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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 09/07/21 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Emergency Preparedness survey, Dyer Nursing and Rehabilitation Center was found in substantial 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 108. Quality Review completed on 09/13/21 The requirement at 42 CFR, Subpart 483.73 is NOT MET as evidenced by:	E 0000	Please accept the following as the facility's plan of correction. 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 requirement. The facility would like to request a desk review. ="" p=""> ="" p=""> ="" span="">	
E 0029 SS=C Bldg. --	403.748(c), 416.54(c), 418.113(c), 441.184(c), 482.15(c), 483.475(c), 483.73(c), 484.102(c), 485.625(c), 485.68(c), 485.727(c), 485.920(c), 486.360(c), 491.12(c), 494.62(c) Development of Communication Plan §403.748(c), §416.54(c), §418.113(c), §441.184(c), §460.84(c), §482.15(c), §483.73(c), §483.475(c), §484.102(c), §485.68(c), §485.625(c), §485.727(c), §485.920(c), §486.360(c), §491.12(c), §494.62(c).			

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least every 2 years [annually for LTC facilities]. Based on record review and interview, the facility failed to maintain an emergency preparedness communication plan that complies with Federal, State, and local laws was reviewed and updated at least annually in accordance with 42 CFR 483.73(c). This deficient practice could affect all occupants. Findings include: Based on review of the Disaster Manual on 09/09/21 between 9:30 a.m. and 11:45 a.m. with the Plant Manager and Maintenance Director present, the facility has an emergency preparedness plan to develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws, however, it was discovered to be inaccurate. In the Communication Plan section, the manual stated 'There is a binder with current residents' facesheets that is kept at the reception desk that has all of the residents' identifying information and contact information for family if the computers are down." Based on interview at the time of record review, the Administrator said the reception desk is at the nurse's station, where you would be received and that is where the binders are kept. They were not kept at the area inside the main entrance that the Administrator called 'the front desk'. Based on interview with the Unit Manager at the nurse's station; when asked where the reception desk was located, she stated 'oh it's way up front right as you walk in	E 0029	=”” span=””> **Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** E 029 Please accept the following as the facility's plan of correction. 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 requirement. We kindly request a desk review. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility has now placed a face sheet binder at the reception desk.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in an emergency situation and information for resident care could not be acquired by emergency officials.*	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	the main door.' The unit manager supplied a binder that included resident identifying information that was located at the nurse's station. The Plant Manager acknowledged that the binder is not kept at the reception desk as indicated per the communication plan. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference.		**What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Staff was educated on placement of face sheets at reception desk. A weekly audit for 3 months will be performed by maintenance to ensure face sheets are at reception area.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
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: 09/07/2021	K 0000	Please accept the following as the facility's plan of correction. 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 requirement. The	

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	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, 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 108 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 09/13/21		facility would like to request a desk review. ="" p=""> ="" p=""> ="" span="">	
K 0331 SS=E Bldg. 01	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 EXISTING Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and have a flame spread rating of Class A or Class B. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. 10.2, 19.3.3.1, 19.3.3.2			

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure materials used as an interior finish in resident rooms of North Wing had a flame spread rating of Class A or Class B in accordance with 19.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff, residents or visitors in the North Wing. Findings include: Based on observations during a tour of the facility with the Plant Manager and Maintenance Director on 09/07/21 between 12:25 p.m. and 2:25 p.m., the resident rooms numbered	K 0331	**Dyer Nursing & Rehabilitation Life Safety Code Recertification** K (331) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The facility has obtained the documentation of the flame spread rating of laminate wall assembly in North wing rooms. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors only if the laminate assembly were not fire rated and were combustible.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on*	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	126-149 located in the North Wing had a faux wood laminate on the wall behind the headboards of the beds. This laminate measured 72" up from the floor. Based on interview at the time of observation, the Plant Manager acknowledged the laminate and stated there were interior finish documentation somewhere for the laminate; but was unable to provide documentation for a flame spread classification of Class A or B for the aforementioned interior finish at the time of the survey. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)		*having proper documentation of the flame spread rating. Property manager will audit flame spread binder to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
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 _____			

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility from 12:25 p.m. to 2:25 p.m. with the Plant Manager and Maintenance Director on 09/07/21 the following was noted: a. An adjustable crescent wrench, not a sprinkler wrench, was inside the spare sprinkler cabinet located in the kitchen b. An adjustable crescent wrench, not a sprinkler wrench, was inside the spare sprinkler cabinet located in the receiving room across from resident room 150. Based on interview at the time of the observations, the Maintenance Director	K 0353	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** K (353) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility has obtained the correct wrench for the spare sprinkler head boxes located in the kitchen area, receiving area, and maintenance office.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the facility in an emergency situation and sprinkler heads needed change out.* **What measures will the facility take or what systems will the**	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	acknowledged the adjustable crescent wrenchs were inside the spare sprinkler cabinets at the aforementioned locations. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)		**facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance was educated on correct wrench needed for all spare sprinkler heads. A one time audit of the spare sprinkler boxes will be performed by maintenance to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *A copy of audit will be reviewed at safety meeting for 3 months. All deficient sprinkler wrenches if any will be changed out immediately.* **Date of Completion: 9/13/21**	
K 0364 SS=E Bldg. 01	NFPA 101 Corridor - Openings Corridor - Openings Transfer grilles are not used in corridor walls or doors. Auxiliary spaces that do not contain flammable or combustible materials are permitted to have louvers or be undercut. In other than smoke compartments containing patient sleeping rooms, miscellaneous openings are permitted in vision panels or doors, provided the openings per room do not exceed 20 square inches and are at or below half the distance from floor to ceiling. In sprinklered rooms, the			

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	openings per room do not exceed 80 square inches. Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) 18.3.6.5.1, 19.3.6.5.2, 8.3 Based on observation and interview, the facility failed to ensure 1 of 1 doctor's lounge were free of miscellaneous openings required by LSC Section 19.3.6.5. Section 19.3.6.5.1 states Miscellaneous openings, such as mail slots, pharmacy pass-through windows, laboratory pass-through windows, and cashier pass-through windows, shall be permitted to be installed in vision panels or doors without special protection, provided that both of the following criteria are met: (1) The aggregate area of openings per room does not exceed 20" squared. (2) The openings are installed at or below half the distance from the floor to the room ceiling. This deficiency could affect up to 10 residents, staff and visitors near the Doctor Lounge . Findings Include: Based on observation during a tour of the facility from 12:25 p.m. to 2:25 p.m. on 9/7/21 with the Plant Manager and Maintenance Director, there was a window to the corridor that slid open measuring 26" by 44" in the doctor's lounge across from family visitation. Based on interview at the time of observation, the Plant Manager acknowledged the corridor opening in the doctor's lounge. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference.	K 0364	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** K (364) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The sliding window located in the doctors office has had a locking mechanism installed to ensure resistants of passage of smoke to corridor.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the smoke compartment if doctors office had a fire and smoke was*	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	3.1-19(b)		*not contained and impeded evacuation.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on smoke containment of corridors. A one time audit was performed by maintenance to ensure compliance in other offices of the facility.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
K 0511 SS=E Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric			

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the main entrance foyer was protected. NFPA 70, 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle faceplates shall be installed so as to completely cover the opening and seat against the mounting surface. This deficient practice could affect up to 15 residents, staff and visitors in the main entrance foyer. Findings include: Based on observation during a tour of the facility with the Maintenance Director on 09/07/21 at 12:26 p.m., the outlet on the left wall inside the main entrance was missing a cover plate. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition and confirmed that exposed wiring was visible. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)	K 0511	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** K (511) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The electrical outlet cover plate located in the reception area has been replaced.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect staff, residents, and visitors if the outlet was shorted during use.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *An inservice was given to maintenance on electrical safety. A random audit*	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
			of outlet covers will be performed weekly for 3 months to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
K 0711 SS=F Bldg. 01	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview; the facility failed to provide a written plan that	K 0711	**Dyer Nursing & Rehabilitation Life Safety Code Recertification**	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	addressed all components in 1 of 1 written fire plans. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of 'Fire Procedure Plan All Shifts' documentation with the Maintenance Director during record review at 11:39 a.m. on 09/07/21, the written fire safety plan did not address item #2 Transmission of alarm to fire department. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned written fire safety plan did not address Transmission of alarm to fire department. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)		K (711) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility has amended the fire alarm panel to include the activation of transmission of fire alarm signal in required 90 seconds to the fire alarm board.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors if signal was not received in required 90 seconds in a fire and staff was not aware of policy.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *The staff was educated on the amended fire preparedness plan including transmission of activation of*	

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
			alarm to alarm board in required 90 seconds. Property manager will audit fire drills for a 3 month duration to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
K 0751 SS=E Bldg. 01	NFPA 101 Draperies, Curtains, and Loosely Hanging Fabr Draperies, Curtains, and Loosely Hanging Fabrics Draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. 18.7.5.1, 18.3.5.11, 19.7.5.1, 19.3.5.11, 10.3.1			

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	Based on observation and interview, the facility failed to ensure curtains in 1 of 1 theaters met criteria in the flame propagation performance criteria contained in NFPA 701 and LSC 19.7.5.1. LSC 19.7.5.1 states draperies, curtains including cubicle curtains and loosely hanging fabric or films shall be in accordance with 10.3.1. Excluding curtains and draperies: at showers and baths; on windows in patient sleeping room located in sprinklered compartments; and in non-patient sleeping rooms in sprinklered compartments where individual drapery or curtain panels do not exceed 48 square feet or total area does not exceed 20 percent of the wall. This deficient practice could affect up rto 15 residents and staff in the theater. Findings include: Based on observation during a tour of the facility at 12:45 p.m. on 9/7/21 with the Plant Manager and Maintenance Director, the theater had floor-to-ceiling velour curtains that covered a stage that covered the south wall. There was no affixed tag on the curtains to indicate the NFPA 701 flame propagation criteria. Based on interview, the Plant Manager acknowledged the theater curtains and stated he is unable to locate documentation at the time of the survey that shows they met NFPA 701 criteria for draperies, curtains and loosely hanging fabrics. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference.	K 0751	**Dyer Nursing & Rehabilitation Life Safety Code Recertification** K (751) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility has obtained the documentation of the flame spread rating for the curtains in the theater.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the theater only if curtains were not fire rated correctly.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *The maintenance department was educated on having proper documentation on flame spread ratings. Property manager will*	09/13/2021

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	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
			audit the flame spread binder to ensure compliance. How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
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). Survey Date: 09/07/2021 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	K 0000	Please accept the following as the facility's plan of correction. 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 requirement. The facility would like to request a desk review. ="" p=""> ="" p=""> ="" span="">	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	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 108 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 09/21/21			
K 0331 SS=E Bldg. 04	NFPA 101 Interior Wall and Ceiling Finish Interior Wall and Ceiling Finish 2012 NEW Interior wall and ceiling finishes, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, have a flame spread rating of Class A. The reduction in class of interior finish for a sprinkler system as prescribed in 10.2.8.1 is permitted. Individual rooms not exceeding four persons may have a Class A or B finish. Lower half of corridor walls, not exceeding 4 feet in height, may have a Class A or B flame spread rating. 10.2, 18.3.3.1, 18.3.3.2 Indicate flame spread rating(s). _____ Based on observation and interview, the facility failed to ensure materials used as an interior finish in resident rooms of North Wing had a	K 0331	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** K (331)	09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	flame spread rating of Class A or Class B in accordance with 18.3.3.1. LSC 101 10.2.3.4 states products required to be tested in accordance with ASTM E 84, Standard Test Method for Surface Burning Characteristics of Building Materials or ANSI/UL 723, Standard for Test for Surface Burning Characteristics of Building Materials shall be grouped in the following classes in accordance with their flame spread and smoke development. (a) Class A Interior Wall and Ceiling Finish. Flame spread 0-25; smoke development 0-450. Includes any material classified at 25 or less on the flame spread test scale and 450 or less on the smoke test scale. Any element thereof, when so tested, shall not continue to propagate fire. (b) Class B Interior Wall and Ceiling Finish. Flame spread 26-75; smoke development 0-450. Includes any material classified at more than 25 but not more than 75 on the flame spread test scale and 450 or less on the smoke test scale. (c) Class C Interior Wall and Ceiling Finish. Flame spread 76-200; smoke development 0-450. Includes any material classified at more than 75 but not more than 200 on the flame spread test scale and 450 or less on the smoke test scale. This deficient practice could affect staff, residents or visitors in the Rehabilitation Wing. Findings include: Based on observations during a tour of the facility with the Plant Manager and Maintenance Director on 09/07/21 between 12:25 p.m. and 2:25 p.m., the resident rooms numbered 126-149 located in the North and Rehabilitation Wing had a faux wood laminate on the wall behind the headboards of the beds. This laminate measured 72" up from the floor. Based on		Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** The facility has obtained the documentation of the flame spread rating of laminate wall assembly in North wing rooms. **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors only if the laminate assembly were not fire rated and were combustible.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on having proper documentation of the flame spread rating. Property manager will audit flame spread binder to ensure compliance.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	interview at the time of observation, the Plant Manager acknowledged the laminate and stated there were interior finish documentation somewhere for the laminate; but was unable to provide documentation for a flame spread classification of Class A or B for the aforementioned interior finish at the time of the survey. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)		How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
K 0351 SS=F Bldg. 04	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 NEW Buildings are to be protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state and local regulations prohibit sprinklers. Listed quick-response or listed residential sprinklers are used throughout smoke compartments with patient sleeping rooms. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed six square feet and sprinkler coverage covers the closet footprint as required by			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	NFPA 13, Standard for Installation of Sprinkler Systems. 18.3.5.1, 18.3.5.4, 18.3.5.5, 18.3.5.6, 9.7, 9.7.1.1(1), 18.3.5.10 Based on observation and interview, the facility failed to provide sprinkler coverage and install sprinklers in accordance with the requirements of NFPA 101 - 2012 edition, Sections 18.3.5 and 9.7 which refers to NFPA 13 - 2010 edition sections 8.6.5, 8.6.5.2.1 and 8.6.5.2.1.1 This deficient practice could affect all of the approximately 10 residents in the middle east wing and Rehabilitation wing. Findings include: Based on observation and interview with the Plant Manager and Maintenance Director on 09/07/21 during a tour of the facility from 12:25 p.m. to 2:25 p.m. the overhang measuring 92" that extended out from the building at the ambulance entrance by resident room 138 was not protected by sprinklers. The Plant Manager and Maintenance Director acknowledged the overhang was not proteced by sprinklers at the time of observation. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)	K 0351	**Dyer Nursing & Rehabilitation Life Safety Code Recertification** K (351) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility contracted sprinkler company to install sprinkler coverage to 92" overhang outside the ambulance door.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff and residents in that smoke compartment if overhang caught on fire and spread into facility.* **What measures will the facility take or what systems will the facility alter to ensure that the**	09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
			problem will be corrected and will not recur? *The Maintenance Department was educated on overhangs over 4 feet needing sprinkler coverage. A one time audit of soffits or any overhang facility will be performed by maintenance to ensure compliance in other areas.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audits will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	
K 0353 SS=F Bldg. 04	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			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	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 coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler systems was maintained with spare sprinklers, a spare sprinkler cabinet and a sprinkler wrench on the premises. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 5.4.1.4 states a supply of spare sprinklers (never fewer than six) shall be maintained on the premises so that any sprinklers that have been operated or damaged in any way can be promptly replaced. The sprinklers shall correspond to the types and temperature ratings of the sprinklers on the property. The sprinklers shall be kept in a cabinet located where the temperature in which they are subjected will at no time exceed 100 degrees Fahrenheit. A special sprinkler wrench shall be provided and kept in the cabinet to be used in the removal and installation of sprinklers. This deficient practice could affect all residents and staff in the facility. Findings include: Based on observations during a tour of the facility from 12:25 p.m. to 2:25 p.m. with the Plant Manager and Maintenance Director on 09/07/21 the following was noted: a. An adjustable crescent wrench, not a sprinkler	K 0353	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** K (353) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility has obtained the correct wrench for the spare sprinkler head boxes located in the kitchen area, receiving area, and maintenance office.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors in the*	09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	wrench, was inside the spare sprinkler cabinet located in the kitchen b. An adjustable crescent wrench, not a sprinkler wrench, was inside the spare sprinkler cabinet located in the receiving room across from resident room 150. Based on interview at the time of the observations, the Maintenance Director acknowledged the adjustable crescent wrenchs were inside the spare sprinkler cabinets at the aforementioned locations. This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)		*facility in an emergency situation and sprinkler heads needed change out.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance was educated on correct wrench needed for all spare sprinkler heads. A one time audit of the spare sprinkler boxes will be performed by maintenance to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *A copy of audit will be reviewed at safety meeting for 3 months. All deficient sprinkler wrenches if any will be changed out immediately.* **Date of Completion: 9/13/21**	
K 0711 SS=F Bldg. 04	NFPA 101 Evacuation and Relocation Plan Evacuation and Relocation Plan There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. Employees are periodically instructed and kept informed with their duties under the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	plan, and a copy of the plan is readily available with telephone operator or with security. The plan addresses the basic response required of staff per 18/19.7.2.1.2 and provides for all of the fire safety plan components per 18/19.2.2. 18.7.1.1 through 18.7.1.3, 18.7.2.1.2, 18.7.2.2, 18.7.2.3, 19.7.1.1 through 19.7.1.3, 19.7.2.1.2, 19.7.2.2, 19.7.2.3 Based on record review and interview; the facility failed to provide a written plan that addressed all components in 1 of 1 written fire plans. LSC 18.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to fire department (3) Emergency phone call to fire department (4) Response to alarms (5) Isolation of fire (6) Evacuation of immediate area (7) Evacuation of smoke compartment (8) Preparation of floors and building for evacuation (9) Extinguishment of fire This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of 'Fire Procedure Plan All Shifts' documentation with the Maintenance Director during record review at 11:39 a.m. on 09/07/21, the written fire safety plan did not address item #2 Transmission of alarm to fire department. Based on interview at the time of record review, the Maintenance Director acknowledged the aforementioned written fire safety plan did not address Transmission of alarm to fire department.	K 0711	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification** K (711) Please accept the following as the facility's plan of correction. 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 requirement. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The facility has amended the fire alarm panel to include the activation of transmission of fire alarm signal in required 90 seconds to the fire alarm board.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors if signal was not received in required 90*	09/13/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	09/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(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
	This finding was reviewed with the Plant Manager and Maintenance Director at the exit conference. 3.1-19(b)		*seconds in a fire and staff was not aware of policy.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *The staff was educated on the amended fire preparedness plan including transmission of activation of alarm to alarm board in required 90 seconds. Property manager will audit fire drills for a 3 month duration to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 9/13/21**	