	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE C A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIE		601 S⊦	ADDRESS, CITY, STATE, ZIP COD	E	
	URSING AND REF	ABILITATION CENTER	DYER,	IN 46311		
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR	D BE	(X5) COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
0000						
Bidg. 00			F 0000	Please accept the followir facility's plan of correction plan of correction does no constitute an admission o liability by the facility and submitted only in respons regulatory requirement. T facility would like to reque desk review.	. This ot f guilt or is e to the he	
	Federal/state defic allegations are cite Complaint IN0034 Federal/state defic	0893: Substantiated. iencies related to the d at F689 and F693. 3183: Substantiated. iencies related to the d at F580 and F692.				
	Federal/state defic allegations are cite Complaint IN0034	3626: Substantiated. iencies related to the d at F561 and F677. 3747: Substantiated. iencies related to the d at F692.				
	Federal/state defic	4105: Substantiated. iencies related to the d at F580, F684 and F689.				
		7980: Substantiated. No d to the allegations were cited.				
	-	8906: Substantiated. State gs related to the allegations				
	Survey dates: Ma	rch 22, 23, 24, and 25, 2021.				

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			COl	(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIE	ABILITATION CENTER		STREET A 601 SH DYER,	ODE			
(X4) ID		TATEMENT OF DEFICIENCIES	-	ID			(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI	HOULD BE	COMPLETIO	
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE A DEFICIENCY)	APPROPRIATE	DATE	
	Facility number: 0							
	Provider number: AIM number: 100							
	Census Bed Type:							
	SNF/NF: 72							
	SNF: 21 Residential: 35							
	Total: 128							
	Census Payor Type							
	Medicare: 21							
	Medicaid: 51 Other: 21							
	Total: 93							
	These deficiencies accordance with 41	reflect State Findings cited in 0 IAC 16.2-3.1.						
	Quality review con	npleted on 3/29/21.						
0561	483.10(f)(1)-(3)(8	)						
SS=D	Self-Determinatio							
Bldg. 00	§483.10(f) Self-de	the right to and the facility						
		d facilitate resident						
		through support of						
		ncluding but not limited to d in paragraphs (f)(1)						
	through (11) of th							
		resident has a right to						
		schedules (including						
		ing times), health care and h care services consistent						
		erests, assessments, and						
		other applicable provisions						

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

PRINTED: 04/14/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155220	A. BU B. WI		00	03/	MPLETED 25/2021
	PROVIDER OR SUPPLIE	R IABILITATION CENTER		601 S⊦	address, city, state, zip co IEFFIELD AVE IN 46311	DE	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE API DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
	make choices ab in the facility that resident. §483.10(f)(3) The interact with mer participate in cor and outside the f §483.10(f)(8) The participate in oth social, religious, that do not interfer residents in the f Based on record re facility failed to he resident's preferen given bed baths for preferences. (Resi Finding includes: The closed record on 3/24/21 at 12:2 but were not limited diabetes, obesity, at The Admission M assessment, dated resident was alert totally dependent of The New Admissi dated 10/19/20, in showers over bed Tuesday and Frida	e resident has a right to er activities, including and community activities ere with the rights of other acility. we and interview, the onor resident choices related a ce to be showered over being r 1 of 3 residents reviewed for dent E) for Resident E was reviewed 8 p.m. Diagnoses included, ed to, major depression, and hypertension. inimum Data Set (MDS) 10/23/20, indicated the and oriented and she was with bathing. on Preference documentation, dicated the resident preferred baths by 10:00 a.m., every	F 05	561	F 561 Self Determination Please accept the follow facility's plan of correction plan of correction does r constitute an admission liability by the facility and submitted only in respon regulatory requirement. What corrective action will be accomplished for residents found to have affected by the deficien practice. Resident E's no longer r facility. No corrective action be made. How the facility will ide other residents having potential to be affected same deficient practice	on. This not of guilt or d is nse to the which or those e been nt resides in tions can entify the I by the	04/02/202

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE C A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	STREET 601 SH DYER,			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES 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 APPROPRIAT DEFICIENCY)	E (X5) COMPLETI DATE	
	11/16, and 11/27/2 11/18, 11/23, and Interview with the 3/25/20 at 11:10 a preferences should	20. She received showers on		All facility residents have to potential to be affected by the same deficient practice. All residents' preferences for showers/bathing have been reviewed. What measures will the facility take or systems the facility w alter to ensure that the proble will be corrected and will not recur. Nursing staff in-serviced on following residents' preferences for showers/bathing including: time of shower/bath including morning or afternoon and bed bath/ shower/ tub ba any other preference that the facility can meet How will the corrective action be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place The Director of Nursing/design will monitor 5 residents shower sheets weekly for 6 months to ensure that showers/bathing an offered per residents' preferences. A summary of the POC audits	y ill m s ath at ur, o? ee	

ENTERS FO	R MEDICARE & MEDIC	AID SERVICES				0	MB NO. 0938-039
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	È é	MULTIPLE CO BUILDING	onstruction <u>00</u>	r í	E SURVEY PLETED
		155220	B. V	WING		03/25/2021	
NAME OF	PROVIDER OR SUPPLIEF	R			ADDRESS, CITY, STATE, ZIP COI	DE	
DYER N	URSING AND REH	ABILITATION CENTER			IEFFIELD AVE IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP	JLD BE	COMPLETIO
TAG	REGULATORY OR	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					be presented to the Q/A Committee for 6 months. months, it will be determine the Q/A Committee if furth monitoring is required.	ined by	
					Date of Completion: Ap 2021	ril 2,	
: 0580 SS=D Bldg. 00	etc.) §483.10(g)(14) Na (i) A facility must i resident; consult v physician; and no her authority, the when there is- (A) An accident in results in injury ar requiring physicia (B) A significant c physical, mental, is, a deterioration psychosocial statt conditions or clinic (C) A need to alte (that is, a need to form of treatment consequences, or of treatment); or (D) A decision to t resident from the §483.15(c)(1)(ii). (ii) When making	s (Injury/Decline/Room, btification of Changes. Immediately inform the with the resident's tify, consistent with his or resident representative(s) wolving the resident which and has the potential for n intervention; hange in the resident's or psychosocial status (that in health, mental, or us in either life-threatening cal complications); r treatment significantly discontinue an existing due to adverse to commence a new form transfer or discharge the facility as specified in notification under (i) of this section, the					

NIEKS FOR	R MEDICARE & MEDI	CAID SERVICES			OMB NO. 0938-039
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155220	B. WING		03/25/2021
NAME OF I	PROVIDER OR SUPPLIE	R	STREE	T ADDRESS, CITY, STATE, ZIP CODE	
DYFR N	URSING AND REF	ABILITATION CENTER		SHEFFIELD AVE R, IN 46311	
(X4) ID		STATEMENT OF DEFICIENCIES	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 APPROPRIATE DEFICIENCY)	DATE
IAG		· · · · · · · · · · · · · · · · · · ·	IAG		DATE
		vided upon request to the			
	physician.				
		ust also promptly notify the			
		resident representative, if			
	any, when there				
		oom or roommate			
		pecified in §483.10(e)(6); or			
		esident rights under			
		aw or regulations as			
	specified in parag	graph (e)(10) of this			
	section.				
	(iv) The facility must record and periodically				
		ss (mailing and email) and			
	phone number of	,			
	representative(s)				
	§483.10(g)(15)				
		omposite distinct part. A			
		omposite distinct part (as			
		) must disclose in its			
	admission agree	•			
	-				
	-	luding the various locations			
		composite distinct part,			
		the policies that apply to			
		tween its different locations			
	under §483.15(c)				
		view and interview, the	F 0580	F 580	04/02/202
		sure the Physician was		Notify of Changes	
		of a change in condition			
		nts of dizziness for 1 of 5		What corrective action(s) will	
		for notification of change.		be accomplished for those	
	(Resident D)			residents found to be affected	
				by the alleged deficient	
	Finding includes:			practice;	
	A confidential inte	rview on 3/23/21 at 2:40 p.m.,		Resident D is no longer at the	
		-		_	an
		amily member indicated it was		facility. No corrective actions ca	211
		get a hold of anyone at the		be made.	
		ed one was in the COVID-19			
	unit. The family g	ot a hold of LPN 1 on		How the facility will identify	

#### PRINTED: 04/14/2021 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 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 03/25/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 SHEFFIELD AVE DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 11/21/20 at 1:30 p.m., at which time the LPN other residents having the had indicated the resident had a fainting spell potential to be affected by the same deficient practice and coming out of the bathroom after having a bowel what corrective action will be movement and his blood pressure was low. The LPN was very defensive when questioned about taken: the episode. The family member indicated the All residents who have changes in Nurse Practitioner (NP) had informed them that condition have the potential to be neither she nor the Physician were notified of affected by the same deficient the fainting spells. practice. The closed record for Resident D was reviewed What corrective measures will on 3/24/21 at 9:20 a.m. The resident was the facility take or will the admitted to the facility on 11/19/20 and facility alter to ensure that the discharged on 11/25/20. Diagnoses included, problem will not occur? but were not limited to, COVID-19, pneumonia, decreased white blood cell count, bacteremia, Licensed nurses were in serviced thrombocytopenia, iron deficiency anemia, on: unsteadiness on feet and weakness. The policy titled "Notification of Resident Change A Nurses' Note, dated 11/19/20 at 7:01 p.m., in Condition". Documentation of indicated the resident arrived via ambulance from the hospital. The resident was alert times 3 and notifications of any changes in able to make his needs known. The resident condition. needed supervision with transfers and he was continent of bowel and bladder. What quality assurance plans will be implemented to monitor A Nurse Practitioner (NP) Note, dated 11/20/20 facility performance to ensure at 7:44 p.m., indicated the resident was seen for a corrections are achieved and new admission. Diagnoses: COVID-19, permanent? pneumonia, anemia. thrombocytopenia, fatigue, weakness. high risk for readmit. The resident The DON/designee will review 5 denies syncopal episode and has no fever. resident charts, including review

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

Nurses' Notes, dated 11/21/20 at 11:12 a.m.,

indicated the resident was a new admit and 15

minute checks continued. The resident was in

respiratory isolation due to COVID. Oxygen at 6 liters per nasal cannula, with no shortness of

breath or temperature noted. The resident had a

dry nonproductive cough and his lung sounds

Event ID: Y

YUW811 Facility ID: 000125

25 If continuation sheet

The DON /designee will present a

of events and progress notes

the physician is notified of any

summary of the audits to the

Quality Assurance committee

changes in condition.

weekly for 6 months to ensure that

ion sheet Page 7 of 27

age i ei zi

### DEPART

	T OF HEALTH AND HU R MEDICARE & MEDIC				PRINTED: 04/14/202 FORM APPROVED OMB NO. 0938-0391	
STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING B. WING	00	COMPLETED	
		155220			03/25/2021	
NAME OF	PROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE		
DYER N	URSING AND REH	ABILITATION CENTER		IN 46311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	episodes of dizzine Nurses' notes. A Physiatrist (Phys Rehabilitation Phys 11/23/20, indicated syncopal episodes/ weekend. He is a b No cough, chest pa or chills. Improving patient. Plan: Patie and syncopal episo	mentation regarding any ss or fainting spells in the sical Medicine and sician) Progress Note, dated I "the patient had a couple of presyncopal episodes over the it dizzy today. No headaches. in, shortness of breath, fevers, g shortness of breath per ent continues to have dizziness des despite stable vitals, ttic related. We will monitor		monthly for 6 months. Therea if determined by the Quality Assurance committee, auditin and monitoring will be done quarterly and present quarterl the QA meeting. Monitoring v be on going. <b>Date of Completion: April 2,</b> <b>2021</b>	g y at	
	11/25/20 at 10:27 p over the weekend h the bathroom. He s out" but denies fall report fall."	ded as a late entry on o.m., indicated "also per staff he had 2 syncopal episodes in stated he felt like he " passed ing. Staff was there and did not mentation to indicate the NP				

dizziness or syncopal episodes. Interview with the Director of Nursing on 3/24/21 at 3:30 p.m., indicated the LPN 1 does not remember him having syncope or passing out. There was no documentation of any fainting or syncope episodes or of the NP or Physician being notified.

or the Physician were notified of the resident's

Interview with LPN 1 on 3/25/21 at 11:05 a.m., indicated she was informed by therapy the resident was dizzy so she went into the room and assessed the resident, took his vital signs, and

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

Event ID:

YUW811 Facility ID: 000125

If continuation sheet

Page 8 of 27

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILI	DING <u>0</u>	0	COMPL	ETED
		155220	B. WING	i		03/25/	2021
NAME OF	PROVIDER OR SUPPLIE	R	S	STREET ADDR	ESS, CITY, STATE, ZIP CODE		
				601 SHEFF			
DYER N	URSING AND REH	ABILITATION CENTER		DYER, IN 4	6311		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	]	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
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TAG		R LSC IDENTIFYING INFORMATION)	Т	ſAG	DEFICIENCY)		DATE
		ation, however, there was no notes of the dizziness or if the					
	Physician was noti						
	i nysician was nou	neu.					
	This Federal tag re	lates to Complaints					
	IN00343183 and I						
	3.1-5(a)(2)						
0677	483.24(a)(2)						
SS=D		ed for Dependent Residents					
3ldg. 00		esident who is unable to					
-	carry out activities	s of daily living receives the					
	-	es to maintain good					
	-	g, and personal and oral					
	hygiene;	1 . 1	E A CE	7 F	<b>\77</b>		0.4.10.0.10.0
		on, record review and ity failed to ensure dependent	F 0677	/	)L Care Provided for		04/02/20
		assistance with showers for 1			pendent Residents		
		wed for activities of daily					
	living. (Resident I	-					
					nat corrective action(s) will		
	Finding includes:				accomplished for those		
		· 1 / T · 1			sidents found to be affected	1	
		ident L was reviewed on m. Diagnoses included, but			the alleged deficient actice;		
		, history of cervical fracture,			10110 <del>0</del> ,		
		rmal gait, blindness in one		De	pendent resident L is provide	ed	
	eye, dementia and				h assistance twice weekly.		
				Sh	owers are being documented	d.	
		num Data Set (MDS) 2/23/21, indicated the resident			w will the facility identify othe	∍r	
		paired for decision making.			sidents who have the potentia		
		we assist with 1 person assist			affected by the same allege		
		id was totally dependent on			ficient practice?		
	staff for bathing.	. –					
					facility residents who are		
	_	ce sheet indicated the resident			pendent on staff for ADL car		
	preterred showers	in the morning. The resident's		ha	ve the potential to be affecte	a	

	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE C A. BUILDING B. WING	00	x3) date survey completed 03/25/2021
	PROVIDER OR SUPPLIE	IABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE IEFFIELD AVE IN 46311	
(X4) ID		STATEMENT OF DEFICIENCIES	ID		(X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
	shower days were	Wednesdays and Saturdays.		by the same deficient practice.	
	indicated the resid least two times a v receive a shower of 2/27/21. There was no Card refused care or sho Interview with the 3/24/21 at 4:00 p.1 to receive a shower	s from 1/2021-3/2021 ent did not receive a shower at week. The resident did not on 1/9, 1/23, 1/30, 2/6, and e Plan to indicate the resident owers. Director of Nursing on m., indicated the resident was r at least 2 times a week. elates to Complaint		<ul> <li>What corrective measures will the facility take or will the facility take or will the facility alter to ensure that the problem will not occur?</li> <li>Nursing staff were in serviced or Documentation on the residents showers/baths at least twice weekly.</li> <li>Providing residents with assistance per resident preference.</li> <li>What quality assurance plans will be implemented to monitor facility performance to ensure corrections are achieved and permanent?</li> <li>The DON/designee will review residents requiring assistance weekly for 6 months to ensure showers/baths were completed per residents' preference and documented on the shower sho</li></ul>	e on: st st or e 5 that t eet. at a A is. e
				meeting. Monitoring will be ongoing. Date of Completion: April 2, 2021	

CT ATEN (E)	R MEDICARE & MEDI						O. 0938-0391
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SUI COMPLET	
AND PLAN	OF CORRECTION	155220	B. WI		00		
		155220	D. W1			03/25/20	21
NAME OF	PROVIDER OR SUPPLIE	R		STREET	ADDRESS, CITY, STATE, ZIP CODE		
TURNE OF				601 S⊦	IEFFIELD AVE		
DYER N	URSING AND REP	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	C	OMPLETION
TAG	REGULATORY C	R LSC IDENTIFYING INFORMATION)	_	TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	DATE
- 0684 SS=D	483.25 Quality of Care						
Bldg. 00	applies to all trea facility residents. comprehensive a facility must ensu treatment and ca professional star	a fundamental principle that atment and care provided to Based on the assessment of a resident, the ure that residents receive are in accordance with adards of practice, the person-centered care plan,					
	Based on observat interview, the faci non-pressure skin and scabs for 2 of	ion, record review, and lity failed to monitor conditions related to scratches 3 residents reviewed for conditions. (Residents Q and	F 06	584	F 684 Quality of Care What corrective action(s) will be accomplished for those		04/02/202
	Findings include:				residents found to have been affected by the deficient practice?		
		Resident Q was reviewed on					
		.m. Diagnoses included, but			Resident R is no longer in the		
		o, alcohol abuse, chronic ult failure to thrive, heart			facility. No corrective actions ca be made.	aii	
	failure and cogniti				The scab to the right plantar lov	wer	
		····			foot for Resident Q is being		
		inimum Data Set (MDS), dated			monitored daily.		
		he resident was severely					
		ed and required an extensive 1 sist with bed mobility.			How will facility identify other residents who have the		
	A Physician's Ord	er, dated 3/2/21, indicated			potential to be affected by the same alleged deficient practic		
		ght plantar lower foot daily.					
		She plantar lower root daily.			The deficient practice has the		
	The 3/2021 Treatr	nent Administration Record			potential to affect all facility		
		he monitoring of the scab to the			residents who have wounds.		
		r foot was only documented as					

STATEME	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C	ONSTRUCTION (X3	B) DATE SURVEY	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155220	B. WING		03/25/2021	
	PROVIDER OR SUPPLIE	D .	STREET	ADDRESS, CITY, STATE, ZIP CODE		
VAIME OF	TROVIDER OR SOTTER		601 SH	HEFFIELD AVE		
DYER N	URSING AND REF	ABILITATION CENTER	DYER,	, IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	DROVIDEDIS DI AN OF CODDECTION	(X5)	
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
	being monitored o	n 3/2, 3/5, 3/12, 3/19, and		Review completed list of resident	ts	
	3/23/21.			with non-pressure areas to ensur	re	
				that orders are in place and		
		Director of Nursing (DON) on		non-pressure areas are being		
		.m., indicated the resident's		monitored.		
	scab should have b	been monitored daily as				
	ordered.			What corrective measures will		
				the facility take or will alter to		
		:20 p.m., LPN 2 was observed		ensure that the problem will no	t	
		assessment for Resident R. At		recur?		
		cated the resident had				
	scratches which ha	ad scabbed over.		Licensed nursing staff were		
	<b>T</b> 10 D	11 (D) 1		educated to ensure the monitorin	ig	
		sident R was reviewed on		of non-pressure areas.		
	-	n. Diagnoses included, but		Training included:		
		o, hemiplegia, thyroid disorder,		Following Physician orders		
		, falls, hypertension, and		• Documentation of		
	anxiety.			non-pressure are in the clinical record		
	The Admission M	inimum Data Set (MDS)		• Monitoring for improvemen	+	
		3/18/21, indicated the resident		or decline	L .	
		gnitively impaired and				
		ive 1 person physical assist				
	-	and an extensive 2 person		What quality assurance plans		
	physical assist wit			will be implemented to monitor		
	1			facility performance to ensure		
	A Physician's orde	er, dated 3/12/21, indicated		corrections are achieved and		
		to left knee and right great toe		permanent?		
	every shift until he					
				DON/designee will randomly aud	lit	
		Body Observation, dated		weekly 5 residents identified to		
		the resident had 2 scratches on		have non-pressure areas, such a		
	her right great toe	and left knee.		bruising/rashes/scabs/etc. weekl	у	
				to ensure that skin areas are		
		nent Administration Record		being monitored as ordered for 6		
		ne scratches to the left knee		months.		
		were not documented as being				
		day shift, 3/16, 3/17, 3/20		The DON/designee will present a	a	
		shift, and 3/15-3/17, 3/21 and		summary of the audits will be		
	3/22/21 night shift	•		presented to QA committee		

	VT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	A. BUILDING B. WING	<u></u>	(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIE	R IABILITATION CENTER	601 \$	et address, city, state, zip cod SHEFFIELD AVE R, IN 46311	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	3/25/21 at 11:10 a.	Director of Nursing (DON) on m., indicated the resident's ave been monitored as lates to Complaint		monthly for 6 months. The if determined by the QA committee, auditing and monitoring will be done q and present quarterly at t meeting. Monitoring will be ongoing. Date of Completion: Apr 2021	uarterly he QA be	
= 0689 SS=D Bldg. 00	remains as free of possible; and §483.25(d)(2)Ead adequate supervi- to prevent accide Based on observat interview, the facili interventions were floor strips for a re- for 1 of 3 residents L) Finding includes: On 3/23/21 at 9:50 observed in bed.	ents. ensure that - e resident environment of accident hazards as is ch resident receives ision and assistance devices	F 0689	F 689 Free of Accident Hazards/Supervision/De What corrective action(s be accomplished for the residents found to have affected by the deficient practice; Resident L was assessed fall interventions were up How the facility will iden	s) will sse been : and her dated.	04/02/202
	very high position low position. The				itify he	

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

		CAID SERVICES		ONETRICTION		MB NO. 0938-0391
	INT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		· · ·	E SURVEY
AND PLAN	NOF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00		PLETED
		155220	B. WING	03/25/2021		
NAME OF	PROVIDER OR SUPPLIE	ER		ADDRESS, CITY, STATE, ZIP CODE		
				IEFFIELD AVE		
DYER N	IURSING AND REF	ABILITATION CENTER	DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	BE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)		DATE
	were no non-skid	floor strips in the bathroom.		same deficient practice a		
				what corrective action wil	l be	
		30 p.m. the resident was		taken;		
		earing a hospital gown and		All residents who have ord		
	-	e were no non-skid floor strips		fall interventions have the		
	in the bathroom.			to be affected by the same	alleged	
				deficient practice.		
		15 p.m., the resident was		An audit of all fall intervent	ions	
	observed in bed wearing a hospital gown. There were no non-skid floor strips in the bathroom.		was completed.			
		floor strips in the bathroom.		What measures will be pu	it into	
				place or what systemic		
	The record for Resident L was reviewed			changes will be made to e		
	3/23/21 at 10:02 a.m. Diagnoses included, but			that the deficient practice	does	
	were not limited to, history of cervical fracture,		not recur;			
	osteoarthritis, abnormal gait, blindness in one eye, dementia and a history of falling.			Staff were in-serviced on fa		
	eye, dementia and	a history of falling.		interventions and to ensure		
				interventions are in place a ordered.	IS	
	The Americal Minin	$\mathbf{D}_{\mathbf{A}} = \mathbf{D}_{\mathbf{A}} + \mathbf{C}_{\mathbf{A}} + \mathbf{M} \mathbf{D}_{\mathbf{C}}$			(-)	
		num Data Set (MDS)		How the corrective action		
		2/23/21, indicated the resident red for decision making. She		will be monitored to ensu deficient practice will not		
		assist with 1 person assist for		i.e., what quality assurance		
		was totally dependent on staff		programs will be put into		
	-	resident had no falls since the		The DON /designee will at	-	
	last assessment.	esident had no fans since the		residents with fall intervent		
	ast assessment.			weekly to ensure fall interv		
	The Care Plan. dat	ted 2/21/20, indicated the		are in place as ordered for		
		k for falling related to		months.	-	
		history for falls, medication		The DON /designee will pre	esent a	
	-	al muscle weakness. The		summary of the audits to the		
		s were to place anti-skid strips		Quality Assurance committ		
	in bathroom.	- •		monthly for 6 months. The	reafter,	
				if determined by the Quality	ý	
	Physician's Orders	s, dated 9/9/20, indicated		Assurance committee, aud		
	nursing intervention	ons: anti-skid strips to bath.		and monitoring will be done	e	
				quarterly and present quarter	terly at	
	A Fall Event, date	d 3/8/21 at 12:56 p.m.,		the QA meeting. Monitorin	g will	
	indicated the resid	ent fell while ambulating.		be on going.		
		12/00/21 / 12 / 1			•	
	Nurses' Notes, dat	ed 3/08/21 at 12:46 p.m.,		Date of Completion: April	2,	

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Event ID:

YUW811 Facility ID: 000125

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PRINTED: 04/14/2021 FORM APPROVED

						B NO. 0938-03	
	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 00	_	COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP IEFFIELD AVE IN 46311	CODE		
	-						
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION		(X5) COMPLETIO	
TAG	× ×	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE DEFICIENCY)		DATE	
0692 SS=D Bldg. 00	indicated summone resident was observe the floor next to the A fall investigation resident stated "I we bathroom." Interview with the I 3/24/21 at 4:00 p.m changed rooms and were not placed dow This Federal tag ref IN00340893 and IN 3.1-45(a)(2) 483.25(g)(1)-(3) Nutrition/Hydratio §483.25(g) (Assist (Includes naso-gat tubes, both percur gastrostomy and jejunostomy, and resident's compre facility must ensure §483.25(g)(1) Mat parameters of nut usual body weigh range and electro resident's clinical	d to the room by CNA. The red sitting on her buttocks on bed. No injuries noted. , dated 3/8/21, indicated the as trying to get to the Director of Nursing on ., indicated the resident had the non-skid floor strips wn and they should have been. ates to Complaint 300344105. In Status Maintenance ed nutrition and hydration. Istric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the re that a resident- intains acceptable ritional status, such as t or desirable body weight lyte balance, unless the condition demonstrates that		2021		DATE	
	indicate otherwise §483.25(g)(2) Is c	e or resident preferences e; ffered sufficient fluid proper hydration and					

TERS FO	R MEDICARE & MEDIC	CAID SERVICES				OMB NO. 0938-0391	
	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CO	ONSTRUCTION	(X3) DATE	
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL		00	COMPL	
		155220	B. WING			03/25	/2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIE	R			IEFFIELD AVE		
OYER N	URSING AND REH	ABILITATION CENTER			IN 46311		
X4) ID	SUMMARY STATEMENT OF DEFICIENCIES ID PROVI		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	PF	REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	§483.25(g)(3) Is a	offered a therapeutic diet					
	when there is a n	utritional problem and the					
	health care provid	der orders a therapeutic					
	diet.						
	Based on observati	sed on observation, record review, and F 0692 F 692		F 692		04/02/2021	
		ity failed to ensure fortified	1 000	-	Nutrition/Hydration Status		0 11 0 21 2 0 2 1
		as ordered and food			Maintenance		
		upplements were monitored					
		history of weight loss for 3	What corrective action(s) will	1			
of 5 resident (Residents D Findings incl	of 5 residents revi				be accomplished for those	-	
					residents found to have beer	<b>,</b>	
	(Residents D, L, al				affected by the deficient	•	
	Findings include:				practice?		
	Findings include.				practice		
	1 The closed reco	rd for Resident D was			Resident D no longer		
	reviewed on $3/24/21$ at 9:20 a.m. The resident				resides in the facility. No		
	-	e facility on 11/19/20 and			corrective actions can be mad	<u>م</u>	
		5/20. Diagnoses included,			Resident L's diet was reviewe		
	-	d to, COVID-19, pneumonia,			the RD, recommendations we	-	
		ood cell count, bacteremia,			made and new orders receive		
					Resident M's diet was reviewe		
	unsteadiness on fee	iron deficiency anemia,				-	
	unsteadiness on red	et and weakness.			the RD, recommendations we made and new orders receive		
	The resident reside	d in the COVID-19 unit after			made and new orders receive	J.	
	admission.	a in the COVID-17 unit after			How will facility identify othe	r	
	admission.				residents who have the	•	
	Physician's Orders	, dated 11/20/20, indicated			potential to be affected by th	P	
		akes every shift and meal			same alleged deficient practi		
		eakfast, lunch and dinner.			The deficient practice has the		
		Cakrast, Iunon and Unner.			potential to affect all facility		
	There were no	1 consumptions do sum anted			residents.		
		I consumptions documented					
		) for dinner, 11/21, 11/22, and			What corrective reconnections		
	11/23/20 for all 3 r	neais			What corrective measures w		
	T1	1 1 1 1			the facility take or will alter to		
		d intakes documented on			ensure that the problem will	not	
	11/19, 11/21, 11/22	2, and 11/23/20.			recur?		
	Interview with the	Director of Nursing on			Nursing staff educated on:		
		Director of Nursing on			Nursing staff educated on:		
		n., indicated the resident's			• Monitoring residents'	~	
	means and fluid int	akes were not complete and			consumption of meals includin	y	

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

Event ID:

YUW811 Facility ID: 000125

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 03/25/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 SHEFFIELD AVE DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) documented during his stay. fortified foods and supplements. Dietary staff educated on: 2. On 3/23/21 at 12:30 p.m., the resident was Following meal ticket observed in bed. A CNA was observed standing at the bedside and feeding the resident. She was orders and the provision of served fish, combread, rice and a dessert. There fortified foods and dietary was a health shake on the resident's tray. The supplements. resident needed assistance with eating. There A list of residents with orders for were no fortified mashed potatoes observed on fortified foods was complied. A list of residents with orders for the resident's meal tray. supplements was complied. Nursing orders for meal On 3/24/21 at 12:15 p.m., the resident was observed lying in bed on her left side, with her consumption were reviewed eyes closed. CNA 2 took the resident's meal tray What quality assurance plans into the room, removed the lid and placed it on the over bed table in front of the resident and left will be implemented to monitor the room. The resident was not awakened or facility performance to ensure repositioned to feed herself. The resident was corrections are achieved and served a health shake, applesauce, meat sauce permanent? over noodles and mixed vegetables. The resident was not served fortified mashed potatoes. At DON/ designee will audit 15 12:47 p.m., the resident remained in the same residents' meal consumption records and supplement records position and no staff had been in the room to assist or help the resident eat. The resident had weekly x 6 months to ensure not even touched her food and the health shake documentation is in place. remained unopened. Administrator/ designee will audit The record for Resident L was reviewed on 15 resident trays weekly x6 months to ensure fortified foods 3/23/21 at 10:02 a.m. Diagnoses included, but were not limited to, history of cervical fracture, are in place. osteoarthritis, abnormal gait, blindness in one eye, dementia and a history of falling. The DON/designee will present a summary of the audits will be presented to the Quality The Annual Minimum Data Set (MDS) Assurance committee monthly for assessment, dated 2/23/21, indicated the resident 6 months. Thereafter, if was moderately impaired for decision making. determined by the Quality Assurance committee, auditing She needed extensive assist with 1 person assist for bed mobility and was totally dependent on and monitoring will be done quarterly and present quarterly at staff for bathing. The resident's weight was 83

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Event ID:

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Facility ID: 000125

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PRINTED: 04/14/2021 FORM APPROVED

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	JILDING NG	00	(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES 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)	TE	(X5) COMPLETI DATE
	pounds with no curr A Care Plan, dated resident was limited regards to eating an resident required su perform eating/drin resident would rece through the next rev were to assure the r alignment while eat assistance at the lev The resident's weig and her current weig pounds. A Registered Dietit at 2:11 p.m., indicar Mass Index of 15 (n to show a significar resident received su care shake at lunch potatoes at lunch, ar milliliters (ml) three for nutritional supp Physician's Orders, regular diet with no	rent weight loss. 2/21/20, indicated the 1 in functional status in d drinking independently. The pervision and assist to king. The goal indicated the ive assistance with all meals view. The nursing approaches esident was in good body ing/ drinking, and provide el the resident required. ht on 12/3/20 was 129 pounds ght on 3/21/21 was 87 ian (RD) note, dated 3/17/21 ted the resident had a Body underweight), and continued at wt loss times 90 days. The per cereal at breakfast, ready and dinner, fortified mashed nd a house supplement 90 e times a day between meals		the QA meeting. Monitoring w be on going. Date of Completion: April 2, 2021	vill	DATE
	breakfast, and fortif Document all meals Physician's Orders,	ied mashed potatoes at lunch. s in the point of care. dated 2/12/21, indicated				
		0 ml three times a day. ion logs for 2/2021 and ows:				
	- No documentation	of dinner on 2/1-2/7, 2/15,				

STATEME	R MEDICARE & MEDIC NT OF DEFICIENCIES OF CORRECTION	AID SERVICES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	A. BUI	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		(X3) DA CON 03/2	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIEF	ABILITATION CENTER			FIELD AVE	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
		1, 3/5, 3/6, 3/9, 3/11, 3/12,						
	- No documentation 3/7/21.	n of lunch on 2/16, 2/26, and						
	- No documentation	n of breakfast on 2/16/21.						
	intakes on the Medi	nentation of the health shake ication Administration oplement section in the /2021 and 3/2021.						
	3/24/21 at 4:00 p.m consumption logs w three meals and the	Director of Nursing (DON) on ., indicated the meal vere not complete for all resident should have received l potatoes for lunch.						
	indicated the facilit documentation of th and there was no w	DON on 3/25/21 at 8:45 a.m., y had no policy regarding the ne intake of the health shakes ay to indicate how much the every time she was served a						
	observed in bed. T his bed and he was The resident's eyes was observed untou on the over bed tab rice, black beans, cc was no fortified ma plate. At 12:45 p.m resident's room and	2:35 p.m., Resident M was he lights were turned off over dressed in a hospital gown. were closed. His lunch tray uched with the lid still in place le. He was served ground fish, ornbread and a dessert. There shed potatoes noted on the h., a CNA walked into the picked up his tray and walked ssist or feed him or offer any						
	On 3/24/21 at 12:30	) p.m., the resident was						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	A. BUILDING <u>00</u> B. WING			(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP C IEFFIELD AVE IN 46311	CODE		
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A	HOULD BE	(X5) COMPLETIC	
TAG	served his lunch tray over noodles, mixed He was not served f The record for Resid 3/23/21 at 1:05 p.m on 10/14/20. Diagn limited to, dysphagi A Significant Chang assessment, dated 2 was not alert and or with set up for eatin pounds with no curr The Care Plan, date resident required a to was currently under disease. The nursin available substitutes with the food being with meals prn (as r Physician's Orders,	dated 12/5/20, indicated	TAG	DEFICIENCY)		DATE	
	serve a mechanical and thin liquids. Pr breakfast, and fortif The resident's curre pounds. The reside	soft diet with ground meat, ovide super cereal at ied mashed potatoes at lunch. nt weight on 3/9/21 was 128 nt weighed 145 pounds on					
	8:19 p.m., indicated and was currently re diet with ground me cereal at breakfast a	an's Note, dated 3/11/21 at the resident was on hospice ecceiving a mechanical soft eat. He was receiving super nd fortified mashed potatoes ent presented with 6.6%					

ENTERS FO	R MEDICARE & MEDIC	AID SERVICES				(	OMB NO. 0938-039	
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	A. I	MULTIPLE CO BUILDING VING	DNSTRUCTION 00	COM	(X3) DATE SURVEY COMPLETED 03/25/2021	
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZI	P CODE		
DYER N	URSING AND REH	ABILITATION CENTER			IEFFIELD AVE IN 46311			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE IE APPROPRIATE	(X5) COMPLETIO	
TAG		LISC IDENTIFYING INFORMATION) tion logs for 2/2021 and ows:		TAG	DEFICIENCY		DATE	
	- No documentation 3/7, 3/8, 3/11, 3/18	1 of breakfast on 2/11, 2/16, , and 3/20/21.						
	- No documentation 3/7, 3/8, 3/11, 3/18	n of lunch on 2/11, 2/16, 3/4, , and 3/20/21.						
		n of dinner on 2/1, 2/2, 2/5, 5, 2/19, 2/27-2/28, 3/1, 3/4, 1, 3/21, and 3/23/21.						
	3/24/21 at 3:30 p.m. should have receive	Director of Nursing on , indicated the resident ed the fortified mashed and the meal consumption te.						
	This Federal tag rel IN00343183 and IN	-						
	3.1-46(a)(1)							
<sup>-</sup> 0693 SS=D Bldg. 00	§483.25(g)(4)-(5) (Includes naso-ga tubes, both percu gastrostomy and jejunostomy, and	estric and gastrostomy taneous endoscopic percutaneous endoscopic enteral fluids). Based on a hensive assessment, the						
	to eat enough alo fed by enteral me							

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 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 03/25/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 601 SHEFFIELD AVE DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) DATE §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. F 693 Based on record review and interview, the F 0693 04/02/2021 facility failed to ensure a resident received **Tube Feeding** Management/Restore Eating adequate hydration and nutrition through enteral feedings related to water flushes not being Skills administered as ordered by the Physician for 1 of What corrective action(s) will be accomplished for those 5 residents reviewed for nutrition. (Resident C) residents found to be affected by the alleged deficient Finding includes: practice; The closed record for Resident C was reviewed on 3/24/21 at 1:48 p.m. The resident was Resident C is no longer at facility. No corrective actions can be admitted to the facility on 3/3/20 and discharged on 4/15/20. Diagnoses included, but were not made. limited to, tracheostomy, stroke, chronic respiratory How will the facility identify other residents who have the potential to failure, anemia, and acute kidney failure. be affected by the same alleged The Admission Minimum Data Set (MDS) deficient practice? assessment, dated 3/9/20, indicated the resident All facility residents with orders for had short and long term memory problems and was severely impaired for decision making. The tube feedings flushes have the resident was dependent on staff for all of her potential to be affected by the activities of daily living and had a feeding tube. same deficient practice. Residents with orders for tube feeding flushes were audited. No Physician's Orders, dated 3/3/20, indicated the resident was NPO (nothing by mouth). The concerns were noted. resident was to receive an enteral feeding of Jevity 1.2 at 55 cubic centimeters (cc) What corrective measures will continuously with a water flush of 200 cc every 6 the facility take or will the hours. facility alter to ensure that the problem will not occur?

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

Event ID:

YUW811 Facility II

Facility ID: 000125

If continuation sheet

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PRINTED:

04/14/2021

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENT

ARTMENT OF HEALTH AND HU	FORM APPROVED OMB NO. 0938-0391				
STATEMENT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPL A. BUILDING B. WING	<u></u>		
JAME OF PROVIDER OR SUPPLIE	R		ET ADDRESS, CITY, STATE, ZIP COD SHEFFIELD AVE	Е	
OYER NURSING AND REH	ABILITATION CENTER	DYE	R, IN 46311		
X4) ID SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)	
	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPF DEFICIENCY)		
<ul> <li>Physician's Orders, general water flush bolus feeding.</li> <li>The Medication Ac dated 3/2020, indic not signed out as bo 3/3-3/18/20. The v out as being admin 6 p.m., 3/22 at 12 p 3/24-3/27 at 6 p.m.</li> <li>The MAR, dated 4, flushes were not signed on 4/150 cc water flush administered on 4/4/13/20 at 3 p.m.</li> <li>Interview with the 3/24/21 at 3:30 p.m were not signed out</li> </ul>	, dated 4/7/20, indicated a of 150 cc times 5, daily with dministration Record (MAR), cated the water flushes were eing administered vater flushes were not signed istered on 3/21 at 12 p.m., and p.m., 3/23 at 12 p.m., , and 3/31 at 6 p.m. /2020, indicated the water gned out as being 1 at 6 p.m., 4/6 at 12 p.m. The was not signed out as being 10 at 3 and 8 p.m., and on Director of Nursing on n., indicated the water flushes t as being administered and mentation of the water flushes Luntil 3/19/20.		Licensed nurses and Q.M were in serviced on: Ensuring residents adequate hydration/nutrit related to water flushes. Following Physiciar related to enteral feeding water flushes. Documentation of tube feed flushes for residents with feedings. Documented of tube feeding flushes on the me administration record as of What quality assurance will be implemented to r facility performance to e corrections are achieved permanent? The DON/designee will re residents with orders for the feeding flushes weekly for months to ensure that the flushes are documented of medication administration as ordered. The DON/designee will p summary of the audits to committee monthly for 6 of Thereafter, if determined QA committee, auditing a	A.A's receive ion n orders and he eding tube e edication ordered. plans monitor ensure d and eview 5 tube ir 6 e water on the n record present a the QA months. by the	

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

Event ID:

YUW811 Facility ID: 000125

If continuation sheet

meeting. Monitoring will be

ongoing.

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í	ULTIPLE C UILDING	ONSTRUCTION 00	(X3) DATE SURVE COMPLETED		
		155220	B. W	ING	<u>.</u>	03/2	03/25/2021	
NAME OF	PROVIDER OR SUPPLIE	ŪR.			ADDRESS, CITY, STATE, ZIP	CODE		
DYER N	URSING AND REF	ABILITATION CENTER			HEFFIELD AVE , IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)	
PREFIX	-	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	E APPROPRIATE	COMPLETIO	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
					Date of Completion: 2021	April 2,		
R 0000								
Bldg. 00			RO	000	Please accept the fol facility's plan of corre- plan of correction do constitute an admiss liability by the facility submitted only in res regulatory requireme facility would like to r desk review.	ection. This es not ion of guilt or and is ponse to the nt. The		
	Complaint IN0034 Federal/state defic	13183: Substantiated. iencies related to the ed at F580 and F692.						
	Federal/state defic	13626: Substantiated. iencies related to the ed at F561 and F677						
	-	13747: Substantiated. iencies related to the ed at F692.						
		4105: Substantiated. iencies related to the						

	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE C A. BUILDING B. WING	CONSTRUCTION (X 00	(X3) DATE SURVEY COMPLETED 03/25/2021	
	PROVIDER OR SUPPLIE	R ABILITATION CENTER	601 SI	ADDRESS, CITY, STATE, ZIP CODE HEFFIELD AVE , IN 46311		
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) d at F580, F684 and F689.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIO DATE	
	deficiencies related	7980: Substantiated. No to the allegations were cited. ch 22, 23, 24, and 25, 2021.				
	Facility number: 00 Residential Census These State Reside accordance with 41	: 35 ntial Findings are cited in				
t 0350 Bldg. 00	<ul> <li>(b) Clinical record discharge:</li> <li>(1) for a minimum the facility and five (2) for a minor, un age.</li> </ul>	1(b)(1-2) Noncomformance is must be retained after period of one (1) year in e (5) years total; or ntil twenty-one (21) years of	R 0350	R 350	04/02/202	
<ul> <li>Based on record review and interview, the facility failed to ensure clinical records were maintained after discharge for 1 of 2 closed records reviewed. (Resident T)</li> <li>Finding includes:</li> <li>The closed record for Resident T was reviewed on 3/24/21 at 3:15 p.m. Diagnoses included, but were not limited to, Parkinson's, hypertension, obsessive compulsive disorder, schizophrenia, and bipolar disorder. The resident was admitted to the facility on 1/5/21 and discharged on 1/13/21.</li> <li>Nurses' Notes, dated 1/13/21 at 9:30 a.m.,</li> </ul>			Clinical Records Nonconformance What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident T no longer resides in the facility. The facility has reached out to Resident T and Resident T's emergency contact and requested the original copy			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED:	04/14/2021
FORM AP	PROVED
OMB NO.	0938-0391

AND PLAN	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	A. BUILDING B. WING	<u>00</u>	completed 03/25/2021
	PROVIDER OR SUPPLIE	R IABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE HEFFIELD AVE IN 46311	
(X4) ID PREFIX	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIC
TAG	indicated the reside	R LSC IDENTIFYING INFORMATION) ent's personal belongings and given to him upon discharge as	TAG	medication administration record The original has not been returne to facility.	
	Administration Ref for review. Interview with the on 3/25/21 at 9:30 January MAR coul it may have been so Interview with the 1:30 p.m., indicate Attorney (POA) w. MAR was sent wit	hary 2021 Medication cord (MAR) was not available Health Services Coordinator a.m., indicated the resident's id not be found. She indicated ent with the resident. Administrator on 3/25/21 at d the resident's Power of as contacted and the original h the resident. The cated a copy should have been		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 deficien practice. What measures will be put into place or what systemic changes will be made to ensure	t
	made for the reside kept the original fo	ent and the facility should have orm. tial Finding relates to		that the deficient practice does not recur; Licensed nurses were in-service on: Medication Administration Record will be available for revie	d
				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 The Sheffield director will audit 5	; ;
				The Shenleid director will addit of resident's MARs weekly for 6 months to ensure they remain pa of residents' medical charts. The Nursing Director/designee w present a summary of the audits	art /ill
				to the Quality Assurance	

	OF HEALTH AND HU MEDICARE & MEDIC				FORM APPROV OMB NO. 0938-0
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CO A. BUILDING B. WING	DNSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/25/2021
	ROVIDER OR SUPPLIE	R ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROF TAG DEFICIENCY)		IATE (X5) COMPLETI DATE
				Committee monthly for 6 mor Thereafter, if determined by t Quality Assurance committee auditing and monitoring will b done quarterly and present quarterly at the QA meeting. Monitoring will be ongoing.	he e,
				Date of Completion: April 2, 2021	

Event ID: YUW811 Facility ID: 000125 If continuation sheet Page 27 of 27