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	01/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	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 APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 01/29/24 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Emergency Preparedness survey, Dyer Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73 The facility has 161 certified beds. At the time of the survey, the census was 116. Quality Review completed on 01/31/24	E 0000		
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 01/29/24 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Life Safety Code survey, Dyer Nursing	K 0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Maurice	Administrator	02/16/2024

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

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	and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The facility has a capacity of 161 and had a census of 116 at the time of this survey. All areas where residents have customary access and all areas providing facility services were sprinklered. Quality Review completed on 01/31/24			
K 0131 SS=E Bldg. 01	NFPA 101 Multiple Occupancies Multiple Occupancies - Sections of Health Care Facilities Sections of health care facilities classified as other occupancies meet all of the following: o They are not intended to serve four or more inpatients for purposes of housing, treatment, or customary access. o They are separated from areas of health care occupancies by construction having a minimum two hour fire resistance rating in accordance with Chapter 8. o The entire building is protected throughout by an approved, supervised automatic sprinkler system in accordance			

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	with Section 9.7. Hospital outpatient surgical departments are required to be classified as an Ambulatory Health Care Occupancy regardless of the number of patients served. 19.1.3.3, 42 CFR 482.41, 42 CFR 485.623 Based on observation and interview, the facility failed to ensure 1 of 1 separation fire doors would limit the spread of fire and restrict the movement of smoke. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.3.4.1 states every opening in a fire barrier shall be protected to limit the spread of fire and restrict the movement of smoke from one side of the fire barrier to the other. This deficient practice could affect approximately 5 staff and an unknown number of residents. Findings include: Based on an observation during a tour of the facility with the Maintenance Director on 01/29/24 between 11:27 a.m. and 1:55 p.m., the set of fire doors that separated health care from assisted living did not latch when tested three times. This condition would not limit the spread of smoke from one side of the fire barrier to the other. Based on interview at the time of observation, the Maintenance Director agreed the occupancy separation doors would not latch and would have to be adjusted. The door was fixed and able to latch by the end of the survey. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)	K 0131	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*)**Immediate actions taken for those residents identified:** The door that separates health care from assisted living was fixed and able to latch by the end of the survey. This was observed by the surveyor and documented on the 2567. **How the facility identified other residents:** Visitors, staff, and residents that reside at the facility have the potential to be affected by the	02/16/2024

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			alleged deficient practice. **Measures put into place/ System changes** The Maintenance Director or Designee will inspect smoke barrier doors weekly for one month and monthly thereafter to ensure the latching hardware is working properly and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator designee by 2/7/24.	
K 0345 SS=F Bldg. 01	NFPA 101 Fire Alarm System - Testing and Maintenance Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 Based on record review, observation and interview, the facility failed to ensure 1 of 1 fire alarm systems was maintained in accordance with LSC 9.6.1.3. LSC 9.6.1.3 requires a fire alarm system to be installed, tested, and maintained in accordance with NFPA 70, National Electrical Code and NFPA 72, National Fire Alarm Code. NFPA 72, Section 14.2.1.2.2 requires that system defects and malfunctions shall be corrected. This deficient practice could affect all occupants.	K 0345	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of*	02/16/2024

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	Findings include: Based on record review with the Maintenance Director on 01/29/24 between 08:55 a.m. and 11:25 a.m., the last fire system inspection dated 09/19/23 by the facility's fire alarm vendor indicated numerous devices failed inspection including smoke detectors, fire panel batteries and door holders. Upon further investigation, the smoke detectors and fire panel batteries were fixed, however door holders were not repaired. The room door holders were for resident rooms 100, 102, 106, 112, 114, 118, 124, 129, 132, 134, 162, 165, 173, and 183. The contracted fire alarm company was able to be contacted during record review. When asked about the following deficiency, the fire alarm company noted that in November 2023, a technician was out to take inventory of the deficient items listed above and was supposed to send a quote out to the facility to acknowledge the work. However, in the fire alarm company's records, they indicate that the quote was sent, however the status was still open. Meaning that the repairs have not been made or the facility has not signed the quote and sent it back to start the process of repairs. Based on interview at the time of record review, the Maintenance Director confirmed the aforementioned issues and stated he knew the fire alarm company was out to do repairs and inspections, however was unsure where the process was to try and fix the door holders. Furthermore, earlier in the month, the sprinkler system had a breakage which caused damage to the fire alarm system in the Memory Care unit. Upon observation of the fire alarm panel between 11:27 a.m. and 1:55 p.m. with the Maintenance Director, the "disable" light and trouble light was illuminated on the fire panel. When interviewing the Maintenance Director upon observation, he stated that the fire alarm		*correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified** The room door holders for residents' room #100, #102, #106, #112, #114, #118, #124, #129, #132, #134, #162, #165, #173, and #183 will be installed on April 30, 2024 (see temporary waiver) **Fire watch was initiated on Memory care unit.** **Memory Unit smoke detectors were installed, and fire alarm was enabled to full operation on 2/13/24** **How the facility identified other residents:** Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **Measures put into place/ System changes:** The Maintenance Director will be re-educated on the Preventative Maintenance Program including the requirement for door holders to be functioning and in good repair and fire watch policy by the Administrator /designee by 2/7/24. The Maintenance Director is responsible for compliance. **How the corrective actions will**	

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	company had done something to the system where it disabled the fire alarm for the particular area affected by the damage from the sprinkler pipe break. The fire alarm contractor had been able to get hold of the technician who did the adjustment of the fire alarm and confirmed that they bypassed "zone 2", which was the Memory Care unit, due to the fire alarm being continuously tripped due to the damage and no smoke detectors in certain rooms. Leaving the Memory Unit unprotected by the fire alarm system. A fire watch had ended January 25th from the original sprinkler incident and the facility haven't conducted one since. The Maintenance Director confirmed and acknowledged all the aforementioned issues above. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)		**be monitored** The Administrator will review the Preventative Maintenance Worksheets monthly for compliance. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on			

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	coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on record review and interview, the facility failed to maintain 1 of 1 automatic sprinkler system in accordance with NFPA 25. LSC 9.7.5 requires all sprinkler systems shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. NFPA 25, 2011 Edition, Section 4.1.4.1 states the property owner or designated representative shall correct or repair deficiencies or impairments that are found during the inspection, test and maintenance required by this standard. Corrections and repairs shall be performed by qualified maintenance personnel or a qualified contractor. NFPA 25, 4.3.1 requires records shall be made for all inspections, tests, and maintenance of the system components and shall be made available to the authority having jurisdiction upon request. This deficient practice could affect all residents, staff, and visitors in the facility. Findings include: Based on records review of the annual fire sprinkler report titled "Report of Inspection / Test" documentation dated 09/25/23 with the Maintenance Director on 01/29/24 between 08:55 a.m. and 11:25 a.m., under the deficiencies section on pages 22, 23 and 24 of the report; the following deficiencies were noted: 1) Supervisory switch are not wired in for the following: East antifreeze loop 2) No signs onsite indicating locations and quantities of low points for both dry systems 3) There are quick response pendents and upright heads in the spare head box and in service that are	K 0353	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **Immediate actions taken for those residents identified:** Supervisory switch was installed for the east antifreeze loop. Signage installed to identify location and quantities of low point for dry systems. Quick response pendent sans upright heads and inservice West and East antifreeze loop was recharged with a factory premix solution. West and East antifreeze loop Placards and signs installed. **2) How the facility identified**	03/01/2024

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	at the 20 year mark. There are records onsite indicating that the batch testing has been completed 4) No records onsite indicating that the loop in question has been recharged with a factory premix solution. Recommend recharging loop with the proper listed solution and install signs and placards. Noted for the 2-1/2" shipping/receiving antifreeze loop 5) There are no records onsite indicating that the loop was recharged with the proper factory pre-mix solution. Recommend recharging and install placards and signs. Noted for 2-1/2" West Antifreeze loop 6) No records onsite indicating that the solution in question is a factory premix solution. Recommend recharging with the proper listed solution and install placards and signs. Noted for the 2" East Antifreeze loop. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned issues on the sprinkler system and was unaware if all of the deficiencies were fixed or not. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)		**other residents:** Staff, Visitors, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** The Maintenance Director or Designee will complete monthly visual inspection of the dry system. Inspections will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by the Administrator /designee by 2/7/24 The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** The Administrator will review the Preventative Maintenance Worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0363 SS=D Bldg. 01	NFPA 101 Corridor - Doors Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies.			

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	19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. Based on observation and interview, the facility failed to ensure 1 of 37 resident room corridor doors on the East wing were provided with a means suitable for keeping the door closed, had no impediment to closing, latching and would resist the passage of smoke. This deficient practice could affect approximately 2 residents in room 103. Findings include: Based on observation with the Maintenance Director on 01/29/24 between 11:27 a.m. and 1:55 p.m., the corridor door to resident room 103 did not latch into the frame when tested three times. Based on interview at the time of observation, the Maintenance Director agreed that the door did not latch and would have to be adjusted. The door was fixed and able to latch by the end of the survey. The finding was reviewed with the Maintenance Director during the exit conference. 3.1-19(b)	K 0363	**K363 NFPA 101 Corridor- Doors** **The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** Resident room # 103 door was fixed and able to latch by the end of survey. This was observed by the surveyor and documented on the 2567. **2) How the facility identified other residents:** Residents that reside at the	02/16/2024

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			facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:** The Maintenance Director or Designee will complete monthly visual inspection of 10 resident's room doors in different areas of the building to ensure proper operation and will document it on the Preventative Maintenance Worksheet. The Maintenance Director will be re-educated on the Preventative Maintenance Program by 2/7/24. The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** The Administrator will review the Preventative Maintenance worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	

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K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to			

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	avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) Based on observation and interview, the facility failed to ensure a minimum distance of at least five feet separated combustible materials from oxygen storage equipment in 1 of 2 oxygen storage/transfilling areas. NFPA 99, 11.3.2.3 requires oxidizing gases such as oxygen shall be separated from combustibles by one of the following: (1) a minimum distance of 20 feet. (2) a minimum distance of 5 feet if the required storage location is protected by an automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. (3) Enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. This deficient practice could affect approximately 40 residents and staff. Findings include: Based on observation during the tour of the facility with the Maintenance Director on 01/29/24 between 11:27 a.m. and 1:55 p.m., one cardboard cylinder carrier was located within approximately two feet from the transfilling/storage area. Based on interview at the time of observation, the Maintenance Director agreed that the combustible material was within five feet of the transfilling area and should be placed somewhere else. A nearby staff member then stated that the holder has been there for some time and was unsure why it was there. Findings were discussed with the Maintenance Director at exit conference. 3.1-19(b)	K 0923	**The facility requests paper compliance for this citation.** *This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* **1)Immediate actions taken for those residents identified:** Cardboard cylinder carrier was removed from the oxygen room. **2) How the facility identified other residents:** Staff, and residents that reside at the facility have the potential to be affected by the alleged deficient practice. **3) Measures put into place/ System changes:**	02/16/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	01/29/2024

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			The Maintenance Director or Designee will complete visual weekly inspection of oxygen room to ensure no combustible items are present. The Maintenance Director will be re-educated on the Preventative Maintenance Program, by the Administrator /designee by 2/7/24 The Maintenance Director is responsible for compliance. **4)How the corrective actions will be monitored:** The Administrator will review the Preventative Maintenance worksheets monthly. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.	
K 0000 Bldg. 04	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a).	K 0000		

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	155220	A. BUILDING 04 B. WING	01/29/2024

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	Survey Date: 01/29/2024 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Life Safety Code survey, Dyer Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, LSC (Life Safety Code) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18, New Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with hard wired smoke detection in resident rooms, in corridors and in spaces open to the corridors. The facility has a capacity of 161 and had a census of 116 at the time of this survey. All areas where residents have customary access and all areas providing facility services were sprinklered. Quality Review completed on 01/31/24			