PRINTED:	01/30/2023
FORM API	PROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION (X 00	(3) DATE SURVEY COMPLETED 01/06/2023
	PROVIDER OR SUPPLIE	R IABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311	
(X4) ID		STATEMENT OF DEFICIENCIE	1		(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETION
TAG F 0000	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCE	DATE
Bldg. 00	the Recertification and the Investigation IN00392575, and I 11/22/22. This visit was doned Investigation of Concentration Complaint IN0039 Complaint IN0039 Complaint IN0039 Federal/State defice allegations are cite	5443 - Substantiated. iencies related to the d at F677.	F 0000	The facility kindly requests a der	sk
Survey dates: January 5 and 6, 2023. Facility number: 000125 Provider number: 155220 AIM number: 100266740 Census Bed Type: SNF/NF: 112 Residential: 35 Total: 147 Census Payor Type: Medicare: 14 Medicaid: 76					
LABORATOR Natalie Po		VVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE 01/27/2023

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

PRINTED: 01/30/2023 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220			(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 01/06/2023
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	601 SH	address, city, state, zip cod IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION reflect State Findings cited in	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (X5) COMPLETION DATE
⁼ 0677 SS=D Bldg. 00	accordance with 41 Quality review corr 483.24(a)(2) ADL Care Provide §483.24(a)(2) A re carry out activities necessary service nutrition, grooming hygiene; Based on record rev failed to ensure dep with Activities of D twice a week show residents reviewed Finding includes: Resident B's closed at 9:41 a.m. Diagno limited to, anxiety of high blood pressure The Discharge Min assessment, dated 1 was cognitively inte The December 202 indicated the reside following days: - 12/12/22 - 12/29/22	apleted on 1/10/23. ed for Dependent Residents esident who is unable to s of daily living receives the es to maintain good g, and personal and oral view and interview, the facility endent residents received help Daily Living (ADLs) related to ers/bed baths for 1 of 3 for ADLs. (Resident B) record was reviewed on 1/5/23 oses included, but were not disorder, diabetes mellitus, and	F 0677	Dyer Nursing & Rehabilitatio 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. F677 ADL Care Provided for Dependent Residents What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident B- Shower or bed bat has been provided twice week Resident B was assessed, up return from the hospital, and n adverse effects were noted. How the facility will identify other residents having the potential to be affected by th same deficient practice and	an y the n I n ath dy. on io
	1:49 p.m., indicated she was unable to pu further documentation related to at least			what corrective action will be taken;	e

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE	SURVEY
ND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BUILDING B. WING	00	COMPLETED 01/06/2023	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
DYER N	IURSING AND REF	ABILITATION CENTER		HEFFIELD AVE IN 46311		
K4) ID SU	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	COMPLETIO
TAG		R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	week bed baths be	ing given for the resident.		Residents dependent on ADL		
	T1 · 1 / ·	· 1 11/22/22 TH 6 11:		have the potential to be affect	ed	
	-	as cited on $11/22/22$. The facility		by the same alleged deficient		
	-	nt a systemic plan of correction		practice.		
	to prevent recurren	nce.		What measures will be put in	ito	
	2 1 29(1-)(2)			place or what systemic		
	3.1-38(b)(2)			changes will be made to ensure that the deficient		
				practice does not recur;		
				Staff were re-educated on		
				providing all residents, with a		
				focus on dependent residents		
				assistance with ADL care to	,	
				include general grooming, hai	r	
				washing, regular showers or b		
				baths per resident's plan of ca		
				Showers/bed bath master		
				schedule was reviewed to ens	sure	
				all resident beds have assigned	ed	
				shower/bed bath days twice		
				weekly.		
				Wound care coordinator will v	erify	
				showers/bed baths were prov	ided	
				daily according to master		
				schedule and any refusals we	re	
				documented accordingly.		
				Education provided in all new		
				orientation and agency orienta		
				How the corrective action(s)		
				will be monitored to ensure t	ine	
				deficient practice will not		
				recur, i.e., what quality assurance programs will be	nut	
				into place;	μαι	
				DON/designee will randomly		
				observe 10 residents three tim	nes	
				weekly, with a focus on deper		
				residents, to ensure that they		
				receiving assistance with ADL		
				care including grooming, hair	•	
	1		1	I sais moraning grooming, han		

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

Event ID: JOJW12 Facility ID: 000125

If continuation sheet Page 3 of 18

	R MEDICARE & MEDI						MB NO. 0938-039
	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING			(X3) DATE SURVEY COMPLETED 01/06/2023	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	•	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD 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 CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON DBE DPRIATE	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00	483.45(c)(3)(e)(1 Free from Unnec Use §483.45(e) Psycl §483.45(c)(3) A p drug that affects with mental proce drugs include, bu the following cate (i) Anti-psychotic (ii) Anti-depressa (iii) Anti-depressa (iii) Anti-anxiety; (iv) Hypnotic Based on a comp resident, the facil §483.45(e)(1) Re psychotropic drug)-(5) Psychotropic Meds/PRN notropic Drugs. psychotropic drug is any brain activities associated esses and behavior. These it are not limited to, drugs in egories: ; nt; and prehensive assessment of a ity must ensure that esidents who have not used gs are not given these drugs ation is necessary to treat a			 washing, facial hair removashowers or bed baths are provided. DON/designee will present summary of the audits to the Quality Assurance committee, audits and monitoring will be don quarterly and present quart the QA meeting. Monitoring be on going. Date by which systemic corrections will be complete 1/26/2023 	t a he ereafter, y liting e terly at ng will	

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE A. BUILDING B. WING	construction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/06/2023	
	PROVIDER OR SUPPLIE	HABILITATION CENTER	601 \$	t address, city, state, zip cod SHEFFIELD AVE R, IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	IATE COMPLETION DATE	
	§483.45(e)(2) Repsychotropic dru reductions, and b unless clinically of to discontinue the §483.45(e)(3) Repsychotropic dru unless that media a diagnosed spe documented in th §483.45(e)(4) PF drugs are limited provided in §483 physician or press that it is appropri extended beyond document their ra medical record a the PRN order. §483.45(e)(5) PF drugs are limited renewed unless to prescribing pract	ne clinical record; esidents who use gs receive gradual dose behavioral interventions, contraindicated, in an effort ese drugs; esidents do not receive gs pursuant to a PRN order cation is necessary to treat cific condition that is ne clinical record; and RN orders for psychotropic to 14 days. Except as .45(e)(5), if the attending scribing practitioner believes ate for the PRN order to be d 14 days, he or she should ationale in the resident's nd indicate the duration for RN orders for anti-psychotic to 14 days and cannot be the attending physician or itioner evaluates the resident teness of that medication.				
	failed to ensure re- unnecessary media indications for use for unnecessary m	eview and interview, the facility sidents did not receive cations without adequate tor 1 of 3 residents reviewed edications. (Resident 3)	F 0758	Dyer Nursing & Rehabilitation Please accept the following a facility's credible allegation of compliance. This plan of correction does not constitute admission of guilt or liability b	as the f e an by the	
		d was reviewed on 1/5/23 at 1:03 cluded, but were not limited to,		facility and is submitted only response to the regulatory requirement. F758 Free from unnecessar		

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION X:	B) DATE SURVEY COMPLETED
		155220	B. WING		01/06/2023
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD	
DYER N	URSING AND REF	ABILITATION CENTER		HEFFIELD AVE , IN 46311	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	anxiety disorder, n	najor depressive disorder, and		psychotropic meds/PRN use	
	insomnia.			What corrective action(s) will	
				be accomplished for those	
	The Quarterly Mir	nimum Data Set (MDS)		residents found to have been	
		12/12/22, indicated the resident		affected by the deficient	
		tact for daily decision making.		practice;	
		eceived insulin, anti-anxiety		Resident 3 - MD aware and orde	r
		ntidepressant medications daily		received to discontinue	
	for the past seven	days.		Olanzapine.	
				Resident 3 assessed and no	
	A Physician's Ord	er, dated 12/6/22, indicated		adverse reaction noted to the	
	paroxetine (an anti	idepressant medication) 10		administration of Olanzapine.	
	milligrams (mg) ta	iblet once a day.		How the facility will identify	
				other residents having the	
	A Physician's Orde	er, dated 12/8/22, indicated		potential to be affected by the	
	xanax (an anti-anx	iety medication) 0.25 mg twice a		same deficient practice and	
	day.			what corrective action will be	
				taken;	
	A Physician's Orde	er, dated 12/29/22, indicated		All Residents receiving	
	olanzapine (an ant	ipsychotic medication) 2.5 mg		psychotropic medications have the	ne
	tablet once a day f	or agitation.		potential to be affected by the	
				same alleged deficient practice.	
	The record lacked	documentation related to any		What measures will be put into	
	behaviors.			place or what systemic	
				changes will be made to	
	Interview with the	Director of Nursing on 1/6/23 at		ensure that the deficient	
	1:44 p.m., indicate	ed the resident had not been seen		practice does not recur;	
	-	avioral health services and she		Staff were re-educated on ensuri	ng
		ndication for use for the		there is an appropriate	-
	olanzapine.			diagnosis/indication for use of	
	-			psychotropic medications. Staff	
	This deficiency wa	as cited on 11/22/22. The facility		were also educated on	
	failed to implement	a systemic plan of correction		documenting behaviors after	
	to prevent recurren	nce.		notifying the physician of the	
				behaviors.	
	3.1-48(a)(4)			Education included in all new hire	e
				orientation as well as agency sta	
				orientation.	
				An audit has been conducted of	all
				residents with psychotropic	

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE C A. BUILDING B. WING			e survey pleted 6/2023
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPF DEFICIENCY)	TION LD BE ROPRIATE	(X5) COMPLETIC DATE
0812 SS=E Bldg. 00	483.60(i)(1)(2) Food Procurement,Sto	re/Prepare/Serve-Sanitary safety requirements.		medication orders to ensu psychotropic medications adequate Diagnosis /indic use. Facility has contracted wi psychiatric services. How the corrective action will be monitored to ensu deficient practice will not recur, i.e., what quality assurance programs will into place; DON/Designee will rando 10 residents with new psychotropic medications weekly to ensure there is appropriate diagnosis/ind its use, and related behave been documented. The Director of Nursing/d will present a summary of audits to the Quality Assu committee monthly for 6 r Thereafter, if determined Quality Assurance commi- auditing and monitoring w done quarterly and prese quarterly at the QA meeti Monitoring will be on goin Date by which systemic corrections will be comp 1/26/2023	had an cation for th new on(s) ure the ot I be put mly audit twice an ication for viors have esignee f the urance months. by the ittee, vill be nt ng.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	A. BUILDING <u>00</u> COM B. WING 01/			x3) date compi 01/06	LETED
	PROVIDER OR SUPPLIE	HABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	E	(X5) COMPLETIO DATE
	approved or con- federal, state or (i) This may inclu directly from loca applicable State regulations. (ii) This provision facilities from usi gardens, subject applicable safe of practices. (iii) This provisio from consuming facility. §483.60(i)(2) - S serve food in acc standards for foo Based on observat interview, the faci food under sanitar food equipment, s standing mixer for had the potential t received food from Kitchen) Findings include: During the Kitche 9:45 a.m. with the Manager, the follo a. The storage raci pans were sticky t on the racks that h inside with a dirty	 ade food items obtained al producers, subject to and local laws or an does not prohibit or prevent ang produce grown in facility to compliance with growing and food-handling an does not preclude residents foods not procured by the tore, prepare, distribute and cordance with professional od service safety. tion, record review, and lity failed to serve and prepare y conditions related to dirty team tables, wire racks, and r 1 of 1 kitchens observed. This o affect the 111 residents who n the kitchen. (The Main n Sanitation Tour on 1/6/23 at Assistant Dietary Food owing was observed: ks that housed clean pots and o touch. The plastic containers ooused clean utensils were dirty	F 08	12	Dyer Nursing & Rehabilitation F 812 Food Procurement, Store/ Prepare/Serve-Sanitary Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute a admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;	the an the	01/26/202

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

STATEME! AND PLAN			A. BUILDING <u>00</u> B. WING		COMPLETED 01/06/2023	
NAME OF I	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP COD		
DYER N	URSING AND REF	ABILITATION CENTER		HEFFIELD AVE , IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETI	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE	
	food and crumbs o	n the stove top.		The storage racks that housed		
				clean pots and pans were		
		avy accumulation of burned		cleaned. The plastic containers	on	
		grease on the inside of both		the racks that housed clean		
		and on the inside of the glass		utensils and spoons were clear	ied.	
	the ovens.	grease noted on the sides of		The accumulation of humad for	ad	
	ule ovens.			The accumulation of burned for and crumbs on the stove top w		
	d There was a he	avy accumulation of dried food		cleaned.	ere	
		e on the back splash of the				
	griddle and stove.	on the block splash of the		The accumulation of burned for	bod	
	gridale and stove.			spillage and grease on the insid		
	e. There was a hea	avy accumulation of food		of both convection ovens and c		
		tom of the steam table.		the inside of the glass doors we		
	1 0			cleaned. The grease noted on		
	f. There was a hea	vy accumulation of dirt, dried		sides of the ovens was cleaned		
	food spillage, and	grease on a portable steam				
	table.			The accumulation of dried food	t	
		Assistant Dietary Manager at		spillage and grease on the bac	k	
		d the steam table was not in use		splash of the griddle and stove		
	and not functional			was cleaned.		
	g. There was a di	rty food stained piece of plastic		The accumulation of food spil	lage	
	over the stand mix	er. There was a moderate		on the bottom of the steam tab	le	
		umbs on the stand and around		was cleaned.		
	the bowl and a bro	wn liquid noted inside the				
	bowl.			The accumulation of dirt, dried		
				food spillage, and grease on a		
		Assistant Dietary Food		portable steam table was clear	ied.	
	Manager at that fir was in need of clea	ne, indicated all of the above		The food stained sizes of start	ia	
	was in need of clea	annig or repair.		The food stained piece of plast over the stand mixer was clear		
	The plan of correct	tion weekly audits, indicated		The food crumbs on the stand		
	the following:	tion workly audits, indicated		around the bowl and a brown li		
		: floors dirty-yes, deep clean		noted inside the bowl was	4~~~	
		usekeeping. Oven dirty-yes		cleaned.		
	scheduled deep cle					
		2: floors-yes deep cleaned with		Phoenix Industrial Cleaning		
	machine.			services came out to deep clea	in	
	- Week of 12/19/2	2: top of stove-cleaned. Flat		the kitchen as follows: stove,		
		1				

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	r í	ILDING	DNSTRUCTION 00
	PROVIDER OR SUPPLIE	R IABILITATION CENTER		601 S⊦	ADDRESS, CITY, STATE, ZIP CO IEFFIELD 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 CORI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)
	cleaned. Table und Dish room cleaned				double oven, and wash baseboard on 1/12/23. A kitchen sanitation au completed on 1/19/23 l
	a.m., indicated the	Administrator on 1/6/23 at 10:45 Dietary Food Manager has eek. Prior to her leaving, she			facility's registered diet no findings.
	in the kitchen. The	anitation was being completed Registered Dietitian had not tion tour of the kitchen.			How the facility will id other residents having potential to be affected same deficient practic
		as cited on 11/22/22. The facility at a systemic plan of correction ace.			what corrective action taken;
	1				All facility uses interested by

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(X3) DATE SURVEY COMPLETED

		ABILITATION CENTER	DYER,	IN 46311	(25
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY	(X5) COMPLE
TAG	top-cleaned. - Week of 12/25/22 cleaned. Table under Dish room cleaned. Interview with the <i>A</i> a.m., indicated the I been gone for 1 wear was making sure sa in the kitchen. The completed a sanitat This deficiency was	Administrator on 1/6/23 at 10:45 Dietary Food Manager has ek. Prior to her leaving, she nitation was being completed Registered Dietitian had not ion tour of the kitchen. s cited on 11/22/22. The facility a systemic plan of correction	TAG	 double oven, and wash floor and baseboard on 1/12/23. A kitchen sanitation audit was completed on 1/19/23 by the facility's registered dietician with no findings. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff have been re-educated regarding, proper cleaning and sanitation of equipment, and drying techniques. All new dietary staff will be educated regarding proper cleaning and sanitation of equipment and drying techniques. All alleged concerns have been added to routine dietary cleaning schedule. How the corrective action(s) 	DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	00 DIALED DIALED DIALED DIALED DE DI	(X3) DATE SURVEY COMPLETED	
		155220	B. WING		01/06/2023	
		R IABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311		
DIEKI		ABIEITATION CENTER		111 403 1 1		
(X4) ID		STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG		NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETIO	
IAU	REGULATORI C	R LSC IDENTIFTING INFORMATION	IAU	deficient practice will not	DATE	
				recur, i.e., what quality		
				assurance programs will be pu into place;	ut	
				Administrator or designee to au sanitation of kitchen area 5 time a week for 6 months.		
				Administrator/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months Thereafter, if determined by the Quality Assurance committee,	S.	
				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: 1/26/2023		
⁻ 0921 SS=E Bldg. 00	§483.90(i) Other The facility must	Sanitary/Comfortable Environ Environmental Conditions provide a safe, functional,				
	residents, staff a Based on observat	nfortable environment for nd the public. ion, record review and ity failed to ensure the kitchen	F 0921	Dyer Nursing & Rehabilitation	01/26/202	
	area was clean and floors, dirty trash o up on the floors ar	in good repair related to dirty cans, lime build up, food build d baseboards, and food for 1 of 1 kitchen areas. (The		Please accept the following as t facility's credible allegation of compliance. This plan of correction does not constitute a		

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 01/06/2023	
		155220					
NAME OF	PROVIDER OR SUPPLIE	ČR.			ADDRESS, CITY, STATE, ZIP COD	_	
OYER NURSING AND REHABILITATION CENTER			601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	-	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PR	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	Main Kitchen.)				admission of guilt or liability by		
	Endiana includer				facility and is submitted only in	ו	
	Findings include:				response to the regulatory		
	During the Kitcher	n Sanitation Tour on 1/6/23 at			requirement. F921		
	-	Assistant Dietary Food			Safe/Functional/Sanitary/Col	mf	
	Manager, the follo			ortable Environment	•••		
	initial ger, and reme			What corrective action(s) will	1		
	a. The white PVC			be accomplished for those	-		
	were dirty with dri			residents found to have been	n		
					affected by the deficient		
	b. There was a mo	oderate amount of lime build up			practice;		
	on floor under the	dish machine and under the			The white PVC pipes under th	e	
	food prep table.				dish machine were power was	shed	
					and cleaned.		
		oderate amount of adhered dirt			The lime build up on floor und		
		e base board in the entire			the dish machine and under the	ne	
	kitchen.				food prep table was cleaned.		
	J The sector is a f	-11 4h			The adhered dirt and grime al	ong	
	with dried food su	all the garbage cans were dirty			the base board in the entire		
	with arrea 100a su	ostance.			kitchen was cleaned. The outside of all the garbage		
	e The white PVC	pipes under a food prep sink			cans were cleaned.		
		ood prep sink was not in working			The white PVC pipes under a	food	
		that way for a very long time.			prep sink were cleaned. The f		
		s dried food spillage and there			prep sink, dried food spillage		
		underneath on the floor.			lime build up underneath on t		
					floor were cleaned.		
		avy accumulation of food			The food crumbs and debris u	Inder	
	crumbs and debris	under the tables and along the			the tables and along the wall	were	
	wall.				cleaned.		
					Phoenix Industrial Cleaning		
		Assistant Dietary Manager at			services came out to deep cle	an	
		d all of the above was in need of			the kitchen as follows: stove,		
	cleaning or repair.				double oven, wash floor and		
	The glass of				baseboard on 1/12/23.		
	_	tion weekly audits, indicated			A kitchen sanitation audit was		
	the following:	: floors dirty-yes, deep clean			completed on 1/19/23 by the	ith	
		usekeeping. Oven dirty-yes			facility's registered dietician w no findings.	1111	

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

Event ID:

JOJW12 Facility ID: 000125

If continuation sheet

Page 12 of 18

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	CONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED
		155220	B. WING		01/06/2023
NAME OF	PROVIDER OR SUPPLIE	R	STREET	ADDRESS, CITY, STATE, ZIP COD	
				HEFFIELD AVE	
DYER N	URSING AND REF	ABILITATION CENTER	DYER	, IN 46311	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI	E COMPLET
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)	DATE
	scheduled deep cle			How the facility will identify	
		2: floors-yes deep cleaned with		other residents having the	
	machine			potential to be affected by the	•
	- Week of 12/19/22	2: top of stove-cleaned. Flat		same deficient practice and	
	top-cleaned.			what corrective action will be	
		2: steamer needs cleaning-yes		taken;	
		er juice machine-yes cleaned.		All residents have the potential	
	Dish room cleaned	•		be affected by the same allege	d
				deficient practice.	
		Administrator on 1/6/23 at 10:45		What measures will be put int	O
		Dietary Food Manager has		place or what systemic	
	e	eek. Prior to her leaving, she		changes will be made to	
		anitation was being completed		ensure that the deficient	
		Registered Dietitian had not		practice does not recur;	
	completed a sanita	tion tour of the kitchen.		Staff were re-educated on the	
				procedure of notifying	
		is cited on $11/22/22$. The facility		maintenance/environmental	
	-	t a systemic plan of correction		services of any necessary	
	to prevent recurrent	ice.		repairs/cleaning needed.	
				All new employees will be	
	3.1-19(f)			educated on the procedure of	
				notifying	
				maintenance/environmental	
				services of any necessary	
				repairs/cleaning needed.	
				How the corrective action(s)	
				will be monitored to ensure the	le
				deficient practice will not	
				recur, i.e., what quality assurance programs will be p	
				into place;	u
				Environmental services	
				supervisor/Maintenance	
				department/ designee will audit	15
				rooms per week on alternating	
				units for Environmental/cleanin	a
				issues and maintenance issues	۳
				Any identified issues will be	·-
				corrected.	
				Dietary Manager/designee will	
	1		1	Listary manager/ussignes will	1

	R MEDICARE & MEDI						MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 01/06/2023	
	PROVIDER OR SUPPLIE			601 SH	DDRESS, CITY, STATE, ZIP COD EFFIELD AVE N 46311		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY) audit the kitchen 5 days a for cleanliness and possibl that need to be addressed Administrator/designee wil present a summary of the to the Quality Assurance committee monthly for 6 m Thereafter, if determined b Quality Assurance commit auditing and monitoring wi	week le items l audits oonths. oy the tee,	(X5) COMPLETION DATE
R 0000					done quarterly and presen quarterly at the QA meetin Monitoring will be on going Date by which systemic corrections will be compl 1/26/2023	g. J.	
Bldg. 00	the State Residenti on 11/22/22. This Recertification and the Investigation of	Post Survey Revisit (PSR) to al Licensure Survey completed visit included a PSR to the State Licensure Survey and f Complaints IN00392424, N00392985 completed on	R 00	00	The facility kindly requests review.	a desk	
	Investigation of Co Complaint IN0039 Complaint IN0039 Complaint IN0039						
	-	5443 - Substantiated. iencies related to the					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DPLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE (A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/06/2023	
	PROVIDER OR SUPPLIE	R IABILITATION CENTER	601 S	f address, city, state, zip cod HEFFIELD AVE 8, IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIE NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION ed at E677	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
R 0273 Bidg. 00	Survey dates: Janu Facility number: 0 Residential Censu This State Resider accordance with 4 410 IAC 16.2-5-5 Food and Nutritic (f) All food prepa (excluding areas maintained in acc local sanitation a standards, incluc Based on observat interview, the faci food under sanitar food equipment, si standing mixer for had the potential to received food from Kitchen) Findings include: During the Kitche 9:45 a.m. with the Manager, the follo a. The storage rack pans were sticky to	ary 5 and 6, 2023. 00125 s: 35 tial Finding is cited in 10 IAC 16.2-5.	R 0273	Dyer Nursing & Rehabilitation R 273 Food Procurement, Store/ Prepare/Serve-Sanitary Please accept the following as a facility's credible allegation of compliance. This plan of correction does not constitute a admission of guilt or liability by facility and is submitted only in response to the regulatory requirement. What corrective action(s) will be accomplished for those residents found to have been	the n
	inside with a dirty	-		affected by the deficient practice;	

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/30/2023 FORM APPROVED OMB NO. 0938-039

	ENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C A. BUILDING	onstruction 00	(X3) DATE S	ETED
		155220	B. WING		01/06/	2023
NAME OF	PROVIDER OR SUPPLIE	3		ADDRESS, CITY, STATE, ZIP CO	OD	
				HEFFIELD AVE		
DYER N	IURSING AND REH	ABILITATION CENTER	DYER,	IN 46311		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A	IOULD BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY)		DATE
	food and crumbs or	n the stove top.		The storage racks that	housed	
				clean pots and pans we	ere	
	c. There was a hea	vy accumulation of burned		cleaned. The plastic co	ontainers on	
	food spillage and g	rease on the inside of both		the racks that housed of	clean	
	convection ovens a	nd on the inside of the glass		utensils and spoons we	ere cleaned.	
		grease noted on the sides of				
	the ovens.			The accumulation of bu	urned food	
				and crumbs on the stov	ve top were	
	d. There was a hea	vy accumulation of dried food		cleaned.		
		on the back splash of the				
	griddle and stove.	1		The accumulation of b	urned food	
	8			spillage and grease on		
	e There was a hea	vy accumulation of food		of both convection over		
		om of the steam table.		the inside of the glass of		
	spinage on the oot	on of the steam table.		cleaned. The grease n		
	f There was a hear	vy accumulation of dirt, dried		sides of the ovens was		
		grease on a portable steam		sides of the overis was	cleaneu.	
	table.	grease on a portable steam		The accumulation of d	riad food	
		Assistant Dietary Manager at				
		the steam table was not in use		spillage and grease on		
	and not functional.	the steam table was not in use		splash of the griddle ar was cleaned.	la slove	
	and not functional.			was cleaned.		
	g. There was a dir	ty food stained piece of plastic		The accumulation of f	ood spillage	
		er. There was a moderate		on the bottom of the ste	-	
	amount of food cru	mbs on the stand and around		was cleaned.		
	the bowl and a brow	wn liquid noted inside the				
	bowl.			The accumulation of di	rt. dried	
				food spillage, and grea		
	Interview with the	Assistant Dietary Food		portable steam table wa		
		ne, indicated all of the above				
	was in need of clea			The food stained piece	of plastic	
		or		over the stand mixer w		
	The plan of correct	ion weekly audits, indicated		The food crumbs on the		
	the following:	ier weenig addits, indicated		around the bowl and a		
	-	floors dirty-yes, deep clean		noted inside the bowl w	·	
		isekeeping. Oven dirty-yes		cleaned.	va3	
	scheduled deep clea					
	-			Dhooniy Inductivial Ol-	ning	
		2: floors-yes deep cleaned with		Phoenix Industrial Clea		
	machine.			services came out to de		
	- Week of 12/19/22	: top of stove-cleaned. Flat	1	the kitchen as follows:	stove,	

Event ID: JOJW12 Facility ID: 000125 If continuation sheet

Page 16 of 18

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED:	01/30/2023
FORM AP	PROVED
OMB NO.	0938-039

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE CO A. BUILDING B. WING	<u>00</u>	(X3) DATE SURVEY COMPLETED 01/06/2023	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE IN 46311		
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC	
TAG	top-cleaned. - Week of 12/25/22 cleaned. Table und Dish room cleaned Interview with the a.m., indicated the been gone for 1 we was making sure sa in the kitchen. The completed a sanitat This deficiency wa	Administrator on 1/6/23 at 10:45 Dietary Food Manager has sek. Prior to her leaving, she anitation was being completed Registered Dietitian had not tion tour of the kitchen. s cited on 11/22/22. The facility t a systemic plan of correction	TAG	DEFICIENCY) double oven, wash floor and baseboard on 1/12/23. A kitchen sanitation audit was completed on 1/19/23 by the facility's registered dietician with no findings. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken; All facility residents have the potential to be affected by the same alleged deficient practice What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur; Dietary staff have been re-educated regarding, proper cleaning and sanitation of equipment, and drying technique All new dietary staff will be educated on proper cleaning and sanitation is chedule. How the corrective action(s) will be monitored to ensure that	p ess.	

TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CONSTRUCTION A. BUILDING D B. WING		OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 01/06/2023		
NAME OF PROVIDER OR SUPPLIER		601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD 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 (FACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPP DEFICIENCY) deficient practice will not recur, i.e., what quality assurance programs will be into place; Administrator or designee to sanitation of kitchen area 5 t a week for 6 months. Administrator/designee will present a summary of the au to the Quality Assurance committee monthly for 6 mon Thereafter, if determined by Quality Assurance committe auditing and monitoring will done quarterly and present quarterly at the QA meeting.	e put e audit times udits nths. the e, be	(X5) COMPLETION DATE
				Monitoring will be on going. Date by which systemic corrections will be complet 1/26/2023	ted:	