7 days, he had 5 doses of an antibiotic medication. Physician's Orders, dated 2/9/22, indicated medications as follows: - Protonix (a medication for gastric reflux) 40 milligrams (mg) daily at 6:00 a.m. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Cyclobenzaprine (a muscle relaxer) 10 mg three times a day at 9:00 a.m., 2:00 p.m., and 8:00 p.m. - Colace (a stool softener) 100 mg daily at 9:00 a.m. - buspirone (an anti-anxiety medication) 5 mg three times a day at 9:00 a.m., 2:00 p.m., and 8:00 p.m. - Metoprolol (a heart medication) 100 mg daily at 9:00 a.m. - Nifedipine (a heart medication) 30 mg daily at 9:00 a.m. The Medication Administration Record (MAR) for 2/2022, indicated the Protonix was not signed out as being administered on 2/9, 2/10, and 2/12-2/18/22. The Cyclobenzaprine was not signed out as being administered on 2/9 at 9:00 a.m. and 2:00 p.m., and the Colace was not signed out as being administered on 2/9 and 2/10/22. The buspirone was not signed out as being administered on 2/9 at 9:00 a.m. and 2:00 p.m., 2/15 and 2/18 at 2:00 p.m., and 2/24 at 9:00 a.m. The Metoprolol and Nifedipine was not signed out as being administered on 2/9, 2/11, and 2/24/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated medication should be administered as ordered by the doctor. 3. The closed record for Resident E was reviewed on 4/12/22 at 3:30 p.m. The resident was admitted to the facility on [DATE] and discharged to the hospital on 2/21/22. Diagnoses included, but were not limited to, throat and neck cancer, viral pneumonia, high blood pressure, tracheostomy, peg (a tube inserted in the stomach) tube, repeated falls, aphasia, dysphagia, and weakness. The 5 day Minimum Data Set (MDS) assessment, dated 2/21/22, indicated the resident was alert and oriented and needed extensive assist with 1 person physical assist for transfers and bed mobility. The resident had a tracheostomy and oxygen while a resident. Nurses' Notes, dated 2/15/22 at 1:44 p.m., indicated the resident arrived to the facility per EMS. He was alert, could make his needs known in Spanish, but understood some English. A tracheostomy was in place and respirations were even and unlabored. Physician's Orders, dated 2/15/22, indicated medications as follows: - Levothyroxine (a thyroid medication) 300 (micrograms) mcg daily at 6:00 a.m. - Carvedilol (a blood pressure medication) 6.25 milligrams (mg) at 6:00 a.m. and 6:00 p.m. - Eliquis (a blood thinner) 5 mg at 6:00 a.m. and 6:00 p.m. - Amlodipine (a blood pressure medication) 10 mg daily at 6:00 a.m. - Atorvastatin (a cholesterol medication) 40 mg daily at 6:00 a.m. - Famotidine (a medication for gastric reflux) 20 mg at 6:00 a.m. and 6:00 p.m. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Furosemide (a diuretic) 20 mg at 6:00 a.m. and 6:00 p.m. The Medication Administration Record for 2/2022, indicated the Levothyroxine was not signed out as being administered on 2/16-2/18/22. The amlodipine and atorvastatin were not signed out as being administered on 2/16/22. The Eliquis, Carvedilol, famotidine, and furosemide were not signed out for the 6:00 a.m. dose on 2/16 and 2/20/22 and the 6:00 p.m. dose on 2/17/22. Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated medication should be administered as ordered by the doctor. This Federal tag relates to Complaint IN00374097. 3.1-48(a)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review and interview, the facility failed to ensure residents were free of any significant medication errors related to not receiving anticoagulant (blood thinner) medications which resulted in a re-hospitalization for pulmonary emboli (blood clots in lungs) and new onset cardiomegaly (enlarged heart) for 2 of 3 residents reviewed for anticoagulant use. (Residents F and R) The facility also failed to ensure insulin and intravenous (IV) antibiotics were administered for 2 of 4 residents reviewed for unnecessary medications. (Residents F and D) The immediate jeopardy began on 3/5/22 when the resident's anticoagulant was not delivered to the facility after admission from the hospital. The pharmacy had contacted the facility on 3/6 and 3/10/22 for a clarification order with no response from facility staff. On 3/10 and 3/14/22, the resident had complaints of chest pain and shortness of breath. The resident was sent out 911 on 3/14/22 after an abnormal EKG and was admitted to the hospital with bilateral large pulmonary emboli with new onset cardiomegaly. The Administrator was notified of the immediate jeopardy at 11:00 a.m. on 4/14/22. Findings include: 1. The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on [DATE]. a. Prior to admission, Resident F was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. A Physician's Order, dated 3/4/22, indicated the resident was to receive Enoxaparin (a blood thinner) syringe 100 milligrams (mg)/milliliters (ml) 112.5 mg subcutaneous daily. The order was discontinued on 3/12/22. A Physician's Order, dated 3/12/22, indicated the resident was to receive Eliquis (a blood thinner) 5 mg by mouth twice a day. The March 2022 Medication Administration Record (MAR) was not available for review. The Administrator indicated the Diabetic Flowsheet was found but not the MAR with the resident's other medications. Interview with the Pharmacist on 4/13/22 at 4:41 p.m., indicated the resident's Enoxaparin had not been sent to the facility due to a clarification order being needed. On 3/6/22, the Pharmacist spoke with LPN 1, indicating a clarification order needed to be obtained. He indicated he never received a response from the facility. On 3/10/22, another Pharmacist spoke with RN 1 and indicated a clarification order for the Enoxaparin needed to be obtained so it could be sent to the facility. The Pharmacy received no response from the facility. (continued on next page)

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	155220	A. Building B. Wing	04/14/2022

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Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Nurse Practitioner (NP) Progress Notes, dated 3/10/22 at 4:15 p.m., indicated the resident had reported midsternal chest pain without radiation or changes with breathing. The resident denied nausea, dizziness, or headache. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. NP Progress Notes, dated 3/14/22 with a time stamp of 5:32 p.m., indicated the resident had her EKG that day. The resident continued to complain of chest pain and some shortness of breath (SOB). STAT EKG results were abnormal. Continued complaints of midsternal chest pain with occasional SOB. Discussed results with Physician. Sending resident out for further evaluation to determine if resident was having an active MI (heart attack). No abdominal pain or fevers were noted per nursing report. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. Breath sounds clear but diminished to bilateral bases. The resident was sent out 911 on 3/14/22 at 4:00 p.m. The Hospital Admission Note, dated 3/14/22, indicated the resident was a recent admission for bilateral pulmonary emboli on full dose Lovenox (a blood thinner). The repeat CT scan redemonstrated bilateral pulmonary emboli with infiltrates. On 3/14/22, CT Chest Angiography with MIP Imaging showed, bilateral large pulmonary emboli with cardiomegaly. Diffuse consolidative infiltrates bilaterally with small bibasilar effusions. Cardiomegaly is identified. The cardiomegaly (enlarged heart) was new onset. A two view Chest X-Ray Report, completed on 1/31/22 during the resident's previous hospital stay, indicated the resident's heart size was grossly within normal limits. Interview with the Administrator on 4/13/22 at 4:45 p.m., indicated the resident's March MARs still could not be found. The resident's Enoxaparin should have been received as ordered and the facility should have followed up with the pharmacy regarding the clarification order. b. Resident F had a Physician's Order, dated 3/4/22, which indicated blood glucose monitoring was to be done four times a day. The Physician was to be notified if the resident's blood sugar was less than 60 or greater than 400. The March 2022 Insulin/Diabetic Flowsheet, indicated the resident's blood sugar was not monitored on the following dates and times: - 3/6/22 at 12:00 p.m. and 8:00 p.m. - 3/8/22 at 8:00 a.m., 12:00 p.m., and 8:00 p.m. - 3/10/22 at 8:00 a.m. A Physician's Order, dated 3/4/22, indicated the resident was to receive Tresiba Flex Touch insulin pen 50 units subcutaneously daily. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The March 2022 Insulin/Diabetic Flowsheet, indicated the Tresiba insulin was not given as ordered at 8:00 a. m. on 3/6, 3/8, and 3/13/22. A Physician's Order, dated 3/4/22, indicated the resident was to receive Novolog insulin, 27 units three times a day (tid). The March 2022 Insulin/Diabetic Flowsheet, indicated the Novolog insulin was not given as ordered at 8:00 a. m. on 3/6, 3/8, and 3/13/22. The 12:00 p.m. dose of insulin was not given on 3/8 and 3/13/22. Interview with the Director of Nursing on 4/14/22 at 2:20 p.m., indicated the insulin should have been given as ordered. He also indicated the resident's blood sugar should have been monitored as ordered. 10770 2. The record for Resident D was reviewed on 4/13/22 at 9:45 a.m. Diagnoses included, but were not limited to, status post pancreatosplenectomy due to abscess on abdominal wall. The resident was sent out to the hospital on 1/27/22 and returned on 2/8/22 at 2:32 p.m. At that time, he had his pancreas and spleen removed. The Quarterly Minimum Data Set (MDS) assessment, dated 2/14/22, indicated the resident was cognitively intact and had major surgery for removal of the spleen. In the last 7 days, he had 5 doses of an antibiotic medication. A Nurses' Note, dated 2/8/22 at 2:45 p.m., indicated during report from another nurse, it was stated this resident was on IV (intravenous) Zosyn (an antibiotic), the order could not be found on the medication list from the hospital, also the resident had new allergies to Zosyn per the discharge papers. The nurse called admissions asking if they had the current medication list to see what antibiotic the resident was supposed to be on and were awaiting a call back. Nurses' Notes, dated 2/9/22 at 5:49 a.m., indicated an order for Zosyn every 8 hours x 28 days confirmed with admissions and Physician. If side effects such as itching or rash occur, reach out to Physician for order to cope with effects. Physician's Orders, dated 2/9/22, indicated Piperacillin-Tazobactam (Zosyn) 3.375 grams, 1 bag IV every 8 hours times 28 days. Administration times were 12:00 a.m., 8:00 a.m., and 4:00 p.m. The Medication Administration Record (MAR) for 2/2022 and 3/2022, indicated the IV antibiotic was not signed out as being administered on the following dates and times: - 12:00 a.m. on 2/10, 2/17, 2/28, and 3/8/22 - 8:00 a.m. on 2/9, 2/10, 2/13, 2/25, 2/26, 2/27, 2/28, 3/3, 3/4, and 3/7/22 - 4:00 p.m. on 2/9, 2/10, 2/13, 2/14, 2/15, 2/16, 2/26, 2/27, 2/28, 3/5, 3/6, and 3/7/22 (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Interview with the Director of Nursing on 4/13/22 at 2:15 p.m., indicated the Zosyn was not given when the resident came back from the hospital due to a new documented allergy of Zosyn. They called the doctor to clarify and he indicated to go ahead and give the IV Zosyn and monitor the resident for itching or an allergic reaction. The Zosyn should have been administered as ordered by the doctor. 3. The record for Resident R was reviewed on 4/14/22 at 11:00 a.m. The resident was admitted to the facility on [DATE] at 2:05 p.m. Diagnoses included, but were not limited to, fusion of cervical spine, neuropathy, low back pain, cardiac murmur, and spinal stenosis. Nurses' Notes, dated 4/13/22 at 3:04 p.m., indicated the resident arrived to the facility per EMS. The resident was alert and oriented times 4 and able to make his needs known. Physician's Orders, dated 4/13/22, indicated Heparin (a blood thinner) 5000 units/milliliters (ml) 0.5 ml (5000 units) three times a day, scheduled times were 6:00 a.m., 12:00 p.m., and 6:00 p.m. every 8 hours times 30 days. The fax sent to pharmacy from nursing staff indicated, heparin (porcine) solution; 5,000 unit/ml Directions: amount 0.5 mls (5,000 units); injection; three times a day special instructions: Inject (5,000 units) into skin every 8 hrs x 30 days. The discharge instructions from the hospital, dated 4/13/22, indicated the Heparin was last administered on 4/13/22 at 5:37 a.m. Interview with Agency LPN 2 on 4/14/22 at 11:00 a.m., indicated she just printed off the resident's medication sheets, as he was admitted yesterday afternoon, and before the ambulance left, the family wanted a private room, so they moved him to a different room. He was only in that room for maybe 30 minutes. LPN 2 had worked a double shift that day, east unit in the morning and west unit for the evening shift. She helped the nurse with the admission and put the Physician's Orders into the computer. The LPN indicated she typed in three times a day and not every 8 hours, so the computer came up with those times. She had overlooked the every 8 hours directive and did not double check the order or call the doctor and clarify the order. She came back today and was working on the east unit where the resident resided. There were no medication sheets available for review, so she had to print new medication sheets. She had not administered any of his medications today. The medication cart was observed at 11:20 a.m., and the resident's oral medications were located in the cart, however, the Heparin medication was not in the cart. The LPN was unsure if the heparin medication was available in the EDK (Emergency Drug Kit). Interview with the Risk Management Consultant on 4/14/22 at 12:30 p.m., indicated the Heparin order was faxed to the pharmacy yesterday, however, the wrong dose was documented/transcribed, therefore, the pharmacy did not send the medication because they needed a clarification. (continued on next page)

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The immediate jeopardy that began on 3/5/22 was removed on 4/14/22 after the facility implemented a systemic plan that included the following actions: the pharmacy provided their policy related to clarification of medication orders, facility licensed nurses and agency nurses working onsite at the facility were inserviced regarding prompt follow up with the Physician/NP for any anticoagulant medication requiring order clarification when notified by the pharmacy, facility licensed nurses and agency nurses working onsite at the facility were inserviced regarding prompt follow up with the pharmacy for any anticoagulant medication order in the Medication Administration Record (MAR) that was missing, an audit of all residents with orders for anticoagulants was completed. All residents with orders for anticoagulants had the medication present and available. The facility requested the pharmacy to review any resident anticoagulant orders that had not been filled due to requiring clarification from the NP/Physician. The pharmacy verified there were no outstanding orders requiring clarification. The facility inserviced licensed nursing staff on pharmacy notification for any anticoagulation medication that required clarification from the NP/Physician so the medication could be dispensed by the pharmacy, prompt pharmacy notification for any anticoagulant medication listed in the medication administration record that was missing, Physician/NP notification for any anticoagulant medication not able to be filled by pharmacy for alternative orders, and notification of the DON and facility leadership for anticoagulation medications that had been clarified but had not been delivered. The facility did have an emergency medication (KAPSA) machine on site. The KAPSA could be accessed for missing anticoagulant medication and pharmacy could be called for any difficulty with access to the KAPSA machine. For any staff who had not received the inservice due to PRN status, agency status, or being unable to reach at the time, the facility would complete the above inservice prior to the start of their next scheduled shift. The DON/designee would complete an investigation for anticoagulants in which orders were not filled to determine the root cause of why the medication ordered was not filled/dispensed to the facility. The facility DON/designee would audit each new admission and readmission to verify that anticoagulant medications ordered had been delivered and secured in the medication cart. The pharmacy would be contacted immediately for any missing anticoagulant medication. The facility would complete a random audit twice weekly for all residents with orders for anticoagulant medications to ensure the medication was available and was being given as ordered and signed out on the MAR. An emergency QA meeting was held with the Medical Director, Administrator, DON, Social Service Director, HIM Director, and the Director of Nursing at Pharmacy on 4/14/22 at 2:00 p.m. The immediate jeopardy was removed on 4/14/22, but noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy, because not all staff had been educated and monitoring of the implemented systems was ongoing. This Federal tag relates to Complaints IN00374097 and IN00376606. 3.1-48(c)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to ensure diagnostic services were obtained in a timely manner related to obtaining a STAT (immediate) chest x-ray and electrocardiogram (EKG) for 1 of 3 residents reviewed for change in condition. (Resident F) Finding includes: The closed record for Resident F was reviewed on 4/12/22 at 11:35 a.m. Diagnoses included, but were not limited to, multiple subsegmental pulmonary emboli (blood clots in the lung) without acute cor pulmonale (a condition that causes the right side of the heart to fail), type 2 diabetes, and peripheral vascular disease. The resident was admitted to the facility on [DATE]. Prior to admission, the resident was hospitalized from 1/31/22 to 3/4/22 for bilateral pulmonary with large saddle embolus, right heel osteomyelitis (bone infection), and COVID-19 pneumonia. The Admission Minimum Data Set (MDS) assessment, dated 3/10/22, indicated the resident was cognitively intact and required extensive assistance with bed mobility. Nurse Practitioner (NP) progress notes, dated 3/10/22 at 4:15 p.m., indicated the resident had reported midsternal chest pain without radiation or changes with breathing. The resident denied nausea, dizziness, or headache. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. A STAT EKG was ordered since the resident had a history of atrial fibrillation. A STAT chest x-ray was also ordered. There was no documentation of the resident's chest pain in the nursing progress notes and the STAT orders. NP Progress Notes, dated 3/14/22 with a time stamp of 5:32 p.m., indicated the resident had her EKG that day. The resident continued to complain of chest pain and some shortness of breath (SOB). STAT EKG results were abnormal. Continued complaints of midsternal chest pain with occasional SOB. Discussed results with Physician. Sending resident out for further evaluation to determine if resident was having an active MI (heart attack). No abdominal pain or fevers were noted per nursing report. At that time, the resident did not appear to be in any distress. No other needs, wants, or concerns were expressed. Breath sounds clear but diminished to bilateral bases. The resident was sent out 911 on 3/14/22 at 4:00 p.m. and hospitalized . The STAT EKG and CXR weren't completed until 3/14/22. There was no documentation in the nursing progress notes related to the delay and no Physician or NP notification. Interview with the Nurse Consultant on 4/14/22 at 5:30 p.m., indicated staff should have reached out to the diagnostic company to see why the EKG and CXR had not been completed STAT as ordered. She also indicated documentation of the delay should have been completed in the nursing progress notes. (continued on next page)

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This Federal tag relates to Complaint IN00376606. 3.1-49(g)