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<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>COMPLETION DATE</th>
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<tbody>
<tr>
<td>F 164</td>
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<td><strong>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</strong></td>
<td>F 164</td>
<td></td>
<td><strong>F164 483.10(e), 483.75(l)(4). See page two.</strong></td>
<td>7/08/11</td>
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The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.

The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:

Based on policy review, review of the "Medication Guide for the Long-Term Care Nurse", observation and interview, it was determined the facility failed to ensure 1 of 7 (Nurse #1) nurses observed during the

acceptable for use from 6-24-11 to 9-23-11

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 patient. (See instructions.) Except for nursing homes, the findings stated above are discloseable 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 discloseable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is required to continued program participation.
Continued from page 1
medication pass failed to maintain the confidentiality of resident's medical records by not covering or closing the Medication Administration Record (MAR) when unattended.

The findings included:

1. Review of the "Medication Guide for the Long-Term Care Nurse" sixth edition, page 68 documented, "Remember to protect confidentiality of patient records, including the MAR book. The nurse should flip the MAR pages face down when the book is unattended."

2. Review of the facility's "Your Rights: Rights of Tennessee Nursing Facility Residents" documented, "Confidentiality and Privacy: 1. Confidentiality of your personal and clinical records will also be maintained."

3. Observations outside of room 302 on 6/6/11 at 1:35 PM, Nurse #1 left the MAR open, revealing the resident's information in public view to anyone who passed by.

4. During an interview in the conference room on 6/8/11 at 9:15 AM, the Administrator stated, "...We go by HIPAA [Health Insurance Portability and Accountability Act of 1996] rules. They [employees] are trained to cover the MAR and not leave information open..."

5. During an interview at the south nurses' station on 6/8/11 at 9:55 AM, the Director of Nursing (DON) stated, "...Expect the MAR to be covered when nurse is present..."

Confidentiality of patient information will be maintained.

Additional training was provided to all licensed nurses on June 9, 2011 by the Administrator, Director of Nursing and the Assistant Director of Nursing.

The Director of Nursing or designee will monitor medication administration randomly on all shifts, 5 med passes per day for 4 weeks, 3 med passes per day for 4 weeks and then two med passes per week for 4 months. Med pass audit results will be reported to Performance Improvement nurse who will report the audit results to the Performance Improvement committee. The Performance Improvement committee will monitor audit results and initiate additional interventions as needed to ensure confidentiality of information is maintained.

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<td>F 164</td>
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<td>Continued from page one.</td>
<td>Confidentiality of patient information will be maintained.</td>
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<td>F 221</td>
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<tr>
<td>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</td>
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### F 221 Continued From page 2

The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

This **REQUIREMENT** is not met as evidenced by:
- Based on policy review, medical record review and interview, it was determined the facility failed to ensure a pre-restraint assessment and a consent for the use of a restraint were obtained for 1 of 7 Resident #10 sampled residents with restraints.

The findings included:
- Review of the facility's "Physical Restraints" policy documented, "...The assessment documentation will indicate how the device is to be used... Restraints are used upon consent of the resident or authorized representative... to make an informed choice about the use of restraints..."

Medical record review for Resident #10 documented an admission date of 4/12/11 with diagnoses of Advanced Dementia, Severe Agitation, Schizophrenia and Incontinent Bowel and Bladder. Review of a physician's order dated 4/21/11 documented, "...Resdtt [resident] ^ [up] in wc [wheelchair] c [with] lap buddy for positioning and to hold items of interest such as snacks and magazines. Check q [every] 30 min [minutes] & [ask] release q 2 [hours]..." The facility was unable to provide documentation that a pre-restraint assessment and consent were obtained for the use of the lap buddy restraint.

### F 221 Continued from page two.

Residents will be free from any physical restraints not required to treat the resident's medical condition.

Therapy had been working with resident #10 on April 21, 2011 in an attempt to reduce the restraint from a geri-chair with tray to a wheelchair with a lap buddy. An order was obtained for the reduced restraint but the pre-restraint assessment was not completed. Resident #10 was assessed on June 21, 2011 to insure that the current restraint is appropriate.

All licensed nurses received additional training on June 9, 2011 by the Administrator, D.O.N. and Assistant D.O.N. and on June 21, 2011 by the Assistant Administrator on the requirement that a pre-restraint assessment be completed prior to the application of a restraint or a change in a restraint.

Performance Improvement nurse will audit all restraint orders to ensure that a pre-restraint assessment has been completed for each restraint.

The Performance Improvement nurse will monitor order changes for any change in restraint and will determine if the pre-restraint assessment has been completed.
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<td>F 221</td>
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<tr>
<td>F 241</td>
<td>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</td>
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<td>F 241</td>
<td>483.15(a)</td>
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<td>SS-D</td>
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During an interview at the south nurses' station on 6/8/11 at 9:55 AM, the Director of Nursing (DON) stated, "I am not seeing a pre-assessment [pre-restraint assessment] for the lap buddy..."

During an interview in the conference room on 6/8/11 at 2:05 PM, Nurse #8 was asked if she had completed a pre-restraint assessment and obtained a consent for the use of the lap buddy restraint. Nurse #8 stated, "That's my bad, I didn't put the lap buddy on the pre-assessment form..."

This REQUIREMENT is not met as evidenced by:

- Based on observation and interview, it was determined 2 of 25 staff members (Certified Nursing Assistant (CNA) #2 and Laundry Staff #1) failed to knock on the door or gain permission prior to entering the resident's room.

The findings included:

1. Observations in the 200 hall on 6/7/11 at 5:40 PM, revealed CNA #2 entered resident room 224 without knocking or gaining permission to enter.
2. Observations in the 200 hall on 6/7/11 at 4:20 PM, revealed CNA #2 entered resident room 224 without knocking or gaining permission to enter.

The facility will maintain or enhance each resident's dignity and respect in full recognition of his or her individuality.

All staff were provided with training on June 9, 2011 by the Administrator, D.O.N. and Assistant D.O.N. on residents' rights and privacy.

A general inservice is scheduled for all staff on July 7, 2011 by the D.O.N. for additional training on residents' rights.

The Director of Nursing or designee will randomly monitor staff behavior on all shifts for a period of 3 months.
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<th>F241 Continued From page 4</th>
<th>F241 F241 Continued from page four. and report the results to the Performance Improvement nurse who will report the results to the P.I. committee. The P.I. committee will initiate additional interventions as needed to maintain dignity and respect.</th>
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<td>F 241</td>
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<td>PM, revealed Laundry staff #1 entered resident room 228 and then entered room 229 without knocking or gaining permission to enter. 3. During an interview in the conference room on 6/8/11 at 8:18 AM, the Administrator stated, &quot;...They [employees] are trained on Resident's Rights which includes knocking...&quot;</td>
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<td>F 280</td>
<td>SS=D</td>
<td>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</td>
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<td>F 280</td>
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<td>F280 483.20(d)(3), 483.10(k)(2) The facility will update care plans to reflect the current status of residents. Resident #12 was discontinued from contact isolation on February 9, 2011. The care plan was updated June 21, 2011. Care plans have been audited. Each care plan was updated properly as status changed. The Performance Improvement nurse will audit care plans to ensure that care plans accurately reflect isolation status and report to the P.I. committee. The P.I. committee will initiate additional interventions as needed to ensure that care plans reflect the current status of residents.</td>
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This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, it was determined the facility failed to revise the comprehensive care plan for isolation for 1 of 23
### Summary Statement of Deficiencies

**F 280** Continued From page 5
(Resident #12) sampled residents.

The findings included:

Medical record review for Resident #12 documented an admission date of 4/18/07 with a readmission date of 11/26/10 with diagnoses of Dementia, Depression, Peripheral Vascular Disease, Renal Insufficiency and Hypertension. Review of the comprehensive care plan reviewed on 3/11/11 documented, "...Contact isolation per facility protocol d/t [due to] MRSA [Methicillin Resistant Staph Aureus]." Review of a physician's order dated 5/26/11 had no documentation of Resident #12 having an infection and no order for contact isolation. The care plan was not revised to reflect that Resident #12 did not have a current infection nor was the resident currently in contact isolation.

During an interview at the south nurses' station on 9/7/11 at 9:15 AM, Nurse #5 was asked if any resident was in contact isolation. Nurse #5 stated, "No, not at the present moment."

During an interview at the south hall nurses' station on 9/7/11 at 4:00 PM, the Director of Nursing (DON) was asked if any resident was in contact isolation. The DON stated, "...No, there is no one in isolation in our building..."

### F 328 483.25(k) Treatment/Care for Special Needs

The facility must ensure that residents receive proper treatment and care for the following special services:
- Injections;
- Parenteral and enteral fluids;

Oxygen will be administered in accordance with physician's orders.

The physician was notified of

Continued on page 7.
**F 328** Continued From page 6

Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.

This REQUIREMENT is not met as evidenced by:

Based on medical record review, observation and interview, it was determined the facility failed to administer oxygen at the physician’s prescribed rate for 2 of 8 (Residents #5 and 15) sampled residents receiving oxygen.

The findings included:


Observations in room 319 on 6/9/11 at 8:50 AM and 12:15 PM and on 6/11/11 at 8:05 AM, revealed Resident #5 was receiving oxygen per trachea mask at 5 liters per minute.

Observations in room 319 on 6/7/11 at 3:50 PM, revealed Resident #5's trachea mask was on but the oxygen was not on and the tubing was disconnected from oxygen concentrator.

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**F 328** Continued from page 6.

Improper flow rate for resident #5 and that oxygen tubing had been disconnected. The resident's O₂ saturation was monitored hourly for four hours and then every four hours for sixteen hours and found to be in an acceptable range.

Resident #15's O₂ was set correctly on June 9, 2011. O₂ saturation was in an acceptable range.

All licensed nurses received training on June 9, 2011 by the Administrator, D.O.N. and Assistant D.O.N. on the need to set oxygen flow rates properly and to ensure that those settings remain at the proper rate.

Additional training is scheduled for July 7, 2011 by the D.O.N. and will include oxygen flow rates and monitoring procedures to ensure that oxygen rates remain at the physician ordered rate.

All licensed nurses have been instructed to monitor O₂ rates every shift. Performance Improvement nurse will monitor weekly on random shifts for 4 weeks or until audit results are acceptable and then monthly thereafter. The P.I. nurse will report to the P.I. committee. The P.I.
**F328 Continued from page 7**

During an interview in room 319 on 6/7/11 at 3:50 PM, Nurse #4 was asked if when the trachea collar was put back on was the oxygen tubing supposed to be connected. Nurse #4 stated, "...Yes..."

2. Medical record review for Resident #15 documented an admission date of 4/28/11 with diagnoses of End Stage Renal Disease, Hemodialysis, Tachycardia and Bradycardia Syndrome, Atrial Fibrillation, Type II Diabetes, Depression and Anxiety. Review of a physician's order dated 5/18/11 documented, "...O2 @ [at] 4L [LITers] BNC [binausal cannula]..."

Observations in room 203 on 6/6/11 at 9:10 AM, revealed Resident #16 receiving O2 @ 2L via BNC.

**F364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP**

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:

- Based on observation and interview, it was determined the facility failed to ensure that meals were palatable and at the proper temperature to ensure nutritive value, flavor and appearance.

  Four (4) of 7 (Resident #14, Random Resident (RR) #1, RR #2 and RR #3) alert and oriented residents attending the group interview voiced food complaints. Review of the facility's 'Master
F 364 Continued from page 8

Resident's list of diets dated 6/6/11 documented that 114 residents received a diet. The facility had a current census of 116.

The findings included:

1. Observations of the meal tray pass in the north hall on 6/7/11 at 7:15 AM, revealed there was still one tray on the delivery cart 45 minutes after being delivered.

2. During the supper meal pass on 6/7/11 at 6:10 PM, a test tray was done after the last tray was delivered. The food temperatures were recorded as followed:
   a. Milk - 41 degrees Fahrenheit (F).
   b. Pureed turkey - 60 degrees F.
   c. Pureed bread - 62 degrees F.
   d. Pureed carrots - 100 degrees F.
   e. Veggie strips - 88 degrees F.
   f. Jello - 60 degrees F.
   g. Ice cream - 32 degrees F and partially melted.
   e. Lettuce and tomato - 62 degrees F.

   The surveyor completed a taste test and the food was not palatable.

3. Observations in the dining room on 6/7/11 at 5:30 PM, revealed a resident was served melted ice cream that she poured from the bowl onto her tray.

4. During the group interview in the activity room on 6/7/11 at 9:00 AM, Resident #14, RR #1, RR #2, and RR #3 complained that hot foods were cold and ice cream was melted when delivered.

F 441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

F 441

Continued on page 10.
**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**X1 PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:**

445468

**X2 MULTIPLE CONSTRUCTION**

A. BUILDING: ______

B. WING: ______

**X3 DATE SURVEY COMPLETED:**

06/08/2011

**NAME OF PROVIDER OR SUPPLIER:**

DYER NURSING AND REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE:**

1124 NORTH MAIN

DYER, TN 38330

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| F441 | **Continued From page 9**  
The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  
(a) Infection Control Program  
The facility must establish an Infection Control Program under which it -  
(1) Investigates, controls, and prevents infections in the facility;  
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and  
(3) Maintains a record of incidents and corrective actions related to infections.  
(b) Preventing Spread of Infection  
(1) When the infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.  
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  
(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  

This REQUIREMENT is not met as evidenced | F441 | **Continued from page 9.**  
The facility will ensure practices to prevent the potential spread of infection.  
All staff received training on June 9, 2011 by the Administrator, D.O.N. and Assistant D.O.N. on hand washing/hand hygiene and changing gloves. All nursing staff were required to read and sign the standard precautions policy and hand washing/hygiene policy with specific deficit practices highlighted on June 21, 2011.  
The Staff Development coordinator will train all new staff on hand washing/hand hygiene and standard precautions. The Staff Development coordinator will observe five staff members perform peri-care weekly for four weeks to ensure compliance and report findings to the Performance Improvement nurse. The Staff Development coordinator, the Director of Nursing and Assistant Administrator will observe food delivery on three residents each week for four weeks to assure that no food or eating utensils are contaminated. Result of meal audits will be reported to the P.I. nurse who will report to the P.I. committee.  
Additional training is scheduled for | 7/09/11 |

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**FORM CMS-2587(02-06) Previous Versions Obsolete**  
**Event ID: FPXN11**  
**Facility ID: TN2703**  
**If continuation sheet Page 10 of 14**
F 441 Continued From page 10

by:

Based on policy review, observation and interview, it was determined the facility failed to ensure practices to prevent the potential spread of infection were maintained when 1 of 2 Certified Nursing Assistant (CNA #3) failed to perform Foley catheter care without potential for cross-contamination and 5 of 25 staff members (CNA #1, 2 and 5, Nurse assistant (NA) #4 failed to practice sanitary hand hygiene during the meal pass.

The findings included:

1. Review of the facility's "Standard Precautions" policy documented, "...2.e. Change gloves, as necessary, during the care of a resident to prevent cross-contamination from one body site to another (when moving from a "dirty" site to a "clean" one)"

2. Review of the facility's "Handwashing/Hand Hygiene" policy documented, wash hands "...5.c. Before and after direct resident contact..."f. Before and after eating or handling food (hand washing with soap with water)... g. Before and after assisting a resident with meals...l. Upon and after coming in contact with a resident's intact skin, (when lifting a resident)... u. After removing gloves or aprons..."

3. Observations in room 218 on 6/7/11 at 5:45 PM, revealed CNA #1 removed a sandwich from the wrapper with her bare hand and held the sandwich down with one hand while using a knife to cut the sandwich in half.

Observations in room 220 on 6/7/11 at 5:47 PM,
Continued from page 11

revealed CNA #1 removed a sandwich from the wrapper with her bare hand and held the sandwich down with one hand while using a knife to cut the sandwich in half.

4. Observations in room 224 on 6/7/11 at 5:40 PM, revealed CNA #2 cranked the head of the bed up, set up the meal tray and touched the straw with her bare hand without washing her hands.

5. Observations in Resident #6's room on 6/7/11 at 9:00 AM, CNA #3 washed her hands and donned gloves, set-up the equipment, laid the resident down on bed and pulled down his pants and diaper and proceeded to perform Foley catheter care without washing hands or changing gloves throughout the entire process.

6. Observations during meal pass in room 323 on 6/7/11 at 7:56 AM, revealed CNA #5 cranked the head of the bed up, turned on the light with the pull chain, prepared the meal tray and fed the resident without washing her hands.

7. Observations during meal pass in room 317 on 6/7/11 5:10 PM, NA #4 raised the head of the bed, pulled the resident upright in bed, pulled a chair up beside the resident and set up the tray and started feeding the resident without washing her hands.

8. During an interview at the south nurses' station on 6/8/11 at 9:55 AM, the Director of Nursing (DON) was asked what is the expectation of staff and hand hygiene during meal tray pass. The DON stated, "...expect them [staff] to wash hands after touch the resident or their
**NAME OF PROVIDER OR SUPPLIER:** Dyer Nursing and Rehabilitation Center  

**STREET ADDRESS, CITY, STATE, ZIP CODE:** 1124 North Main, Dyer, TN 38330  

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| F 441             | Continued From page 12 environment... do not touch the food with their bare hand...”              | F 441        | F504 483.75(j)(2)(i) Laboratory tests will be performed only on receipt of a physician's order.  
                  |                                                 |              | Licensed nurses completed an audit on June 13, 2011 to ensure the presence of a physician's order for  
                  |                                                 |              | all lab tests.  
                  |                                                 |              | Scheduled labs will be checked against physician orders by the licensed nurse to ensure accuracy.  
                  |                                                 |              | On receipt of lab results, the licensed nurse will again check labs against physician orders. Results of these  
                  |                                                 |              | audits will be reported to the Performance Improvement nurse weekly. The Performance  
                  |                                                 |              | Improvement nurse will audit lab reports to ensure that an order exists for each lab performed. Results will  
                  |                                                 |              | be reported to the P.I. Committee. The P.I committee will initiate  
                  |                                                 |              | additional audits as needed to ensure that lab tests are only performed on receipt of a physician's order.  
                  |                                                 |              | The P.I committee consists of the Medical Director, Administrator,  
                  |                                                 |              | Assistant Administrator, D.O.N. P.I nurse, Staff Training Coordinator, a  
                  |                                                 |              | Therapy representative, Social Service, an Activities representative, a  
                  |                                                 |              | Dietary representative, a Housekeeping representative and a  
                  |                                                 |              | Maintenance representative.  

**ID PREFIX TAG** Continued from page 12 environment... do not touch the food with their bare hand...”  

**ID PREFIX TAG** The facility must provide or obtain laboratory services only when ordered by the attending physician.  

**ID PREFIX TAG** The findings included:  

1. Review of the facility's "Resident Lab Test" policy documented, "...Make sure lab is drawn as ordered and document this in resident's medical record...”  

2. Medical record review for Resident #9 documented an admission date of 1/16/03 and a readmission date of 11/11/09 with diagnoses of Alzheimer's Dementia, Depression, Coronary Artery Disease, Hypertension, Osteoporosis and Aspiration. Review of the physician's order to cover the month of January 2011 had no order to obtain a Complete Blood Count (CBC) with differential and a Thyroid Stimulating Hormone (TSH) level. Review of the test results in Resident #9's medical record revealed a CBC with differential and a TSH was obtained on 1/19/11.
**DYER NURSING AND REHABILITATION CENTER**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

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<th>(X3) DATE SURVEY COMPLETED</th>
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<td>F 504</td>
<td>Continued From page 13, during an interview in the conference room on 6/7/11 at 3:57 PM, after reviewing the medical record, Nurse #4 stated, &quot;I don't find any orders for the labs.&quot; 3. Medical record review for Resident #13 documented an admission date of 1/10/11 with diagnoses of Alzheimer's, Atrial Fibrillation, Cellulitis, Coronary Artery Disease and Hypertension. Review of the Resident #13's standing lab orders dated 1/10/11 did not include an order to obtain a Complete Metabolic Panel (CMP) or a CBC with differential. Review of the lab test results in Resident #13's medical record revealed a CMP and a CBC with differential was obtained on 1/19/11. During an interview at the north nurse's station on 6/6/11 at 12:50 PM Nurse #6 stated, &quot;...I'm not seeing the orders for the CMP or the CBC.&quot; 4. Medical record review for Resident #19 documented an admission date of 7/23/07 with diagnoses of Chronic Angina, Osteoarthritis, Anemia and Hypertension. Review of the physician's standing orders documented, &quot;...if [resident] is on an iron supplement to obtain a hgb [hemoglobin] every 6 months... if [resident] is on a diuretic obtain a bnp [basic metabolic panel] every 6 months...&quot; Review of the test results in Resident #19's medical record, documented a CBC and CMP was obtained every 3 months without a physician's order.</td>
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JUN 22 2011