PRINTED: 12/29/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155220	B. WING		11/22/2022
		ABILITATION CENTER STATEMENT OF DEFICIENCIE	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 0000 Bldg. 00	This visit was for a Licensure Survey are Complaints IN0039 IN00392985. This Residential Licensur Complaint IN00392 Federal/State deficial allegations are cited Complaint IN00392 Federal/State deficial legations are cited Complaint IN00392 Federal/State deficial legations are cited allegations are cited all	Recertification and State and the Investigation of 12424, IN00392575, and visit included a State are Survey. 12424 - Substantiated. 12424 - Substantiated. 12575 - Substantiated. 12575 - Substantiated. 12575 - Substantiated. 12677 and F921. 12985 - Substantiated. 12985 - Substantiated. 12985 - Substantiated. 1307 and F921. 12985 - Substantiated. 1307 and F921. 1308 - Substantiated. 1309 and F921. 1309 - Substantiated. 1309 - Substantiated. 1309 - Substantiated. 1409 - Substantiated. 1509 - Substantiated. 1609 - Substantiated. 1709 - Substantiated. 1809 - Substantiated. 1909 - Substan	F 0000	The facility kindly requests a creview.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

Natalie Porcaro Administrator 12/14/2022

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclodays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155220	B. W	NG		11/22	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIER	8			EFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER			IN 46311		
			ı		T		T
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	· ·	ICY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION reflect State Findings cited in		TAG	BLITCHNOT		DATE
	accordance with 41	Č					
	accordance with 41	0 IAC 10.2-3.1.					
Quality review completed on 11/29/22.		unleted on 11/29/22					
	Quanty review com	ipieted on 11/25/22.					
F 0554	483.10(c)(7)						
SS=D	, , , ,	nin Meds-Clinically Approp					
Bldg. 00		right to self-administer					
_	- ',','	interdisciplinary team, as					
	defined by §483.2	1(b)(2)(ii), has determined					
	that this practice is	s clinically appropriate.					
	Based on observation	on, record review, and	F 03	554	Dyer Nursing & Rehabilitatio	'n	12/12/2022
		ty failed to ensure residents			Annual Survey: 11/22/2022		
	had Physician's Ord	lers for medications and an					
		administer their own			Please accept the following as	s the	
		f 2 residents reviewed for			facility's credible allegation of		
		of medication. (Residents 32			compliance. This plan of		
	and 38)				correction does not constitute		
	TC' 1' ' 1 1				admission of guilt or liability by	-	
	Findings include:				facility and is submitted only in	1	
	1 On 11/19/22 at 9	3:50 a.m., Resident 32 asked			response to the regulatory		
		statin (an anti-fungal) powder.			requirement. F554 Resident Self Admin		
		powder to the resident and left			Meds-Clinically Appropriate		
	it in the room.	powder to the resident and left			What corrective action(s) wil	i.	
	it in the room.				be accomplished for those	•	
	The record for Resi	dent 32 was reviewed on			residents found to have been	n	
		n. Diagnoses included, but			affected by the deficient		
		type 2 diabetes and functional			practice;		
	quadriplegia.				A self-administration assessm	ent	
					was completed for Residents	32	
	The 10/22/22 Quart	terly Minimum Data Set (MDS)			and MD order received for sel	f	
	assessment, indicate	ed the resident was			administration of medication.		
	cognitively intact.				A self- administration assessn		
					was competed for Resident 38	3 and	
		t have a Care Plan for			MD order received for self		
		of medications nor did she			administration of medication.		
		nistration of medication			How the facility will identify		
	assessment.				other residents having the		
			I		potential to be affected by th	e	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE A Physician's Order, dated 7/8/22, indicated the same deficient practice and resident was to receive Nystatin powder 100,000 what corrective action will be unit/gram, apply to affected areas daily as needed. All facility residents with There was no order indicating the medicated medication orders have the powder could be left at the bedside or the resident potential to be affected by the could apply it. same alleged deficient practice. What measures will be put into Interview with the Nurse Consultant on 11/21/22 place or what systemic at 2:15 p.m., indicated the medication should not changes will be made to have been left at the bedside and the resident ensure that the deficient would be assessed for self administering the practice does not recur; powder. 2. On 11/14/22 at 10:13 a.m., Resident 38 Staff were educated on not leaving was observed sitting up in his bed. At that time medications at resident bedside there were 2 bottles of Over The Counter (OTC) unless there is an order for medications of Prevagen and Super Beta Prostate self-administration in place. on the over bed table. He indicated his family had Staff were also educated on brought the medications to him and he does take ensuring medications are stored them every day by himself. properly. How the corrective action(s) On 11/16/22 at 9:23 a.m., the resident was will be monitored to ensure the observed lying in bed dressed in a shirt. At that deficient practice will not time the 2 OTC bottles of Prevagen and Super recur, i.e., what quality Beta Prostate were observed on the dresser. assurance programs will be put into place; On 11/16/22 at 11:30 a.m. and 11/17/22 at 10:00 Facility Angel's will audit 15 a.m., the resident was not in the room and the 2 residents 3 days per week to bottles of OTC medications remained on top of ensure no medication is the dresser. improperly stored at the bedside. The Director of Nursing/designee The record for Resident 38 was reviewed on will present a summary of the 11/15/22 at 2:20 p.m. The resident was admitted audits to the Quality Assurance on 4/1/22. Diagnoses included, but were not committee monthly for 6 months. limited to, dementia without behaviors, high blood Thereafter, if determined by the pressure, atrial fibrillation, heart failure, and Quality Assurance committee, cognitive communication. auditing and monitoring will be done quarterly and present The Quarterly Minimum Data Set (MDS) quarterly at the QA meeting. assessment, dated 10/16/22, indicated the resident Monitoring will be on going.

was moderately impaired for decision making.

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE (A. BUILDING B. WING			
	PROVIDER OR SUPPLIER	ABILITATION CENTER	601 S	r Address, City, State, ZIP COD HEFFIELD AVE 8, IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	DBE COMPLETION
	There was no Care administer his own	Plan for the resident to self medications.		Date by which systemic corrections will be comp 12/12/2022	oleted:
	-	dated 10/10/22, indicated osule daily in the morning mily will provide.			
	-	cian's Order for the OTC Beta Prostate supplement.			
	There was no self at assessment available	dministration of medication e for review.			
	at 12:45 p.m., indica medication assessm day.	Nurse Consultant on 11/21/22 ated a self administration of ent was just completed that			
F 0623 SS=B Bldg. 00	Before a facility tra resident, the facilit (i) Notify the reside representative(s) of and the reasons for a language and m facility must send representative of t Long-Term Care (ii) Record the rea discharge in the rea accordance with p section; and	nts Before e ce before transfer. ansfers or discharges a y must- ent and the resident's of the transfer or discharge or the move in writing and in anner they understand. The a copy of the notice to a he Office of the State Ombudsman. sons for the transfer or esident's medical record in aragraph (c)(2) of this			

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DEPARTMENT		FORM APPROVED OMB NO. 0938-039						
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	, ,	JILDING	ONSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIE	R IABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311					
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(X5) COMPLETION DATE	
	and (c)(8) of this transfer or discharser or discharsection must be r 30 days before the discharged. (ii) Notice must be practicable before (A) The safety of would be endang (i)(C) of this section (B) The health of would be endang (i)(D) of this section (C) The resident's to allow a more in discharge, under section; (D) An immediate required by the reneeds, under parsection; or (E) A resident has for 30 days. §483.15(c)(5) Cowritten notice spetthis section must (i) The reason fo (ii) The effective of	cified in paragraphs (c)(4)(ii) section, the notice of arge required under this made by the facility at least are resident is transferred or e made as soon as a transfer or discharge when- individuals in the facility ered under paragraph (c)(1) on; individuals in the facility ered, under paragraph (c)(1)						

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transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2022 FORM APPROVED OMB NO. 0938-039

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	LETED
		155220	B. W	ING		11/22	/2022
NAME OF I	PROVIDER OR SUPPLIEF			STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					EFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR	IATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		peal hearing request;					
	, ,	dress (mailing and email)					
	and telephone number of the Office of the						
	State Long-Term Care Ombudsman;						
	(vi) For nursing facility residents with						
	intellectual and developmental disabilities or related disabilities, the mailing and email						
		_					
		hone number of the agency					
		e protection and advocacy developmental disabilities					
	established under	•					
		sabilities Assistance and of 2000 (Pub. L. 106-402,					
	_	i.C. 15001 et seq.); and					
		acility residents with a					
		r related disabilities, the					
		address and telephone					
	_	ency responsible for the					
	_	vocacy of individuals with a					
	1 3	stablished under the					
		lvocacy for Mentally III					
	Individuals Act.	1400doy for Micritally III					
	arviddaio / tot.						
	§483.15(c)(6) Cha	anges to the notice.					
	- ' ' ' '	in the notice changes prior					
		ansfer or discharge, the					
	_	te the recipients of the					
	1	practicable once the					
		on becomes available.					
	§483,15(c)(8) Not	ice in advance of facility					
	closure	-					
		lity closure, the individual					
		strator of the facility must					
		tification prior to the					
	I -	e to the State Survey					
		e of the State Long-Term					
		n, residents of the facility,					
		epresentatives, as well as					
		ansfer and adequate					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	/2022
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			IEFFIELD AVE		
DYER NII	IRSING AND REH	ABILITATION CENTER			IN 46311		
DILIVIN	CROING AND REIL	ADETATION CENTER		D'LIN,	114 70011		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		esidents, as required at §					
	483.70(I).						
		view and interview, the facility	F 00	623	Dyer Nursing & Rehabilitatio	n	12/12/2022
	failed to ensure a re				Annual Survey: 11-22-22		
		were notified in writing related					
		hospital for 5 of 6 residents			Please accept the following as	s the	
	_	alization. (Residents 1, 73, 110,			facility's credible allegation of		
	72, and 77)				compliance. This plan of		
					correction does not constitute		
	Findings include:				admission of guilt or liability by		
					facility and is submitted only in	า	
	1. The record for Resident 1 was reviewed on				response to the regulatory		
	11/17/22 at 3:41 p.m. Diagnoses included, but				requirement.		
		, hemiplegia and hemiparesis			F623 Notice Requirements		
	,	and paralysis) affecting his			Before Transfer/Discharge		
	_	following a stroke and altered			What corrective action(s) wil	I	
	mental status.				be accomplished for those		
					residents found to have been	า	
		imum Data Set (MDS)			affected by the deficient		
		0/26/22, indicated the resident			practice;		
		paired for daily decision			Facility notice of transfer		
	making.				discharge including the bed he	old	
					policies were mailed to the		
		d 8/23/22 at 10:22 p.m.,			responsible parties for Reside	nts	
		reported to the nurse the			1, 73, and 77.		
		olored emesis. The nurse			Residents 72, 110 are no long	jer in	
		nt with coffee ground emesis.			the facility.		
	· ·	notified and orders were			How the facility will identify		
		e resident to the emergency			other residents having the		
		n. 911 was called for transport.			potential to be affected by th	е	
		Imitted to the hospital with the			same deficient practice and		
		shock and returned to the			what corrective action will be	9	
	facility on 8/29/22.				taken;		
	Th 1				All residents that are transferr		
		mentation indicating the			discharged have the potential		
		ble Party had been notified in			be affected by the same allege	ed	
	writing of the trans	ier.			deficient practice.	.4	
	T.,4.,	A durinistanton on 11/21/22			What measures will be put in	ito	
		Administrator on 11/21/22 at			place or what systemic		
	2:15 p.m., indicated	d no transfer notice was given			changes will be made to		

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he was unable to speak or respond. His eyes were

corrections will be completed:

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 SHEFFIELD AVE DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE open but his body was rigid. 911 was called and 12/12/2022 the resident was transported to the hospital. He returned to the facility on 10/28/22. There was no documentation indicating the resident's Responsible Party had been notified in writing of the transfer. Interview with the Administrator on 11/21/22 at 2:15 p.m., indicated no transfer notice was given because the resident was sent out 911. record for Resident 72 was reviewed on 11/16/22 at 2:14 p.m. Diagnosis included, but were not limited to, stroke, anemia, thyroid disorder, depression, and dysphagia (swallowing difficulties). The Significant Change in Status Minimum Data Set (MDS) assessment, dated 11/1/22, indicated the resident was severely cognitively impaired for daily decision making. Nurses' Notes, dated 10/19/22 at 6:06 a.m., indicated the resident was lying in her room with her eyes closed, when spoken to the resident made babbling noises but did not open her eyes. The residents arms were noted to have jerking movements. Vitals were assessed and she was not noted to be in respiratory distress. The Physician was notified at 5:55 a.m. and gave an order to send the resident to the hospital. There was no documentation to indicate the State approved transfer form was completed and sent with the resident.

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hospital.

There was no documentation to indicate the resident's Responsible Party had received written notification of the resident's transfer to the

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	PROVIDER OR SUPPLIER URSING AND REHA	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CO HEFFIELD AVE IN 46311	DD
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE COMPLETION
	at 11:19 a.m., indicated documentation related	Director of Nursing on 11/22/22 ated there was no ted to the State transfer form resident or to the resident's			
	11/16/22 at 9:37 a.r not limited to, sepsi	esident 77 was reviewed on n. Diagnoses included, but were is, high blood pressure, mentia, respiratory failure, and			
	assessment, dated 1	mum Data Set (MDS) 1/6/22, indicated the resident act for daily decision making.			
	indicated the reside responsive, vital sig	d 10/24/2022 at 10:52 a.m., nt was lethargic and not gns were taken and orders were Jurse Practitioner to send the ital for evaluation.			
	· · · · · · · · · · · · · · · · · · ·	d 10/24/2022 at 11:00 a.m., nt was transferred to the ion.			
		mentation to indicate the State orm was completed and sent			
	resident's Responsil	mentation to indicate the ble Party had received written esident's transfer to the			
	at 11:19 a.m., indicated documentation related	Director of Nursing on 11/22/22 ated there was no ted to the State transfer form resident or to the resident's			

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AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. WI	NG _		11/22/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	t			EFFIELD AVE		
DYFR NI	JRSING AND REHA	ABILITATION CENTER			IN 46311		
בונוווו	C. C.I. TO / II TO I I I I						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Responsible Party.						
	2.4.42()(0)						
	3.1-12(a)(6)						
	3.1-12(A)(ii)						
	3.1-12(A)(iii)						
F 0657	402 21/h\/2\/;\ /:::\						
SS=D	483.21(b)(2)(i)-(iii) Care Plan Timing						
88-D Bldg. 00							
Diag. 00		rehensive Care Plans omprehensive care plan					
	must be-	omprenensive care plan					
		in 7 days after completion					
	of the comprehens	· · · · · · · · · · · · · · · · · · ·					
		n interdisciplinary team, that					
	includes but is not						
	(A) The attending						
	. ,	urse with responsibility for					
	the resident.	urse with responsibility for					
		vith responsibility for the					
	resident.	viti responsibility for the					
		ood and nutrition services					
	staff.						
	(E) To the extent p	oracticable, the					
		e resident and the resident's					
		An explanation must be					
		lent's medical record if the					
		e resident and their resident					
		determined not practicable					
		ent of the resident's care					
	plan.						
	-	iate staff or professionals in					
		ermined by the resident's					
	· ·	ested by the resident.					
	(iii)Reviewed and	•					
	interdisciplinary te	am after each assessment,					
	including both the	comprehensive and					
	quarterly review a						
	Based on record rev	view and interview, the facility	F 06	557	Dyer Nursing & Rehabilitatio	n	12/12/2022
		dents were invited to their			ANNUAL SURVEY: 11/22/22		
	Care Plan conference	ces for 2 of 2 residents					

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Event ID:

JOJW11 Facility ID: 000125

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/22/2022		
	PROVIDER OR SUPPLIEF JRSING AND REH.	R ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reviewed for care p	lanning. (Residents 38 and D)			Please accept the following as	s the	
					facility's credible allegation of		
	Findings include:				compliance. This plan of		
					correction does not constitute	an	
	1. During an interview with Resident 38 on				admission of guilt or liability by	y the	
	11/14/22 at 10:19 a.m., he indicated he does not				facility and is submitted only in	า	
	recall being invited to attend a care conference.				response to the regulatory		
					requirement.		
	The record for Resident 38 was reviewed on				F657 Care Plan Timing and		
	11/15/22 at 2:20 p.m. The resident was admitted				Revision		
	on 4/1/22. Diagnoses included, but were not				What corrective action(s) will	II	
	limited to, dementia without behaviors, high blood				be accomplished for those		
	pressure, atrial fibrillation, heart failure, and				residents found to have been	n	
	cognitive communication.				affected by the deficient		
					practice:		
		imum Data Set (MDS)			Resident 38- care plan		
	· ·	0/16/22, indicated the resident			conference held 11/16/22, resident		
	was moderately imp	paired for decision making.			was invited to attend.		
					Resident D- care plan confer		
		mentation of a care conference			held 11/21/22, resident was in	vited	
	for the resident since	ce admission.			to attend.		
					How the facility will identify		
		Nurse Consultant on 11/21/22			other residents having the		
	-	ated the resident had a care			potential to be affected by the	ie	
	conference held tod	lay.			same deficient practice and		
	2.5	' 'd n 'd (n			what corrective action will be	е	
	-	view with Resident D on			taken;		
		.m., she indicated she did not			All residents with a change in		
	know anything abo	ut a care conference.			condition have the potential to	pe	
	Th	ident D was reviewed on			affected by the same alleged		
		m. Diagnoses included, but			deficient practice.	· t o	
	•	m. Diagnoses included, but, major depressive disorder,			What measures will be put in	itO	
		esity due to excess calories,			place or what systemic changes will be made to		
	and fibromyalgia.	estry due to excess calonies,			ensure that the deficient		
	and noronnyaigia.				practice does not recur:		
	The Quarterly Mini	imum Data Set (MDS)			Management staff educated of	ın	
		0/18/22, indicated the resident			having care conference meeti		
		act. The resident was an			timely and inviting the	iigə	
		h a 2 plus person physical			resident/responsible party to		
	CALCHSIVE ASSIST WIL	ii a 2 pius person physicai			resident/responsible party to		

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	î í	ULTIPLE CO	ONSTRUCTION 00	(X3) DATE S	
AND FLAN	OF CORRECTION	155220	B. W		<u> </u>	11/22/	
NAME OF P	ROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER	DYER, IN 46311				
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
TAG	*	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
_		lity, dressing, toilet use,			attend.		
	personal hygiene, a	nd bathing.			How the corrective action(s) will be monitored to ensure		
	The last documente	ed care conference was 7/26/22.			deficient practice will not	uie	
	Interview with the Administrator on 11/21/22 at				recur, i.e., what quality	nut	
		ed the resident had a care			assurance programs will be into place;	put	
	conference held tod				Administration/designee will a		
	3.1-35(d)(2)(B)				10 residents monthly to ensur care conferences are held tim		
					The Director of Nursing/desig	-	
					will present a summary of the		
					audits to the Quality Assurand committee monthly for 6 month		
					Thereafter, if determined by the	ne	
					Quality Assurance committee		
					auditing and monitoring will be done quarterly and present	9	
					quarterly at the QA meeting.		
					Monitoring will be on going.		
					Date by which systemic	.d.	
					corrections will be complete 12/12/2022	u.	
F 0677	483.24(a)(2)	16 8 1 18 11 1					
SS=D Bldg. 00		ed for Dependent Residents esident who is unable to					
g. ••	. , , ,	s of daily living receives the					
	_	es to maintain good					
	nutrition, grooming hygiene;	g, and personal and oral					
	Based on observation	on, record review and	F 00	677	Dyer Nursing & Rehabilitation	on	12/05/2022
		ty failed to ensure dependent nelp with Activities of Daily			Annual Survey: 11/22/22		
	Living (ADLs) rela	ted to repositioning in bed, hair			Please accept the following as	s the	
		rs, for 2 of 9 residents . (Residents D and B)			facility's credible allegation of		
	Teviewed for ADLS	. (Residents D and D)			compliance. This plan of correction does not constitute	an	

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PRINTED: 12/29/2022 FORM APPROVED

CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155220	B. WING		11/22/2022
			CER FEET	A DODDESC CUTY CTATE TID COD	
NAME OF I	PROVIDER OR SUPPLIEF	₹		ADDRESS, CITY, STATE, ZIP COD	
DVED N	LIDOING AND DELL	ADII ITATION CENTED		IEFFIELD AVE	
DYEKIN	URSING AND REH	ABILITATION CENTER	DYER,	IN 46311	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	Findings include:			admission of guilt or liability by	the the
				facility and is submitted only ir	1
	During an interv	view with Resident D on		response to the regulatory	
	11/14/22 at 10:45 a	.m., she indicated her hair was		requirement.	
	greasy and had not	been washed in a very long		F677 ADL Care Provided for	
	time. Her bathing p	preference was a bed bath,		Dependent Residents	
	which she received	2 times a week.		What corrective action(s) will	I
				be accomplished for those	
	On 11/16/22 at 11:	15 a.m., the resident was		residents found to have beer	n
	observed lying in b	ed. The right side of the bed		affected by the deficient	
	was against the wal	ll. At that time, CNA 1 was		practice;	
	observed standing r	next to the bed holding a bed		Resident B- no longer resides	in
	pan in one hand. Th	ne resident indicated she had		the facility.	
	_	ovement. The CNA instructed		Resident D- shower offered.	
	the resident to turn	onto her right side so she		CNA 1 educated on proper	
		pan under her. The resident		position of residents D.	
	_	d was unable to turn by herself		How the facility will identify	
	-	CNA placed both of her hands		other residents having the	
		t hip and physically pushed		potential to be affected by th	e
		er side. The resident was heard		same deficient practice and	
		e was hurting her while		what corrective action will be	<u> </u>
		The resident already had the		taken;	
		o the CNA provided		All dependent residents have t	the
		The CNA did not stop to get or		potential to be affected by the	···
		ny other staff member.		same alleged deficient practice	_
				What measures will be put in	
	Interview with CN	A 1 at that time, indicated the		place or what systemic	
		sed to be a 2 person physical		changes will be made to	
		pility, however, when she had		ensure that the deficient	
		om there was no time to get		practice does not recur;	
	anyone to help.	an insis was no time to get		Staff were re-educated on	
	l series			providing residents assistance	
	On 11/17/22 at 11:3	20 a.m., the resident was		with ADL care including gener	
		t that time, her hair was		grooming, hair washing, regula	
	disheveled and grea			showers, and transfers as per	
	aisiic veica una giet	, ·		resident's plan of care.	
	Interview with the	resident at that time, indicated		How the corrective action(s)	
		have hair washed at that time.		will be monitored to ensure t	he
	She did not want to	o nan masioa at tilat tilito.		deficient practice will not	
	The record for Resi	ident D was reviewed on		recur, i.e., what quality	
	I THE TECOTO TOT INCST	GOIL D WAS ICVICWED UII	I	recui, i.e., what quality	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. WI	NG		11/22/	/2022
				CTDEET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIER	8			EFFIELD AVE		
DVED NI	IDSING AND DELL	ABILITATION CENTER			IN 46311		
DIENN	JASING AND REIT	ABILITATION CENTER		DIEK,	111 40311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	n. Diagnoses included, but			assurance programs will be p	put	
		major depressive disorder,			into place;		
	morbid (severe) obe	esity due to excess calories,			DON/designee will randomly		
	and fibromyalgia.				observe 10 residents weekly w	vith	
					a focus on dependent resident	ts to	
		mum Data Set (MDS)			ensure assistance with ADL ca	are	
		0/18/22, indicated the resident			including grooming, hair wash	ed,	
	was cognitively intact. The resident was an				facial hair removed, showers		
	extensive assist with a 2 plus person physical				offered, and transfers are prov	rided	
	assist for bed mobility, dressing, toilet use,				per plan of care.		
	personal hygiene, as	nd bathing.			Nurse manager/designee will		
					present a summary of the aud	its	
	A Care Plan, dated 5/22/22, indicated the resident				to the Quality Assurance		
		of care and refused bed baths.			committee monthly for 6 month		
		re staff would provide		Thereafter, if determined by the			
		ks and consequences of their			Quality Assurance committee,		
	refusal of care.				auditing and monitoring will be	;	
					done quarterly and present		
		5/22/22, indicated the resident			quarterly at the QA meeting.		
	required assistance	with ADLs.			Monitoring will be on going.		
	The alexander of a second	for 11/2022 indicated there was			Bata harrakish sasatamis		
		he resident received a bed			Date by which systemic	.J.	
	bath.	ne resident received a bed			corrections will be completed	a:	
	Datii.				12/12/2022		
	The computer Point	t of Care charting indicated the					
	•	complete bed bath on 11/9/22.					
		al bed bath on 11/8, 11/10,					
	11/13 and 11/15/22						
	11/13 and 11/13/22	•					
	There was no docur	nentation the resident had her					
	hair washed.	ion wie resident naa ner					
	man maniou.						
	Interview with the V	West Assistant Director of					
		n 11/16/22 at 2:45 p.m.,					
		should have asked for help in					
	turning the resident over to provide incontinence						
		required a 2 plus person assist					
	for repositioning in						

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	OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BUILDING B. WING	00	COMPI 11/22	LETED
	PROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Ε	(X5) COMPLETION DATE
	the shower aide in the shower sheets for all was an evening bed the resident a bed be evening CNA would be evening to even a different typ hair could be washed be evening by the evening the ev	ne resident refusing to have ing the complete bed baths.2. record was reviewed on an an an an an an area and a single for the resident was admitted and a single for the resident was admitted.				

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Event ID:

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	2022
	ROVIDER OR SUPPLIER	ABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE
F 0684	at 11:19 a.m., indica any more document week showers being	Director of Nursing on 11/22/22 ated she was unable to provide ation related to at least twice a given for the resident. ates to Complaint IN00392424.					
SS=D Bldg. 00	Quality of Care § 483.25 Quality of Care is a applies to all treating facility residents. Ecomprehensive as facility must ensure treatment and care professional stand comprehensive per and the residents' Based on observations.	a fundamental principle that ment and care provided to Based on the sessment of a resident, the e that residents receive e in accordance with lards of practice, the erson-centered care plan,	F 00	584	Dyer Nursing & Rehabilitation Annual Survey: 11/22/22	n	12/12/2022
	residents reviewed finon-pressure related. Finding includes: On 11/14/22 at 9:59 sitting in a chair ins resident's entire force and her cheek bones. The record for Resident's entire force and her cheek bones.				Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F684 Quality of Care What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident E- Bruises were	an / the n	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/G		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	ETED
		155220	B. W	ING _		11/22	/2022
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIE	R			EFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER			IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	DATE
1110		ith other behavioral			assessed and new orders we	re	BITTE
	· ·	ted falls, weakness, and high			received to monitor bruises.		
	blood pressure.	ine initial, weariness, und ingi			How the facility will identify		
	olood pressure.				other residents having the		
	The Quarterly Mini	imum Data Set (MDS)			potential to be affected by the	ne	
		10/6/22, indicated the resident			same deficient practice and		
	· ·	intact and had no mood or			what corrective action will b	е	
		ident needed extensive assist			taken;		
	with 2 person phys	ical assist for transfers. The			All residents have the potenti	al to	
	resident had no fall	s since the last assessment.			be affected by the same alleg		
					deficient practice.		
	Nurses' Notes, date	ed 11/09/22 at 2:20 a.m.,			What measures will be put i	nto	
	indicated the reside	ent was observed lying on the			place or what systemic		
		oor mat. A hematoma was noted			changes will be made to		
	to the left forehead.	. The resident was also noted			ensure that the deficient		
	with a moderate an	nount of blood from her nose.			practice does not recur;		
	The resident was tr	ansferred to the emergency			Nurses were re-educated on		
	room for treatment.				assessing and documenting		
					changes in skin condition		
		ed 11/09/22 at 10:13 a.m.,			(pressure/non-pressure), noti		
		ent returned to the facility from			physician, and obtaining orde	ers	
	_	vas diagnosed with a			for treatment/monitoring.		
		acture of left orbital. There			Assistive clinical staff were		
		the left side of her face, with			educated on notifying the nur	se of	
		sing to the left eye and the left			any change in skin condition.		
	side of her forehead	a.			How the corrective action(s)		
	Dhyaiciant- Out	datad 11/11/22 in 3:t-3			will be monitored to ensure	tne	
	•	dated 11/11/22, indicated			deficient practice will not		
	_	aily to left forehead/cheek/eye.			recur, i.e., what quality	nut	
	bruising every shift	ad hematoma daily. Monitor all			assurance programs will be	put	
	ormsing every shill				into place;	MAD	
	The 11/2022 Medic	cation Administration Record			DON/Designee will audit the li weekly to ensure that all resid		
	-	nere was no documentation for			requiring monitoring of bruisi		
	` ′	sing every shift on 11/12/22 and			are receiving the monitoring a	•	
	_	y shift and 11/12/22 and			that staff are documenting thi		
	11/13/22 for the ev	-			the MAR for 3 months.	3 011	
	11/11/22 101 1110 00	oming sinite.			Director of Nursing/designee	will	
	The 11/2022 MAR	indicated there was no			present a summary of the aud		
		monitoring the hematoma to			to the Quality Assurance	4110	

		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUI	ILDING	00	COMPL	
		155220	B. WII			11/22/	2022
NAME OF P	PROVIDER OR SUPPLIER	2			ADDRESS, CITY, STATE, ZIP COD		
DYER NU	JRSING AND REH	ABILITATION CENTER			EFFIELD AVE IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION 11/12/22 and 11/13/22 for the		TAG	committee monthly for 6 mont		DATE
		/22 and 11/14/22 for the			Thereafter, if determined by the		
	evening shift.	22 and 11/11/22 for the			Quality Assurance committee,		
	8				auditing and monitoring will be		
	The 11/2022 MAR	indicated there was no			done quarterly and present		
	documentation for r	_			quarterly at the QA meeting.		
		bruising on 11/12/22 and			Monitoring will be on going.		
		y shift and 11/11/22 and			Date by which systemic	_	
	11/14/22 for the eve	ening shift.			corrections will be complete	d:	
	Interview with the N	Nurse Consultant on 11/21/22			12/12/2022		
		ated the bruises were to be					
	monitored as ordere						
		3					
	3.1-37(a)						
F 0688	483.25(c)(1)-(3)						
SS=D	. , , , ,	Decrease in ROM/Mobility					
Bldg. 00	§483.25(c) Mobilit						
	§483.25(c)(1) The	facility must ensure that a					
		rs the facility without limited					
	-	oes not experience					
		of motion unless the					
		condition demonstrates					
	unavoidable; and	range of motion is					
	unavoldabic, and						
	§483.25(c)(2) A re	esident with limited range of					
	- ' ' ' '	ppropriate treatment and					
		se range of motion and/or to					
	prevent further de	crease in range of motion.					
	8/18/2 25/01/21 / 50	esident with limited mobility					
	- ' ' ' '	ate services, equipment, and					
		ntain or improve mobility					
		n practicable independence					
	unless a reduction						
	demonstrably una	-					
	,	on, record review, and	F 06	88	Dyer Nursing & Rehabilitatio	n	12/12/2022
	interview, the facili	ty failed to ensure splints were			Annual Survey: 11/22/22		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIE	R			EFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER	DYER, IN 46311				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	DEFICIENCY)		DATE
		and range of motion was					
	_	3 residents reviewed for limited			Please accept the following a		
	range of motion (R	OM). (Residents 1, 30, and 90)			facility's credible allegation of	!	
					compliance. This plan of		
	Findings include:				correction does not constitute		
					admission of guilt or liability b	-	
		10:00 a.m., Resident 1 was			facility and is submitted only i	n	
		m seated in a broda chair. The			response to the regulatory		
	resident's right han	d had a splint in place.			requirement.		
					F688 Increase/Prevent		
		24 a.m., the resident's right hand			Decrease in ROM/Mobility		
	was closed in a firs	et and no anti-contracture					
	device was in use.				What corrective action(s) wi	II	
					be accomplished for those		
		04 a.m. and 1:31 p.m., the			residents found to have bee	n	
	resident was wearing	ng a right hand splint.			affected by the deficient		
					practice;		
	On 11/17/22 at 10:	17 a.m., 11:44 a.m., and 3:50 p.m.,			Resident 1- no longer resides	in	
		t wearing the splint to his right			the facility.		
	hand.				Resident 90-resident was		
					re-evaluated by therapy to		
	On 11/18/22 at 8:2	0 a.m., the splint was not in use.			determine ROM programming	J.	
					Resident 30- resident is no lo	nger	
	On 11/21/22 at 9:4	0 a.m. and 11:58 a.m., the splint			in the facility.		
	was not in use.				How the facility will identify		
					other residents having the		
		ident 1 was reviewed on			potential to be affected by the		
	_	m. Diagnoses included, but			same deficient practice and		
		, hemiplegia and hemiparesis			what corrective action will b	е	
	(muscle weakness	and paralysis) affecting his			taken;		
	_	e following a stroke and altered			All residents with splints have	the	
	mental status.				potential to be affected by the	;	
					same alleged deficient praction	e.	
	The Quarterly Min	imum Data Set (MDS)			What measures will be put in	nto	
	assessment, dated	10/26/22, indicated the resident			place or what systemic		
	was moderately im	paired for daily decision			changes will be made to		
	making. The resid	ent had a functional limitation in			ensure that the deficient		
	range of motion (R	OM) on one side of his upper			practice does not recur;		
	and lower extremit	ies.			Nursing staff were educated of	on	
					ensuring splints are in place բ		

PRINTED: 12/29/2022 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE A Care Plan, dated 7/22/22, indicated the resident physician orders. had a history of a stroke with right sided Nursing staff educated on ensuring hemiparesis. Interventions included, but were not Restorative programming is being limited to, monitor and record any increased followed based on therapy stiffness in joints and follow physical and recommendations. occupational therapy guidelines. How the corrective action(s) will be monitored to ensure the The November 2022 Physician's Order Summary deficient practice will not (POS), indicated the resident had no order for the recur, i.e., what quality hand splint. assurance programs will be put into place; There was no documentation on the October or DON/designee will randomly audit November Medication and/or Treatment records 4 residents with splints weekly to indicating the splint was applied. ensure splint are in place as physician orders. Interview with the Nurse Consultant on 11/21/22 DON/Designee will audit 10 at 2:15 p.m., indicated the order for the splint residents weekly to ensure needed to be clarified. restorative programing is being completed per therapy A new Physician's Order, dated 11/21/22, recommendation. indicated the resident was to wear the splint to his Nurse manager/designee will right hand, apply in the morning and remove at present a summary of the audits bedtime, may remove for hygiene. to the Quality Assurance committee monthly for 6 months. 2. The record for Resident 30 was reviewed on Thereafter, if determined by the 11/16/22 at 2:56 p.m. Diagnoses included, but Quality Assurance committee, were not limited to, Parkinson's and stiffness of auditing and monitoring will be unspecified joint. done quarterly and present quarterly at the QA meeting. The 10/6/22 Quarterly Minimum Data Set (MDS) Monitoring will be on going. assessment, indicated the resident was cognitively impaired for daily decision making and Date by which systemic required extensive assistance with bed mobility corrections will be completed: and transfers. The resident had a functional 12/12/2022 limitation in range of motion (ROM) on one side of his lower extremities.

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The Physical Therapy discharge summary, dated 10/5/22, indicated a restorative nursing program

was recommended for passive ROM.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		, ,	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BUILDING B. WING	j	00	COMPI 11/22	
		100220				11/22	12022
NAME OF F	PROVIDER OR SUPPLIEF	₹			DDRESS, CITY, STATE, ZIP COD		
DYER NI	JRSING AND REH	ABILITATION CENTER			N 46311		
(X4) ID		STATEMENT OF DEFICIENCIE	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION	TAG	\dashv	BEIGENOT		DATE
	The Occupational T	Therapy discharge summary,					
	•	cated a restorative nursing					
	program was recom	nmended for active and passive					
		is current level of performance					
	and prevent decline).					
	There was no docum	mentation indicating the					
		ed ROM as recommended by					
	therapy.	•					
		Administrator on 11/22/22 at					
	· ·	ed there was no documentation had received ROM per his					
	therapy discharge re	-					
	therapy discharge is	econimendations.					
	3. Interview with R	Resident 90 on 11/14/22 at 10:25					
	a.m., indicated she	had been discharged from					
		d to restorative. She had been					
	seen by restorative	only once.					
	The record for Resi	dent 90 was reviewed on					
		.m. Diagnoses included, but					
		chronic obstructive pulmonary					
	· · · · ·	eart failure, and stiffness of					
	unspecified joint.						
	The Quarterly Mini	mum Data Set (MDS)					
		0/28/22, indicated the resident					
		paired for daily decision making					
		tensive assistance with bed					
	1	ers. She had no functional					
	limitation in range	of motion (ROM).					
	The Physical Thera	py discharge summary, dated					
	1	the resident had reached her					
		. A restorative nursing program					
		to facilitate maintaining her					
	_	formance and to prevent					
	I decline. The follow	ving restorative nursing					I

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	
		155220	B. W	NG		11/22	/2022
		1		STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEI	R			EFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION developed and instruction	-	TAG	DEFICIENCE		DATE
		nterdisciplinary Team for bed					
	mobility and passiv						
	moonity and passiv	ic Row.					
	The Occupational Therapy discharge summary, dated 10/27/22, indicated the resident had a good						
		ain her current level of function					
		ff follow through. Restorative					
	-	mended for active and passive					
	ROM.						
	Social Service note	es, dated 11/14/22 at 1:44 p.m.,					
		ent inquired about restorative					
		she would start services. The					
		he restorative aide about the					
	resident's services.	The aide informed the writer					
	that once the nurse	determined her schedule she					
	would inform the re	esident.					
	Casial Campias mata	og datad 11/21/22 at 0:47 a m					
		es, dated 11/21/22 at 9:47 a.m., ent expressed concerns about					
		s receiving from the restorative					
		pressed that she did not feel					
		ing enough therapy to					
	complete her goal o	of going home.					
		esponse section indicated the					
		ctive ROM on the following					
	dates and times:						
	-11/15/22 at 12:55	p.m. and 3:37 p.m.					
	-11/17/22 at 10:43	a.m. and 3:51 p.m.					
	-11/19/22 at 9:41 a.	.m.					
	-11/20/22 at 9:33 a.	.m.					
		Administrator on 11/22/22 at ed the resident should have					

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIP A. BUILDIN B. WING	LE CONSTRUCTION NG <u>00</u>	(X3) DATE SURVEY COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	STR 60° DY	D		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREF	CROSS-REFERENCED TO THE APP	ULD BE COMPLETION	
F 0689 SS=D Bldg. 00		estorative case load in a more	TAC		DATE	
	remains as free of possible; and §483.25(d)(2)Eac	ensure that - e resident environment f accident hazards as is th resident receives sion and assistance devices				
	Based on observati interview, the facil interventions were history of falls with floor mattress and residents reviewed C) Findings include: 1. On 11/14/22 at observed sitting in time the resident's both eyes and her opurple color. On 11/15/22 at 10: observed in bed. At was standing up on beside the bed. At Nurse walked into resident for COVII	on, record review, and ity failed to ensure fall in place for residents with a n and without injury related to a mon-slip socks for 3 of 4 for falls. (Residents E, F, and 9:59 a.m., Resident E was a chair inside her room. At that entire forehead, nose, around theek bones were red and 9:66 a.m., the resident was at that time, the floor mattress a end and not on the floor 10:08 a.m. the Restorative the room and swabbed the 0-19. She left the room and lefting on end. At 10:21 a.m., the	F 0689	Dyer Nursing & Rehabil Annual Survey: 11-22-2 F 689 Free of Accident Hazards/Supervision/De What corrective action(be accomplished for the residents found to have affected by the deficient practice; Resident C- Staff ensure floor mat was in place. Resident E- Staff ensure floor mat was in place. Resident F- Staff ensure floor mat was in place. Resident F- Staff ensure floor mat was in place. Resident F- Staff ensure non-skid socks were in place to the residents having potential to be affected same deficient practice what corrective action was not taken:	evices (s) will ose e been at ed that the ed that object. Intify the by the e and	

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12/29/2022 PRINTED: DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE mattress was still standing on end and not on the All residents have the potential to floor beside the resident. At 10:45 a.m., LPN 1 be affected by the same alleged entered the room and placed the mattress on the deficient practice. floor beside the bed. What measures will be put into place or what systemic On 11/16/22 at 1:30 p.m., the resident was changes will be made to observed in bed. She was awake and sitting up. ensure that the deficient The floor mattress was observed standing on end practice does not recur; and not on the floor beside the resident's bed. At Licensed staff were in-serviced on 1:40 p.m., Agency CNA 1 walked into the room ensuring all resident with history of and put the mattress down beside the bed. fall have appropriate fall interventions in place. The record for Resident E was reviewed on How the corrective action(s) 11/16/22 at 9:45 a.m. The resident was admitted to will be monitored to ensure the the facility on 8/22/22. Diagnoses included, but deficient practice will not were not limited to, depression, fractured right recur, i.e., what quality femur, dementia with other behavioral assurance programs will be put disturbances, repeated falls, weakness, and high into place; blood pressure. DON/Designee will review 10 residents weekly to ensure fall The Quarterly Minimum Data Set (MDS) interventions are in place for 3 assessment, dated 10/6/22, indicated the resident months. After 3 months. DON/ was not cognitively intact and had no mood or designee will audit, for 3 more behaviors. The resident needed extensive assist months, weekly 5 residents to with 2 person physical assist for transfers. The ensure fall interventions are in resident had no falls since the last assessment. place. The Director of Nursing/designee

A Care Plan, dated 8/23/22, indicated the resident was at risk for falling related to impaired mobility. The approaches were to place a floor mattress

Nurses' Notes, dated 9/9/22 at 10:32 a.m., indicated the resident was found on the floor in her room. She was observed with the left leg extended and the right leg bent. At that time, she complained of pain to the right hip. The resident was transferred to the emergency room.

Nurses' Notes, dated 9/9/22 at 2:58 p.m., indicated

will present a summary of the audits to the Quality Assurance committee monthly for 3 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.

Date by which systemic corrections will be completed: 12/12/2022

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next to the bed.

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	- I	LETED
		155220	B. WING		_	2/2022
NAME OF P	PROVIDER OR SUPPLIEF			ET ADDRESS, CITY, STATE, ZIP C	COD	
DYER NII	IRSING AND REH	ABILITATION CENTER		SHEFFIELD AVE R, IN 46311		
	Т			I		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S		(X5) COMPLETION
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE A DEFICIENCY)		DATE
		from the hospital and the				
		dmitted with a fractured right				
	hip.					
	Nurses' Notes date	d 11/09/22 at 2:20 a.m.,				
		ent was observed lying on floor				
		at. A hematoma was noted to				
		he resident was also noted				
		nount of blood from her nose. ansferred to the emergency				
	room for treatment.					
		d 11/09/22 at 10:13 a.m.,				
		ent returned to the facility from vas diagnosed with a				
		acture of left orbital. There				
		the left side of her face, with				
		sing to the left eye and the left				
	side of her forehead	d.				
	Physician's Orders.	dated 11/9/22, indicated				
	mattress at bedside.					
		Nurse Consultant on 11/21/22				
	_	ated the floor mattress was to				
	was in bed.					
		10:28 a.m., Resident F was				
		one half of the bed and her feet the side of the bed on the				
	1	dent was not wearing any socks				
	on her feet.	5 ,				
	0 11/16/22 : 0.23	11.10				
		3 a.m., 11:10 a.m., and 1:30 p.m., served sitting in a reclined				
		served sitting in a rectined use times, she was wearing				
	plain socks that wer	_				
	On 11/17/22 at 9:30	0 a.m., 10:15 a.m., and 11:00 a.m.,				

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	ROVIDER OR SUPPLIER	2			EFFIELD AVE		
DVER NI	IRSING AND REH	ABILITATION CENTER			IN 46311		
DILIVINO	DISTING AND INCH	ADILITATION CENTER		DILIX,	110 40311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		served sitting in a reclined					
		se times, she was wearing					
	plain socks that wer	re not non-slip.					
		dent F was reviewed on					
		.m. The resident was admitted					
	_	6/22. Diagnoses included, but					
	·	insomnia, anxiety disorder,					
	•	entia in other diseases					
		e, unspecified severity, with					
	agitation, and major	r depressive disorder.					
	The Admission Min	eimann Data Sat (MDS))					
		nimum Data Set (MDS)) /12/22, indicated the resident					
		intact. The resident needed					
		h 1 person physical assist for					
		Pers, dressing, eating, toilet use,					
		ne. She had a history of falls					
		n the last month. In the last 7					
	_	ceived an antipsychotic					
	-	an antidepressant medication					
		medication 6 times.					
	o times, a hypnotic	medication o times.					
	A Care Plan dated	9/16/22, indicated the resident					
	·	ng related to dementia, impaired					
		nition, and safety awareness.					
		re to provide proper,					
	well-maintained for						
	Well maintained loc	stricus.					
	A Fall Event, dated	9/28/22 at 11:37 a.m., indicated					
	-	all out of the wheelchair. A					
		ed to the top of the ride side of					
	the head.	r					
	Nurses' Notes, date	d 9/28/22 at 11:47 a.m.,					
	· ·	nt was sitting at the Nurses'					
		hair. She stood up and lost her					
		eways, hitting her head on the					
		small lump to the ride top side					
	of the head						
	1		1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		r í		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BU B. WI	ILDING NG	00	11/22	
		100220	B. WII			1 1/22	12022
NAME OF F	PROVIDER OR SUPPLIEF	1			ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER			IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	· ·	ICY MUST BE PRECEDED BY FULL]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG			DATE
	Interview with the 1	Nurse Consultant on 11/21/22					
	at 2:15 p.m., indica	ted the resident was to be					
		on-slip socks at all times.3.					
		was reviewed on 11/17/22 at					
	_	is included, but were not limited					
	to, heart failure, hig	-					
	depression, and dys	mentia, anxiety disorder,					
	swallowing).	phagia (unincuity					
	sanomg).						
	A Significant Chan	ge Minimum Data Set (MDS)					
		0/4/22, indicated the resident					
		gnitively impaired for daily					
	_	he resident required extensive					
		vo person assist for bed					
	1	dressing, toilet use, bathing					
	and personal hygier	ie.					
	Nurses' Notes, date	d 8/12/2022 at 2:31 a.m.,					
	indicated the reside	nt was observed face down on					
	the side of the bed	closest to the window. The					
		d back to bed via a hoyer lift,					
		ment was conducted, and a					
	_	t knee was noted. The resident					
		g to get up to get water. The place, he had no socks or					
		vearing a gown. The Physician					
	and the resident's fa						
		•					
	Nurses' Notes, date	d 10/17/2022 at 2:00 a.m.,					
		nt was observed lying on the					
		on his back. The resident					
		g to get up and turn on the					
	1	n and the resident's family					
	were notified.						
	The Fall Investigati	on for the fall on 10/17/22 at					
		I the resident had attempted to					
		n on the news. He was					

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	l í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155220	B. W.			11/22		
	PROVIDER OR SUPPLIER	ABILITATION CENTER	•	601 SHI	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	was wearing regular mattress in place on an abrasion to the reto his right leg. A Care Plan, dated was a risk for falling diagnoses, and med included, but were refloor mattress. Interview with the I at 11:19 a.m., indicatinformation.	soom at the time of the fall and r socks. There was not a bed the floor. The fall resulted in esident's head and a skin tear 5/25/22, indicated the resident g related to limited mobility, ication profile. Interventions not limited to, placement of a Director of Nursing on 11/22/22 ated she had no further ates to Complaint IN00392985.						
	3.1-45(a)(2)							
F 0690 SS=D Bldg. 00	483.25(e)(1)-(3) Bowel/Bladder Inc §483.25(e) Inconti §483.25(e)(1) The resident who is co bowel on admissic assistance to mair or her clinical cond	continence, Catheter, UTI inence. If facility must ensure that intinent of bladder and on receives services and intain continence unless his dition is or becomes such not possible to maintain.						
	incontinence, base comprehensive as ensure that- (i) A resident who an indwelling cath unless the resident demonstrates that necessary;	a resident with urinary ed on the resident's esessment, the facility must enters the facility without eter is not catheterized it's clinical condition catheterization was enters the facility with an						

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary: and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. Based on interview and record review, the facility F 0690 **Dyer Nursing and Rehab** 12/12/2022 failed to ensure a resident with a urinary catheter Annual Survey: 11/22/22 received the necessary treatment and services related to completing catheter care as ordered for Please accept the following as the 2 of 2 residents reviewed for urinary catheters. facility's credible allegation of (Residents J and 84) compliance. This plan of correction does not constitute an Findings include: admission of guilt or liability by the facility and is submitted only in 1. Interview with Resident J on 11/14/22 at 1:48 response to the regulatory p.m., indicated the resident did not always receive requirement. catheter care every shift. F690 Bowel/Bladder Incontinence, Catheter, UTI The record for Resident J was reviewed on What corrective action(s) will 11/16/22 at 2:01 p.m. Diagnoses included, but were be accomplished for those not limited to, high blood pressure, paraplegia, residents found to have been chronic lung disease, diabetes mellitus, and affected by the deficient depression. practice; Residents J – catheter care was

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The Quarterly Minimum Data Set (MDS)

assessment, dated 10/23/22, indicated the resident

was cognitively intact for daily decision making.

The resident required extensive assistant with bed

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provided.

provided.

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Resident 84- catheter care was

How the facility will identify

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. Bl	JILDING	00	COMPLETED	
	155220		B. W	ING	11/22/2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD	
NAME OF PROVIDER OR SUPPLIER					IEFFIELD AVE	
DYER NURSING AND REHABILITATION CENTER					IN 46311	
DIEN NONGING AND NEHABIEITATION GENTER				DILIX,		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	G REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)	DATE
	mobility, dressing, toilet use, and personal				other residents having the	
	1 ' "	n indwelling catheter and an			potential to be affected by the	ie
	ostomy.				same deficient practice and	
					what corrective action will b	e
		4/27/22, indicated the resident			taken;	
		ling catheter. Interventions			All residents who have foley	
		not limited to, provide catheter			catheters have the potential to	be
		l as needed, and provide			affected by the same alleged	
	assistance for cathe	eter care.			deficient practice. The facility	has
					completed an audit and has	
	1	er, dated 9/8/22, indicated			identified all residents that ha	ve a
	catheter care every	shift.			foley catheter.	
					What measures will be put in	ıto
	_	dication Administration Record			place or what systemic	
	1 1	ne resident did not have			changes will be made to	
	1	rmed on the following dates			ensure that the deficient	
	and shifts:	0/40/00 0/44/00 0/40/00			practice does not recur;	
	-	9/10/22, 9/11/22, 9/12/22,			Clinical Staff were in-serviced	
		/15/22, 9/16/22, 9/22/22, 9/23/22,			ensuring catheter care is prov	
		/29/22, and 9/30/22			How the corrective action(s)	
	- Evening shift: 9/2				will be monitored to ensure	ine
	- Night shift: 9/24/	22, 9/25/22, 9/27/22, and 9/29/22			deficient practice will not	
	TI O . 1 M II				recur, i.e., what quality	
		cation Administration Record			assurance programs will be	put
	1 1	ne resident did not have			into place;	124
	1	rmed on the following dates			DON/Designee will randomly	
	and shifts:				5 residents with foley catheter	S
	- Day shift: 10/7/22				weekly to ensure that	1-41
	- Night Shift: 10/5/.	22, 10/7/22, and 10/9/22			documentation is being comp	eted
	International state that	Danianal Numa Consultant on			related to urinary output and	
	Interview with the Regional Nurse Consultant on				catheter care.	noo
	11/21/22 at 10:10 a.m., indicated she had no further information.				The Director of Nursing/desig	
	milorination.				will present a summary of the	
	2. The record for Resident 84 was reviewed on				audits to the Quality Assurance	
	2. The record for Resident 84 was reviewed on 11/16/22 at 1:40 p.m. Diagnoses included, but were				committee monthly for 6 mont	
	_	er, heart failure, high blood			Thereafter, if determined by the	
		a, bipolar disorder and			Quality Assurance committee	
	1	a, orporar disorder and			auditing and monitoring will be	[‡]
	depression.				done quarterly and present	
				quarterly at the QA meeting.		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU A PUBLISHING OO COMPLET					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BUILDING 00 COMPLETE B. WING 11/22/202					
100220			D	_	DDDDGG CYMY CM CMC GYD COD	11/22	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE		
DYER NURSING AND REHABILITATION CENTER			_		IN 46311		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
	The Quarterly Minimum Data Set (MDS)				Monitoring will be on going.		
	· ·	0/26/22, indicated the resident					
		act for daily decision making.			Date by which systemic	_	
	-	ed extensive assistance with ing, toilet use, and personal			corrections will be complete 12/12/2022	d:	
	-	indwelling catheter.			12/12/2022		
		-					
	-	r, dated 10/20/22, indicated to					
	clean the suprapuble needed.	c catheter site daily and as					
	needed.						
		12/1/21, indicated the resident					
		oic catheter related to					
	neuromuscular dystobstructive uropath	function of bladder and					
	oostructive uroputii	у.					
	The Medication Ad	ministration Record (MAR) for					
		ated suprapubic catheter care					
	dates and shifts:	completed on the following					
		2, 10/21/22, 10/23/22, 10/24/22,					
	-	, 10/27/22, 10/28/22, 10/29/22,					
	10/31/22	00/00 40/04/00					
	- Evening shift: 10/20	20/22, 10/26/22 /22, 10/21/22, 10/24/22, 10/26/22,					
	10/28/22	22, 10/21/22, 10/24/22, 10/20/22,					
		Director of Nursing on 11/22/22					
	at 11:19 a.m., indic information to prov	ated she had no further					
	mornation to prov						
	3.1-41(a)(2)						
F 0692	483.25(g)(1)-(3)						
SS=D	Nutrition/Hydration	n Status Maintenance					
Bldg. 00	- '-'	ed nutrition and hydration.					
	,	stric and gastrostomy					
		taneous endoscopic percutaneous endoscopic					
		enteral fluids) Based on a					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES	
CENTERS FOR MEDICARE & MEDICAID SERVICES	

STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA			(X3) DATE	DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBE		IDENTIFICATION NUMBER				COMPL	COMPLETED	
	155220		B. W	B. WING		11/22/2022		
			<u> </u>	STREET A	ADDRESS, CITY, STATE, ZIP COD			
NAME OF PROVIDER OR SUPPLIER					EFFIELD AVE			
DYER NURSING AND REHABILITATION CENTER			DYER, IN 46311					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG				TAG	DEFICIENCY)	. =	DATE	
	resident's comprehensive assessment, the facility must ensure that a resident-							
	§483.25(g)(1) Mai parameters of nutuusual body weight range and electrol resident's clinical of that this is not pospreferences indical to maintain proper standard on observation interview, the facility were obtained, food completed and suppresidents with a hist residents reviewed to the standard of the stand	ntains acceptable ritional status, such as or desirable body weight yte balance, unless the condition demonstrates sible or resident ate otherwise; ffered sufficient fluid intake r hydration and health; ffered a therapeutic diet utritional problem and the er orders a therapeutic diet. on, record review, and ty failed to ensure reweights consumption logs were elements were provided for tory of weight loss for 2 of 4 for nutrition. (Residents H and mum Data Set (MDS) /9/22, indicated the resident act and required extensive ng. The resident had no	F 00	592	Dyer Nursing & Rehabilitation Annual Survey: 11/22/22 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F692 Nutrition/Hydration State Maintenance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B- no longer resides the facility. Resident H - re-weight received	an the the tus	12/12/2022	
	weight issues and red	eceived a mechanically altered			per RD recommendation. How the facility will identify			
	aict.				other residents having the			

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	Γ OF HEALTH AND HU R MEDICARE & MEDIC					FO	RM APPROVED IB NO. 0938-039
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 11/22/2022	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD		
DYER N	URSING AND REF	IABILITATION CENTER			HEFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	resident required a Interventions inclu	wed on 11/10/22, indicated the mechanically altered diet. ded, but were not limited to, ht per facility protocol. Notify			potential to be affected by the same deficient practice and what corrective action will be taken:		
	_	family of any significant weight			taken; All residents have the potential be affected by the same allegated deficient practice.		
	A Care Plan, reviewed on 11/10/22, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, observe and record intake of food and fluids.				What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur;	nto	
	11/13/22 at 3:10 p. presented with a 20 30 days, 32.8% we	tian (RD) progress note, dated m., indicated the resident 6.0% weight loss over the past eight loss over the past 90 days,			Nursing staff was in-serviced providing supplements per MI order and following RD recommendations. Nursing staff were in-serviced)	
	Question the accur Ready care shakes nutritional support	loss over the past 180 days. acy of the resident's weight. and supercereal in place for as well as double portions at mend one can of Ensure daily			documenting meal intake in P of Care. How the corrective action(s) will be monitored to ensure to deficient practice will not		
	and add weekly we weight.	sident weighed 189 pounds. On			recur, i.e., what quality assurance programs will be into place;	-	
	11/11/22, the resid re-weight had beer	ent weighed 140 pounds. No a completed.			Nurse Managers will audit me intake documentation for 10 residents in Point of Care wee to ensure documentation		
	_	tion log for the month of cated the following meals were			compliance. Nurse Managers will audit Medication Administration Rev	cord	

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-No breakfast or lunch documented on 10/21,

-No dinner documented on 10/27 and 10/29/22.

November 2022, indicated the following meals

-No dinner was documented on 11/7 and 11/13/22.

The food consumption log for the month of

10/24, 10/28, and 10/30/22.

were not documented:

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for 5 residents weekly to ensure

consumption was provided and

The Director of Nursing/designee

will present a summary of the

audits to the Quality Assurance

committee monthly for 6 months.

nutritional supplement

documented.

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		X1) PROVIDER/SUPPLIER/CLIA	r í	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER			UILDING	COMPLETED			
155220		B. W	ING		11/22/2022		
NAME OF PROVIDER OR SUPPLIER			-		ADDRESS, CITY, STATE, ZIP COD		
					EFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	1	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Interview with the	Nurse Consultant on 11/21/22			Thereafter, if determined by the Quality Assurance committee		
		ted a reweight should have			auditing and monitoring will be		
		the food consumption sheets			done quarterly and present		
	completed.	1			quarterly at the QA meeting.		
					Monitoring will be on going.		
	_	w with the Nurse Consultant at			Date by which systemic		
	_	d the resident was reweighed			corrections will be complete	d:	
	_) pounds. 2. Resident B's			12/12/2022		
		reviewed on 11/16/22 at 9:47					
		vas admitted into the facility on					
	8/29/22 and expired on 10/12/22. Diagnoses included, but were not limited to, heart disease,						
		e, non-Alzheimer's dementia,					
	depression, and ren						
		j					
	The Quarterly Mini	imum Data Set (MDS)					
	assessment, dated 9	0/21/22, indicated the resident					
		tively impaired for daily					
	_	he resident required extensive					
		mobility, dressing, eating, and					
	personal hygiene.						
	A Registered Dietic	cian note, dated 9/15/22 at 6:31					
	1 -	resident had weight loss over					
	l * '	6 weight loss) and since					
	admission into the	facility (10.8% weight loss).					
	The resident had po	oor oral intake per the food					
		ds. The recommendations					
	included an increase of the 4 ounce ready care						
	shake to three times a day, supercereal at						
	breakfast, and a weekly weight the following						
	week.						
	The Weekly Weigh	its for the resident were					
	completed on the following dates:						
	- 9/1/22: 100.8 pour	nds (lbs)					
	- 9/7/22: 96.6 lbs						
	- 9/14/22: 89.9 lbs						
- 9/21/22: 91.8 lbs							

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/29/2022 FORM APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BUILDING 00 COMPLETED B. WING 11/22/2022			LETED			
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		601 SH	STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311					
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE		
	(MAR) indicated the ready care shake on - 9:00 a.m.: 9/16/22, 9/20/22, 9/21/22, 9/2 9/26/22, 9/27/22, 9/2 - 2:00 p.m.: 9/16/22, 9/26/22, 9/21/22, 9/2 9/26/22, 9/27/22, 9/2 - 8:00 p.m.: 9/16/22 9/23/22, and 9/28/22 Interview with the E at 11:19 a.m., indicatinformation.	lication Administration Record to resident did not receive the the following dates and times: 1,9/17/22, 9/18/22, 9/19/22, 12/22, 9/23/22, 9/24/22, 9/25/22, 12/22, 9/29/22, and 9/30/22, 12/22, 9/23/22, 9/24/22, 9/25/22, 12/22, 9/23/22, 9/24/22, 9/25/22, 12/22, 9/29/22, and 9/30/22, 12/22, 9/29/22, and 9/30/22, 12/22, 9/29/22, and 9/30/22, 12/22, 9/29/22, 12						
F 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) I (Includes naso-gas tubes, both percut gastrostomy and p jejunostomy, and c resident's compret facility must ensure §483.25(g)(4) A re	stric and gastrostomy aneous endoscopic ercutaneous endoscopic enteral fluids). Based on a nensive assessment, the						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. Based on observation, record review, and F 0693 **Dyer Nursing and Rehab** 12/12/2022 interview, the facility failed to ensure gastrostomy Annual Survey: 11/22/22 tube placement was checked prior to administering medications and the water flush and Please accept the following as the medications were instilled via gravity for 1 of 1 facility's credible allegation of gastrostomy tube medication administrations. compliance. This plan of (Resident 24) correction does not constitute an admission of guilt or liability by the Finding includes: facility and is submitted only in response to the regulatory On 11/18/22 at 11:27 a.m., LPN 2 was observed requirement. preparing medications for Resident 24. The F693 Tube Feeding resident was going to receive Oyster Shell Management/Restore Eating Calcium 500 milligrams (mg), Prevacid (a Skills medication for gastroesophageal reflux) 30 mg, What corrective action(s) will and Sucralfate (an antacid) 1 gram by the way of be accomplished for those her gastrostomy tube (G Tube). residents found to have been affected by the deficient At 11:45 a.m., the LPN entered the resident's room. practice; Prior to giving the medications, the LPN placed Resident 24 was immediately her stethoscope on the resident's abdomen and assessed and noted with no she listened to the resident's bowel sounds for adverse reactions related to not placement of the tube. She did not instill an air checking the g-tube for placement bolus or check for residual. The LPN then prior to the administration of proceeded to administer a water flush prior to medications and not giving the giving the medications, she used the plunger of medication and water flushes via the syringe and pushed the water through the gravity. tube instead of letting the water instill via gravity. LPN 2- was re-in serviced

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BU	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/22/2022		
NAME OF I	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER			IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		ered each med separately with a een and after the medications			regarding medication		
		ne used the plunger of the			administration via g-tube.		
	_	e medications and the water			How the facility will identify other residents having the		
		cations and water flushes were			potential to be affected by the	16	
	not instilled via gra				same deficient practice and		
		,			what corrective action will b	е	
	The record for Resi	ident 24 was reviewed on			taken;		
	11/21/22 at 3:24 p.i	m. Diagnoses included, but			All residents with g-tubes have	e the	
		, stroke, dysphagia (difficulty			potential to be affected by the		
	swallowing), and g	astrostomy.			same alleged deficient praction		
					What measures will be put in	nto	
		ission Minimum Data Set			place or what systemic		
	, ,	indicated the resident was			changes will be made to		
	cognitively impaire	ed and required a feeding tube.			ensure that the deficient		
	A Cara Plan datad	10/14/22, indicated the resident			practice does not recur;	al a.a.	
		tube feeding for total			Clinical staff were re-educate proper medication administrate		
	nutrition and hydra	_			technique for residents with	.1011	
	-	Ity and refusal to eat related to			g-tubes including medications		
	_	eimer's. Interventions included,			should be instilled via gravity		
		d to, verify feeding tube			placement must be checked b		
		ency every shift. Check for			either air bolus or residual prid	-	
	residual per Physic	ian Orders and report noted			the administration of medicati	on.	
	abnormalities to the	e Physician.			How the corrective action(s)		
					will be monitored to ensure	the	
		Nurse Consultant on 11/21/22			deficient practice will not		
	•	ted the water flushes and			recur, i.e., what quality		
		have been instilled by gravity			assurance programs will be	put	
	•	t checked either by air bolus or			into place;		
	residual.				Nurse manager will randomly audit/observe 2 nurse's admir	viotor	
	3.1-44(a)(2)				medications via feeding tube		
	J.1-77(a)(2)				times per week to ensure prop		
					medication administration	J-01	
					technique.		
					DON/designee will present a		
					summary of the audits to the		
					Quality Assurance committee		
					monthly for 6 months. Therea	after,	

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CENTERS FOI	R MEDICARE & MEDIC	AID SERVICES				OM	B NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	, ,	JILDING	ONSTRUCTION 00	(X3) DATE COMPL 11/22/	ETED
	PROVIDER OR SUPPLIER	ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0697 SS=D Bldg. 00	483.25(k) Pain Managemen §483.25(k) Pain M The facility must e management is pr require such servi professional stand comprehensive pe and the residents' Based on record restailed to ensure a rereceived scheduled for 1 of 3 residents Finding includes: Interview with Restaindicated she did not medications. The record for Restaindicated she did not medications. The record for Restaindicated she did not medicated she did not medications.	t danagement. ensure that pain rovided to residents who ces, consistent with dards of practice, the erson-centered care plan, goals and preferences. Fiew and interview, the facility sident with complaints of pain medication to relieve the pain reviewed for pain. (Resident J) dent J on 11/14/22 at 1:53 p.m., of always receive her pain dent J was reviewed on m. Diagnoses included, but were blood pressure, paraplegia, e, diabetes mellitus, and	F 00		if determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarter the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 12/12/2022 Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b facility and is submitted only i response to the regulatory requirement. F697 Pain Management What corrective action(s) wi be accomplished for those residents found to have bee affected by the deficient practice;	ly at will ed: an y the n	12/12/2022
	The Quarterly Mini	mum Data Set (MDS)			Pain medication was administ	tered	

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assessment, dated 10/23/22, indicated the resident

was cognitively intact for daily decision making.

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as per orders for resident J.

How the facility will identify

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OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE The resident required extensive assistance with other residents having the bed mobility, dressing, toilet use, and personal potential to be affected by the hygiene. She had an indwelling catheter and an same deficient practice and ostomy. She received a scheduled pain medication what corrective action will be regimen. taken: All facility residents that require A Care Plan, dated 4/7/22, indicated the resident pain management have the had complaints of chronic pain related to potential to be affected by the intractable back pain and wounds. Interventions same alleged deficient practice. included, but were not limited to, administer What measures will be put into medications and monitor and record effectiveness. place or what systemic changes will be made to A Physician's Order, dated 11/9/22, indicated ensure that the deficient hydrocodone-acetaminophen 10-325 milligram practice does not recur; (mg), 1 tablet every six hours. Nurses were re-educated on administering medications as per The September and October 2022 Medication orders. Administration Record (MAR) indicated the How the corrective action(s) resident did not receive the will be monitored to ensure the hydrocodone-acetaminophen tablet on the deficient practice will not following dates and times: recur, i.e., what quality - 9/9/22 at 12:00 a.m. and 6:00 a.m. assurance programs will be put - 9/29/22 at 6:00 a.m. into place; - 10/27/22 at 12:00 a.m. and 6:00 a.m. DON/designee will randomly audit 5 residents' medication Interview with the Regional Nurse Consultant on administration record 2 times per 11/21/22 at 10:10 a.m., indicated she had no further week to ensure mediations are information to provide. provided as per orders. Director of Nursing/designee will This Federal tag relates to Complaint IN00392575. present a summary of the audits to the Quality Assurance 3.1-37(a) committee monthly for 6 months. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.

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Date by which systemic

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		· /				(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BU B. WI	JILDING NG	00	COMPL: 11/22/	
		100220	D. WI	_		1 1/22/	<u> </u>
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER			IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	corrections will be complete	q٠	DATE
					12/12/2022	u.	
E 0757	400 45(1)(4) (0)						
F 0757 SS=D	483.45(d)(1)-(6)	Fron from Unnocoons					
Bldg. 00	Drugs	Free from Unnecessary					
ug. 00		essary Drugs-General.					
	, ,	ug regimen must be free					
	I	drugs. An unnecessary					
	drug is any drug w	hen used-					
	8483 45(d)(1) In e	xcessive dose (including					
	duplicate drug the	` •					
	§483.45(d)(2) For	excessive duration; or					
	§483.45(d)(3) With	nout adequate monitoring;					
	§483.45(d)(4) With for its use; or	nout adequate indications					
	8483 45(d)(5) In th	ne presence of adverse					
	- ' ' ' '	ich indicate the dose					
	'	d or discontinued; or					
		combinations of the					
	(5) of this section.	paragraphs (d)(1) through					
		riew and interview, the facility	F 07	757	Dyer Nursing & Rehabilitation	n	12/12/2022
	failed to ensure insu	ılin was administered as		,	Annual Survey: 11-22-22		12/12/2022
		iding scale insulin for 2 of 5					
		for unnecessary medications.			F 757 Hamana		
	(Residents G and J)				F 757 Unnecessary Medication Plan of Correction	ons	
	Findings include:						
	1 Th 10 D	: 1 C 1			Submission of this Plan of		
		esident G was reviewed on n. The resident was admitted to			Correction by Dyer Nursing ar Rehabilitation Center is not a		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 SHEFFIELD AVE DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE the facility on 8/24/22. Diagnoses included, but admission that a deficiency exists were not limited to, metabolic encephalopathy, or that this Statement of stroke, high blood pressure, type 2 diabetes, Deficiencies was correctly cited. repeated falls, major depressive disorder, In addition, preparation and syncope, specified dementia, unspecified severity, submission of this POC does not with other behavioral disturbance. constitute an admission or agreement of any kind by the The Quarterly Minimum Data Set (MDS) facility of the truth of any facts set assessment, dated 10/4/22 indicated the resident forth in this allegation by the was not cognitively intact. In the last 7 days the survey agency. resident received insulin 7 times and an antipsychotic medication 7 times. How will corrective action will be accomplished for those A Care Plan, dated 11/9/22, indicated the resident residents found to have been received insulin related to diabetes mellitus. The affected by the deficient approaches were to administer insulin per doctor's practice? order. Residents G and J did not suffer Physician's Orders, dated 11/8/22, indicated any adverse effects related to the Insulin Aspart U-100 per sliding scale as follows: documentation not being If Blood Sugar was 71 to 180, give 0 Units. completed for insulin If Blood Sugar was 181 to 230, give 4 Units. administration. If Blood Sugar was 231 to 280, give 7 Units. If Blood Sugar was 281 to 330, give 10 Units. How will the facility will If Blood Sugar was 331 to 350, give 13 Units. identify other residents having If Blood Sugar was greater than 350, give 13 Units. the potential to be affected by If Blood Sugar was greater than 350, call Medical the same deficient practice? Doctor. All residents with insulin orders The 9/2022 Medication Administration Record have the potential to be affected (MAR) indicated the following: by the alleged deficiency. - There was no documentation (was blank) on 9/15 at 8:00 a.m. and 12:00 p.m. What measures will be put into - There was no documentation of the blood sugar place, or systemic changes and 10 units were administered on 9/3 and 9/11 at made, to ensure that the

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- There was no documentation of how many units

of Insulin was administered on 9/11 at 5:00 p.m.,

- There was no documentation (was blank) on

and the blood sugar was 379.

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recur?

deficient practice will not

Director of Nursing or designee

re-educated staff nurses on the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPI		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22	/2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			EFFIELD AVE		
DVED NI	IDSING AND DEH	ABILITATION CENTER			IN 46311		
DIEKN	UKSING AND KEH	ABILITATION CENTER		DIEK,	111 40311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	9/18/22 at 5:00 p.m				facility Insulin Administration		
		umentation of how many units			policy, specifically on		
		inistered on 9/23 at 5:00 p.m.,			administering insulin as order	ed	
	and the blood sugar	: was 230.			and signing the Insulin		
					Administration Record		
		indicated the following:			immediately post administration		
		umentation (was blank) on 10/8			This documentation includes		
	and 10/9/22 at 12:0	-			documentation of what the blo		
		umentation of how many units			sugar was and how many unit	s of	
		inistered on 10/9/22 at 8:00 a.m.,			insulin was administered.		
	and the blood sugar						
		umentation of how many units			How will the facility will		
		inistered on 10/17/22 at 12:00			monitor its corrective action	s to	
	p.m., and the blood				ensure that the deficient		
		umentation (was blank) on			practice is being corrected a	ınd	
	10/24 at 12:00 p.m.				will not recur?		
	Interview with the l	Nurse Consultant 11/21/22 at			DON/designee will audit twice	;	
	12:45 p.m., indicate	ed the insulin was either not			weekly 7 residents with blood		
	signed out on the M	IAR, missing units			glucose monitoring orders and		
	administered or mis	ssing the blood sugar.2. The			insulin administration orders to	0	
	record for Resident	J was reviewed on 11/16/22 at			ensure that the nurse docume	ents	
	2:01 p.m. Diagnose	es included, but were not limited			and records in the MAR both	the	
	to, high blood press	sure, paraplegia, chronic lung			blood glucose results and the		
	disease, diabetes me	ellitus, and depression.			amount of insulin administere	d for	
					3 months. After 3 months,		
		mum Data Set (MDS)			DON/designee will audit, for 3	;	
	· ·	0/23/22, indicated the resident			more months, weekly 7 resident	ents	
	was cognitively inta	act for daily decision making.			to ensure blood glucose resul	ts	
					and insulin administration is		
		r, dated 9/8/22, indicated			recorded in the MAR.		
	•	unit/milliliter, administer three					
		ing scale as follows:			The Director of Nursing/desig	nee	
	_	ss than 70, call Physician.			will present a summary of the		
	_	0 to 200, give 2 units.			audits to the Quality Assurance		
	_	1 to 250, give 4 units.			committee monthly for 6 mont		
	_	1 to 300, give 6 units.	Thereafter, if determined by the				
	_	1 to 350, give 8 units.			Quality Assurance committee		
	If blood sugar is gre	eater than 250, call Physician.			auditing and monitoring will be)	
	I		1		done quarterly and present		I

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î î		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		UILDING	00	COMPLE	
		155220	B. W	ING		11/22/2	2022
NAME OF P	PROVIDER OR SUPPLIER			601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE		
DYER NU	JRSING AND REHA	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	_	2 Medication Administration			quarterly at the QA meeting.		
	Record (MAR) indi				Monitoring will be on going.		
		umentation of how many units inistered with a blood sugar of			Date by which systemic	d.	
	151 on 9/11/22 at 8:				corrections will be complete 12/12/2022	u.	
		amentation (was blank) on			12/12/2022		
	9/14/22 at 7:00 a.m.						
	- There was no docu	umentation of how many units					
	of insulin were adm	inistered with a blood sugar of					
	159 on 9/17/22 at 1						
		umentation of how many units					
		inistered with a blood sugar of					
	167 on 9/21/22 at 8:	:00 p.m. umentation of how many units					
		inistered with a blood sugar of					
	154 on 9/28/22 at 8:						
		umentation (was blank) on					
	9/29/22 at 7:00 a.m.						
		Regional Nurse Consultant on					
		m., indicated she had no further					
	information to provi	ide.					
	3.1-48(a)(6)						
		4-1					
F 0758	483.45(c)(3)(e)(1)						
SS=D Bldg. 00		Psychotropic Meds/PRN					
blug. 00	Use §483.45(e) Psycho	otronic Druge					
		sychotropic drug is any					
		rain activities associated					
	•	sses and behavior. These					
		are not limited to, drugs in					
	the following cated						
	(i) Anti-psychotic;						
	(ii) Anti-depressan						
	(iii) Anti-anxiety; a	nd					
	(iv) Hypnotic						
	Based on a compr	rehensive assessment of a					

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CENTERS FOR	OM	B NO. 0938-039				
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPL	ETED
		155220	B. WING		11/22/	2022
NAME OF I	PROVIDER OR SUPPLIEI		STREET .	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	ROVIDER OR SUPPLIED			EFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER	DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	resident, the facili	ty must ensure that				
	\$492.4E(a)(1) Day	aidente who have not used				
		sidents who have not used is are not given these drugs				
		ation is necessary to treat a				
		as diagnosed and				
	documented in the	_				
		o omnoci record,				
	§483.45(e)(2) Res	sidents who use				
		s receive gradual dose				
		ehavioral interventions,				
		ontraindicated, in an effort				
	to discontinue the	se drugs;				
		sidents do not receive				
	1	s pursuant to a PRN order				
		ation is necessary to treat				
		ific condition that is				
	documented in the	e clinical record; and				
	§483.45(e)(4) PR	N orders for psychotropic				
		to 14 days. Except as				
	_	45(e)(5), if the attending				
		cribing practitioner believes				
	that it is appropria	te for the PRN order to be				
	extended beyond	14 days, he or she should				
	document their ra	tionale in the resident's				
		d indicate the duration for				
	the PRN order.					
	8/18/3 //5/ _{(A})//5) DD	N orders for anti-psychotic				
	` ` ` ` `	to 14 days and cannot be				
	•	ne attending physician or				
		ioner evaluates the resident				
		eness of that medication.				
		on, record review, and	F 0758	Dyer Nursing & Rehabilitation	1	12/12/2022
		ty failed to ensure residents did	1 0,30	Annual Survey: 11-22-22	-	12/12/2022
		ssary medications without		Please accept the following as	the	

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adequate indications for use and prn (as needed)

anti-anxiety medication were only administered

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compliance. This plan of

facility's credible allegation of

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	NG		11/22/	2022
				CENTER	A DODDEGG CHTM CTATE THE COD		
NAME OF I	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP COD		
DVED N	LIDOING AND DELL	ADU ITATION CENTED			IEFFIELD AVE		
DYERN	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		eutical interventions were			correction does not constitute	an	
	_	residents reviewed for			admission of guilt or liability by	/ the	
	unnecessary medica	ations. (Residents G and F)			facility and is submitted only ir	า	
					response to the regulatory		
	Findings include:				requirement.		
					F758 Free from unnecessary		
		9:34 a.m., Resident G was			psychotropic meds/PRN use		
		a wheelchair in the memory			What corrective action(s) wil	I	
	_	At that time, his head was low			be accomplished for those		
		losed. At 11:15 a.m., the			residents found to have beer	า	
		with his eyes closed. At 1:30			affected by the deficient		
	_	vas observed sitting in his			practice;		
	wheelchair with his	s back facing the room door. At			Resident G - Diagnosis/indica	tion	
	that time, his head	was low and his eyes were			of use for Seroquel was received	/ed	
	closed.				and updated in the medical re-	cord.	
					Also, MD notified and order		
		ident G was reviewed on			received for the resident to be		
	_	m. The resident was admitted to			seen by psych services.		
		22. Diagnoses included, but			Resident F- No adverse react	ion	
		, metabolic encephalopathy,			to prn Haldol and Lorazepam	given	
		pressure, type 2 diabetes,			without prior intervention.		
	-	or depressive disorder,			How the facility will identify		
		fied dementia, unspecified			other residents having the		
	severity, with other	behavioral disturbance.			potential to be affected by th	е	
					same deficient practice and		
		imum Data Set (MDS)			what corrective action will be	9	
	· ·	0/4/22 indicated the resident			taken;		
		intact. In the last 7 days the			All residents receiving		
		sulin 7 times and an			psychotropic medications have		
	antipsychotic medic	cation 7 times.			potential to be affected by the		
					same alleged deficient practic		
		8/25/22, indicated the resident			What measures will be put in	ito	
		erse consequences related to			place or what systemic		
		notic medication for treatment			changes will be made to		
	of dementia with be	ehavioral disturbance.			ensure that the deficient		
					practice does not recur;		
	A Hospital Note, dated 8/25/22, indicated the				Staff were educated on ensuring		
		ing Seroquel 25 milligrams (mg)			there is an appropriate		
	_	tion. A History and Physical			diagnosis/indication for use of		
	Note from the hosp	ital indicated the resident was			psychotropic medications and		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	00	COMPL	LETED
		155220	B. W	ING		11/22/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEF	R			EFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER			IN 46311		
	Г		1		T		OV.5
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	1	TAG			DATE
	not taking Seroquel hospitalization.	at nome prior to			notification to psychiatrist for a	-	
	nospitanzation.				indication of use needed. Also		
	Physician's Orders	dated 8/25/22, indicated			any resident who admits to the facility on psychotropic	5	
	1 -	ychotic medication) 25 mg at			medications be referred to psy	(ch	
		edication was discontinued on			services.	CII	
	8/31/22.	discontinued on			Staff were educated on attem	ntina	
	0,51,22.				non-pharmacological interven	•	
	Physician's Orders	dated 8/31/22, indicated			and recording these attempts		
	1 -	ab three times a day. The			the EMR prior to giving a prn		
		continued on 11/16/22.			psychotropic medication.		
	incurson was also				How the corrective action(s)		
	Physician's Orders.	dated 11/16/22, indicated			will be monitored to ensure t	he	
	1 -	ice a day for insomnia.			deficient practice will not		
		,			recur, i.e., what quality		
	There were no psyc	chiatric Physician Progress			assurance programs will be	put	
		admission to current regarding			into place;	,	
	the Seroquel medic				DON/designee will audit 5		
	•				residents receiving prn		
	The resident was no	ot being seen by the outside			psychotropics weekly to ensur	e	
	behavioral health co	onsultant.			prior interventions were attem		
					Social Services Director/Design	jnee	
	Interview with the 1	resident's spouse on 11/17/22			will randomly audit 5 residents	;	
	at 3:11 p.m., indica	ted the resident had been			receiving psychotropic		
	sleeping all the time	e and that concerned her. The			medications weekly to ensure		
		an antipsychotic medication			there is an appopriate		
	while at home when	n she was taking care of him.			diagnosis/indication for use is	in	
					place.		
		Nurse Consultant 11/21/22 at			The Director of Nursing/design	nee	
	-	d the resident had not been seen			will present a summary of the		
	*	ealth consultants since			audits to the Quality Assurance		
	admission				committee monthly for 6 mont		
					Thereafter, if determined by th		
		Resident F was reviewed on			Quality Assurance committee,		
		.m. The resident was admitted			auditing and monitoring will be)	
		6/22. Diagnoses included, but			done quarterly and present		
		, insomnia, anxiety disorder,			quarterly at the QA meeting.		
	_	entia in other diseases			Monitoring will be on going.		
		e, unspecified severity, with			Date by which systemic		
I	Lagitation and major	r denressive disorder	1		corrections will be complete	۸.	I

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EPARTMENT OF HEALTH AND HUMAN SERVICES ENTERS FOR MEDICARE & MEDICAID SERVICES						FORM APPROVED OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220		JILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	(X5) COMPLETION DATE
	The Admission Mi assessment, dated 9 was not cognitively extensive assistance for bed mobility, truse, and personal he falls prior to admiss last 7 days the reside medication 6 times 6 times, and a hyproperior of the falls prior to admiss last 7 days the residence of times, and a hyproperior of times, and a h	nimum Data Set (MDS) 0/12/22, indicated the resident v intact. The resident needed e with 1 person physical assist ansfers, dressing, eating, toilet tygiene. She had a history of sion in the last month. In the dent received an antipsychotic , an antidepressant medication notic medication 6 times. 9/16/22, indicated the resident xiety medication related to aviors. The approaches were to objectively document the /mood. dated 9/6/22, indicated i-anxiety medication) 0.5 ry 6 hours as needed (prn). dated 9/7/22, indicated nilligrams (mg) under the tongue			12/12/2022		

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10/29/22 or 10/30/22.

There was no documentation in the Nurses' Notes

of any interventions attempted prior to administering the prn medications on 10/25/22,

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	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER 155220		BUILDING 00 COMPLETED WING 11/22/2022			
		.00220			ADDRESS, CITY, STATE, ZIP COD	. 1/22/	
NAME OF P	ROVIDER OR SUPPLIER				EFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER			IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION
F 0761 SS=D Bldg. 00	The resident was mon 11/2/22. Interview with the Mat 12:45 p.m., indicated documentation of in administration of the Lorazepam. This Federal tag reliable of the Lorazepam. 483.45(g)(h)(1)(2) Label/Store Drugs (a) (a) (b) (b) (c) (b) (c) (c) (b) (c) (c) (b) (c) (c) (c) (c) (c) (c) (c) (c) (c) (c	ates to Complaint IN00392424 and Biologicals ag of Drugs and Biologicals cals used in the facility accordance with currently conal principles, and include accessory and cautionary acceptant and Biologicals acceptance with state and accordance with State and accility must store all drugs locked compartments acceptant accepta		TAG	DEFICIENCY		DATE

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER 155220	A. BU	A. BUILDING <u>00</u>		COMPL	(3) DATE SURVEY COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIER URSING AND REHABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	λΤΕ	(X5) COMPLETION DATE	
	package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, record review, and interview, the facility failed to ensure medication carts were locked when out of view on 1 of 3 units throughout the facility. (The West Unit) Finding includes: On 11/17/22 at 4:27 p.m., RN 1 entered Resident 90's room to administer her medications. The medication cart was left unlocked and the cart was out of the RN's view when she was in the resident's room. At 4:44 p.m., the RN remained in the resident's room and the cart was still unlocked and out of her view. Interview with the Nurse Consultant on 11/21/22 at 2:15 p.m., indicated the medication cart should have been locked prior to entering the resident's room. A facility policy, titled "Storage of Medications" was provided by the Administrative Consultant on 11/22/22 at 3:04 p.m. The policy indicated medication rooms, carts, emergency kits/boxes, and medication supplies were to be locked when not attended by persons with authorized access. 3.1-25(m)	F 07		Dyer Nursing & Rehabilitation Annual Survey: 11/22/22 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. F761 Label/Storage Drugs & Biologicals What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Medications were immediately secured when notified. RN 1 educated on locking medication cart when not in vithow the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All residents have the potential be affected by the same alleg deficient practice. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; Nurses were educated ensuring	an y the n v the n v the e e e e e e e e e e e e e e e e e e	12/12/2022	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDIN	ig <u>00</u>	COMPLETED	
		155220	B. WING		11/22/2022	
			STR	EET ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIE	R		SHEFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER		ER, IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFI	CROSS-REFERENCED TO THE APPROPR	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAC	DEFICIENCY)	DATE	
				medication carts are locked	when	
				out of view of nurse.		
				How the corrective action(s	•	
				will be monitored to ensure	the	
				deficient practice will not		
				recur, i.e., what quality		
				assurance programs will be	put	
				into place;		
				Facility angels will round 5 til		
				per week x 3 months to ensumedication carts are locked		
				not in view of a nurse.	Mileii	
				Nurse manager/designee wil		
				present a summary of the au		
				to the Quality Assurance		
				committee monthly for 3 mor	nths.	
				Thereafter, if determined by		
				Quality Assurance committee		
				auditing and monitoring will be		
				done quarterly and present		
				quarterly at the QA meeting.		
				Monitoring will be on going.		
				Date by which systemic	. 4.	
				corrections will be complet 12/12/2022	ea:	
				12/12/2022		
F 0800	483.60					
SS=D		ets Needs of Each Resident				
Bldg. 00		d nutrition services.				
	-	provide each resident with a				
		able, well-balanced diet that				
	meets his or her of	daily nutritional and special				
		king into consideration the				
	preferences of ea					
		on, record review, and	F 0800	Dyer Nursing and Rehab	12/12/2022	
		ity failed to provide a resident		Annual Survey: 11/22/2022		
		and well-balanced diet and				
		pecial dietary needs for 1 of 3		Please accept the following a		
1	residents reviewed	for nutritional services.		facility's credible allegation o	f	

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CENTERS FOR	R MEDICARE & MEDIC				OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155220	B. WING		11/22/2022
			CERTIFIER.	ADDRESS CITY STATE THE SOR	
NAME OF F	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
D)/ED 111	IDONIO AND DELL	45U ITATION OFNITED		HEFFIELD AVE	
DYER N	JRSING AND REH	ABILITATION CENTER	DYER,	IN 46311	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	`	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
1710	(Resident J)	RESCRIBENTIFITING INFORMATION	1710	compliance. This plan of	DATE
	(Resident 3)			1 · · · · · · · · · · · · · · · · · · ·	
	E' 1' ' 1 1			correction does not constitute	
	Finding includes:			admission of guilt or liability by	
				facility and is submitted only in	1
	-	w on 11/14/22 at 1:28 p.m.,		response to the regulatory	
		d she had an allergy to corn		requirement.	
	-	but the facility staff were still			
	serving her corn pr	oducts. She indicated she		F800 Diet	
	often just ate less d	luring her meals because of it.			
				What corrective action(s) wil	ı
	During an observat	tion of a lunch meal on 11/21/22		be accomplished for those	
	-	esident received her lunch		residents found to have been	n
	-	barbeque meat loaf, mashed		affected by the deficient	
		rn gravy, seasoned corn,		practice?	
	*	nd a S'Mores bar dessert. The		practice:	
	-	d was still on the tray, which		Desident I had no advance	
		•		Resident J had no adverse	
		meals the resident was to		reaction to being served corn.	
	-	tein and juice with lunch. The			
		be served: corn, cornbread,		How will facility identify other	ır
	•	barbeque sauce, jelly, crackers,		residents who have the	
		any desserts, or grits. The		potential to be affected by the	e
	residents allergies v	were listed as corn. The meal		same alleged deficient	
	card indicated the r	resident was not to receive any		practice?	
	corn products at all	l.			
				The deficient practice has the	
	The record for Resi	ident J was reviewed on		potential to affect all facility	
	11/16/22 at 2:01 p.:	m. Diagnoses included, but were		residents.	
	*	blood pressure, paraplegia,			
	_	se, diabetes mellitus, and		What corrective measures w	iii
	depression.	, <u> </u>		the facility take or will alter to	
	acpression.			ensure that the	
	The Ougetonly Min	imum Data Sat (MDS)			
		imum Data Set (MDS)		problem will not recur?	
		10/23/22, indicated the resident		5	
	was cognitively int	act for daily decision making.		Dietary staff were educated or	
				ensuring the diet order/restrict	ions
	-	er, dated 11/9/22, indicated a		are being followed.	
		added salt, no concentrated			
	sweets diet with sp	ecial instructions for super		What quality assurance plan	s
	cereal at breakfast,	double protein at all meals,		will be implemented to monit	

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ground meats, and no corn or corn products.

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facility performance to ensure

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE A. BUILDING B. WING	E CONSTRUCTION G 00	(X3) DATE COMPI 11/22	LETED	
	PROVIDER OR SUPPLIER	ABILITATION CENTER	601	ET ADDRESS, CITY, STATE, ZIP COD SHEFFIELD AVE FR, IN 46311	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	DEFICIENCY)	LD BE ROPRIATE	(X5) COMPLETION DATE
		Administrator on 11/21/22 at she had no further information		corrections are achieved permanent? Dietary manager/designe audit 3 meals weekly on alternating shifts x 3 mon ensure the diet tickets are followed as written. Administrator/designee were present a summary of the to the Quality Assurance committee monthly for 3 in Thereafter, if determined Quality Assurance command auditing and monitoring we done quarterly and prese quarterly at the QA meeting Monitoring will be on going the state of the system changes will be completed 12/12/2022	e will ths to e being vill e audits months. by the ittee, vill be nt ng.	
F 0804 SS=E Bldg. 00	Temp §483.60(d) Food a Each resident reco provides- §483.60(d)(1) Food conserve nutritive appearance; §483.60(d)(2) Food	eives and the facility d prepared by methods that value, flavor, and				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 00 B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE appetizing temperature. Based on observation and interview, the facility F 0804 Dyer Nursing & Rehabilitation 12/12/2022 failed to ensure food served to resident rooms Annual Survey: 11/22/22 was received hot for 1 of 2 units observed. This had the potential to affect the 56 residents who resided on that unit and received food from the F 804 Food Temperatures kitchen. (East Unit) Finding includes: What corrective action(s) will be accomplished for those Interview with Resident J. who resided on the East residents found to have been Unit, on 11/14/22 at 1:43 p.m., indicated the food affected by the deficient was not warm for a lot of the meals she had been practice? served. Temperatures have been taken On 11/21/22 at 12:34 p.m., the last tray from the and meals have been served at the East Unit food tray cart was removed. It was proper temperature. There have delivered with the plastic dome lid covering the been no complaints related to cold plate. At that time, the Dietary Manager removed food served. the plastic dome lid and used a food thermometer to obtain the following food temperatures: How will facility identify other - Barbeque meatloaf: 127 degrees residents who have the - Mashed potatoes with brown gravy: 125 degrees potential to be affected by the - Seasoned corn: 113 degrees same alleged deficient practice? Interview with the Dietary Manager at that time, indicated she would like the temperature to be a The deficient practice has the little warmer, approximately 135 degrees or warmer. potential to affect all facility residents. 3.1-21(a)(2) What corrective measures will the facility take or will alter to ensure that the problem will not recur? Facility staff educated on passing meals/trays in a timely manner to

avoid food getting cold.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	X3) DATE SURVEY COMPLETED 11/22/2022
	PROVIDER OR SUPPLIER URSING AND REH	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
				Facility staff also educate on reheating resident food if requested.	
				What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?	or e
				Administrator/designee will aud meals per week on various shift 6 months to ensure meals are being served in a timely manner and at the proper temperature.	fts x er
				A summary of the audits will b presented to the Quality Assurance Committee monthly 6 months.	
				By what date the systemic changes will be completed: 12/12/2022	
F 0812 SS=E Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.			
	approved or cons federal, state or lo (i) This may include	de food items obtained producers, subject to			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED 155220 B. WING 11/22/2022 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL. DEFICIENCY) TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DATE regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. Based on observation and interview, the facility F 0812 12/12/2022 Dyer Nursing & Rehabilitation failed to serve and prepare food under sanitary conditions related to dirty food equipment, steam Annual Survey: 11-22-22 tables, wire racks, standing fans, and standing mixer for 1 of 1 kitchens observed. This had the F 812 Food and Nutritional potential to affect the 116 residents who received Services food from the kitchen. (The Main Kitchen) Please accept the following as the Findings include: facility's credible allegation of compliance. This plan of During the Brief Kitchen Sanitation Tour on correction does not constitute an 11/14/22 at 9:18 a.m. with the Dietary Food admission of guilt or liability by the Manager, the following was observed: facility and is submitted only in response to the regulatory a. There was a moderate amount of dirt and dust requirement. on the storage racks that housed clean pots and pans. What corrective action(s) will be accomplished for those b. There was a heavy accumulation of burned residents found to have been food and crumbs on the stove top. affected by the deficient practice; c. There was a heavy accumulation of food Storage racks cleaned spillage and grease on the inside of both Burned food and crumbs removed

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the ovens.

convection ovens and on the inside of the glass

doors. There was grease noted on the sides of

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from stove top

glass doors cleaned.

Convection ovens cleaned and

Ovens, griddle and stove cleaned

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION
TAG	d. There was a hear the sides of the gride. e. The handles to the control of the standing at the steam table. f. There was a hear spillage on the bottom.	ELSC IDENTIFYING INFORMATION vy accumulation of grease on ldle, stove, and both ovens. the ovens were sticky to touch. vy accumulation of dirt and g fan blades blowing directly vy accumulation of food om of the steam table. vy accumulation of dirt, dried	TAG	Standing fan cleaned Steam table cleaned Stand mixer cleaned How the facility will identify other residents having the potential to be affected by th same deficient practice and what corrective action will be taken; All facility residents have the	e e
	table. Interview with the indicated the steam functional. h. There was a tor of plastic over the smoderate amount of and around the bow	Dietary Food Manager on .m., indicated all of the above		potential to be affected by the same alleged deficient practic. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff have been in-servegarding, proper Cleaning and sanitation of equipment, and drying techniques. All alleged concerns have been added to routine dietary clean schedule. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place; Administrator or designee to a sanitation of kitchen area 3 tin	viced d en ing

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BUILDING B. WING	00	COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
F 0880 SS=E Bldg. 00	infection prevention designed to provide comfortable environment and communicable discussions. See Section 1988. See Section 1988. See See See See See See See See See Se	on & Control Control stablish and maintain an an and control program e a safe, sanitary and anment and to help prevent and transmission of eases and infections. on prevention and control establish an infection atrol program (IPCP) that minimum, the following estem for preventing, and, investigating, and ans and communicable sidents, staff, volunteers, individuals providing ontractual arrangement		a week for 6 months. Administrator/designee will present a summary of the au to the Quality Assurance committee monthly for 6 mor Thereafter, if determined by Quality Assurance committee auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 12-12-22	nths. the e, pe

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DEPARTMENT OF HEALTH AND HUMAN SERVICES									
CENTERS FOR MEDICARE & MEDICAID SERVICES									
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION							

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	r í	JILDING	nstruction <u>00</u>	(X3) DATE : COMPL 11/22/	ETED
	PROVIDER OR SUPPLIER	ABILITATION CENTER	<u>, </u>	601 SH	ODDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
	following accepted	ing to §483.70(e) and I national standards; tten standards, policies,					
	and procedures for include, but are not (i) A system of suridentify possible or infections before the persons in the fact (ii) When and to work communicable distinctions to be of infections; (iii) Standard and precautions to be of infections; (iv) When and how for a resident; include (A) The type and or depending upon the organism involved (B) A requirement the least restrictive under the circums (v) The circumstarm must prohibit emporommunicable distinctions from direct their food, if direct disease; and (vi) The hand hygical followed by staff in contact. §483.80(a)(4) A strinction in the circums in the circums of the circums	or the program, which must obt limited to: veillance designed to communicable diseases or hey can spread to other ility; whom possible incidents of ease or infections should transmission-based followed to prevent spread explain but not limited to: duration of the isolation, the infectious agent or land that the isolation should be expossible for the resident trances.					
	§483.80(e) Linens						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER **DYER. IN 46311** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. Based on observation, record review, and F 0880 **Dyer Nursing & Rehabilitation** 12/12/2022 interview, the facility failed to ensure infection **Root Cause Analysis** control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to ensuring hand hygiene was According to the 2567: Based on completed before and after glove removal. The observations, interviews, and facility also failed to ensure lancets were disposed record review that the facility failed of properly for 2 of 2 glucometers observed, to properly follow infection control personal protective equipment (PPE) was worn and prevention policies related to correctly during COVID-19 testing, masks were COVID-19. worn correctly, wash basins were stored correctly, POC 880 Infection Prevention & and multi-use equipment was disinfected for Control random observations for infection control. A discussion was held with the (Residents 58, 90, 102, 82, 85, 41, and G) Administrator, Director of Nursing, Infection Preventionist, Medical Findings include: Director and members of the IDT during an emergency QA 1. On 11/17/22 at 4:08 p.m., RN 1 was preparing to meeting. The discussion detailed check Resident 58's blood sugar. The RN washed the areas the facility was cited on her hands and donned a pair of gloves. She according to the 2567. The wiped the glucometer with a sani wipe, removed Medical Director was in agreement her gloves, did not hand sanitize, and donned a with the plan of correction related new pair of gloves. The RN then proceeded to to infection control and Prevention. punch the resident's pills from the punch card into The Medical Director was made the medication cup. When done, she removed the aware of the education and gloves and used hand sanitizer. auditing put in place by the facility. The RN then proceeded to enter the resident's Education was provided to facility room to check her blood sugar. She sanitized her staff on Infection Prevention and hands prior to donning her gloves, the resident's Control related to PPE related to

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finger was cleansed with an alcohol wipe, then

pricked with the lancet, and a blood sample was

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COVID testing, Personal

Protective Equipment, disinfecting

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLI	ETED
		155220	B. W	ING		11/22/	2022
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	2			IEFFIELD AVE		
DVED NI	IDOING AND DELL	ADULTATION CENTED					
DYER NURSING AND REHABILITATION CENTER			DYEK,	IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	obtained. The RN	removed her gloves, the lancet			multi equipment in between		
	was wrapped up in	one of the gloves and			resident use and proper dispo	sal	
	discarded in the trash can on the side of the medication cart.				of lancets		
					The facility administrator, Dire	ctor	
					of Nursing, and Infection		
	At 4:27 p.m., the R	N entered Resident 90's room to			Preventionist reviewed the 26	57,	
	check her blood sug	gar. When done, the RN			Infection Control and Preventi	on	
	placed the lancet in	one of her gloved hands. She			policies, and CMS guidelines	and	
	proceeded to remov	ve both gloves and disposed of			completed a root cause analys	sis.	
	them in the resident	t's trash can next to her bed.			It was determined that a possi	ble	
					element leading to		
	Interview with RN	1 at 4:46 p.m., indicated she			non-compliance may have		
	should have disposed of both lancets in the				included need for additional		
	sharps container rather than in the trash can.				education with practices relate	ed to	
					infection prevention and control	ol	
	Interview with the	Nurse Consultant on 11/21/22			processes. In addition, the nee	ed to	
	at 2:15 p.m., indica	ted the lancets were to be			have a clear(er) picture of		
	disposed of in the s	harps container and staff had			guidance and when it changes	s as	
	recently been inserv	viced.			there are many agencies prov	iding	
					guidance to Nursing Homes: 0	CDC/	
		10:24 a.m., two gray wash basins			CMS/ PH / Counties/ to aid in		
	were stacked togeth	ner and on the floor next to the			reinforce facility infection conti	rol	
	toilet in Room 155.	Two residents shared the			procedures.		
	bathroom.				The Infection Preventionist an	d	
					Director of Nursing, in conjunc	tion	
		10:12 a.m., there was a wash			with the Medical Director, and		
		the bathroom of Room 167.			senior leadership/Governing E	,	
	The wash basin was	s not contained. One resident			concurrence, shall complete the	ne	
	used the bathroom.				following:		
					Provide on-going education re		
		10:15 a.m., there was a wash			to Infection Prevention and Co		
	· · · · · · · · · · · · · · · · · · ·	not contained, in the bathroom			System Changes: The facility		
	of Room 168. Two	residents shared the bathroom.			shall complete the following		
					actions:		
	_	mental tour on 11/16/22 at			Educate staff on items below:		
		h basins remained on the			Preventing the Spread of	of	
	bathroom floor in R	Rooms 167 and 168.			COVID-19		
					Proper PPE use during		
		Nurse Consultant on 11/22/22			COVID testing		
	at 2:55 p.m., indica	ted the wash basins should not			Disinfecting equipment	in	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	/2022
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			EFFIELD AVE		
DVED VII	IRSING AND REL	ABILITATION CENTER			IN 46311		
DIEKIN	ONOTING AND REDA	ADILITATION CENTER		DIEK,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	<u> </u>	TAG	DEFICIENCY)		DATE
		the floor. 5. During a random	1		between resident use		
		6/22 at 9:50 a.m., Nurse			Proper disposal of lance	ets	
		entered the memory care dining			Hand Hygiene		
	_	assess Resident G. At that			Proper PPE use		
		the resident's chest with her			Completed as of 11/16/2022 s	see	
	_	ecked his oxygen saturation			attachment		
		eximeter she pulled out of her			Monitoring: Monitoring of		
		inger. After the resident's			approaches to ensure infection	ns	
		lked over to Resident 41 and			are controlled will include:		
	checked his oxygen saturation with the same pulse oximeter that had not been disinfected in				- , , , ,		
	_				• The Infection		
		NP 1 did not perform hand			Preventionist, Director of Nurs	-	
	hygiene in between the residents. The NP was then summoned back into the memory care dining				and other nursing leadership		
					conduct audits throughout the		
		dent 91. She removed the			facility to ensure staff are adhe	-	
	_	n her coat pocket and placed it ager and removed her			to the Infection Control policy		
		er coat pocket and listened to			procedures related but not lim		
	_	The pulse oximeter had not			to PPE related to COVID testi	-	
	been disinfected in				Personal Protective Equipment in		
	been distillected in	between residents.			disinfecting multi equipment in		
	6 During a random	observation on 11/16/22 at			between resident use and pro disposal of lancets. Education	-	
		CNA 1 was observed sitting in			be provided immediately to	WIII	
		his cell phone with his face			persons who are not following	the	
		uth and nose. LPN 1 was in the	1		Infection and prevention/contr		
		e unit and not in view of the			practices. Such monitoring wil		
		there were 2 residents in the			completed daily for 6 weeks.	. 50	
		near the Agency CNA. At 1:35	1		Completed daily for 6 weeks. Completed as of: Started		
		ght some dirty clothes and			11/16/2022 and will continue.	See	
	* ·	NA, who then stood up and			attachment		
		over his mouth but not his	1				
		at of the dining room and out			Quality Assurance and		
		ove on one of his hands. He			Performance Improvement		
		nory care unit with his face	1		(QAPI):		
		th only and not his nose. He	1		The facility though the		
		esident E's room at 1:40 p.m.,			QAPI program will review, upo	date	
		r mattress on the side of the			and make changes as needed		
	_	face mask was still observed			sustaining substantial complia		
		left the room and did not			for no less than 6 months.		
		one then walked down the hall					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-039 STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING 00 COMPLETED B. WING 11/22/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER **DYER. IN 46311** (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE into another resident's room. He returned to the Started 11/16/22 and ongoing dining room and pulled out his cell phone with his face mask still below his nose. The same 2 residents remained in the dining room. **Dyer Nursing & Rehabilitation** 7. During a random observation on 11/17/22 at Annual Survey: 11/22/22 9:50 a.m., the Restorative Nurse moved the treatment cart into the memory care dining room. Please accept the following as the At that time, she was preparing to swab residents facility's credible allegation of for COVID-19. The Restorative Nurse was compliance. This plan of wearing a regular surgical face mask. She was not correction does not constitute an wearing any gloves, protective eyewear, or a admission of guilt or liability by the gown. She swabbed Resident 102 and placed the facility and is submitted only in specimen in the package and placed it on the response to the regulatory treatment cart. She did not perform hand hygiene. requirement. She attempted to swab Resident 82, but she F880 Infection Prevention and refused. She walked over to Resident 85 and Control swabbed him, again only wearing a surgical face What corrective action(s) will mask. She obtained the specimen and placed it in be accomplished for those the package and set it on the treatment cart. She residents found to have been did not perform hand hygiene. After swabbing affected by the deficient those residents, she placed a face mask over each practice: of their noses and mouths with her bare hands Resident 58 no adverse reaction and did not perform hand hygiene in between Resident 90 no adverse reaction residents. Resident 102 no adverse reaction to staff testing with improper PPE The current and updated 2/8/22, "COVID-19 Resident 82 no adverse reaction Infection Control Guidance in Long-term Care to staff testing with improper PPE Facilities", indicated hand hygiene (use of Resident 85 no adverse reaction alcohol-based hand rub (ABHR)) was preferred. Resident 41 no adverse reaction Adherence to strict hand hygiene must continue related to oximeter not being for all, particularly HCP, including when entering sanitized in between use the facility and before and after resident care. Resident G no adverse reaction RN 1 educated on proper disposal The updated 4/4/22 CDC guidance for "Guidance of lancets for SARS-CoV-2 Point-of-Care and Rapid Wash basins removed from rooms

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Testing," indicated "For personnel collecting

suspected to be infected with SARS-CoV-2,

maintain proper infection control and use

specimens or working within 6 feet of patients

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155, 167, 168

between resident use.

Nurse Practitioner educated on

disinfecting multi use equipment in

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	(X2) MULTIPLE CONSTRUCTION (X3)			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155220	B. WI	NG		11/22/	2022	
				STREET	ADDRESS, CITY, STATE, ZIP COD			
NAME OF I	PROVIDER OR SUPPLIE	R			EFFIELD AVE			
DYER NURSING AND REHABILITATION CENTER				IN 46311				
	1				1	ı		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION	
TAG		R LSC IDENTIFYING INFORMATION		TAG			DATE	
	_	onal protective equipment			Agency CNA 1 educated on			
		l include an N95 or higher-level mask if a respirator is not			wearing PPE properly Restorative Nurse educated o			
		tection, gloves, and a lab coat			proper PPE to be worn when	n		
	or gown."	ection, gloves, and a lab coat			COVID testing			
	or gown.				How the facility will identify			
	Interview with the	Nurse Consultant on 11/21/22			other residents having the			
		ated the appropriate Personal			potential to be affected by th	e		
	_	ent to swab a person for			same deficient practice and			
		N95 face mask, protective			what corrective action will be	e		
		es. She indicated staff should			taken;			
	be wearing their fa	ce masks over their mouth and			All residents have the potentia	al to		
	nose and multi-use	equipment was to be sanitized			be affected by the same allege			
	in between resident	ts.			deficient practice.			
					What measures will be put in	ito		
	3.1-18(b)				place or what systemic			
					changes will be made to			
					ensure that the deficient			
					practice does not recur;			
					Staff were educated on prope	r		
					PPE, sanitizing equipment in			
					between resident use, hand			
					hygiene after resident contact			
					proper PPR to wear when test for COVID, proper disposal of	~		
					lancets and proper storage of			
					wash basins			
					How the corrective action(s)			
					will be monitored to ensure t	he		
					deficient practice will not			
					recur, i.e., what quality			
					assurance programs will be	put		
					into place;	-		
					DON/designee will conduct			
					surveillance observations 3 x	week		
					for 6 months to ensure			
					improvement of infection conti	rol		
					practices.			
					The DON/designee will preser	nt a		
					summary of the audits to the			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2022	
	ROVIDER OR SUPPLIER JRSING AND REHA	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE
F 0883 SS=D Bldg. 00	483.80(d)(1)(2) Influenza and Pne §483.80(d) Influen immunizations §483.80(d)(1) Influence develop policies at that- (i) Before offering each resident or the receives education potential side effect (ii) Each resident is immunization Octor annually, unless the medically contrained already been immunization or representative has immunization; and	umococcal Immunizations za and pneumococcal tenza. The facility must and procedures to ensure the influenza immunization, are resident's representative are regarding the benefits and cts of the immunization; as offered an influenza abber 1 through March 31 are immunization is dicated or the resident has unized during this time ar the resident's as the opportunity to refuse	TAG	Quality Assurance committee monthly for 6 months. There if determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarter the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 12/12/2022	after, ng ly at will
	, ,	at indicates, at a minimum,			

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the following:

(A) That the resident or resident's

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPI	LETED
		155220	B. W	ING		11/22	/2022
				CENTER	ADDRESS STEV STATE STR SOD		
NAME OF F	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DVED NI	IDOING AND DELL	ADULTATION OF NED			EFFIELD AVE		
DYER NO	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	representative wa	s provided education					
	regarding the ben	efits and potential side					
	effects of influenz	a immunization; and					
	(B) That the reside	ent either received the					
	influenza immuniz	ration or did not receive the					
	influenza immuniz	zation due to medical					
	contraindications	or refusal.					
	. , , , ,	eumococcal disease. The					
	facility must devel	op policies and procedures					
	to ensure that-						
	(i) Before offering the pneumococcal						
		ch resident or the resident's					
	representative receives education regarding						
	the benefits and p	otential side effects of the					
	immunization;						
	1 ' '	is offered a pneumococcal					
		ess the immunization is					
	· -	idicated or the resident has					
	already been imm						
	(iii) The resident of						
	I	s the opportunity to refuse					
	immunization; and						
	1 ' '	medical record includes					
		at indicates, at a minimum,					
	the following:						
	(A) That the reside						
	1 '	s provided education					
	1 -	efits and potential side					
		ococcal immunization; and					
	1 ' '	ent either received the					
	l ·	munization or did not					
	· ·	nococcal immunization due ndication or refusal.					
		and record review, the facility	F 08	002	Dyor Nursing 9 Bahahilitatia	'n	12/12/2022
		idents and/or responsible	F 0	003	Dyer Nursing & Rehabilitatio	111	12/12/2022
		-			Annual Survey: 11/22/22		
		If the opportunity to receive or a and pneumococcal			Diagon appent the following as	a tha	
		orovided education on the			Please accept the following as		
					facility's credible allegation of		
	benefits and potenti	ial side effects of the			compliance. This plan of		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	2022
				CENTER	ADDRESS OF A STATE OF COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DVED NI	IDOING AND DELL	ADULTATION OF NED			EFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	immunizations for 2	2 of 5 residents reviewed for			correction does not constitute	an	
	immunizations. (Re	esidents D and 72)			admission of guilt or liability by	the	
					facility and is submitted only ir	1	
	Findings include:				response to the regulatory		
					requirement.		
	1. The record for R	esident D was reviewed on			F 883 Immunization		
	11/17/22 at 1:30 p.1	m. Diagnoses included, but were			What corrective action(s) will	I	
	not limited to, meta	abolic encephalopathy,			be accomplished for those		
	respiratory syncytia	al virus, respiratory failure,			residents found to have beer	1	
	high blood pressure	e, chronic obstructive			affected by the deficient		
	pulmonary disease,	and dementia.			practice;		
					Residents D and 72 were offer	red	
	There was no docur	mentation the resident was			the influenza and pneumococo	cal	
	offered the influenz	za or pneumococcal			vaccinations		
	immunizations or p	rovided education regarding					
	them.				How the facility will identify		
					other residents having the		
	2. The record for R	esident 72 was reviewed on			potential to be affected by th	е	
	_	m. The resident was admitted on			same deficient practice and		
	_	included, but were not limited			what corrective action will be)	
	_	od pressure, coronary artery			taken;		
	disease, depression,	, and dysphagia.			All residents have the potentia	l to	
					be affected by the same allege	ed	
		mentation the resident was			deficient practice.		
	offered the influenz	•			What measures will be put in	to	
	immunizations or p	rovided education regarding			place or what systemic		
	them.				changes will be made to		
					ensure that the deficient		
		Director of Nursing on 11/22/22			practice does not recur;		
	at 11:15 a.m., indic				An audit was completed to ens		
		ted to the facility offering or			all residents have been offered	d the	
		n on the influenza or			flu and pneumonia vaccine.		
	pneumococcal vacc	cinations to those residents.			Nursing staff were educated o		
					offering the flu/pneumonia vac		
					to residents upon admission a	nd	
					annually.		
					How the corrective action(s)		
					will be monitored to ensure t	ne	
					deficient practice will not		
			1		recur, i.e., what quality		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155220	B. W	NG		11/22	/2022
				CED FEET	ADDRESS OF A STATE OF COD		
NAME OF P	ROVIDER OR SUPPLIEF	8			ADDRESS, CITY, STATE, ZIP COD		
חעבם גיי	IDOING AND DELL	ADILITATION CENTED			EFFIELD AVE		
טזבא NI	DK9ING AND KEH	ABILITATION CENTER	DYER, IN 46311				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					assurance programs will be	put	
					into place;		
					DON/designee will audit 10		
					residents monthly to ensure th	ney	
					are up to date with flu, pneum	-	
					and COVID vaccines.		
					Administrator/designee will		
					present a summary of the aud	lits	
					to the Quality Assurance		
					committee monthly for 6 mont	hs.	
					Thereafter, if determined by th		
					Quality Assurance committee,		
					auditing and monitoring will be	•	
					done quarterly and present		
					quarterly at the QA meeting.		
					Monitoring will be on going.		
					Date by which systemic		
					corrections will be completed 12/12/2022	d:	
					12/12/2022		
E 0024	400.00(:)						
F 0921	483.90(i)						
SS=E		anitary/Comfortable Environ					
Bldg. 00	- ','	Environmental Conditions					
		provide a safe, functional,					
	•	fortable environment for					
	residents, staff an	on and interview, the facility	E 00)21	Dyor Nursing 9 Bababilitatia	n	12/12/2022
		residents' environment as well	F 09	921	Dyer Nursing & Rehabilitatio	111	12/12/2022
		was clean and in good repair			Annual Survey: 11/22/22		
		rs, marred doors, lime build up,			Please accept the following as	s tho	
		overs, dirty baseboards, food			Please accept the following as facility's credible allegation of	s u i c	
		eboards, lime build up on			compliance. This plan of		
	-	e, and dirty transportation			compliance. This plan of correction does not constitute	an	
		e, and dirty transportation en areas and on 3 of 4 units.			admission of guilt or liability by		
		and East, West, and Memory			facility and is submitted only in		
	Care Units)	and Last, west, and wichiti			response to the regulatory	1	
	our omoj				requirement.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Findings include:

Event ID:

JOJW11

Facility ID: 000125

F921

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE S	URVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPLE	ETED
		155220	B. W	ING	_	11/22/2	2022
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			IEFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
					Safe/Functional/Sanitary/Cor	mf	
	_	ronmental tour with the			ortable Environment		
		nance and the Director of			What corrective action(s) wil	I	
		1/16/22 at 10:00 a.m., the			be accomplished for those		
	following was obse	rved:			residents found to have been	า	
					affected by the deficient		
	East Unit				practice;		
					East Unit		
	a. The privacy curt	tain in Room 122 was stained.			Room 122- privacy curtain		
					cleaned		
	I	f the window blind in Room 136			Room 136- window blind fixe	ed.	
		nt of the heating unit was loose			Front of heating unit fixed.		
	and was coming off. One resident resided in this				West Unit		
	room.				Room 151- lime build up		
					cleaned. Floor tile cleaned.		
	West Unit				Door frame repaired		
	l				Room 152- floor tile cleaned		
		n of lime build up was observed			Room 153- floor tile cleaned,		
		ucet in Room 151. The floor			bathroom door repaired, cau	lk	
		was dirty and a black			around toilet re-done,		
		ne floor tile behind toilet. The			baseboard repaired		
		oom was marred and the plastic			Room 155- floor tile cleaned,		
		along the edges. Two			heating unit cleaned		
		the room and shared the			Memory Care Unit		
	bathroom.				Room 167-wheelchair arm		
	1 751 01	d 1 d 0D 150			replaced		
		the bathroom of Room 152 was			Kitchen		
		. Two residents resided in the			White PVC pipes cleaned, lin	I	
	room and shared the	e bathroom.			build up cleaned, base board	I	
	TELL OL ALL	D 152 11 4 14 1 11			cleaned, garbage can cleane	a,	
		Room 153 was dirty with a dull			rubber bumpers cleaned,		
	1	the bathroom door was			wheels cleaned and/or		
		tile in the bathroom was			replaced, white PVC under		
		caulk around the base of the ed. The baseboard behind the			food prep sink cleaned. Food	I	
					prep sink area cleaned, plast	I	
		way from the wall. Two the room and shared the			strip on ice machine replace	u,	
		the room and shared the			food crumbs cleaned		
	bathroom.				How the facility will identify		
	1 751 (1	D 155 11 13 13			other residents having the		
	d. The floor tile in	Room 155 was dirty with a dull	1		potential to be affected by th	e	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	/2022
				CTREET	ADDRESS CITY STATE ZID COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP COD		
DVED NI	LIDOINO AND DELL	ADULTATION OFNITED			IEFFIELD AVE		
DYERN	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	finish. There was d	lried spillage on the front of the			same deficient practice and		
	heating unit. Two i	residents resided in the room.			what corrective action will be	•	
					taken;		
	Memory Care Unit				All residents have the potentia	ıl to	
					be affected by the same allege		
	a. The arm of the v	vheelchair in Room 167 was			deficient practice.		
	ripped and torn. One resident resided in the room.				What measures will be put in	ito	
					place or what systemic		
	Interview with the l	Maintenance and			changes will be made to		
		ectors at the time, indicated all			ensure that the deficient		
		n need of cleaning and/or			practice does not recur;		
	repair.				Staff were re-educated on the		
	_	f Kitchen Sanitation Tour on			procedure of notifying		
		m. with the Dietary Food			maintenance/environmental		
	Manager, the follow				services of any necessary		
					repairs/cleaning needed.		
	a The white PVC:	pipes under the dish machine			How the corrective action(s)		
	were dirty with drie				will be monitored to ensure t	he	
	Word dirty with dire	ou rood springe.			deficient practice will not		
	h There was a moo	derate amount of lime build up			recur, i.e., what quality		
		lish machine and under the			assurance programs will be	nut	
	food prep table.				into place;	put	
	leed prop mere.				Environmental services		
	c There was a mod	derate amount of adhered dirt			supervisor/Maintenance		
		e base board in the entire			department/ will audit 10 room	ie	
	kitchen.	case source in the cities			per week on alternating units		
					Environmental/cleaning issues		
	d The outside of a	ll the garbage cans were dirty			maintenance issues. Any	anu	
	with dried food sub				identified issues will be correct	tad	
	with direct food 5do	stance.			Dietary Manager/designee wil		
	e The rubber burn	per on the outside of 6			audit the kitchen 3 days a wee		
		were dirty with dried food			for cleanliness and possible ite		
	_	els on all of those carts were				51110	
	greasy with adhered				that need to be repaired.		
	greasy with aunered	u unt.			Administrator/designee will	ito	
	f The white DVC	nines under a food area sink			present a summary of the aud	แร	
		pipes under a food prep sink			to the Quality Assurance	L_	
		od prep sink was not in working			committee monthly for 6 mont		
		that way for a very long time.			Thereafter, if determined by the		
		dried food spillage and there			Quality Assurance committee,		
	was lime build up u	underneath on the floor.			auditing and monitoring will be	;	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BUILDING <u>00</u>			COMPL	(3) DATE SURVEY COMPLETED 11/22/2022	
	ROVIDER OR SUPPLIER JRSING AND REHA	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ſĒ	(X5) COMPLETION DATE
	h. There was a hear crumbs and debris to the wall. Interview with the I 10:45 a.m., indicate of cleaning or repair	in the ice machine was peeling by accumulation of food ander the tables and and along Dietary Manager on 11/21/22 at d all of the above was in need r. ates to Complaints IN00392424			done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed 12/12/2022	d:	
R 0000	3.1-19(f)						
Bldg. 00	Survey. This visit in State Licensure Sur Complaints IN0039 IN00392985. Complaint IN00392 Federal/State deficit allegations are cited Complaint IN00392 Federal/State deficit allegations are cited Complaint IN00392 Federal/State deficit allegations are cited alleg	2575 - Substantiated. encies related to the at F697 and F921. 2985 - Substantiated. encies related to the	R 00	000	The facility kindly requests a d review.	esk	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	ATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	NG		11/22/	2022
				·			
NAME OF P	ROVIDER OR SUPPLIER	_			ADDRESS, CITY, STATE, ZIP COD		
D)/ED 111	IDOING AND DELL	15U ITATION OF UTER			EFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE	T-	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	IE.	DATE
	22, 2022.						
	ŕ						
	Facility number: 00	0125					
	Ž						
	Residential Census: 37						
	These State Resider	itial Findings are cited in					
	accordance with 410	_					
	Quality review com	pleted on 11/29/22.					
	•	•	İ				
R 0215	410 IAC 16.2-5-2(b)	İ				
	Evaluation - Defici	ency					
Bldg. 00		ion evaluation (interview)					
	shall provide the b	aseline information for the					
		Subsequent evaluations					
		resident 's current status					
		s on admission and shall					
		that the care the resident					
	requires is within t	he range of personal care					
	•	rovided by a residential care					
	facility.	•					
		riew and interview, the facility	R 0	215	Dyer Nursing & Rehabilitatio	n-	12/12/2022
	failed to complete a	Pre-Admission Evaluation for			Sheffield		
	1 of 7 residents revi	ewed. (Resident 3)			Annual Survey: 11/22/2022		
					_		
	Finding includes:						
					R 215 Pre- Admission		
	Resident 3's record	was reviewed on 11/21/22 at			Evaluation		
	11:13 a.m. Diagnos	ses included, but were not					
	limited to, hyperlipi	demia and hypertension. The			Please accept the following as	the	
	resident was admitte	ed to the facility on 11/1/22.			facility's credible allegation of		
					compliance. This plan of		
	There was a lack of	documentation that a			correction does not constitute	an	
	Pre-Admission Eval	luation had been completed			admission of guilt or liability by	the	
	prior to the resident	being admitted to the facility.			facility and is submitted only in		
					response to the regulatory		
	Interview with the A	Administrator on 11/22/22 at			requirement.		
	11:20 a.m., indicate	d she was unable to provide					
	any further docume				What corrective action(s) will	l	

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	PLAN OF CORRECTION To be a supplier of the control		(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2022	
	ROVIDER OR SUPPLIER JRSING AND REHA	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
				be accomplished for those residents found to have been affected by the deficient practice?	n	
				Resident 3- resident remains the facility, unable to complete pre-admission evaluation. Se plan updated.	e a	
				How will facility identify other residents who have the potential to be affected by the same alleged deficient practice?		
				The deficient practice has the potential to affect all facility residents.		
				What corrective measures w the facility take or will alter t ensure that the problem will not recur?		
				Sheffield Manor licensed nurs staff/designee educated on completing pre- admission evaluations of potential reside		
				What quality assurance plan will be implemented to monifacility performance to ensure corrections are achieved and permanent?	tor re	
				Administrator/designee will re	view	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 11/22/2022	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
R 0216 Bldg. 00	410 IAC 16.2-5-2(Evaluation - Nonce (c) The scope and shall be delineated manual, but at a massessment shall following:	c)(1-4)(d)	TAG	all residents that admit to the facility x 3 months to ensure a pre-admission evaluation screening has been completed. A summary will be presented the Quality Assurance commit monthly x 3 months. Thereafted determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going. By what date the systemic changes will be completed: 12/12/22	d. to ttee er, if g
	(2) The resident 's activities of daily li (3) The resident 's	s weight taken on			
	(4) If applicable, the self-administer me	shall be documented in			
	Based on record rev failed to ensure a m	iew and interview, the facility edication self-administration pleted for 1 of 7 residents	R 0216	Dyer Nursing & Rehabilitatio Sheffield Annual Survey: 11/22/22	n- 12/12/2022

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	UILDING	00	COMPL	
		155220	B. W	ING		11/22/	2022
NAME OF I	DOMINED OF CHIRD TER			STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	C		601 SH	IEFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	reviewed. (Residen	nt 4)					
	F' 1' ' 1 1				Please accept the following as		
	Finding includes:			facility's credible allegation of			
Resident 4's record was reviewed on 11/21/22 at				compliance. This plan of			
					correction does not constitute		
		es included, but were not sion, atrial fibrillation and type			admission of guilt or liability by		
		The resident was admitted to			facility and is submitted only in response to the regulatory	1	
	the facility on 7/17/				requirement.		
	are racinty on //1//				R 216 Evaluation		
	The Medication Ad	ministration Record (MAR),			What corrective action(s) will	_{ll}]	
	dated 11/2022, indi-				be accomplished for those		
		ne following medications:			residents found to have been	n l	
		e eye drops, Spiriva			affected by the deficient		
	(tiotropium bromide	e) inhaler, and brimonidine eye			practice;		
	drops.				Resident 4- A self-administrat	ion	
					assessment was completed a	nd	
		rvice Plan, dated 6/30/22,			resident determined to be able	e to	
		to administer medications to			self-administer medication.		
		did not self-administer any			Service plan updated.		
	medications.				How the facility will identify		
					other residents having the		
	1	der Summary, dated 11/2022,			potential to be affected by the	ie	
	1	or the self-administration of			same deficient practice and		
	medications.				what corrective action will be	e	
	There was a last4	any self-administration of			taken;		
	medications assessr				All facility residents with		
	medications assessi	nent.			medication orders have the potential to be affected by the		
	Interview with the	Administrator on 11/22/22 at			same alleged deficient practic		
		ed she was unable to provide			What measures will be put in		
		of a self-administration			place or what systemic		
	assessment.				changes will be made to		
					ensure that the deficient		
					practice does not recur;		
					Staff were educated on compl	leting	
					a self-administration observat		
					prior to resident having		
					medications in the apartment.		
					Staff educated on writing an o		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2022	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	601 SI	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE , IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				for resident to self-administer medications when appropriate How the corrective action(s) will be monitored to ensure to deficient practice will not recur, i.e., what quality assurance programs will be into place; Nurse Supervisor/Designee waudit 5 residents per month x months to ensure residents ar properly assessed to determine they are appropriate for self-administering medications. The Nurse Supervisor/designed will present a summary of the audits to the Quality Assurance committee monthly for 3 mont. Thereafter, if determined by the Quality Assurance committee auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 12-12-22	put iill 3 re ne if s. ee ce chs. ne
R 0273	410 IAC 16.2-5-5 Food and Nutritio	.1(f) nal Services - Deficiency			
Bldg. 00	(excluding areas maintained in acc local sanitation an standards, includ				
	failed to serve and	on and interview, the facility prepare food under sanitary o dirty food equipment, steam	R 0273	Dyer Nursing & Rehabilitation Sheffield	n- 12/12/2022
	tables, wire racks,	standing fans, and standing		Annual Survey: 11-22-22	

State Form Event ID: JOJW11 Facility ID: 000125 If continuation sheet Page 76 of 83

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	/2022
				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	₹			EFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER			IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	!	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	DATE
		chens observed. This had the					
	potential to affect a	11 37 residents who received			R 273 Food and Nutritional		
	food from the kitch	en. (The Main Kitchen)			Services		
	Findings include:				Please accept the following as	the	
					facility's credible allegation of		
	During the Brief Ki	itchen Sanitation Tour on			compliance. This plan of		
		m., with the Dietary Food			correction does not constitute	an	
	Manager indicated	the following:			admission of guilt or liability by	/ the	
					facility and is submitted only ir	1	
	a. There was a mod	lerate amount of dirt and dust			response to the regulatory		
	on the storage racks	s that housed clean pots and			requirement.		
	pans.						
					What corrective action(s) wil	I	
		vy accumulation of burned			be accomplished for those		
	food and crumbs or	n the stove top.			residents found to have beer	1	
					affected by the deficient		
		vy accumulation of food			practice;		
		on the inside of both			Storage racks were cleaned		
		nd on the inside of the glass			Stove top cleaned and burned	food	
	_	grease noted on the sides of			and crumbs removed		
	the ovens.				Convection ovens and glass d		
	1 771 1	1			cleaned. Accumulation of food	and	
		vy accumulation of grease on			grease removed.		
	the sides of the grid	ldle, stove, and both ovens.			Ovens, oven handles, griddle		
	a The handles 4- 41	he ovens were sticky to touch.			stove cleaned. Accumulation of	ונ	
	e. The handles to the	ne ovens were sticky to touch.			grease removed.		
	e There was a box	vy accumulation of dirt and			Standing fan and blades were cleaned		
		g fan blades blowing directly			Steam table was cleaned.		
	at the steam table.	5 ran blades blowing directly			Accumulation of food spillage,	dirt	
	at the steam table.				and grease were removed.	uiit	
	f There was a heav	vy accumulation of food			Stand mixer cleaned and stan	d	
		om of the steam table.			mixer cover replaced.	u	
	springe on the ooth	om of the steam table.			mixor oover replaced.		
	g. There was a hea	vy accumulation of dirt, dried			How the facility will identify		
	_	grease on a portable steam			other residents having the	ļ	
	table.				potential to be affected by th	e	
		Dietary Manager at that time,			same deficient practice and		
		table was not in use and not			what corrective action will be	e	
	I		1				I

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	00	COMPL	ETED
		155220	B. W	ING		11/22/	/2022
	PROVIDER OR SUPPLIEI	R ABILITATION CENTER	•	STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	1	ID			(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.IE	DATE
	functional.				taken;		
	h. There was a tor of plastic over the s moderate amount o and around the bow	Dietary Food Manager on .m., indicated all of the above			All facility residents have the potential to be affected by the same alleged deficient practic. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff have been in-ser regarding, proper cleaning and sanitation of dietary equipmer. All alleged concerns have been added to routine dietary clean schedule. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be into place; Administrator or designee to a kitchen sanitation 3 times a wifur 6 months. Administrator/designee will present a summary of the audit to the Quality Assurance committee monthly for 6 month. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting.	viced d the put audit eek dits hs.	

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	NT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 11/22/2022
	PROVIDER OR SUPPLIEI	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				Monitoring will be on going. Date by which systemic corrections will be completed 12-12-22	d:
R 0409	410 IAC 16.2-5-12	• •			
Bldg. 00	Infection Control - Noncompliance (d) Prior to admission, each resident shall be required to have a health assessment, including history of significant past or present infectious diseases and a statement that the resident shows no evidence of tuberculosis in an infectious stage as verified upon admission and yearly thereafter. Based on record review and interview, the facility failed to ensure residents had a required health assessment and statement for 1 of 7 residents reviewed for annual health statements. (Resident 3) Finding includes: Resident 3's record was reviewed on 11/21/22 at 11:13 a.m. Diagnoses included, but were not limited to, hyperlipidemia and hypertension. The resident was admitted to the facility on 11/1/22.		R 0409	Dyer Nursing & Rehabilitation Residential Annual Survey 11/22/22 Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability by facility and is submitted only in response to the regulatory requirement.	an / the
		he health statement to indicate the of communicable diseases.		R 409 Health Statement	
	Interview with the 11:20 a.m., indicate	Administrator on 11/22/22 at ed she was unable to provide of an annual health statement.		What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 3- annual health statement received without an adverse findings.	1

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		X1) PROVIDER/SUPPLIER/CLIA	l í	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			00	COMPLETED		
	155220 B. WING		11/22/	2022				
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PROVIDER'S PLAN OF CORRECTI PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO		.TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	16	DATE	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All Residents have the potential be affected by the same deficient practice. What measures will be put implace or what systemic changes will be made to ensure that the deficient practice does not recur; Licensed nurses were educated on obtaining an annual health statement upon admission and yearly thereafter. How the corrective action(s) will be monitored to ensure the deficient practice will not	ee e e e e e e e e e e e e e e e e e e	DATE	
					recur, i.e., what quality assurance programs will be into place;	put		
					Nurse Supervisor/designee wi audit all new admissions x 3 months to ensure the annual health statement is received. The nurse supervisor/designe present a summary of the aud to the Quality Assurance committee monthly for 3 mont Thereafter, if determined by the	e will lits hs.		

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CENTERS FOR	R MEDICARE & MEDIC	AID SERVICES			OMB NO. 0938-039
AND PLAN OF CORRECTION IDENT		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 11/22/2022
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER			601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
				Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	
				Date by which systemic corrections will be complete 12-12-22	d:
R 0410	410 IAC 16.2-5-12 Infection Control -				
Bldg. 00	completed within the admission or upor forty-eight (48) to result shall be recinduration with the by whom administ (f) For residents with documented negal result during the plant months, the basel should employ the first step is negative performed within cafter the first test. testing will depend with tuberculosis. (g) All residents with the tuberculin shave a chest x-ray	uberculin skin test shall be three (3) months prior to a admission and read at seventy-two (72) hours. The orded in millimeters of a date given, date read, and tered and read. Tho have not had a tive tuberculin skin test receding twelve (12) ine tuberculin skin testing two-step method. If the ve, a second test should be one (1) to three (3) weeks The frequency of repeat d on the risk of infection ho have a positive reaction kin test shall be required to y and other physical and ations in order to complete			
	Based on record rev	view and interview, the facility dents had a documented	R 0410	Dyer Nursing & Rehabilitatio Annual Survey: 11-22-22	n 12/12/2022

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Mantoux test (test for tuberculosis) completed

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE		(X3) DATE	SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155220	B. WING			11/22/2022	
				CTREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF PROVIDER OR SUPPLIER							
DYER NURSING AND REHABILITATION CENTER					EFFIELD AVE		
DYERN	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	ID BROWIDER'S BLANGE CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	upon admission and	d yearly for 2 of 7 residents			Please accept the following as	the	
	reviewed for Manto	oux testing. (Residents 3 and 4)			facility's credible allegation of		
					compliance. This plan of		
	Findings include:				correction does not constitute	an	
					admission of guilt or liability by		
	1. Resident 3's reco	rd was reviewed on 11/21/22 at			facility and is submitted only in		
	11:13 a.m. Diagnos	ses included, but were not			response to the regulatory		
	_	idemia and hypertension. The			requirement.		
	resident was admitt	ed to the facility on 11/1/22.					
					R 410 Infection Control		
	There was a lack of	documentation to indicate the					
	resident had receive	ed a Mantoux test prior to or					
	upon admission.				What corrective action(s) will	l	
					be accomplished for those		
	2. Resident 4's reco	ord was reviwed on 11/21/22 at			residents found to have beer	1	
	1:56 p.m. Diagnose	es included, but were not			affected by the deficient		
	limited to, hypertension, atrial fibrillation and type				practice?		
	2 diabetes mellitus.	The resident was admitted to					
	the facility on 7/17/20.				R3 was given an initial Mantoเ	IX	
					test series without any adverse		
	There was a lack of documentation to indicate the resident had received an annual Mantoux test.				findings.		
					R4 was given the annเ	ıal	
	Interview with the	Administrator on 11/22/22 at			Mantoux test without any adve	erse	
11:20 a.m., indicated she was unable to provi		ed she was unable to provide			findings.		
	any documentation	of completed Mantoux					
	testing.				How will facility identify othe	r	
					residents who have the		
					potential to be affected by th	е	
					same alleged deficient		
					practice?		
					The deficient practice has the		
					potential to affect all facility		
					residents.		
					What corrective measures wi		
					the facility take or will alter to)	
					ensure that the problem will		
					not recur?		

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CENTERSTOR	WIEDICARE & WIEDIC	AID SERVICES			ONIB NO. 0936-039		
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPLETED		
		155220	B. WING		11/22/2022		
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	T	(X5)		
PREFIX		CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			
TAG	· ·	R LSC IDENTIFYING INFORMATION	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
1710	REGCE/TION OF	CESC IDENTIFY THAT IN ORMATION	1710	<u> </u>	DATE		
				Sheffield Manor licensed nurs staff educated on administerir test upon admission and annuthereafter.	ng TB		
				What quality assurance plan will be implemented to moni facility performance to ensu corrections are achieved and permanent?	tor re		
				DON/designee will review all admissions x 3 months to ens TB test was administered. DON/designee will review 5 residents monthly with order frannual TB test to ensure the twas administered. A summary of the audits to the Quality Assurance committee monthly for 3 months. Thereatif determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarterly the QA meeting. Monitoring will be on going. By what date the systemic changes will be completed:	e after, g		
			1	1			

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