CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-039	
STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED	
		155220	B. WING		01/06/2023	
		100220			01/00/2020	
NAME OF P	ROVIDER OR SUPPLIER	3		ADDRESS, CITY, STATE, ZIP COD		
		-		IEFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER	DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		(X5)	
PREFIX		ICY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG	·	R LSC IDENTIFYING INFORMATION	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 0000						
Bldg. 00						
Diag. 00			F 0000	The facility kindly requests a c	lack	
	This visit was for a	Post Survey Revisit (PSR) to	1 0000	review.	icsk	
		and State Licensure Survey		Teview.		
	and the Investigation of Complaints IN00392424,					
	IN00392575, and IN00392985 completed on 11/22/22.					
	11/22/22.					
	This visit was done	in conjunction with the				
	This visit was done in conjunction with the Investigation of Complaint IN00395443.					
	investigation of Col	inpianit 11100393443.				
	Complaint IN00392424 - Not Corrected.					
	Complaint IN00392	2575 - Not Corrected.				
	Complaint IN00392	2985 - Corrected.				
	Complaint IN00305	5443 - Substantiated.				
	•	encies related to the				
	allegations are cited					
	unegations are ence	<i>a t</i> 10//.				
	Survey dates: Janua	ary 5 and 6, 2023.				
	Facility number: 00	00125				
	Provider number: 1.					
	AIM number: 1002					
	Census Bed Type:					
	SNF/NF: 112					
	Residential: 35					
	Total: 147					
	•					
	Census Payor Type	:				
	Medicare: 14					
	Medicaid: 76					
	Other: 22					
	Total: 112					

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

TITLE (X6) DATE

Natalie Porcaro Administrator 01/27/2023

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

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	VT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE C A. BUILDING B. WING	onstruction <u>00</u>	(X3) DATE SURVEY COMPLETED 01/06/2023
	PROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F 0677		eflect State Findings cited in 0 IAC 16.2-3.1.			
SS=D Bldg. 00	ADL Care Provide §483.24(a)(2) A re carry out activities necessary service	d for Dependent Residents esident who is unable to of daily living receives the s to maintain good g, and personal and oral			
	Based on record reversal failed to ensure dependent with Activities of Detwice a week shower residents reviewed for Finding includes: Resident B's closed at 9:41 a.m. Diagnol limited to, anxiety of high blood pressure. The Discharge Miniansessment, dated 1 was cognitively into the December 2022 indicated the resident following days: - 12/12/22 - 12/22/22 - 12/29/22 Interview with the I	amum Data Set (MDS) 2/13/22, indicated the resident act for daily decision making. Bath and Skin Report Sheets art received bed baths on the Director of Nursing on 1/6/23 at	F 0677	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 be has been provided twice week Resident B was assessed, upon return from the hospital, and no adverse effects were noted. How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be	an y the n
	_	she was unable to provide any on related to at least twice a		what corrective action will be taken;	e

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

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDING <u>00</u>			COMPLETED	
		155220	B. W	ING		01/06/2023	
				STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF P	PROVIDER OR SUPPLIEF	2			EFFIELD AVE		
DYER NII	IRSING AND REH	ABILITATION CENTER			IN 46311		
DILIVING	SKOING AND KELL	ADEITATION CENTER		DILIX,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	•	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		N
TAG		R LSC IDENTIFYING INFORMATION	1	TAG	DEFICIENCY)	DATE	
	week bed baths being	ng given for the resident.			Residents dependent on ADLs		
					have the potential to be affect	ed	
		s cited on 11/22/22. The facility			by the same alleged deficient		
	failed to implement a systemic plan of correction				practice.		
	to prevent recurrence	ce.			What measures will be put in	to	
	24 204 375				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		
					washing, regular showers or b		
					baths per resident's plan of ca	re.	
					Showers/bed bath master		
					schedule was reviewed to ens		
					all resident beds have assigned	d	
					shower/bed bath days twice		
					weekly.	.,	
					Wound care coordinator will ve	-	
					showers/bed baths were provi	aea	
					daily according to master		
					schedule and any refusals we	e	
					documented accordingly.	hiro	
					Education provided in all new		
					orientation and agency orienta	iuOH.	
					How the corrective action(s) will be monitored to ensure t	ho	
					deficient practice will not	116	
					recur, i.e., what quality		
					assurance programs will be	out	
					into place;	, ut	
					DON/designee will randomly		
					observe 10 residents three time	100	
					weekly, with a focus on depen		
					residents, to ensure that they		
					receiving assistance with ADL		
					care including grooming, hair		
			1		Lears including grounding, fiall	1	

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

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

AND PLAN OF		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MUI A. BUII B. WIN	LDING	nstruction <u>00</u>	(X3) DATE COMPL 01/06/	ETED
	VIDER OR SUPPLIER	ABILITATION CENTER		601 SHE	DDRESS, CITY, STATE, ZIP COD EFFIELD AVE N 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
F 0758 SS=D Bldg. 00 \$ d w d tr (i) (i) (i) (i)	83.45(c)(3)(e)(1)- Free from Unnec F Jse 483.45(e) Psycho 483.45(c)(3) A ps rug that affects bu rugs include, but the following categ) Anti-psychotic; i) Anti-depressan ii) Anti-anxiety; ar v) Hypnotic Based on a compresident, the facility 483.45(e)(1) Res sychotropic drugs nless the medicar	c(5) Psychotropic Meds/PRN Potropic Drugs. Eychotropic drug is any rain activities associated are not limited to, drugs in pories:			washing, facial hair removal a showers or bed baths are provided. DON/designee will present a summary of the audits to the Quality Assurance committee monthly for 6 months. There if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarter the QA meeting. Monitoring with be on going. Date by which systemic corrections will be completed 1/26/2023	after, g ly at vill	

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u>			COMPLETED	
		155220	B. Wl	ING		01/06/2023		
	PROVIDER OR SUPPLIER	ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID			(X5)	
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE	
	documented in the	e clinical record;						
	§483.45(e)(2) Respoychotropic drug reductions, and be unless clinically of to discontinue the §483.45(e)(3) Respoychotropic drug unless that medical a diagnosed specific documented in the §483.45(e)(4) PRI drugs are limited to provided in §483.45 physician or presonant the provided in §483.45 physician or presonant the PRN order. §483.45(e)(5) PRI drugs are limited to renewed unless the prescribing practite for the appropriate to the appropriate standard to ensure resignate and control of the same record responsibility.	sidents who use s receive gradual dose ehavioral interventions, ontraindicated, in an effort	F 07	758	Dyer Nursing & Rehabilitation 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	s the an / the	01/26/2023	
	_	was reviewed on 1/5/23 at 1:03			response to the regulatory requirement.	1		
	p.m. Diagnoses incl	luded, but were not limited to,			F758 Free from unnecessary			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. B	JILDING	00	COMPLETED
		155220	B. W	ING		01/06/2023
				STREET A	ADDRESS, CITY, STATE, ZIP COD	1
NAME OF I	PROVIDER OR SUPPLIEF	3			EFFIELD AVE	
DYER N	URSING AND REH	ABILITATION CENTER			IN 46311	
(X4) ID	CITAMADY	STATEMENT OF DEFICIENCIE	T	ID	Ī	(V5)
PREFIX		STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
mo		ajor depressive disorder, and	+	ING	psychotropic meds/PRN use	
	insomnia.	agor depressive disorder, and			What corrective action(s) will	
					be accomplished for those	'
	The Quarterly Mini	imum Data Set (MDS)			residents found to have been	ո
		2/12/22, indicated the resident			affected by the deficient	
		act for daily decision making.			practice;	
		ceived insulin, anti-anxiety			Resident 3 - MD aware and or	-der
	medications, and ar	ntidepressant medications daily			received to discontinue	
	for the past seven days.				Olanzapine.	
				Resident 3 assessed and no		
	A Physician's Order, dated 12/6/22, indicated				adverse reaction noted to the	
	paroxetine (an antidepressant medication) 10				administration of Olanzapine.	
	milligrams (mg) tablet once a day.				How the facility will identify	
					other residents having the	
		r, dated 12/8/22, indicated			potential to be affected by the	е
	, and the second	ety medication) 0.25 mg twice a			same deficient practice and	
	day.				what corrective action will be	9
		1 . 1 . 1 . 1 . 1 . 1			taken;	
	-	r, dated 12/29/22, indicated			All Residents receiving	
		psychotic medication) 2.5 mg			psychotropic medications hav	
	tablet once a day for	or agitation.			potential to be affected by the	
	The meaned lealered of	do over outotion related to our			same alleged deficient practic	
	behaviors.	documentation related to any			What measures will be put in	ito
	ochaviors.				place or what systemic changes will be made to	
	Interview with the	Director of Nursing on 1/6/23 at			ensure that the deficient	
		d the resident had not been seen			practice does not recur;	
	_	avioral health services and she			Staff were re-educated on ens	surina
	1 -	dication for use for the			there is an appropriate	3
	olanzapine.				diagnosis/indication for use of	
	_				psychotropic medications. Sta	
	This deficiency was	s cited on 11/22/22. The facility			were also educated on	
	failed to implement	a systemic plan of correction			documenting behaviors after	
	to prevent recurrence	ce.			notifying the physician of the	
					behaviors.	
	3.1-48(a)(4)				Education included in all new	hire
					orientation as well as agency	staff
					orientation.	
					An audit has been conducted	of all
					residents with psychotropic	

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

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/06/2023
	ROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				medication orders to ensure psychotropic medications had adequate Diagnosis /indicatio use. Facility has contracted with nepsychiatric services. How the corrective action(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance programs will be into place; DON/Designee will randomly 10 residents with new psychotropic medications twice weekly to ensure there is an appropriate diagnosis/indication its use, and related behaviors been documented. The Director of Nursing/design will present a summary of the audits to the Quality Assurance committee monthly for 6 monit Thereafter, if determined by the Quality Assurance committee auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be complete 1/26/2023	n for ew the put audit ee on for have nee ee chs. ne
F 0812 SS=E Bldg. 00		e/Prepare/Serve-Sanitary afety requirements.			

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CT ATEL CO.	T OF DEFICIENCIES	V1) PROVIDED (CLIPPLIED (CLIP	(V2) MILLERIN E CO	ONICTRICTION	(V2) DATE CLIDVEY		
	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY		
		IDENTIFICATION NUMBER	A. BUILDING	00	COMPLETED		
		155220	B. WING		01/06/2023		
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD			
DYER NU	JRSING AND REH	ABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION	TAG	DEFICIENCY	DATE		
TAG	§483.60(i)(1) - Pro approved or consifederal, state or logical consistency of the consistency of the consistency of the consumer of the consum	coure food from sources dered satisfactory by cal authorities. de food items obtained producers, subject to nd local laws or does not prohibit or prevent g produce grown in facility o compliance with owing and food-handling does not preclude residents bods not procured by the ore, prepare, distribute and ordance with professional diservice safety. On, record review, and the failed to serve and prepare conditions related to dirty am tables, wire racks, and defect the 111 residents who the kitchen. (The Main Sanitation Tour on 1/6/23 at Assistant Dietary Food wing was observed:	F 0812		on 01/26/2023 Ty s the an y the n		
	b. There was a hear	vy accumulation of burned					

STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. Bl	UILDING	00	COMPLETED	
		155220	B. W	ING		01/06/	/2023
			-	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
NAME OF F	PROVIDER OR SUPPLIEF	R			IEFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
	food and crumbs or	the stove top.			The storage racks that house	d	
	a There was a hear	vy accumulation of burned			clean pots and pans were		
		rease on the inside of both			cleaned. The plastic container the racks that housed clean	's on	
		nd on the inside of the glass				anad	
					utensils and spoons were clea	aneu.	
	doors. There was grease noted on the sides of the ovens. d. There was a heavy accumulation of dried food				The accumulation of burned for	and	
					and crumbs on the stove top		
					cleaned.	WCI C	
				oleaned.			
	spillage and grease on the back splash of the griddle and stove.				The accumulation of burned to	food	
	gradie and sieve.				spillage and grease on the ins		
	e. There was a heavy accumulation of food				of both convection ovens and		
	spillage on the bottom of the steam table.				the inside of the glass doors v		
	-F8				cleaned. The grease noted of		
	f. There was a heav	yy accumulation of dirt, dried			sides of the ovens was cleaned		
		grease on a portable steam					
	table.	•			The accumulation of dried for	od	
	Interview with the	Assistant Dietary Manager at			spillage and grease on the ba	ck	
	that time, indicated	the steam table was not in use			splash of the griddle and stove		
	and not functional.				was cleaned.		
		ty food stained piece of plastic			The accumulation of food sp	illage	
		er. There was a moderate			on the bottom of the steam tal	ble	
		mbs on the stand and around			was cleaned.		
		vn liquid noted inside the					
	bowl.				The accumulation of dirt, dried		
					food spillage, and grease on a		
		Assistant Dietary Food			portable steam table was clea	ned.	
	_	e, indicated all of the above					
	was in need of clear	ning or repair.			The food stained piece of plas		
	The also C (1)				over the stand mixer was clear		
	_	ion weekly audits, indicated			The food crumbs on the stand		
	the following:	floore dirty yes door st			around the bowl and a brown	ııquıd	
		floors dirty-yes, deep clean			noted inside the bowl was		
		sekeeping. Oven dirty-yes			cleaned.		
	scheduled deep clea	nn. : floors-yes deep cleaned with			Phoonix Industrial Classics		
	- week of 12/12/22 machine.	. moors-yes deep creaned with			Phoenix Industrial Cleaning	an	
		: top of stove-cleaned. Flat			services came out to deep cle	all	
	1 11 COR OI 12/1 J/ /./.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BU		JILDING	00	COMPLETED		
		155220	B. WI	NG		01/06/2023
				CTREET	ADDRESS SITU STATE ZID COD	
NAME OF I	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP COD	
DVED NI	LIDOINO AND DELL	ADULTATION OFNITED			IEFFIELD AVE	
DYERN	UKSING AND REH	ABILITATION CENTER		DYEK,	IN 46311	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE
	top-cleaned.				double oven, and wash floor a	ind
	- Week of 12/25/22	2: steamer needs cleaning-yes			baseboard on 1/12/23.	
	cleaned. Table und	er juice machine-yes cleaned.				
	Dish room cleaned				A kitchen sanitation audit was	
					completed on 1/19/23 by the	
		Administrator on 1/6/23 at 10:45			facility's registered dietician w	ith
		Dietary Food Manager has			no findings.	
	been gone for 1 week. Prior to her leaving, she					
		anitation was being completed			How the facility will identify	
		Registered Dietitian had not			other residents having the	
	completed a sanitat	tion tour of the kitchen.			potential to be affected by th	e
					same deficient practice and	
	-	s cited on 11/22/22. The facility			what corrective action will be	9
	^	t a systemic plan of correction			taken;	
	to prevent recurren	ce.				
					All facility residents have the	
	3.1-21(i)(3)				potential to be affected by the	
					same alleged deficient practic	e.
					NA/10-24	.4
					What measures will be put in	ilo
					place or what systemic changes will be made to	
					ensure that the deficient	
					practice does not recur;	
					practice does not recui,	
					Dietary staff have been	
					re-educated regarding, proper	
					cleaning and sanitation of	
					equipment, and drying techniq	jues.
					All new dietary staff will be	
					educated regarding proper	
					cleaning and sanitation of	
					equipment and drying technique	ues.
					All alleged concerns have bee	en
					added to routine dietary clean	ing
					schedule.	
					How the corrective action(s)	
					will be monitored to ensure t	he

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BUILDING B. WING	00 00	COMPLETED 01/06/2023
	ROVIDER OR SUPPLIER JRSING AND REHA	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				deficient practice will not recur, i.e., what quality assurance programs will be into place; Administrator or designee to a sanitation of kitchen area 5 time a week for 6 months. Administrator/designee will present a summary of the audito the Quality Assurance committee monthly for 6 month. Thereafter, if determined by the Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed 1/26/2023	its hs.
F 0921 SS=E Bldg. 00	§483.90(i) Other E The facility must p sanitary, and comf residents, staff and	anitary/Comfortable Environ Environmental Conditions rovide a safe, functional, fortable environment for d the public. on, record review and	E 0021	Duar Nursing ⁹ Bahahilitatio	01/26/2022
	interview, the facilit area was clean and i floors, dirty trash ca up on the floors and	ny failed to ensure the kitchen n good repair related to dirty ns, lime build up, food build baseboards, and food r 1 of 1 kitchen areas. (The	F 0921	Please accept the following as facility's credible allegation of compliance. This plan of correction does not constitute	s the

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Event ID:

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	UILDING	COMPLETED		
		155220	B. W	ING	01/06/2023		
		1		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	R			IEFFIELD AVE		
DAED VII	IRSING AND DEL	ABILITATION CENTER			IN 46311		
DIEKIN	ONOTING AND RED.	ADILITATION CENTER		DIER,			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		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	TE COMPLETION	1
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)	DATE	
	Main Kitchen.)				admission of guilt or liability by		
					facility and is submitted only ir	1	
	Findings include: During the Kitchen Sanitation Tour on 1/6/23 at				response to the regulatory		
					requirement.		
					F921		
	9:45 a.m. with the Assistant Dietary Food				Safe/Functional/Sanitary/Cor	nf	
	Manager, the follow	wing was observed:			ortable Environment		
					What corrective action(s) wil	I	
	a. The white PVC pipes under the dish machine				be accomplished for those		
	were dirty with drie	ed food spillage.			residents found to have been	1	
					affected by the deficient		
	b. There was a moderate amount of lime build up				practice;		
	on floor under the dish machine and under the				The white PVC pipes under th		
	food prep table.				dish machine were power was	hed	
					and cleaned.		
		derate amount of adhered dirt			The lime build up on floor und		
		e base board in the entire			the dish machine and under th	ie	
	kitchen.				food prep table was cleaned.		
					The adhered dirt and grime ale	ong	
		ll the garbage cans were dirty			the base board in the entire		
	with dried food sub	ostance.			kitchen was cleaned.		
					The outside of all the garbage		
		pipes under a food prep sink			cans were cleaned.		
		od prep sink was not in working			The white PVC pipes under a		
		that way for a very long time.			prep sink were cleaned. The fo		
		dried food spillage and there			prep sink, dried food spillage a		
	was time build up u	anderneath on the floor.			lime build up underneath on t	ne	
	f Thoma 1	rur accommulation of f 1			floor were cleaned.		
		vy accumulation of food under the tables and along the			The food crumbs and debris u		
	wall.	under the tables and along the			the tables and along the wall v	vere	
	waii.				cleaned.		
	Interview with the	Assistant Dietary Manager at			Phoenix Industrial Cleaning services came out to deep cle	on	
		all of the above was in need of				aii	
	cleaning or repair.	an of the above was in need of			the kitchen as follows: stove, double oven, wash floor and		
	cicannig or repair.				baseboard on 1/12/23.		
	The plan of corrects	ion weekly audits, indicated			A kitchen sanitation audit was		
	the following:	ion weekly audits, illulcated					
	_	floors dirty-yes, deep clean			completed on 1/19/23 by the	th	
		isekeeping. Oven dirty-yes			facility's registered dietician w	uı	
	Scheduled with nou	isekeeping. Oven uirty-yes			no findings.	i	

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X.		X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BU	A. BUILDING <u>00</u> COM		COMPL	COMPLETED	
		155220	B. W			01/06/	/2023	
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
				601 SHEFFIELD AVE				
DYER N	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	scheduled deep clea	an.			How the facility will identify			
	- Week of 12/12/22	: floors-yes deep cleaned with			other residents having the			
	machine			potential to be affected by the		е		
	- Week of 12/19/22	: top of stove-cleaned. Flat			same deficient practice and			
	top-cleaned.	•			what corrective action will be	•		
	- Week of 12/25/22	: steamer needs cleaning-yes			taken;			
		er juice machine-yes cleaned.			All residents have the potentia	ıl to		
	Dish room cleaned.	-			be affected by the same allege			
					deficient practice.	=		
	Interview with the	Administrator on 1/6/23 at 10:45			What measures will be put in	ito		
	a.m., indicated the	Dietary Food Manager has			place or what systemic			
		ek. Prior to her leaving, she			changes will be made to			
	-	nitation was being completed			ensure that the deficient			
	in the kitchen. The Registered Dietitian had not				practice does not recur;			
	completed a sanitation tour of the kitchen.				Staff were re-educated on the			
	completed a summation total of the known.				procedure of notifying			
	This deficiency was cited on 11/22/22. The facility				maintenance/environmental			
	failed to implement a systemic plan of correction				services of any necessary			
	to prevent recurrence.				repairs/cleaning needed.			
	l o proveno recurrent				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 t	he		
					deficient practice will not			
					recur, i.e., what quality			
					assurance programs will be	nut		
					into place;	put		
					Environmental services			
					supervisor/Maintenance			
					department/ designee will aud	it 15		
					rooms per week on alternating			
					units for Environmental/cleani			
					issues and maintenance issue	-		
						ა.		
					Any identified issues will be			
					corrected.			
				Dietary Manager/designee wil	l			

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

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

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CO A. BUILDING B. WING	onstruction 00	(X3) DATE SURVEY COMPLETED 01/06/2023		
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	5.112	
				audit the kitchen 5 days a wee for cleanliness and possible ite that need to be addressed. Administrator/designee will present a summary of the aud to the Quality Assurance committee monthly for 6 mont Thereafter, if determined by th Quality Assurance committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going. Date by which systemic corrections will be completed 1/26/2023	ems its hs. he	
R 0000 Bldg. 00						
nug. 00	This visit was for a Post Survey Revisit (PSR) to the State Residential Licensure Survey completed on 11/22/22. This visit included a PSR to the Recertification and State Licensure Survey and the Investigation of Complaints IN00392424, IN00392575, and IN00392985 completed on 11/22/22.		R 0000	The facility kindly requests a d review.	lesk	
		in conjunction with the mplaint IN00395443.				
	•	424 - Not Corrected.				
	_	2575 - Not Corrected.				
	Complaint IN00392					
	Complaint IN00395 Federal/State deficient	443 - Substantiated. encies related to the				

State Form Event ID: JOJW12 Facility ID: 000125 If continuation sheet Page 14 of 18

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA			· ′	DATE SURVEY		
		IDENTIFICATION NUMBER 155220					COMPLETED 01/06/2023	
			Б. ,,		ADDRESS SITE STATE STROOD	01/00/		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE			
DYER NURSING AND REHABILITATION CENTER					IN 46311			
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIE ID PROVIDER'S PLAN OF CORRECTION			(X5)			
PREFIX TAG	*	CY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.TE	COMPLETION DATE	
TAG	allegations are cited	LSC IDENTIFYING INFORMATION 1 at F677.	+	TAG			DATE	
	Survey dates: Janua	ry 5 and 6, 2023.						
	Facility number: 00	0125						
	Residential Census:	35						
	This State Residenti	ial Finding is cited in						
	accordance with 410							
R 0273	410 IAC 16.2-5-5.	1(f)						
		nal Services - Deficiency						
Bldg. 00	(f) All food preparation and serving areas							
	(excluding areas in residents ' units) are maintained in accordance with state and							
	local sanitation and safe food handling							
	standards, including 410 IAC 7-24.							
			R 0	273			01/26/2023	
		on, record review, and		Dyer Nursing & Rehabilitation		on		
	interview, the facility failed to serve and prepare food under sanitary conditions related to dirty food equipment, steam tables, wire racks, and standing mixer for 1 of 1 kitchens observed. This							
					R 273 Food Procurement,			
					Store/ Prepare/Serve-Sanitary			
	•	affect the 35 residents who						
	received food from the kitchen. (The Main				Please accept the following as			
	Kitchen)				facility's credible allegation of			
	Findings include: During the Kitchen Sanitation Tour on 1/6/23 at 9:45 a.m. with the Assistant Dietary Food				compliance. This plan of correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory			
		Manager, the following was observed:			requirement.			
	a. The storage racks that housed clean pots and pans were sticky to touch. The plastic containers							
					What corrective action(s) will	I		
		-			be accomplished for those residents found to have been	,		
	on the racks that housed clean utensils were dirty inside with a dirty spoon noted.				affected by the deficient	•		
	, ,				practice;			
b. There was a heavy accumulation of burned		vy accumulation of burned						

State Form Event ID: JOJW12 Facility ID: 000125 If continuation sheet Page 15 of 18

STATEMENT OF DEFICIENCIES X1		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		COMPL	ETED		
155220		155220	B. WING		01/06/2023			
				OTD FET	ADDRESS SITY STATE ZID COD			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP COD			
DYER NURSING AND REHABILITATION CENTER				601 SHEFFIELD AVE				
DYERNU	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION			TAG	DEFICIENCY)		DATE	
	food and crumbs or	the stove top.			The storage racks that house	t		
		•			clean pots and pans were			
	c. There was a heav	vy accumulation of burned			cleaned. The plastic container	s on		
		rease on the inside of both			the racks that housed clean			
		nd on the inside of the glass			utensils and spoons were clea	ned		
		rease noted on the sides of						
	the ovens.				The accumulation of burned for	nod		
					and crumbs on the stove top v			
	d There was a hear	vy accumulation of dried food			cleaned.	1010		
		on the back splash of the			oleaned.			
	griddle and stove.	on the outer spinsh of the			The accumulation of burned f	hood		
	gridate and stove.				spillage and grease on the ins			
	e There was a heav	vy accumulation of food			of both convection ovens and			
		-			the inside of the glass doors w			
	spillage on the bottom of the steam table.				_			
	f. There was a heavy accumulation of dirt, dried				cleaned. The grease noted or sides of the ovens was cleane			
		rease on a portable steam			sides of the overts was cleane	eu.		
	table.	rease on a portable steam			The communication of duical for	ام		
		Assistant Distant Managan at			The accumulation of dried for			
		Assistant Dietary Manager at			spillage and grease on the ba			
	and not functional.	the steam table was not in use			splash of the griddle and stove	9		
	and not functional.				was cleaned.			
	a There was a dir	ty food stained piece of plastic			The accumulation of food spi	illago		
		r. There was a moderate			on the bottom of the steam tal	•		
		mbs on the stand and around			was cleaned.	JIE		
		vn liquid noted inside the			was clearied.			
	bowl.	vii fiquid floted flistae the			The accumulation of dirt, dried	1		
	OOWI.				food spillage, and grease on a			
	Interview with the	Assistant Dietary Food			portable steam table was clea			
		e, indicated all of the above			portable steam table was clea	neu.		
	was in need of clear				The feed steined piece of place	tio		
	was in need of clear	ming of Tepair.			The food stained piece of plas over the stand mixer was clea			
	The plan of somest	on weekly audits, indicated			The food crumbs on the stand			
	the following:	ion weekly audits, mulcated						
	_	floors dirty you door along			around the bowl and a brown	ııquıd		
		floors dirty-yes, deep clean			noted inside the bowl was			
		sekeeping. Oven dirty-yes			cleaned.			
	scheduled deep clea				51			
		: floors-yes deep cleaned with			Phoenix Industrial Cleaning			
	machine.				services came out to deep cle	an		
- Week of 12/19/22: top of stove-cleaned. Flat				the kitchen as follows: stove,				

State Form 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 APPROVED OMB NO. 0938-039

AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		A. BUILDING B. WING	00	COMPLETED 01/06/2023		
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE	
		steamer needs cleaning-yes r juice machine-yes cleaned.		double oven, wash floor and baseboard on 1/12/23. A kitchen sanitation audit was		
	a.m., indicated the I been gone for 1 wee	Administrator on 1/6/23 at 10:45 Dietary Food Manager has ek. Prior to her leaving, she		completed on 1/19/23 by the facility's registered dietician w no findings.	ith	
	was making sure sanitation was being completed in the kitchen. The Registered Dietitian had not completed a sanitation tour of the kitchen.			How the facility will identify other residents having the potential to be affected by the same deficient practice and		
		cited on 11/22/22. The facility a systemic plan of correction e.		what corrective action will be taken; All facility residents have the	9	
				potential to be affected by the same alleged deficient practic What measures will be put ir	e	
				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 technic		
				All new dietary staff will be educated on proper cleaning and sanitation of equipment and drying techniques. All alleged concerns have bee added to routine dietary clean schedule.	en	
				How the corrective action(s) will be monitored to ensure to		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

CENTERS FOR	EN TERS FOR MEDICARE & MEDICAID SERVICES UNID NO. 0936-039								
STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY				
AND PLAN OF CORRECTION IDENTIFICATION NUMBER		IDENTIFICATION NUMBER	A. BUILDING <u>00</u>		00	COMPLETED			
155220		B. W	ING		01/06/	2023			
				CTREET	ADDRESS CITY STATE ZID COD				
NAME OF P	ROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP COD						
DVED NI	IDOINO AND DELL	ADULTATION OFNITED	601 SHEFFIELD AVE						
DYER NURSING AND REHABILITATION CENTER			DYER, IN 46311						
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID PROVIDER'S BLANGE CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	TE	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE		
		_			deficient practice will not				
					recur, i.e., what quality				
					assurance programs will be	put			
					into place;	'			
					Administrator or designee to a	udit			
					sanitation of kitchen area 5 tim				
					a week for 6 months.				
					Administrator/designee will				
					present a summary of the aud	its			
					to the Quality Assurance				
				committee monthly for 6 month	hs				
					Thereafter, if determined by the				
					Quality Assurance committee,				
					auditing and monitoring will be				
					done quarterly and present	<i>;</i>			
					quarterly at the QA meeting.				
					1				
					Monitoring will be on going.				
					Date by which systemic	.d.			
					corrections will be completed	a:			
					1/26/2023				
			1				ĺ		

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