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	04/05/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20580 Based on record review and interview, the facility failed to ensure effective services were provided to a dependent resident at risk to develop pressure injuries, and Resident C developed a facility-acquired pressure injury on the sacrum that deteriorated and exhibited signs and symptoms of infection for 1 of 3 residents reviewed for pressure ulcers. This deficient practice resulted in Resident C experiencing a significant change in condition that required hospitalization for wound-related septic shock and surgical debridement of the wound. The immediate jeopardy began on 3/9/24, when the sacral area was found and not thoroughly assessed. Treatment and further interventions for prevention and healing of the DTI were not initiated. The Administrator, Director of Nursing, and the Nurse Consultant were notified of the immediate jeopardy at 4/5/24 at 9:34. The immediate jeopardy was removed on 4/5/24, and the deficient practice corrected on 3/18/24, prior to the start of the survey, and was therefore Past Noncompliance Finding includes: Resident C's record was reviewed on 4/3/24 at 11:48 a.m. The diagnoses included, but were not limited to, stroke, subarachnoid hemorrhage, non-traumatic, respiratory failure, bipolar, aphasia, vascular implants and grafts, spina-bifida with shunts, and history of breast cancer (9/23/22). An Admission Clinical Observation, dated 3/2/24 at 3:09 p.m., indicated the resident was oriented to person and situation, was incontinent of bowel and bladder, bedfast, had a very limited ability to respond meaningfully to pressure related discomfort, the skin was constantly exposed to moisture, was completely immobile, and required maximum assistance with moving. There were no pressure ulcers present. The special instructions and risk factors included, a potential/actual impairment to the skin integrity. The interventions were to educate the resident/family caregivers of causative factors and measures to prevent skin injury, avoid scratching and keep hands and body parts from excessive moisture, keep fingernails short, and follow facility protocols for treatment of injury. Effective interventions to provide complete pressure relief to the bilateral buttocks were not included on the Admission Clinical Observation. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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.

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

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Care Plan, dated 3/4/24, indicated a potential for skin impairment. The interventions were to avoid scratching and keep hands and body parts from excessive moisture. Keep fingernails short. Educate resident/family/caregivers of causative factors and measures to prevent skin injury. Encourage good nutrition and hydration in order to promote healthier skin. Follow facility protocols for treatment of injury. Provide peri care to keep clean and dry as possible. Keep HOB (head of bed) as low as possible when in bed with knee [NAME] (bed adjustment to achieve elevation and bend) raised to prevent shearing injury. Heel boots/elevate heels off mattress with pillows under calves in bed. Assist with repositioning as needed. Barrier cream to buttock/peri area after each incontinent care every shift. A Physician's Order, dated 3/4/24, indicated house barrier cream was to be used after each incontinence episode, every shift, for prevention and could be kept at bedside for the CNAs to apply. The plan of care for potential skin impairment and the Physician Orders, dated 3/4/24, did not include documentation to show the facility implemented effective interventions for pressure relief to prevent the development of pressure injuries. An Admission Minimum Data Set (MDS) assessment, dated 3/9/24, indicated a moderately impaired cognitive status, limited impairment of the bilateral upper extremities, and one side of the lower extremities, a wheelchair was used, eating had not been attempted, had a feeding tube for nutrition and hydration, and received a mechanical altered diet. The resident was dependent for toileting, showers, hygiene, and transfers. She required maximum assistance with bed mobility, was incontinent of bowel and bladder, was a risk for pressure ulcers, and had one unstageable pressure ulcer that was not present on admission. There was an application of dressings and ointments/medications, pressure reducing devices for the chair and bed, and nutrition or hydration interventions, and pressure ulcer care. The March 2024 CNA Task Form indicated the staff were to remind or assist the dependent resident to change positions every two hours. The form indicated staff had not reminded nor assisted with repositioning on 26 of 39 shifts between 3/5/24 and 3/17/24. The form had not included specific documentation that determined whether staff reminded or assisted the dependent resident with repositioning during the remaining 13 shifts. The CNA Skin Condition Task form, dated 3/6/24 at 5:59 p.m., indicated a discolored area was found, was not a new area, and the Nurse was notified. The task form did not include sufficient documentation to determine location of the skin impairment, the specific nurse notified, or when the nurse was notified. The Nurses' Progress Notes, Nursing Assessments, and IDT (Interdisciplinary Team) Progress Notes, dated from 3/6/24 at 6 p.m. through 3/9/24 at 12:25 p.m., had no documentation that indicated an area of skin discoloration had been identified or assessed. A Registered Dietician's (RD) Admission Evaluation, dated 3/7/24, indicated Resident C had no skin impairments. The note indicated the RD recommended to the physician to decrease the resident's calorie intake by 120 calories and protein intake by 25 grams daily. A Physician's Order, dated 3/9/24, indicated a new order was received to decrease the resident's parenteral feeding of Jevity 1.5 (calorically dense, fiber-fortified therapeutic nutrition) to be administered at 70 cc an hour for 16 hours. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Weekly Skin Observation report, dated 3/9/24 at 12:08 p.m., indicated the facility-acquired discoloration on the sacrum area was identified by LPN 5 as a Deep Tissue Injury (purple or maroon area of discolored intact skin due to damage of underlying soft tissue. The area may be preceded by tissue that is painful, firm mushy, boggy, warmer, or cooler than adjacent tissue). There were no measurements or description of the specific wound characteristics. The report did not include documentation to show interventions were implemented to provide complete pressure relief to the sacrum. A Risk Management Form, offered by the DON (Director of Nursing), dated 3/9/24 at 11:31 a.m., indicated, a nursing description of a DTI to the sacrum. The description of action taken was repositioned and notified the Physician and family. The actions taken did not include interventions implemented to provide complete pressure relief and treatment to the facility-acquired DTI on the sacrum. A Communication Progress Note, dated 3/9/24 at 1:39 p.m., indicated the family and Physician were notified of the newly acquired DTI to the sacral area. A Physician's Order, dated 3/14/24, and back-dated to start on 3/9/24, indicated the sacrum area was to be cleansed with normal saline or wound cleanser and skin barrier cream was to be applied to the peri-wound and the facility- acquired DTI was to be covered with a border gauze every Monday, Wednesday, Friday, and as needed. The Treatment Administration Record (TAR), dated 3/2024, indicated the treatment was not provided in accordance with the Physician's order of 3/9/24 for two days, and there were no interventions that provided complete pressure relief to the facility-acquired DTI implemented. A Family Communication Progress Note, dated 3/14/24 at 4:41 p.m., indicated the resident's family was updated on the sacrum area, current treatment, and gave consent for the resident to see the Wound Specialist weekly. There were no Nursing Progress Notes, Wound Progress Notes, nor IDT Progress Notes, dated 3/9/24 through 3/14/24, that included sufficient documentation to show the facility-acquired DTI on the sacrum was effectively assessed or monitored by the staff. There were no interventions initiated that provided complete pressure relief to the facility-acquired DTI. A Care Plan, dated 3/14/24, indicated an impaired skin breakdown on the sacrum. The interventions were, administer treatments as ordered and monitor for effectiveness, assess/record/monitor wound healing as per facility policy, measure length, width and depth where possible, assess and document status of wound perimeter, wound bed and healing progress, report improvements and declines to the nurse and physician, monitor the nutritional status, serve the diet as ordered, monitor intake and record, monitor/document/report PRN (as needed) any changes in skin status: appearance, color, wound healing, signs and symptoms of infection, wound size (length X (by) width X depth), and stage. The plan of care had not included documentation to show interventions were implemented to provide complete pressure relief to the facility-acquired DTI on the sacrum. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The initial facility Wound Nurse assessment, dated 3/15/24 at 10:15 a.m., indicated the facility-acquired DTI on the sacrum had deteriorated to an unstageable (pressure ulcer known but not stageable due to coverage of the wound bed by slough and/or eschar) pressure injury that measured 6.0 cm (centimeters) in length by 6. 0 cm in width by an unknown depth. The wound bed contained 90% necrotic and 10% red tissue with a scant amount of serosanguinous drainage and distinct wound edges. The assessment had not included documentation that indicated interventions to provide complete pressure relief to the facility-acquired DTI that deteriorated to an unstageable sacral wound. The first assessment of the sacral wound was completed on 3/15/24 at 10:15 a.m. and indicated the wound was acquired on 3/9/24. It was now unstageable, with 90% necrotic soft tissue and 10% red non-granulating tissue. There was scant serosanguinous (blood tinged) drainage. The wound edge was distinct and attached. The measurement of the wound was 6.00 centimeters (cm) by 6.00 cm by unknown (length by width by depth). A Skin and Wound Progress Note, dated 3/15/24 at 12:58 p.m., indicated the resident was seen for a wound evaluation with a family member present in the room. The family member was aware of the wound decline. A low air loss mattress would be placed. Supplements were in place to help promote wound healing. The Physician and Registered Dietician were notified of the decline and the treatment was changed. A referral was completed for the Wound Specialist to evaluate the acquired wound on his next visit. The note did not include documentation of an assessment of the wound that included the location, the size, the stage, and the characteristic of the wound in the note. A Physician's Order, dated 3/15/24, indicated the facility-acquired, unstageable sacral wound was to be cleansed with normal saline or wound cleanser and patted dry. Skin prep was to be applied and allowed to dry and then covered with a hydrocolloid (wound protector and moist healing environment) dressing three times a week and as needed. A Physician's Order, dated 3/15/24, indicated a multivitamin was to be administered daily and 30 cc (cubic centimeters) of Prostat (protein supplement) was to be administered daily, and to be started on 3/16/24. The Physician's Orders, dated 3/15/24, had not included sufficient documentation that indicated complete pressure relief should be provided to the facility-acquired unstageable pressure injury on the sacrum. A Nurse's Progress Note, dated 3/27/24 at 3:54 p.m. for 3/18/244 at 3:30 p.m.,indicated a blood pressure of 96/64, a pulse of 108 per minute, respirations of 16 per minute, and temperature of 97.9 degrees. The oxygen saturation was at 87%. The NP (Nurse Practitioner) was notified and an order was received for a transfer to the emergency room for an evaluation and treatment. The Responsible Party was notified. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The emergency room Physician's Progress Note, dated 3/18/24, indicated Resident C was febrile with a temperature of 102 degrees rectally. Respirations were 34 a minute, the blood pressure was 101/74 and the oxygen saturation was 99%. Resident C was ill appearing and a sacral wound was present. The lactic acid (blood test to determine sepsis/infection) was 4.0 (normal level less than 2) and Procalcitonin (test for presence of bacterial infection) was 0.74 (normal less than 0.05). There was significant leukocytosis (high white blood cell count). The chest x-ray did not demonstrate pneumonia. The urinalysis showed no infection. The hospital admission diagnoses were septic shock and sepsis due to skin infection. A Hospitalist Admission Note, dated 3/18/24 at 10:27 p.m., indicated the resident's family said the facility-acquired, unstageable sacral wound had developed about a week ago. The resident was diagnosed with sacral wound infection and septic shock. A Hospital Physician's Note, dated 3/22/24 at 9:32 a.m., indicated the resident presented to the hospital with septic shock, from the sacral wound. The wound culture resulted in polymicrobial (presence of multiple microorganisms) growth and a broad spectrum antibiotic was initiated. On 3/20/24, the superficial wound culture included staphylococcus aureus, e-faecalis, proteus [NAME], and e-coli. A Hospital Physician Progress Note, dated 3/21/24, indicated a surgical debridement of the unstageable sacral wound was scheduled for 3/21/24. The Hospital Operative Report, dated 3/21/24 at 6:28 p.m., indicated the unstageable sacral wound was surgically debrided down to the level of the bone. The area was measured at 7.0 cm length x 9.0 cm wide x 3. 5 cm depth. During an interview, on 4/3/24 at 2:50 p.m., the DON indicated the IDT discussed changes of condition and pressure ulcers every morning. When a pressure wound was found, a Risk Management Form was to be filled out, and the Wound Nurse was to check for the Risk Management forms every morning, and then an assessment, treatment, and documentation was to be initiated. The DON indicated a Risk Management form had been filled out, and the Wound Nurse had indicated she had not seen the form, so an assessment of the area had not been completed. If the Wound Nurse had seen the Risk Management form, the Wound Specialist would have been able to see Resident C prior to the transfer to the Hospital. During an interview, on 4/3/24 at 3:13 p.m., the Director of Nursing (DON) indicated she had been the Manager on Duty (MOD) on 3/9/24. She had already put the barrier cream on the DTI on 3/9/24 and had not written the Physician's Order for the treatment until 3/14/24. LPN 1, the nurse on duty on evening shift on 3/6/24, was interviewed on 4/4/24 at 11:23 a.m., and indicated she did not recall a CNA reporting a discolored area on the resident's skin. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview, on 4/4/24 at 12:14 p.m., RN 3 (the Wound Nurse at the time of the unstageable sacral ulcer identification), indicated she reviewed the Risk Management Forms daily, and if a skin issue was found and the form was filled out, she then would have assessed the wound, notified the Physician and obtained a treatment. She would have also notified the family. RN 3 indicated she looked at the Risk Management Forms three times and the area marked was for a fall, so she had not reviewed the form any further. On 3/14/24, a nurse, unsure of the name, had informed her Resident C had an area on the buttocks. The nurse was directed to fill out a Risk Management Form. The DON had not verbally informed her of the area. If the Risk Management Form had been filled out, she would have assessed the area immediately. During an interview with CNA 2, on 4/4/24 at 2:41 p.m., she indicated the discolored area on 3/6/24 was on the buttocks and she had immediately reported it to the nurse on duty. She was unable to remember which nurse was on duty. A facility skin condition assessment and monitoring policy, dated 9/1/24 and received as current from the Administrator, indicated pressure ulcers would be assessed and measured at least weekly by a licensed nurse and documented in the clinical record. A skin condition assessment and pressure ulcer risk assessment (Braden) would be completed at the time of admission/readmission and would be updated quarterly and as needed. A wound assessment for each identified wound will be completed and will include, the site location, size (length x width x depth), and stage (if applicable). The resident's care plan will be revised as appropriate to reflect the alteration of the skin integrity, approaches and goals for care. A facility policy for pressure ulcer prevention, dated 9/1/20 and received as current from the Administrator, indicated to maintain clean/dry skin during daily hygiene measures, inspect the skin several times daily during bathing, hygiene, and repositioning measures, turn dependent residents approximately every two hours or as needed, and if redness does not disappear within 30 minutes the turning schedule may be shortened to an hour. Pressure reducing (foam) mattresses are used for all residents unless otherwise indicated. Specialty mattresses such as low air loss and alternating pressure, may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple stage two (partial thickness loss of the dermis) or one or more stage three (full thickness tissue loss) and stage four wounds (full thickness tissue loss with exposed bone, tendon, or muscle). Moisture barrier may be applied by CNA as needed to intact skin and may be kept at bedside. The past noncompliance immediate jeopardy began on 3/9/24. The immediate jeopardy was removed and the deficient practice corrected by 4/5/24, after the facility implemented a systemic plan that included the following actions: (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility determined a deficiency in their wound prevention, assessment, and treatment program on 3/14/24 and immediately implemented a plan of improvement. Interventions were initiated for Resident C on 3/16/24. All 19 of 21 nurses were educated on skin assessments at the time of admission and any newly identified skin concerns. They were educated on the policy if a new skin concern was found, a Risk Management Form was to be initiated, the Physician and family were to be notified, a treatment was to be obtained and initiated, and the DON and Wound Nurse was to be notified. Braden scales were to be completed and accurate with appropriate interventions, orders and care plans to be initiated for anyone with a low Braden score. The Clinical team were to audit and follow through with the treatments and plan of care. Additionally, 20 out of 47 CNAs were educated on 3/18/24 to ensure the nurses were notified of all new skin concerns found during care, interventions to be implemented and where to find those interventions. For any concerns, the DON, Wound Nurse, and Administrator may be notified. All residents have had updated Braden Scales and those with changes had interventions initiated for prevention. Four Nursing staff and five CNAs from different shifts were interviewed and all were knowledgeable of the policies and procedures they were educated on. The Administrator was interviewed on 4/8/24 at 11:30 a.m., and indicated staff who had not been educated would receive the education prior to working. Audits had been completed and were still ongoing to ensure Braden assessments, care plans, and interventions were in place. All information would be reviewed and submitted to the facility's Quality Assurance Program. This citation relates to Complaints IN00430826, IN00431391, and IN00431447. 3.1-40(a)(1) 3.1-40(a)(2)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20580 Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided to Resident B during a sit to stand mechanical lift transfer. Resident B required two staff assistance with transfers and was transferred with one CNA and not placed in the correct position on the bed and slid out of the sit to stand transfer sling with her right arm caught in the sling, onto the floor. This resulted in a fracture of the right humeral neck (shoulder). The facility also failed to ensure a fall prevention intervention was in place, related to a call light not with in reach for 2 of 3 residents reviewed for falls. (Residents B and F) Findings include: 1. During an interview on 4/1/24 at 8:52 a.m., Resident B was lying in bed with the head of the bed elevated. She indicated she was lowered to the floor after she slid out of a sling when she was being transferred to bed. She indicated there was only one staff member who assisted her with the transfer. Resident B's record was reviewed on 4/3/24 at 8:48 a.m. The diagnoses included, but were not limited to, stroke with right side paralysis and obesity. An Annual Minimum Data Set (MDS) assessment, dated 2/23/24, indicated an intact cognitive status, had clear speech, made self understood and understood other No behaviors were present, had an impairment of the upper and lower extremity on one side, had not ambulated, had one fall with no major injuries since the last assessment, and was dependent on staff for sit-to-stand position changes and transfers. A Care Plan, dated 12/11/23, indicated Resident B was at risk to experience falls related to a history of a stroke and right-sided paralysis. The interventions indicated the staff were to ensure the resident's needs were anticipated, the call light would be within reach, and she would be encouraged to use the call light when assistance was needed. The staff would ensure the resident was wearing non-skid footwear when ambulating and when she was in the wheelchair. Physical Therapy (PT) would evaluate the resident as ordered by the Physician and as needed. A) A, Post Fall Observation, dated 2/3/24 at 8:45 a.m., indicated two CNA's were using the sit-to-stand mechanical lift to transfer the resident and the resident fell while CNA 6 and CNA 7 was transferring her with the sit-to-stand mechanical lift. The resident was wearing non-skid footwear at the time of the fall. The Nurse indicated a 2.0 centimeter length by 2.0 centimeter width was found on the back of the head. Neurological assessment was without abnormal findings. The Nurse Practitioner (NP) was notified and messages had been left on the family's voicemail. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nurse's Progress Note, dated 2/3/24 at 8:50 a.m., indicated Resident B experienced a witnessed fall and was observe lying in a supine (lying on the back) position on the floor of the shower room with one end of the sit-to-stand belt around the residents back and the other end connected to the mechanical lift. The resident indicated she had bumped her head and received a 2.0 cm by 2.0 cm hematoma (a solid swelling of clotted blood within the tissues) on the back of the head. The Neurological assessment was performed without abnormal findings. The NP and Director of Nursing (DON) were notified. There were several messages left for the Power of Attorney to return a call to the facility. A Care Plan, dated 2/3/24, indicated Resident B experienced a fall. The new intervention implemented to prevent further falls was to have a PT consult conducted to evaluate the resident's strength and mobility and to evaluate the resident's needs for safe transfers with appropriate mechanical lift equipment. The plan of care did not include documentation to show immediate and effective interventions were implemented to prevent further falls. A Fall Interdisciplinary Team(IDT) Progress Note, dated 2/5/24 at 9:38 a.m., indicated the resident experienced a fall during a transfer with the sit-to-stand mechanical lift. The resident started to slide. The root cause was the resident is a hemiplegic. The new intervention added, indicated therapy was to evaluate for full mechanical lift (Hoyer) usage for transfers. An Occupational Therapy (OT) Evaluation and Plan of Treatment, dated 2/6/24, indicated the sit-to-stand mechanical lift for transfers was to continue to be used. The resident had not wanted the full mechanical (Hoyer) lift to be used. The note indicated OT services would be provided for strengthening exercises, wheelchair management, and self-care management. During an interview, on 4/3/24 at 10:57 a.m., the Therapy Supervisor indicated therapy staff recommended the staff use a full mechanical (Hoyer) lift for transfers after the resident fell on [DATE]. The Therapy Supervisor indicated the resident refused the recommendation to use the full mechanical (Hoyer) lift and said she would just not get out of bed if it was used. B) A Nurse's Progress Note, dated 3/12/24 at 8:51 p.m., indicated the CNA (Past Employee CNA 4) reported a witnessed fall and had slid from the sit-to-stand mechanical lift sling to the floor during a transfer from the wheelchair to the bed with the assistance of one staff. The note indicated the nurse observed the resident sitting on the floor of the bedroom and the resident reported pain to the right shoulder. No injuries were noted and the range of motion was within normal limits. The NP and family members were notified. A, Post Fall Observation, dated 3/12/24 at 11:35 p.m., indicated Past Employee CNA 4 had transferred the resident without the assistance of a second staff person using the mechanical sit-to-stand lift. The resident resident reported that Past Employee 4 guided her body to a sitting position on the floor during the fall. Non-skid footwear was not in use at the time of the fall and she experienced right shoulder pain that increased with range of motion. The NP and the resident's family member were notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A Nurse's Note, dated 3/13/24 at 12 a.m., indicated the resident complained of right shoulder pain that radiated to the right hand. The pain was rated at a 7 out of 10. Pain medication was administered (as needed acetaminophen 325 milligrams, two tablets). The resident reported the pain started after her fall. The resident has a history of pain to the right shoulder and reported the pain was worse than what she usually experienced. There was no bruising or swelling observed on the right shoulder. The area was very tender with palpation . The NP was notified and an order was received to obtain an X-ray for the right shoulder, arm, elbow, and wrist as soon as possible. A voicemail was left with the Responsible Party. A Nurse's Note, dated 3/13/24 at 2 p.m., indicated the X-ray results were positive for a fracture. The NP, DON, and family member was notified and the resident was transferred to the Hospital emergency room for treatment. The X-ray results, dated 3/13/24, indicated a right humeral neck fracture with displacement of fracture fragments. A Nurse's Progress Note, dated 3/13/24 at 10 p.m., indicated the resident returned to the facility with an immobilizer and soft cast with elastic bandage to the the right shoulder. An Interdisciplinary Team (IDT) Note, dated 3/14/24 at 9:47 a.m., indicated the resident slid out of the sling down to the floor while being transferred from the wheelchair to the bed. The intervention was to use the full mechanical lift (Hoyer) for all transfers. The note indicated the root cause of the fall was the resident slid out of the sling of the sit-to-stand mechanical lift while being transferred. The fall plan of care, dated 2/3/24, was revised and updated on 3/14/24 and the intervention to use a full mechanical lift (Hoyer) for all transfers. The Administrator provided an undated, unsigned, typed statement on 4/3/24 and indicated it was from Past Employee CNA 4. The statement indicated Past Employee CNA 4 had transferred Resident B without assistance from another staff member, with the mechanical sit-to-stand lift. She had seated the resident on the bed and before she could remove the transfer sling, the resident slid to the floor. She received assistance from another CNA, Nurse, and full mechanical lift (Hoyer) to transfer the resident back into the bed. The statement did not include sufficient documentation to show the CNA was aware two staff should have been present during the sit-to-stand mechanical lift transfer. The Job Specific Orientation Check List for Past Employee CNA 4, indicated orientation had been completed on 11/11/23 for use of the Hoyer and the sit-to-stand mechanical lift. During an interview on 4/3/24 at 11:55 a.m., the Nurse Consultant indicated the instructions on how to transfer the resident were located on the Resident's Dashboard in the computer under special instructions. She was unable to pull-up the past transfer intervention, though knew it was listed as a sit-to-stand mechanical lift and it required two staff to assist. (continued on next page)

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	04/05/2024

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 4/3/24 at 1:02 p.m., the Administrator indicated the investigation found the resident still had the sling hooked up to the lift when she slid out and the resident's right arm was caught in the sling due to the paralysis. She indicated the resident had not been placed on the bed correctly and had slid out. Two staff members were supposed to assist with transfers when using any type of mechanical lift. Past Employee CNA 4 had not said why she had not obtained assistance to help with the transfer. A Facility Transfer and Mechanical lift policy, dated 9/1/20, and received from the Administrator as current, indicated a mechanical lifting device was to be used for any resident who required two-person assistance, or who could not transfer comfortably and /or safely by normal transfer technique. The -transferring needs of the resident would be assessed on an ongoing basis and would be designated into a categories, which included, sit to stand lift with two caregivers. 2. Resident F was observed lying in bed with her head of the bed elevated on 4/1/24 at 9:05 a.m. The resident was interviewed at the time of the observation and indicated she was unsure how to call the staff if she needed assistance. Resident F was observed lying in bed with her head of the bed elevated on 4/1/24 at 10:25 a.m. and at 10:43 a.m. with the call light draped over the side table to the right of the bed and out of the resident's reach. During an interview on 4/1/24 at 10:43 a.m., the DON indicated the call light was not in reach of the resident and placed the call light on the resident's bed. Resident F's record was reviewed on 4/3/24 at 9:42 a.m. The diagnoses included but were not limited to, diabetes mellitus and dementia. Nursing Progress Notes, dated 3/26/24, indicated the resident was found on the floor, assessed, no injuries noted, family and NP (Nurse Practitioner) were notified. A Care Plan, dated 3/11/24, indicated the resident required assistance with bed mobility and transfers. A Care Plan, dated 3/11/24, indicated a risk for falls with actual falls on 11/2/23, 12/28/23, and 2/12/24. The interventions included, but not limited to, ensure the resident's call light was within reach and encourage to use it for assistance as needed. There were no care plan updates or interventions added after the fall on 3/26/24. A fall prevention policy, dated 9/1/20 and received as current from the Administrator, indicated the call light would be placed within the resident's reach at all times. This citation relates to Complaint IN00430737. 3.1-45(a)(2)

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	04/05/2024

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 20580 Based on record review and interview, the facility failed to ensure a Resident's record was completed in a timely manner, related to a change in condition assessment not charted at the time of the change and then had late entries entered 9 days after the event, for 1 of 10 residents reviewed for medical records. (Resident C) Finding includes: Resident C's record was reviewed on 4/3/24 at 11:48 a.m. The diagnoses included, but were not limited to, stroke, subarachnoid hemorrhage, non traumatic, respiratory failure, bipolar, aphasia, vascular implants and grafts, spina-bifida with shunts, and history of breast cancer (9/23/22). A Nurse's Progress Note, dated 3/27/24 at 3:54 p.m. for 3/18/24 at 4:01 p.m., written by LPN 1, indicated the resident was exiting the facility and being transferred to the emergency room by three Paramedics. The resident's Power of Attorney was made aware. The Nurse Practitioner was notified of the transfer. A Change of Condition assessment form, dated 3/27/24 at 3:54 p.m. for 3/18/24 at 3:30 p.m., written by LPN 1, indicated Resident C had abnormal vital signs and a loss of consciousness. The resident's blood pressure was 96/64, pulse was 108 beats per minute, respirations were 16 per minute, and temperature was 97.6 degrees. The oxygen saturation was 87%. The resident was unresponsive. A Nurse's Progress Note, dated 3/27/24 at 3:54 p.m., for 3/18/244 at 3:30 p.m., written by LPN 1, indicated a blood pressure of 96/64, a pulse of 108 per minute, respirations of 16 per minute, and temperature of 97.9 degrees. The oxygen saturation was at 87%. The NP was notified and an order was received for a transfer to the emergency room for an evaluation and treatment. The Responsible Party was notified. During an interview, on 4/4/24 at 11:23 a.m., LPN 1 indicated there had been a lot of things that happened that day and it had been shift change and she had thought the Evening Shift Nurse should have charted the change of condition, though the change of condition occurred on the day shift. This citation relates to Complaint IN00430826. 3.1-50(a)(1)