

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

PRINTED: 10/12/2021  
FORM APPROVED  
OMB NO. 0938-0391

|   |  |   |   |                      |   |
|---|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                  |  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>155220</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING _____<br><br>B. WING _____  |                      | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>10/07/2021</b> |
| NAME OF PROVIDER OR SUPPLIER<br><br><b>DYER NURSING AND REHABILITATION CENTER</b> |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>601 SHEFFIELD AVE</b><br><b>DYER, IN 46311</b>                      |                      |   |
| (X4) ID PREFIX TAG  | SUMMARY STATEMENT OF DEFICIENCIES (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 |   |
| {F 000}   | <p><b>INITIAL COMMENTS</b></p> <p>This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on September 2, 2021. This visit included the PSR to the State Residential Licensure Survey completed on September 2, 2021.</p> <p>This visit was in conjunction with the Investigation of Complaints IN00362341 and IN00362700 and a COVID-19 Focused Infection Control Survey.</p> <p>Complaint IN00362341 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00362700 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: October 5, 6, and 7, 2021</p> <p>Facility number: 000125<br/>Provider number: 155220<br/>AIM number: 1002566740</p> <p>Census Bed Type:<br/>SNF/NF: 117<br/>Residential: 38<br/>Total: 155</p> <p>Census Payor Type:<br/>Medicare: 35<br/>Medicaid: 58<br/>Other: 24<br/>Total: 117</p> <p>Dyer Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the</p> | {F 000}   |   |                      |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE             |  |   | TITLE   |                      | (X6) DATE   |

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.

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| {F 000}   | Continued From page 1<br>PSR to the Recertification and State Licensure Survey.<br><br>Quality review completed on 10/8/21. | {F 000}  |   |   |