STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. 10770 Based on observation, record review and interview, the facility failed to ensure dependent residents were assisted out of bed for 1 of 4 residents reviewed for activities of daily living (ADLs). (Resident G) Finding includes: On 1/30/22 At 11:50 a.m., Resident G was observed in bed dressed in a hospital gown. Interview with the resident indicated he had been in bed and was not asked if he wanted to get up. The resident indicated he was in bed all day on Saturday 1/29/22 as well. On 1/30/22 at 1:00 p.m., the resident remained in bed and was still dressed in a hospital gown. The resident was still in bed at 1:30 p.m. The record for Resident G was reviewed on 1/31/22 at 11:10 a.m. Diagnoses included, but were not limited to, major depressive disorder, PTSD, high blood pressure, and weakness. The Quarterly Minimum Data Set (MDS) assessment, dated 12/8/21, indicated the resident was cognitively intact. The resident was an extensive assist with a 2 person physical assist with bed mobility and transfers. The resident was an extensive assist with a 1 person physical assist for dressing. A Care Plan, dated 6/17/21, indicated the resident preferred to be up at 6 a.m. and for all meals. A Care Plan, dated 12/13/19, indicated the resident will display rejection of care for showers. The approaches were staff to allow the resident to make decisions regarding the scheduling of their care, for example showers, therapy, wakening hours and bedtime hours. A Care Plan, dated 10/6/19, indicated the resident was limited in functional status in regards to the ability to transfer self. The resident required weight bearing assist and used a hoyer lift. The Point of Care responses for transfers and getting out of bed indicated the resident was out of bed on 1/1, 1/6, 1/14, 1/19, 1/24, 1/25, 1/26, and 1/28/22. The activity did not occur on 1/10, 1/11, 1/13, 1/20, 1/23, 1/22, 1/27, and 1/31/22. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview with the Assistant Director of Nursing on 2/1/22 at 2:03 p.m., indicated the resident does refuse sometimes to get up, but that should be documented. The resident should have been assisted out of bed, it that was what he wanted. This Federal tag relates to Complaints IN00365165, IN00368649, IN00371602, and IN00371776 3.1-38(a)(2)(B)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review and interview, the facility failed to ensure orders were obtained for urinary catheters, urinary output was monitored, and catheter care was completed for 3 of 3 residents reviewed for urinary catheter use. (Residents Q, J, and E) Findings include: 1. On 1/31/22 at 1:38 p.m., Resident Q was observed in her room in bed sleeping. The resident did not have a urinary catheter in use. The record for Resident Q was reviewed on 2/1/22 at 11:28 a.m. Diagnoses included, but were not limited to, dementia with behavior disturbance, COVID-19, pneumonia, and altered mental status. The Admission Minimum Data Set (MDS) assessment, dated 11/24/21, indicated the resident was cognitively impaired for daily decision making and required extensive assistance for toilet use. She did not have a urinary catheter and she was always incontinent of urine. There was no Care Plan related to having a urinary catheter. Nurses' Notes, dated 1/15/22 at 4:02 p.m., indicated the resident returned to the facility via transport service with 2 attendants. All assessments were completed and all orders were entered. She was alert and oriented to person with confusion, needed 1-2 assist with all ADLs and was incontinent of bowel and bladder. The resident had a 16 french foley (urinary) catheter in use that was draining amber urine. There was no Physician's Order for the foley catheter and catheter care. A Physician's Order, dated 1/21/22, indicated the resident was to have a foley catheter (no size listed) and catheter care every shift. The January 2022 Treatment Administration Record (TAR), indicated catheter care had not been signed out as being completed for the following dates: Day shift: 1/22, 1/23, 1/24, 1/26, and 1/29/22 Evening shift: 1/21, 1/24, 1/29, and 1/30/22 Night shift: 1/24, 1/25, 1/29, 1/30, and 1/31/22 Nurses' Notes, dated 1/31/22 at 7:38 a.m., indicated orders were received from the Physician to discontinue the foley catheter. Interview with the Assistant Director of Nursing on 2/1/22 at 2:30 p.m., indicated there was a delay in obtaining a Physician's Order for the foley catheter and catheter care was not consistently documented as being completed. She also indicated there was no diagnosis to support the use of the catheter. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	10770 2. On 1/31/21 at 10:45 a.m., Resident J was observed in bed. The resident had a foley catheter hanging on the side of the bed draining yellow urine. The record for Resident J was reviewed on 1/31/22 at 12:06 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, pressure ulcers, high blood pressure, type 2 diabetes, anemia, and benign prostatic hyperplasia. The Admission Minimum Data set (MDS) assessment, dated 1/24/22, indicated the resident was cognitively intact, and was an extensive assist with a 2 person physical assist for bed mobility. The Resident has a foley catheter and was always continent of bowel and bladder. He had unhealed pressure ulcers from Stage 2 to 4, unstageable and deep tissue injuries. A Care Plan, dated 1/19/22, indicated the resident required an indwelling urinary catheter related to pressure ulcers. The approaches were to document urinary output every shift and record the amount, type, color, and odor. Physician's Orders, dated 1/18/22, indicated catheter care every shift for 16 FR (French) indwelling foley catheter due to sacral wound. Change urinary bag as needed. The Treatment Administration Record (TAR) for 1/2022 indicated foley catheter care had not signed out as completed and all shifts/days were blank. There was no documentation of any urinary output since admission. Interview with CNA 3 on 1/31/22 at 2:50 p.m., indicated she emptied the resident's foley catheter once or twice a shift depending on how full it was. She emptied the urine in a clear container and informed the nurse how much was in the foley catheter. She had not documented any urine output in the computer. Interview with the Director of Nursing on 2/1/22 at 2:05 p.m., indicated catheter care was to be done every shift and urinary output was to be monitored, documented, and recorded only if there was a Physician's Order. Interview with the Nurse Consultant on 2/1/22 at 3:10 p.m., indicated the urine output was to be monitored per the facility's policy for all residents with indwelling foley catheters. The current and revised 9/2005 Urinary Catheter Care policy, provided by the Nurse Consultant on 2/1/22 at 3:10 p.m., indicated maintain an accurate record of the resident's daily output per facility policy and procedure. 32788 3. Resident E's closed record was reviewed on 1/31/22 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and anemia. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Significant Change MDS assessment, dated 9/28/21, indicated the resident required an extensive assist of one with personal hygiene and toilet use. A Care Plan indicated the resident required an indwelling urinary catheter. The nursing interventions included, .measure and record intake and output per facility protocol .provide assistance for catheter care . provide catheter care as ordered and as needed . A Physician's Order, dated 8/2021, indicated to complete catheter care every shift. The Medication Administration Record (MAR), dated 10/2021, indicated the catheter care had not been signed out as completed on the following shifts: -Day shift on 10/3/21, 10/4/21, 10/8/21, 10/12/21, 10/15/21, 10/16/21, 10/18/21, 10/19/21, 10/20/21, and 10/30/21. -Evening shift on 10/5/21, 10/9/21, 10/11/21, 10/12/21, 10/13/21, 10/25/21, 10/27/21, and 10/31/21. -Night shift on 10/13/21 and 10/31/21. The urine output documentation, dated 10/2021 through 11/2021, indicated the output had only been recorded on 10/6/21, 10/9/21, and 10/25/21. Interview with the Director of Nursing (DON) on 2/1/22 at 1:56 p.m., indicated the care should have been signed off on the MAR when it was completed. The urine output would only be documented if the resident had a Physician's Order to measure intake and output (I&O). This Federal tag relates to Complaint IN00368649. 3.1-41(a)(1) 3.1-41(a)(2)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on record review and interview, the facility failed to consistently monitor food and fluid intake for at risk residents which resulted in hospitalization for dehydration for 2 of 3 residents reviewed for a change in condition. (Residents D and H) Findings include: 1. The closed record for Resident D was reviewed on 2/1/22 at 8:53 a.m. Diagnoses included, but were not limited to, vascular dementia without behavior disturbance, dysphagia (difficulty swallowing), major depressive disorder, and muscle weakness. The resident was admitted to the facility on [DATE]. The Admission Minimum Data Set (MDS) assessment, dated 11/3/21, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. She needed extensive assistance with eating and received a mechanically altered diet. The Care Plan, dated 11/2/21, indicated the resident was limited in functional status in regards to eating and drinking independently. Interventions included, but were not limited to, notify Physician and Responsible Party with any change in condition, observe for and record intake of food and fluids, and provide assistance at the level the resident required. The resident received a mechanical soft diet 11/1 through 11/17/21. A Physician's Order, dated 11/18/21, indicated the resident was to receive a pureed diet with thin liquids and super cereal at breakfast. A Speech Therapy note, dated 11/17/21 at 1:00 p.m., indicated a diet downgrade recommendation to puree consistency as the resident was pocketing food. Nursing and dietary were notified of the change. A Registered Dietitian (RD) Progress Note, dated 11/18/21 at 3:08 p.m., indicated the resident's weights were reviewed and she had lost approximately 4.6 pounds over the past 9 days. Collaborated with speech therapy, resident was recently downgraded to puree textures. Resident with poor oral intake per food consumption records, typically less than 50% of most meals. Super cereal at breakfast was recommended and to continue with weekly weights. Nurses' Notes, dated 11/24/21 at 8:54 a.m., indicated the resident had a poor appetite that morning for breakfast and was resting in bed at the time. The next entry in the progress notes was completed by the Physician on 11/25/21 at 9:06 p.m., and indicated the resident was confused and suffered from severe dementia. He also indicated she needed to be assisted with feeding and to encourage oral intake. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	The Food and Fluid Intake Sheets for the month of November 2021, indicated no meal intake was documented for 11/11, 11/14, 11/20, 11/21, and no breakfast or lunch on 11/22/21. The resident did not consume any breakfast or lunch on 11/25/21 and there was no documentation for dinner. The resident's average food consumption was 1-25% on days documentation was completed. There was no fluid intake documented for 11/11, 11/14, 11/20 and 11/21/21. On 11/18/21 at 9:22 a.m., the resident consumed 236 milliliters (ml) of fluid. At 1:10 p.m., the resident consumed 240 ml of fluid. The next documented entry related to the resident's fluid intake was on 11/23/21 at 9:55 a.m. which was 120 ml. At 12:45 p.m., she also consumed 120 ml. On 11/24/21 at 8:54 a.m., she consumed 100 ml of fluid. On 11/25/21 at 9:08 a.m. and 1:14 p.m., she consumed 120 ml. Nurses' Notes, dated 11/26/21 at 2:50 a.m., indicated the resident was resting in bed with no acute distress noted. The next documented entry at 2:25 p.m., indicated during rounds, the resident appeared lethargic and was nonresponsive to tactile or verbal stimuli. Her blood pressure was 92/62, her pulse was 92, and her respirations were 20. Temperature was 98.1 and her oxygen saturation was 87% on room air. Oxygen was immediately applied. The Physician was in the facility and orders were obtained to send the resident to the emergency room via 911. The emergency room Progress Note, dated 11/26/21 at 3:20 p.m., indicated the resident was being evaluated for altered mental status. The resident was possibly last normal 7 days ago but exact date was unclear. The resident was unable to provide any history at that time. History and review of symptoms was limited secondary to altered mental status. History was obtained from EMS personnel and nursing staff. Upon arrival to the emergency room , the resident's blood pressure was 78/51, pulse 90, and respirations were 28. emergency room laboratory results indicated the resident's white blood cell count was elevated at 18.5, her blood urea nitrogen (BUN) level was elevated at 119 (normal 6-24, an elevated BUN is also indicative of dehydration or malfunctioning kidneys), and her Creatinine (a kidney function test) was elevated at 7.1 (normal level 0.59 to 1.04). The resident's sodium level was elevated at 164 (normal 135-145, elevated sodium levels can be caused by dehydration). The resident was admitted to the hospital with the diagnoses of acute kidney injury, dehydration, hypernatremia (high sodium levels), and leukocytosis (elevated white count). Preadmission laboratory results, dated 9/15/21, indicated the resident's BUN was normal at 18 and her Creatinine was normal at 1.2. Interview with the Nurse Consultant on 2/1/22 at 3:32 p.m., indicated the resident's food and fluid intake should have been monitored more closely. 10770 2. The closed record for Resident H was reviewed on 1/31/22 at 4:50 p.m. The resident was admitted on [DATE] and discharged to the hospital on 1/5/22. Diagnoses included, but were not limited to, stroke, high blood pressure, type 2 diabetes, convulsions, aphasia, altered mental status, slurred speech, and major depressive disorder. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	The Admission Minimum Data Set (MDS) assessment, dated 11/30/21, indicated the resident was alert and oriented and needed extensive assist with a 2 person physical assist for bed mobility. The resident needed extensive assist with a 1 person assist for dressing and personal hygiene, and was totally dependent on staff for toilet use and bathing. A Care Plan, dated 11/25/21, indicated the resident received a diuretic medication and was at risk for dehydration. The approaches were to observe the cardiovascular system and fluid status to determine effectiveness of diuretic therapy for example edema, mental confusion, shortness of breath, abnormal breath sounds, or abnormal heart sounds, observe for and report symptom of dehydration such as dizziness on sitting/standing, change in mental status, decreased urine output, concentrated urine, poor skin turgor, dry, cracked lips, dry mucus membranes, sunken eyes, constipation, fever, or infection. A Care Plan, dated 11/25/21, indicated the resident was limited in functional status in regards to eating and drinking independently. The approaches were to observe and record intake of food and fluids and refer to OT/ST as needed. A NP (Nurse Practitioner) Note, dated 11/26/21, indicated the resident was being seen for a new admission. She presented to the ER (emergency room) with stroke-like symptoms and the MRI demonstrated those findings. The resident was nonverbal and was admitted to the acute rehab at the hospital and then discharged to the facility for further rehab. The assessment and plan for the resident for the seizure disorder was to monitor weekly weights, fluid intake, and provide a low sodium diet. Lab work from the resident's hospital admission of 11/9/21 indicated labs were drawn on 11/24/21 right before the resident was admitted to the facility. Her WBC count (White Blood Cell) was 10.54 (normal 4. 5-11), BUN (Blood Urea Nitrogen, measures the function of the kidneys) was 21 (normal 6-24) and CR (Creatinine, measures the function of the kidneys) was 1.02 (normal 0.7-1.3). The resident weighed 156 on 11/24/21, 148 pounds on 11/30 and 12/2, and 150 on 12/7/21. There was no recorded weight for 1/2022. Meal consumption logs for 12/2021 indicated on 12/28 and 12/29 the resident consumed 76-100% of dinner. On 12/29, the resident consumed 76-100% of lunch. On 12/30 the resident consumed 26-50% of dinner. On 12/31/21 the resident consumed 1-25% for breakfast and lunch and 26-50% for dinner. Meal consumption logs for 1/2022 indicated 1/1-1/3 for all meals, the resident consumed 1-25%. There was no documentation on 1/4/22 of any meal and on 1/5 the resident consumed 1-25% for breakfast. The only fluid intake documented was on 12/28/21 which indicated the resident consumed 240 milliliters of fluid. There was no other documentation of any other oral intake. Physician Orders, dated 11/24/21, indicated furosemide (a diuretic medication) 40 milligrams (mg) daily. There was no therapy ordered for the resident such as PT, OT, or ST. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	A RD (Registered Dietitian) Note, dated 11/28/21 at 1:16 p.m., indicated labs and weight were addressed. The resident was not at risk for malnutrition and recommend a no concentrated and no added salt diet and textures per Physician or speech therapy. The last RD Note was on 12/9/21 at 3:08 p.m., which indicated the resident's weights were stable and to discontinue weekly weights and follow up with monthly weights. A Physician Note, dated 12/17/21 at 3:33 p.m., indicated the resident was seen and had no new complaints. Vital signs were stable and she was seen by dietary. She would like to participate in PT. A Nurses' Note, dated 1/3/22, indicated the resident received a PCR COVID-19 test. The next entry in Nurses' Notes was on 1/5/22 at 1:30 p.m., which indicated Writer called 911 to report change in resident's status. Writer spoke with daughter and made her aware of resident's change in condition. Resident has a change in AMS [altered mental status] resident loss of appetite today, tolerated medications this AM without any difficulty, however resident is very lethargic now. Afebrile, VS [vital signs] abnormal. Resident will be sent out to the hospital to eval [evaluate] and treat. DON [Director of Nursing] is aware. Nurses' Notes, dated 1/5/22 at 1:51 p.m., indicated the Physician was made aware of the resident's change in condition. Nurses' Notes, dated 1/5/22 at 1:52 p.m., indicated the EMT's were present at the resident's bedside. The resident was transferred to the hospital and admitted with acute renal failure and acute encephalopathy. A Physician's Note, dated 1/5/22 at 11:22 p.m., (Recorded as Late Entry on 1/22/22 at 11:24 a.m.) indicated the resident was discharged to the hospital. The resident has been lethargic and had not been doing well and apparently had been dehydrated and not making urine. Discussed with staff will transfer to nearby hospital. Hospital emergency room Notes, dated 1/5/22 at 2:40 p.m., indicated the resident had altered mental status and was last seen normal at 8:30 a.m. at the nursing home. Apparently she was found unresponsive at some point and she cannot talk or open her eyes but can move her eyelids a little bit. She looks clinically dehydrated. Her vital signs were blood pressure 100/63, pulse 115 and oxygen saturation at 92%. Her weight was 137 pounds. Laboratory tests were obtained on 1/5/22 in the hospital and the resident's WBC was 22.5 (a high value), BUN was 103 (a high value) and CR was 5.9 (a high value). The resident was admitted with acute renal failure and acute encephalopathy. A Nephrology consult, dated 1/5/22 at 6:55 p.m., indicated the plan was for aggressive fluids, foley catheter and renal ultrasound. Hospital labs, dated 1/13/22, indicated the resident's BUN was now 17 and the CR was 1.4. There was no documentation from 1/1-1/5/22 regarding the resident's mental status or an assessment of her eating and drinking. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0692 Level of Harm - Actual harm Residents Affected - Few	Interview with the Nurse Consultant on 2/1/22 at 3:10 p.m., indicated there was no documentation from 1/1-1/5/22 regarding the resident's condition of not eating or drinking. The resident's fluid intake was not monitored, nor was her mental status. This Federal tag relates to Complaints IN00368066 and IN00371776. 3.1-46(b)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 32788 Based on record review and interview the facility failed to ensure tracheostomy (a surgically created opening in the neck/trachea) care was completed for 1 of 1 residents reviewed for tracheostomy care. (Resident E) Finding includes: Resident E's closed record was reviewed on 1/31/22 at 10:05 a.m. Diagnoses included, but were not limited to, hypertension, type 2 diabetes mellitus, and anemia. The Significant Change MDS assessment, dated 9/28/21, indicated the resident required an extensive assist of one with personal hygiene and received tracheostomy care. A Care Plan indicated the resident had a tracheostomy and was at risk for adverse consequences. The nursing interventions included the completion of tracheostomy care. A Physician's Order, dated 8/2021, indicated to complete tracheostomy care every shift. The Medication Administration Record (MAR), dated 10/2021, indicated the tracheostomy care had not been signed out as completed on the following shifts: -Day shift on 10/3/21, 10/4/21, 10/6/21, 10/8/21, 10/12/21, 10/14/21, 10/15/21, 10/18/21, 10/19/21, 10/20/21, and 10/22/21. -Evening shift on 10/9/21, 10/11/21, 10/12/21, 10/14/21, 10/27/21, 10/28/21, 10/29/21, and 10/30/21. -Night shift on 10/11/21, 10/17/21, and 10/30/21. Interview with the Director of Nursing (DON) on 2/1/22 at 1:56 p.m., indicated the care should have been signed off on the MAR when it was completed. This Federal tag relates to Complaints IN00368649 and IN00369641. 3.1-47(a)(6)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide medically-related social services to help each resident achieve the highest possible quality of life. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10770 Based on record review and interview, the facility failed to provide medically related social services related to ensuring family requests for therapy were communicated to the appropriate department for authorization for 1 of 3 residents reviewed for therapy services. (Resident H) Finding includes: The closed record for Resident H was reviewed on 1/31/22 at 4:50 p.m. The resident was admitted on [DATE] discharged to the hospital on 1/5/22. Diagnoses included, but were not limited to, stroke, high blood pressure, type 2 diabetes, convulsions, aphasia, altered mental status, slurred speech, and major depressive disorder. The Admission Minimum Data Set (MDS) assessment, dated 11/30/21, indicated the resident was alert and oriented and needed extensive assist with a 2 person physical assist for bed mobility. The resident needed extensive assist with a 1 person assist for dressing and personal hygiene, and was totally dependent on staff for toilet use and bathing. A NP (Nurse Practitioner) Note, dated 11/26/21, indicated the resident was being seen for a new admission. She presented to the ER (emergency room) with stroke-like symptoms and the MRI demonstrated those findings. The resident was non-verbal and was admitted to the acute rehab at the hospital and then discharged to the facility for further rehab. The assessment and plan for the resident for her seizure disorder was to monitor weekly weights, fluid intake, and provide a low sodium diet. There were no Physician's Orders for any type of therapy. Social Service (SS) Notes, dated 11/28/21 at 12:32 p.m., indicated the resident was a new admission. She was alert and oriented and was unsure of her stay at that time. SS to remain available as needed. An SS Note, dated 12/8/2021 at 5:15 p.m., indicated the writer spoke with the resident's daughter, who had requested an update on the resident's therapy sessions. The writer informed her the resident was currently residing at the facility with a payer source of Medicaid and she was not currently receiving therapy. The SS asked if the resident had secondary insurance or Medicare. The daughter believed the resident had Medicare and would go to the resident's apartment located at an assisted living facility to retrieve the insurance card. The daughter was to send the card in and the insurance would be contacted to see if resident had benefits that would allow her to participate in therapy. SS to remain available as needed. An SS Note, dated 12/29/21 at 9:10 a.m., indicated the writer returned the resident's daughter's call and received voicemail. SS left a message with a call back number. SS to remain available as needed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The next and last SS Note was on 12/30/21 at 11:47 a.m., which indicated writer spoke to the resident's daughter concerning resident receiving therapy. SS informed her the Medicare insurance information was received the day prior and was sent to admissions to run for verification. The daughter verbalized understanding. A Physician Note, dated 12/17/21 at 3:33 p.m., indicated the resident was seen and had no new complaints. Vital signs were stable and she was seen by dietary. She would like to participate in PT. The Hospital Face Sheet, dated 11/9/21, indicated the resident's Medicare Advantage insurance number was located under payor source and was scanned in under the resident's documents in the clinical record. The Acute Rehabilitation Facility Discharge Summary Note, dated 11/23/21, indicated physical therapy, speech therapy and occupational therapy were all recommended to be continued at the SNF facility. Interview with the Admissions Coordinator on 2/1/22 at 11:25 a.m., indicated the resident was admitted under Medicaid. The case manager at the hospital and the Physician for the Acute Rehabilitation facility spoke with the insurance company and a peer to peer review was denied. The resident had Medicare Advantage insurance and not the traditional Medicare insurance. The hospital Physician was agreeable to having the resident stay at the hospital for 1 more week if the insurance company would accept that. The case manager had spoken with her on 11/24/21 and they agreed to accept the resident under the secondary insurance of Medicaid as the primary was not approving. The Admission Coordinator indicated the case manager at the hospital informed the resident's daughter of the situation and she was aware of the information and the daughter was in agreement. At the time of admission, when the resident arrived to the facility she had given the therapy department the payor source for the resident and since she was Medicaid, therapy did not pick her up at all during her stay. The family was made aware the resident would not be receiving therapy at the time of admission. Interview with Social Service on 2/1/22 at 11:38 a.m., indicated she had notified the assisted living facility for the insurance information and the director had sent it to her. She gave all the information to admissions to verify and explained the daughter wanted her to have therapy, and that was where her duties stopped. She indicated the daughter kept calling and leaving messages regarding therapy and when was it going to start. She was unaware the insurance information was in the hospital admission paper work under resident documents. Interview with the Admissions Coordinator and the Administrator on 2/1/22 at 11:50 a.m., indicated there was no communication between SS and her department indicating the resident's family wanted to see if the resident qualified for therapy under her Medicare Advantage insurance. The Medicare Advantage insurance number was already in the clinical record from the hospital information at the time of admission. The Admissions Coordinator stated, If the family wanted the facility to run authorization for therapy again, that would not have been a problem, however, I was never informed of that request. Interview with the Social Service Director on 2/1/22 at 1:55 p.m., indicated she unaware of the situation with the resident and the family's request for therapy. This Federal tag relates to Complaint IN00371776. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3.1-34(a)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 10770 Based on observation and interview, the facility failed to serve food under sanitary conditions related to passing uncovered beverages down the hallway to residents in their rooms for 2 of 3 units observed for dining service. This had the potential to affect 66 residents who resided on the [NAME] and Dementia care units. (The [NAME] and Dementia care units) Findings include: 1. During an observation on the [NAME] unit on 1/30/22 at 11:55 a.m., a dietary employee was pushing a tall transportation cart full of lunch trays down to the unit. The trays themselves were not covered and the beverages on the cart were also not covered. At 11:57 a.m. a CNA was observed removing 5 cups of coffee from a crate on top of the [NAME] unit nurses' station. The coffee cups had no lids on them and she carried all five cups of coffee down the hallway to resident rooms. At 12:05 p.m. an enclosed food cart was delivered to the [NAME] unit. There were trays on top of the cart with no lids on the juices. Two staff members removed the trays and passed them to the residents in their rooms without covering the drinks. At 12:10 p.m., the staff on [NAME] unit were observed passing trays with no lids on the juice or coffee cups down the hallway to resident rooms. 2. During an observation of the Dementia Care unit, on 1/30/22 at 12:07 p.m., indicated a CNA was observed passing trays to residents in their rooms. She was removing the trays from a tall transportation cart that was not covered. The beverages on the trays were uncovered. Interview with the CNA at that time, indicated the cart came down to the unit uncovered. Interview with the Administrator on 2/1/22 at 2:05 p.m., indicated dietary carts were to come down to the units with all the food and beverages covered. Lids should have been on the beverages and the tall transportation carts should have been covered with plastic. This Federal tag relates to Complaint IN00365165. 3.1-21(i)(3)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 10326 Based on observation, record review, and interview, the facility failed to ensure infection control guidelines were in place and implemented, including those to prevent and/or contain COVID-19, related to not wearing personal protective equipment (PPE) correctly when entering a transmission based precaution (TBP) isolation room, wearing gloves in the hallway, not completing hand hygiene prior to donning PPE, incorrect mask use by staff and visitors, lack of eye protection during resident contact, and not monitoring residents who were in TBP for COVID-19 or suspected COVID-19 for 1 of 3 residents reviewed for infection control and for 1 of 2 treatments observed. This had the potential to affect 124 residents who resided in the facility. (Residents K, R, S, J, U, and T) Findings include: 1. During a random observation on 1/31/22 at 11:03 a.m., CNA 1 was observed in the hallway charting at the kiosk. He had his N95 mask pulled down below his chin. Interview with the Assistant Director of Nursing on 2/1/22 at 2:30 p.m., indicated the CNA's mask should not have been below his chin. 2. On 1/31/22 at 11:03 a.m., Resident K was observed in his room in bed. He had a kerlix gauze dressing to his left foot which had fresh blood present. At 11:10 a.m., the resident was repositioned in bed by CNA 1. The CNA indicated the resident's dressing was not like that earlier and the blood was fresh. At 11:28 a.m., the treatment nurse indicated the resident was seen by the Wound Care Physician that morning and he had debrided an area on the top of the resident's foot. She donned a gown and a disposable glove to the right hand prior to entering the room. She did not perform hand hygiene prior to donning the personal protective equipment (PPE). She retrieved items from the treatment cart prior to entering the room. When entering the room, she donned the glove to the left hand without completing hand hygiene. The treatment nurse applied a pressure dressing to the resident's left foot. She removed her gloves and proceeded to the bathroom. The resident had dried blood to his left lateral knee at that time and the treatment nurse indicated she was going to clean that area as well. She donned cleaned gloves and cleansed the area with wound cleanser. She removed her gloves, donned new gloves without completing hand hygiene, and proceeded to finish cleaning the knee area. She applied a dry dressing when she was done. At 1:34 p.m., some break through bleeding was observed on the resident's left foot dressing. Interview with the treatment nurse at 3:18 p.m. indicated she had not been back to the unit to check on the resident's foot, but she had called the unit and they indicated his dressing was dry. At 3:20 p.m., the treatment nurse observed the resident's dressing and she indicated she would notify the Wound Care Physician. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 3:42 p.m., the treatment nurse indicated she was going to change the resident's dressing to his left foot. She donned a gown and gloves and entered the resident's room. Again, hand hygiene was not completed prior to donning PPE. Prior to removing the dressing, she applied another pair of gloves over the ones she was already wearing. The resident's dressing was removed. The treatment nurse removed her gloves and applied a new pair of gloves without completing hand hygiene. Calcium alginate pads were applied to the top of the resident's foot and it was wrapped in kerlix gauze with an ace wrap covering the gauze. After completing the treatment, the nurse removed her gown and gloves in the bathroom and washed her hands. Interview with the Assistant Director of Nursing on 2/1/22 at 2:30 p.m., indicated hand hygiene was to be completed prior to and after glove removal. 3. On 1/31/22 at 3:18 p.m., two visitors were observed walking down the main hallway. They were both wearing face shields and masks, however, one of the visitors had her mask below her nose. The Director of Nursing saw the two visitors and the visitor was not educated to pull up her mask. 4. On 1/31/22 at 2:20 p.m., Agency CNA 2 was observed at the [NAME] Unit nurses' station. He donned a pair of disposable gloves at the nurses' station and he proceeded down the hallway and entered a resident's room to provide incontinence care. He did not perform hand hygiene prior to donning the gloves. Interview with the Nurse Consultant on 2/1/22 at 2:30 p.m., indicated the CNA should have performed hand hygiene prior to applying the gloves and gloves were not to be worn in the hallway. 5. On 1/31/22 at 2:25 p.m., Agency CNA 1 was observed going in and out of resident rooms on the [NAME] Unit. She was not wearing a face shield and she had a pair of safety glasses hanging from her scrub top. The CNA had been within 6 feet of each resident. At 2:36 p.m., the MDS Coordinator informed the CNA she needed to wear a face shield when she was in the residents' rooms. Interview with the Nurse Consultant on 2/1/22 at 2:30 p.m., indicated the CNA should have either worn her safety glasses or a face shield when in resident rooms. 6. During a random observation on 2/1/22 at 10:24 a.m., two visitors were in the Memory Care Unit lounge with a female resident. Neither the visitors nor the resident were wearing face masks. Another resident was seated in a chair in the corner at that time. His mask was pulled down below his chin. Interview with the Administrator on 2/1/22 at 2:30 p.m., indicated they were having trouble with some visitors wearing masks and they needed to be reminded. 10770 7. During a random observation on 1/30/22 at 11:35 a.m., the screener at the door allowed 4 visitors to enter. She took their temperature after they had signed in and stated Do you know where you are going? they all said yes and walked down the hallway. There was no instruction given to them as far as personal protective equipment (PPE) and ensuring they all wore their face masks while visiting the resident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:30 p.m., a visitor for Resident R was observed seated in a chair by the resident's bed with her face mask around her neck. The resident was not wearing a face mask. The resident's roommate was observed in his bed with no mask over his face. At 12:34 p.m., CNA 5 walked into the resident's room and picked up his lunch tray. The CNA did not instruct the visitor to put on her face mask over her mouth and nose. At 12:50 p.m., the visitor was still sitting in the chair with no face mask over her mouth and nose. On 1/31/22 at 1:29 p.m., the same visitor was seated in a chair by the resident's bed. Her face mask was pulled down beneath her chin. The resident was not wearing a face mask and the resident's roommate was observed in his bed. 8. On 1/30/22 at 1:25 p.m., a visitor entered Resident S's room wearing a face mask over his nose and mouth. After entering the room, the visitor sat in the resident's bed and removed his face mask. The resident was not wearing a face mask, nor was her roommate who resided in the first bed. Interview with the Administrator on 2/1/22 at 2:05 p.m., indicated the staff were to be monitoring visitors to ensure face masks were being worn while visiting the residents. They also were aware they needed to provide privacy during the visits and signs were posted throughout the facility for visitors to wear their face masks during the visits. The current and revised 11/22/21 IDOH COVID-19 Regulatory Visitation and Activities Guidance for Long-term Care policy indicated Indoor Visitation during an Outbreak (this section only pertains to SNF/NFs facilities required to conduct outbreak testing): When a new case of COVID-19 among residents or staff is identified, a facility should conduct an investigation and begin outbreak testing. - It is safer for visitors to not enter during the outbreak investigation, but they must still be allowed in the facility if the resident wishes to have visitors. The visitors should be made aware of the potential risks and the need to adhere to the core principles of COVID-19 infection prevention. If the visitor chooses to visit, they should wear a face covering (regardless of vaccination status) and visits should be in the resident room. Visitors: If community transmission is substantial to high for the facility, all residents and visitors (regardless of vaccination status) must wear masks and physically distance at all times. 9. During a random observation on 1/30/22 at 11:40 a.m., on East unit, the Wound Nurse and RN 1 were observed talking to one another outside Resident J's room. At that time the Wound Nurse was dressed in full PPE with a gown, gloves, N95 face mask, and face shield on and RN 1 was standing next to her with his face mask below his chin. He pulled up his surgical face mask and walked into the COVID unit with no eye protection on. The Wound Nurse was observed to walk inside the resident's room with all of the PPE on. She positioned the over bed table and touched other items in the room with her gloved hands. She walked out of the room to the treatment cart which was located right outside the room and picked up other items from the cart to change the resident's bandages. The Wound Nurse did not doff any of the PPE and with the same gloved hands walked back into the room and closed the door. 10. During a random observation on 1/30/22 at 11:45 a.m., there were 4 clean linen carts located in the halls on the East unit. All of the covers were lifted up and the clean linen was exposed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	11. During a random observation on 1/30/22 at 11:55 a.m., Agency LPN 1 was observed wearing a face shield that was not fitted snug to her face or forehead. There was a large gap down the center. The LPN was observed walking in and out of resident rooms on the [NAME] unit. At 12:03 p.m., Agency LPN 1 was still observed wearing the wrong face shield. The Agency LPN indicated she was unaware it was the wrong kind of eye protection. Review of the CDC current county positivity rates, indicated the local county was high risk for transmission of COVID-19. The current and updated 11/22/21 IDOH COVID-19 Infection Control Guidance in Long-term Care Facilities policy, indicated All healthcare professionals must wear eye protection for resident care when community transmission is substantial or high. Eye protection should be close to face with no gaps at top, bottom, or sides of eyes. 12. During a random observation on 1/30/22 at 12:01 p.m., CNA 5 was observed to don an isolation gown and clean gloves to both hands to enter Resident U's room. The CNA did not perform hand hygiene prior to donning the gown and gloves. The resident was in contact isolation for C-diff. 13. During a random observation on 1/30/22 at 12:15 p.m., CNA 4 was observed walking down the hall with a lunch tray. She stopped at Resident J's room. The resident had signs on his door that indicated he was in droplet/contact isolation. The CNA was observed to don an isolation gown and clean gloves to both hands. She did not perform hand hygiene before donning the PPE. During a random observation on 1/30/22 at 12:52 p.m., CNA 3 was observed to answer Resident T's call light. She walked out of that room carrying a dirty lunch meal tray and walked into Resident J's room. There was a sign on Resident J's door that indicated he was in droplet/contact isolation. The CNA did not don any PPE prior to entering the room. She picked up his dirty lunch tray and waked out of the room. She did not perform hand hygiene after leaving either room. Interview with the CNA at that time indicated she was aware she did not don PPE before entering the room, she stated I was in a hurry to pick up the lunch trays. The current and updated 11/22/21 IDOH COVID-19 Infection Control Guidance in Long-term Care Facilities policy indicated Hand hygiene [use of alcohol-based hand rub (ABHR) is preferred]: Adherence to strict hand hygiene must continue for all, particularly HCP, including when entering the facility and before and after resident care. ABHR >60% are preferred unless hands are visibly soiled or when handwashing is advocated by CDC guidance. 14. During a random observation on 1/31/22 at 11:39 a.m., CNA 6 was observed walking down the hallway carrying clean linens she just removed from the linen cart up against her body. Interview with the Director of Nursing on 2/1/22 at 2:05 p.m., indicated staff were to be performing hand hygiene before donning PPE to enter a resident's room who was in isolation. Staff were to be wearing the correct eye protection and gowns and gloves were to be doffed before leaving a TBP room. Linens were to be carried away from the body. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. Building B. Wing	02/02/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15. 2. On 1/30/21 at 11:45 a.m., Resident J was observed in bed. There was sign posted on his door that indicated the resident was in droplet/contact isolation. The record for Resident J was reviewed on 1/31/22 at 12:06 p.m. The resident was admitted to the facility on [DATE]. Diagnoses included, but were not limited to, pressure ulcers, high blood pressure, type 2 diabetes, anemia, and benign prostatic hyperplasia. The Admission Minimum Data set (MDS) assessment, dated 1/24/22 indicated the resident was cognitively intact, and was an extensive assist with a 2 person physical assist for bed mobility. The Resident has a foley catheter and was always continent of bowel and bladder. He had unhealed pressure ulcers from Stage 2 to 4, unstageable and deep tissue injuries. A Care Plan, dated 1/19/22, indicated the resident has the need for droplet and contact isolation due to recent hospital admission. Physician's Orders, dated 1/18/22, indicated droplet isolation related to new admission. The COVID-19 symptom assessment was completed on 1/18/22 at 10:58 p.m., 1/28/22 at 3:06 a.m., 1/30/22 at 3:53 a.m., and 1/31/22 at 10:54 a.m. Vital signs were documented on every shift, however, there was no assessment completed of the resident's lungs and breathing status. Interview with the Assistant Director of Nursing on 2/1/22 at 3:15 p.m., indicated nurses were to be completing the COVID-19 screening assessments every shift for all residents in transmission based precautions. The resident was in TBP due to being a new admission and unvaccinated for COVID-19. The Indiana Department of Health current and updated 1/4/22 Long-term Care COVID-19 Clinical Guidance policy indicated, Screen all residents daily for fever and for COVID-19 symptoms. Ideally, include an assessment of oxygen saturation via pulse oximeter. Increase monitoring of residents with suspected or confirmed COVID-19, including assessment of symptoms, vital signs, oxygen saturation via pulse oximeter, and respiratory exam, to at least three times daily to identify and quickly manage serious infection. This Federal tag relates to Complaints IN00365165 and IN00371776 3.1-18(b)