STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155220		A. BU	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 09/07/2021		
	ROVIDER OR SUPPLIE	R ABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
E 0000							
SS=C Bldg	conducted by the Irin accordance with Survey Date: 09/0 Facility Number: 0 Provider Number: AIM Number: 100 At this Emergency Nursing and Rehabsubstantial complia Preparedness Requived Medicaid Participated 2 CFR 483.73  The facility has 16 of the survey, the conductive Cond	7/21  200125 155220 2266740  Preparedness survey, Dyer bilitation Center was found in since with Emergency irements for Medicare and ting Providers and Suppliers,  1 certified beds. At the time ensus was 108.  Impleted on 09/13/21  42 CFR, Subpart 483.73 is enced by:  (4(c), 418.113(c), 5(c), 483.475(c), (2(c), 485.625(c), (7(c), 485.920(c), (7(c), 485.	E 00	000	Please accept the following as facility's plan of correction. The plan of correction does not constitute an admission of guiliability by the facility and is submitted only in response to regulatory requirement. The facility would like to request a desk review.  ="" p=""> ="" p=""> ="" span=""> ="" span="">	ilt or the	
I A DOD ATON	§485.68(c), §485 §485.920(c), §48 §494.62(c).	.625(c), §485.727(c), 6.360(c), §491.12(c), vider/supplier representative's si			TITLE		(X6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155220		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING			(X3) DATE SURVEY COMPLETED 09/07/2021		
DYER N		ABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP CODE EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	an emergency preplan that complies local laws and must least every 2 yes facilities]. Based on record revision facility failed to material preparedness common with Federal, State, and updated at least 42 CFR 483.73(c). affect all occupants with Findings include:  Based on review of 09/09/21 between 90 the Plant Manager at present, the facility preparedness plan to emergency prepared that complies with 1 however, it was disting the Communication stated 'There is a bin facesheets that is keen has all of the reside and contact information computers are down time of record revier reception desk is at you would be received binders are kept. The inside the main entricalled 'the front desting the Unit Manager at asked where the received the unit Manager at asked where the received the computer of the Unit Manager at asked where the received the computer of the unit Manager at asked where the received the computer of the unit Manager at asked where the received the computer of the unit Manager at asked where the received the unit Manager at the uni	the Disaster Manual on:30 a.m. and 11:45 a.m. with and Maintenance Director	E 0	029	="" span=""> Dyer Nursing & Rehabilitatio Life Safety Code Recertificat E 029 Please accept the following as facility's plan of correction. Th plan of correction does not constitute an admission of gui liability by the facility and is submitted only in response to regulatory requirement. We ki request a desk review.  What corrective action will b accomplished for those residents found to have been affected by the deficient practice? The facility has not placed a face sheet binder at a reception desk.  How will the facility identify other residents having the potential to be affected by th 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.	ion the the hdly  v the	09/13/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 09/07/2021
DYER NI		ABILITATION CENTER	601 SH DYER,	ADDRESS, CITY, STATE, ZIP CODE HEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	
	binder that included information that wa station. The Plant M binder is not kept at indicated per the co	unit manager supplied a resident identifying s located at the nurse's Ianager acknowledged that the the reception desk as mmunication plan. viewed with the Plant Manager irector at the exit conference.		What measures will the factake or what systems will the facility alter to ensure that problem will be corrected a will not recur? Staff was educated on placement of fasheets at reception desk. A weekly audit for 3 months with performed by maintenance the ensure face sheets are at reception area.  How will the corrective action monitored to ensure the definity practice will not recur and with quality assurance program with put into place? Copy of audit be reviewed at safety commitmeeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	ne the the and ace ill be o  n be cient nat vill be it will ittee
K 0000				Date of Completion: 9/13/2	1
Bldg. 01	Licensure Survey w	Recertification and State as conducted by the Indiana th in accordance with 42	K 0000	Please accept the following a facility's plan of correction. T plan of correction does not constitute an admission of guilability by the facility and is submitted only in response t regulatory requirement. The	uilt or

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPL	ETED
		155220	B. WI	NG		09/07/	2021
				CTDEET A	DDDEGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
D)/ED 111	100110 AND DELL	A D.U. ITA TION OF NITED			EFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER		DYER, I	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Facility Number: 0	00125			facility would like to request a		
	Provider Number:	155220			desk review.		
	AIM Number: 1002	266740			="" p="">		
					="" p="">		
	-	Code survey, Dyer Nursing			="" span="">		
	and Rehabilitation Center was found not in						
	-	equirements for Participation					
		aid, 42 CFR Subpart					
		ety from Fire and the 2012					
	edition of the Nation						
	•	) 101, Life Safety Code					
		Existing Health Care					
	Occupancies and 41	10 IAC 16.2.					
	This one story facili	ity was determined to be of					
		ruction and fully sprinklered.					
		re alarm system with hard					
		ion in resident rooms, in					
		ces open to the corridors.					
	-	apacity of 161 and had a					
		time of this survey.					
	consus of 100 at the	time of time survey.					
	All areas where resi	dents have customary access					
		ing facility services were					
	sprinklered.						
	•						
	Quality Review con	npleted on 09/13/21					
K 0331	NFPA 101						
SS=E	Interior Wall and C	•					
Bldg. 01	Interior Wall and C	Ceiling Finish					
	2012 EXISTING						
		eiling finishes, including					
	•	urfaces of buildings such					
		le walls, partitions,					
		e a flame spread rating of					
		3. The reduction in class of					
		sprinkler system as					
	prescribed in 10.2						
	10.2, 19.3.3.1, 19.	.J.J.Z					

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155220	B. Wl	NG	-	09/07/	/2021
				CENTER	ADDRESS SITE OF THE SID CODE		
NAME OF I	PROVIDER OR SUPPLIER	3			ADDRESS, CITY, STATE, ZIP CODE		
					EFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TC	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	Indicate flame spr	read rating(s).					
	Based on observation	on and interview, the facility	K 0	331	Dyer Nursing & Rehabilitatio	n	09/13/2021
	failed to ensure ma	terials used as an interior			Life Safety Code Recertificat	ion	
	finish in resident rooms of North Wing had a				K (331)		
	flame spread rating of Class A or Class B in				Please accept the following as	the	
	accordance with 19	.3.3.1. LSC 101 10.2.3.4			facility's plan of correction. Thi	is	
	states products required to be tested in				plan of correction does not	ļ	
		STM E 84, Standard Test			constitute an admission of guil	lt or	
		Burning Characteristics of			liability by the facility and is		
	Building Materials	or ANSI/UL 723, Standard			submitted only in response to	the	
	for Test for Surface Burning Characteristics of				regulatory requirement.		
	Building Materials shall be grouped in the						
	following classes in accordance with their flame				What corrective action will be	е	
	spread and smoke of	-			accomplished for those		
		Wall and Ceiling Finish.			residents found to have beer	1	
		smoke development 0-450.			affected by the deficient		
	1	ial classified at 25 or less on			practice? The facility has		
	_	st scale and 450 or less on the			obtained the documentation of		
		ny element thereof, when so			flame spread rating of laminate	е	
		ntinue to propagate fire.			wall assembly in North wing		
		Wall and Ceiling Finish.			rooms.		
		5; smoke development 0-450.					
		ial classified at more than 25			How will the facility identify		
		75 on the flame spread test			other residents having the		
		ss on the smoke test scale.			potential to be affected by th		
		Wall and Ceiling Finish.			same deficient practice? The	!	
		00; smoke development			deficient practice has the		
		y material classified at more			potential to affect all staff,		
		re than 200 on the flame			residents, and visitors only if the		
	_	d 450 or less on the smoke			laminate assembly were not fi	re	
		cient practice could affect			rated and were combustible.		
	stan, residents or v	isitors in the North Wing.					
	Findings include:						
	Findings include:				What measures will the facili	_	
	Bosed on observed:	ons during a tour of the			take or what systems will the		
		ant Manager and Maintenance			facility alter to ensure that th		
		21 between 12:25 p.m. and			problem will be corrected an	d	
					will not recur? Maintenance		
	2.23 p.m., the resid	ent rooms numbered			department was educated on		

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	OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ULTIPLE CC JILDING	ONSTRUCTION 01	COMPI	
ANDILAN	OI CORRECTION	155220	B. WI		01	09/07	
		100220	2			09/07	12021
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
DYER NII	IRSING AND REH	ABILITATION CENTER			EFFIELD AVE IN 46311		
					111 +0011		1
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
TAG		he North Wing had a faux		TAU	having proper documentation	of	DATE
		ne wall behind the headboards			the flame spread rating. Prop		
		ninate measured 72" up from			manager will audit flame spre	-	
		interview at the time of			binder to ensure compliance.	·uu	
	observation, the Pla	nt Manager acknowledged the					
	laminate and stated	there were interior finish					
		ewhere for the laminate; but			How will the corrective action	be	
		de documentation for a flame			monitored to ensure the defic		
	-	of Class A or B for the			practice will not recur and wh		
		rior finish at the time of the			quality assurance program w		
	survey.				put into place? Copy of audi		
This finding was reviewed with the Plant Manager				be reviewed at safety commit	ttee		
		rector at the exit conference.			meeting for a duration of 3		
					months. All other deficient		
	3.1-19(b)				practices will be immediately		
					corrected upon occurrence.		
					Date of Completion: 9/13/21		
K 0252	NFPA 101						
K 0353 SS=F		Maintenance and Testing					
Bldg. 01		Maintenance and Testing  Maintenance and Testing					
Diag. 01	· ·	er and standpipe systems					
	-	ted, and maintained in					
	-	IFPA 25, Standard for the					
	Inspection, Testing	g, and Maintaining of					
	Water-based Fire	Protection Systems.					
	_	n design, maintenance,					
	•	ting are maintained in a					
		d readily available.					
	a) Date sprinkler	system last checked					
	b) Who provided	 system test					
	S) Willo provided	oyotom toot					
	c) Water system	supply source					
	, , ,						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155220	B. Wl	NG		09/07/	2021
				CERTE	A DDDDGG GITY GT ATE JID GODE		
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					IEFFIELD AVE		
DYER NU	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES	1	ID			(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
1110		RKS information on	-				BIIIE
		non-required or partial					
	automatic sprinkle						
	-						
	9.7.5, 9.7.7, 9.7.8,		17.0	2.52	Brook Norming O Bakabilitatia	_	00/12/2021
		on and interview, the facility	K 0	353	Dyer Nursing & Rehabilitation		09/13/2021
		1 sprinkler systems was			Life Safety Code Recertification K (353)		
	_	are sprinklers, a spare					
	•	d a sprinkler wrench on the			Please accept the following as		
	-	5, Standard for the Inspection,			facility's plan of correction. Thi	S	
	_ ·	enance of Water-Based Fire			plan of correction does not		
		2011 Edition, Section			constitute an admission of guil	t or	
		oly of spare sprinklers (never			liability by the facility and is		
	i i	l be maintained on the			submitted only in response to	the	
		sprinklers that have been			regulatory requirement.		
	-	d in any way can be promptly					
	replaced. The sprin	klers shall correspond to the			What corrective action will be	9	
	types and temperatu	are ratings of the sprinklers		accomplished for those			
	on the property. Th	e sprinklers shall be kept in a			residents found to have beer	1	
	cabinet located whe	re the temperature in which			affected by the deficient		
	they are subjected v	vill at no time exceed 100			practice? The facility has		
	degrees Fahrenheit.	A special sprinkler wrench			obtained the correct wrench fo	r	
	shall be provided ar	nd kept in the cabinet to be			the spare sprinkler head boxes	3	
	used in the removal	and installation of sprinklers.			located in the kitchen area.		
	This deficient practi	ice could affect all residents			receiving area, and maintenan	ce	
	and staff in the facil	lity.			office.		
	Findings include:				How will the facility identify		
	-	ons during a tour of the			other residents having the		
		p.m. to 2:25 p.m. with the			potential to be affected by the	_	
		Maintenance Director on			same deficient practice? The		
	09/07/21 the follow				·	-	
		scent wrench, not a sprinkler			deficient practice has the		
		the spare sprinkler cabinet			potential to affect all staff,		
	located in the kitche				residents, and visitors in the		
		escent wrench, not a sprinkler			facility in an emergency situati	on	
	-	the spare sprinkler cabinet			and sprinkler heads needed		
		ving room across from			change out.		
	resident room 150.	<i>Θ</i>					
	Based on interview	at the time of the			What measures will the facili	ty	
	observations, the M				take or what systems will the		
	Josef varions, the IVI	annonunce Director			ĺ		

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155220		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 09/07/2021
	PROVIDER OR SUPPLIER  URSING AND REHABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE IEFFIELD AVE 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 APPROPRIA DEFICIENCY)	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 an will not recur? Maintenance we ducated 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 monitored to ensure the defici practice will not recur and what quality assurance program will 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.	d was be ent at I be
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		Date of Completion: 9/13/21	

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	l í		ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. B	UILDING	01	COMPL	ETED
		155220	B. W	ING		09/07/	/2021
				CTDEET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8					
DVED NI	IDOING AND DELL	ADULTATION OF NITED			IEFFIELD AVE		
DYERNU	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	VIE.	DATE
	openings per roon	n do not exceed 80 square					
	inches.	·					
	Vision panels in co	orridor walls or doors shall					
	be fixed window a	ssemblies in approved					
	frames. (In fully sp						
	compartments, the	ere are no restrictions in					
	-	esistance of glass and					
	frames.)	-					
	18.3.6.5.1, 19.3.6.	.5.2, 8.3					
	Based on observation and interview, the facility		K 0	364	Dyer Nursing & Rehabilitation	n	09/13/2021
		f 1 doctor's lounge were free			Life Safety Code Recertificat		
	of miscellaneous openings required by LSC				K (364)		
	Section 19.3.6.5. Section 19.3.6.5.1 states				Please accept the following as	s the	
	Miscellaneous open	ings, such as mail slots,			facility's plan of correction. Th	is	
	pharmacy pass-thro	ugh windows, laboratory			plan of correction does not		
	pass-through windo	ws, and cashier pass-through			constitute an admission of gui	lt or	
	windows, shall be p	permitted to be installed in			liability by the facility and is		
	vision panels or doo	ors without special			submitted only in response to	the	
	protection, provided	that both of the following			regulatory requirement.		
	criteria are met: (1)	The aggregate area of					
	openings per room	does not exceed 20" squared.			What corrective action will b	е	
	(2) The openings ar	e installed at or below half			accomplished for those		
	the distance from th	e floor to the room ceiling.			residents found to have been	n	
	This deficiency cou	ld affect up to 10 residents,			affected by the deficient		
	staff and visitors ne	ar the Doctor Lounge			practice? The sliding window	/	
					located in the doctors office ha	as	
	Findings Include:				had a locking mechanism		
					installed to ensure resistants of	of	
		on during a tour of the facility			passage of smoke to corridor.		
		2:25 p.m. on 9/7/21 with the					
	_	Maintenance Director, there			How will the facility identify		
		e corridor that slid open			other residents having the		
		4" in the doctor's lounge			potential to be affected by th	ne	
		visitation. Based on interview			same deficient practice? The		
		vation, the Plant Manager			deficient practice has the		
	I -	corridor opening in the			potential to affect all staff,		
	doctor's lounge.				residents, and visitors in the		
					smoke compartment if doctors	e	
		viewed with the Plant Manager			office had a fire and smoke w		
	and Maintenance D	irector at the exit conference.			omoe nad a me and smoke w	us	

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	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 09/07/2021
	ROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE IEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(b)			not contained and impeded evacuation.	
				What measures will the faci take or what systems will the facility alter to ensure that the problem will be corrected a will not recur? Maintenance department was educated or smoke containment of corridor A one time audit was perform by maintenance to ensure compliance in other offices of facility.	ne he
				How will the corrective action monitored to ensure the defice practice will not recur and who quality assurance program who put into place? Copy of audion be reviewed at safety commitmeeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	cient nat ill be it will ttee
K 0511 SS=E Bldg. 01	complies with NFF	Electric gas or related gas piping PA 54, National Fuel Gas		Date of Completion: 9/13/21	
		iring and equipment PA 70, National Electric			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 01 155220 B. WING 09/07/2021 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **601 SHEFFIELD AVE** DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID (X5) PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG  $\mathsf{TAG}$ DEFICIENCY) 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 Dyer Nursing & Rehabilitation Based on observation and interview, the facility K 0511 09/13/2021 failed to ensure 1 of 1 electrical outlets in the Life Safety Code Recertification main entrance foyer was protected. NFPA 70, K (511) Please accept the following as the 2011 Edition. Article 406.6, Receptacle Faceplates (Cover Plates), requires receptacle facility's plan of correction. This faceplates shall be installed so as to completely plan of correction does not cover the opening and seat against the mounting constitute an admission of guilt or surface. This deficient practice could affect up to liability by the facility and is 15 residents, staff and visitors in the main submitted only in response to the entrance foyer. regulatory requirement. What corrective action will be Findings include: accomplished for those Based on observation during a tour of the facility residents found to have been with the Maintenance Director on 09/07/21 at affected by the deficient 12:26 p.m., the outlet on the left wall inside the practice? The electrical outlet main entrance was missing a cover plate. Based cover plate located in the on interview at the time of observation, the reception area has been Maintenance Director acknowledged the replaced. aforementioned condition and confirmed that exposed wiring was visible. How will the facility identify other residents having the This finding was reviewed with the Plant Manager potential to be affected by the and Maintenance Director at the exit conference. same deficient practice? The deficient practice has the 3.1-19(b) 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

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		IDENTIFICATION NUMBER:  155220	A. BUILDING 01  B. WING		COMPLETED 09/07/2021	
	ROVIDER OR SUPPLIER JRSING AND REH <i>A</i>	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE	
				of outlet covers will be perform weekly for 3 months to ensure compliance.		
				How will the corrective action I monitored to ensure the deficie practice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committe meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	ent It I be <i>will</i>	
				Date of Completion: 9/13/21		
K 0711 SS=F Bldg. 01	patients and for the of an emergency. Employees are pe kept informed with plan, and a copy of available with telepsecurity. The plan response required and provides for all components per 18.7.1.1 through 1 18.7.2.2, 18.7.2.3, 19.7.1.3, 19.7.2.1.	elocation Plan clan for the protection of all ceir evacuation in the event riodically instructed and their duties under the f the plan is readily chone operator or with addresses the basic of staff per 18/19.7.2.1.2 Il of the fire safety plan 8/19.2.2. 8.7.1.3, 18.7.2.1.2, 19.7.1.1 through 2, 19.7.2.2, 19.7.2.3				
		iew and interview; the vide a written plan that	K 0711	Dyer Nursing & Rehabilitatio Life Safety Code Recertificat		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	01	COMPL	ETED
		155220	B. W	NG		09/07/	′2021
				CED FEET	ADDRESS OF A STATE OF SORE		
NAME OF P	ROVIDER OR SUPPLIER	t			ADDRESS, CITY, STATE, ZIP CODE		
					EFFIELD AVE		
DYER N	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWING BY AN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	T.C.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	16	DATE
	addressed all compo	onents in 1 of 1 written fire			K (711)		
	plans. LSC 19.7.2.2 requires a written health care				Please accept the following as	the	
	occupancy fire safety plan that shall provide for				facility's plan of correction. Thi		
	the following:				plan of correction does not		
	(1) Use of alarms				constitute an admission of guil	t or	
	(2) Transmission of alarm to fire department				liability by the facility and is		
	(3) Emergency pho	ne call to fire department			submitted only in response to	the	
	(4) Response to alarms				regulatory requirement.		
	(5) Isolation of fire						
	(6) Evacuation of immediate area				What corrective action will be	е	
	(7) Evacuation of si	moke compartment			accomplished for those		
	(8) Preparation of f	loors and building for			residents found to have beer	1	
	evacuation				affected by the deficient		
	(9) Extinguishment of fire				practice? The facility has		
	This deficient pract	ice could affect all residents,			amended the fire alarm panel	to	
	staff and visitors.				include the activation of		
					transmission of fire alarm sign	al	
	Findings include:				in required 90 seconds to the t	fire	
					alarm board.		
		'Fire Procedure Plan All					
		on with the Maintenance			How will the facility identify		
		ord review at 11:39 a.m. on			other residents having the		
	· ·	n fire safety plan did not			potential to be affected by the	е	
		insmission of alarm to fire			same deficient practice? The	ļ.	
	_	on interview at the time of			deficient practice has the		
		Maintenance Director			potential to affect all staff,		
	_	forementioned written fire			residents, and visitors if signal	,	
	· -	address Transmission of alarm			was not received in required 9	0	
	to fire department.				seconds in a fire and staff was		
	This finding was re	viewed with the Plant Manager			not aware of policy.		
		irector at the exit conference.			, ,		
	and Maintenance D	nector at the exit conference.			What measures will the facili	ty	
	3.1-19(b)				take or what systems will the	_	
	5.1 17(0)				facility alter to ensure that th	е	
					problem will be corrected and	d	
					will not recur? The staff was		
					educated on the amended fire		
					preparedness plan including		
					transmission of activation of		
			1				l

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	of correction identification number:  155220	A. BUILDING B. WING	01	COMPLETED 09/07/2021
	PROVIDER OR SUPPLIER  URSING AND REHABILITATION CENTER	STREET 601 SH DYER,		
(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 B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) E COMPLETION DATE
			alarm to alarm board in requ 90 seconds. Property manag will audit fire drills for a 3 mo duration to ensure compliant	ger onth
			How will the corrective action monitored to ensure the defined practice will not recur and with quality assurance program with put into place? Copy of audie be reviewed at safety commitment for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	cient hat vill be lit will ittee
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		Date of Completion: 9/13/2	1
	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			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPLETED
		155220	B. W	NG		09/07/2021
				STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹				
DVED NI	IDCING AND DELL	ADII ITATION CENTED		l	EFFIELD AVE	
DIERNO	JRSING AND REH	ABILITATION CENTER		DYER,	IN 46311	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	Based on observation	on and interview, the facility	K 0	751	Dyer Nursing & Rehabilitatio	n 09/13/2021
	failed to ensure cur	tains in 1 of 1 theaters met			Life Safety Code Recertificat	ion
	criteria in the flame	propagation performance			K (751)	
	criteria contained in	n NFPA 701 and LSC			Please accept the following as	the
	19.7.5.1. LSC 19.7.	5.1 states draperies, curtains			facility's plan of correction. Thi	s
	including cubicle co	urtains and loosely hanging			plan of correction does not	
	fabric or films shall	be in accordance with			constitute an admission of guil	t or
	10.3.1. Excluding c	eurtains and draperies: at			liability by the facility and is	
	showers and baths;	on windows in patient			submitted only in response to	the
	sleeping room located in sprinklered				regulatory requirement.	
	compartments; and	in non-patient sleeping rooms				
	in sprinklered compartments where individual				What corrective action will be	e
	drapery or curtain panels do not exceed 48				accomplished for those	
	square feet or total	area does not exceed 20			residents found to have beer	1
	percent of the wall. This deficient practice could				affected by the deficient	
	affect up rto 15 resi	dents and staff in the theater.			practice? The facility has	
					obtained the documentation of	f
	Findings include:				the flame spread rating for the	
					curtains in the theater.	
		on during a tour of the facility				
	_	7/21 with the Plant Manager			How will the facility identify	
		pirector, the theater had			other residents having the	
		our curtains that covered a			potential to be affected by th	e
		he south wall. There was no			same deficient practice? The	
		urtains to indicate the NFPA			deficient practice has the	
		ion criteria. Based on			potential to affect all staff,	
		Manager acknowledged the			residents, and visitors in the	
		stated he is unable to locate			theater only if curtains were no	ot
		ne time of the survey that			fire rated correctly.	
		PA 701 criteria for draperies,			me rated correctly:	
	curtains and loosely	y hanging fabrics.			What measures will the facili	tv
					take or what systems will the	- I
		viewed with the Plant Manager			facility alter to ensure that th	
	and Maintenance D	rirector at the exit conference.			problem will be corrected an	
					will not recur? The	
					maintenance department was	
					educated on having proper	
					documentation on flame sprea	nd
					-	
					ratings. Property manager will	'

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDING	01	COMPL	ETED
		155220	B. WING			09/07/2021	
				STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				EFFIELD AVE		
DVER NI	IRSING AND REHA	ABILITATION CENTER			IN 46311		
				· .	114 +0011		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL	]	PREFIX  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI		E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
					audit the flame spread binder t	ю	
					ensure compliance.		
					How will the corrective action by		
					monitored to ensure the deficie		
					practice will not recur and wha		
					quality assurance program will		
					put into place? Copy of audit		
					be reviewed at safety committee	ee	
			meeting for a duration of 3				
				months. All other deficient			
			corrected upon occurrence.		practices will be immediately		
					D		
					Date of Completion: 9/13/21		
K 0000							
K 0000							
Bldg. 04							
Bidg. 04	A Life Safety Code	Recertification and State	K 00	000	Please accept the following as	the	ı
	•	as conducted by the Indiana	K UC	100	facility's plan of correction. This		
	_	th in accordance with 42			plan of correction does not	3	
	CFR 483.90(a).	in in accordance with 12			constitute an admission of guil	t or	
	C11( 103.50(u).				liability by the facility and is	. 0.	
	Survey Date: 09/07	/2021			submitted only in response to t	he	
	, <i></i>				regulatory requirement. The		
	Facility Number: 00	00125			facility would like to request a		
	Provider Number: 1				desk review.		
	AIM Number: 1002				="" p="">		
					="" p="">		
	At this Life Safety (	Code survey, Dyer Nursing			="" span="">		
	and Rehabilitation C	Center was found not in					
	compliance with Re	quirements for Participation					
	in Medicare/Medica	id, 42 CFR Subpart					
	483.90(a), Life Safe	ty from Fire and the 2012					
	edition of the Nation	nal Fire Protection					
	Association (NFPA)	) 101, LSC (Life Safety					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155220		l í	JILDING	onstruction  04	(X3) DATE COMPL <b>09/07</b> /	ETED	
	ROVIDER OR SUPPLIER JRSING AND REHA	ABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP CODE EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΤE	(X5) COMPLETION DATE
K 0331 SS=E Bldg. 04	and Therapy was sur Health Care Occupations and Inspection of the facility has a finguired smoke detection of the facility has a carensus of 108 at the All areas where resigned all areas provides sprinklered.  Quality Review consumption of the facility has a carensus of 108 at the All areas where resigned all areas provides sprinklered.  Quality Review consumption of the facility has a carensus of 108 at the All areas where resigned all areas provides sprinklered.  Quality Review consumption of the facility of the facili	ty was determined to be of ruction and fully sprinklered. The alarm system with hard on in resident rooms, in ces open to the corridors. Spacity of 161 and had a time of this survey.  In the survey of the customary access ing facility services were on the customary access ing facility services were on the celling Finish celling Finish celling Finish celling finishes, including surfaces of buildings such the walls, partitions, ame spread rating of Class on class of interior finish for as prescribed in 10.2.8.1 of exceeding four persons A or B finish. The dor walls, not exceeding 4 or have a Class A or B flame of the survey of	K 0	331	Dyer Nursing & Rehabilitatio Life Safety Code Recertificat K (331)		09/13/2021

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	04	COMPL	ETED
		155220	B. WI	NG		09/07/	2021
NAME OF I	PROVIDER OR SUPPLIEF	₹			ADDRESS, CITY, STATE, ZIP CODE		
					EFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	DROWINED'S DEAN OF CODDECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		DATE
	flame spread rating	of Class A or Class B in			Please accept the following as	s the	
	accordance with 18	.3.3.1. LSC 101 10.2.3.4			facility's plan of correction. Th	is	
	states products required to be tested in				plan of correction does not		
	accordance with ASTM E 84, Standard Test				constitute an admission of gui	lt or	
	Method for Surface	Burning Characteristics of			liability by the facility and is		
	Building Materials	or ANSI/UL 723, Standard			submitted only in response to	the	
	for Test for Surface	Burning Characteristics of			regulatory requirement.		
	Building Materials shall be grouped in the						
	following classes in accordance with their flame				What corrective action will b	е	
	spread and smoke development.				accomplished for those		
	(a) Class A Interior Wall and Ceiling Finish.				residents found to have been	n	
	Flame spread 0-25; smoke development 0-450.				affected by the deficient		
	Includes any material classified at 25 or less on				practice? The facility has		
	the flame spread tes	st scale and 450 or less on the			obtained the documentation o	f the	
	smoke test scale. A	ny element thereof, when so			flame spread rating of laminat	е	
	tested, shall not cor	ntinue to propagate fire.		wall assembly in North wing			
	(b) Class B Interior	Wall and Ceiling Finish.			rooms.		
	Flame spread 26-75	s; smoke development 0-450.					
	Includes any materi	ial classified at more than 25			How will the facility identify		
	but not more than 7	5 on the flame spread test			other residents having the		
	scale and 450 or les	ss on the smoke test scale.			potential to be affected by the	ie	
	(c) Class C Interior	Wall and Ceiling Finish.			same deficient practice? The	,	
	_	00; smoke development			deficient practice has the		
	0-450. Includes an	y material classified at more			potential to affect all staff,		
		re than 200 on the flame			residents, and visitors only if t	he	
	_	d 450 or less on the smoke			laminate assembly were not fi	re	
		cient practice could affect			rated and were combustible.		
	staff, residents or v	isitors in the Rehabilitation					
	Wing.						
					What measures will the facili	ity	
	Findings include:				take or what systems will the	•	
					facility alter to ensure that th	ie	
		ons during a tour of the			problem will be corrected an	d	
	•	ant Manager and Maintenance			will not recur? Maintenance		
		21 between 12:25 p.m. and			department was educated on		
	_	ent rooms numbered			having proper documentation	of	
		the North and Rehabilitation			the flame spread rating. Prope		
	_	ood laminate on the wall			manager will audit flame spre	-	
		rds of the beds. This laminate			binder to ensure compliance.		
	measured 72" up fro	om the floor. Based on			Sind to one are compliance.		

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	AND PLAN OF CORRECTION  AND PLAN OF CORRECTION  IDENTIFICATION NUMBER:  155220		04	COMPLETED 09/07/2021
	PROVIDER OR SUPPLIER  JRSING AND REHABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE EFFIELD AVE 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 APPROPRIA 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 monitored to ensure the defici practice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.  Date of Completion: 9/13/21	ent at I be <i>will</i>
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			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU  A. BUILDING 04 COMPLET					
		155220		B. WING 09/07/20			
		ABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311			(X5)	
PREFIX TAG	(EACH DEFICIEN	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
	Sprinkler Systems 18.3.5.1, 18.3.5.4 9.7.1.1(1), 18.3.5 Based on observati failed to provide sp sprinklers in accord of NFPA 101 - 201 and 9.7 which refer sections 8.6.5, 8.6.5 deficient practice c approximately 10 r wing and Rehabilit Findings include:  Based on observati Plant Manager and 09/07/21 during a t p.m. to 2:25 p.m. that extended out fi ambulance entrance not protected by sp and Maintenance E overhang was not ptime of observation. This finding was resulted to the second secon	on and interview, the facility prinkler coverage and install dance with the requirements 2 edition, Sections 18.3.5 as to NFPA 13 - 2010 edition 5.2.1 and 8.6.5.2.1.1 This could affect all of the esidents in the middle east ation wing.  on and interview with the Maintenance Director on our of the facility from 12:25 are overhang measuring 92" from the building at the e by resident room 138 was rinklers. The Plant Manager Director acknowledged the protected by sprinklers at the	K 0	351	Dyer Nursing & Rehabilitatio Life Safety Code Recertificat K (351) Please accept the following as facility's plan of correction. Thi plan of correction does not constitute an admission of guil liability by the facility and is submitted only in response to regulatory requirement.  What corrective action will be accomplished for those residents found to have beer affected by the deficient practice? The facility contract sprinkler company to install sprinkler coverage to 92" overhang outside the ambulant door.  How will the facility identify other residents having the potential to be affected by th same deficient practice? The deficient practice has the potential to affect all staff and residents in that smoke compartment if overhang caug on fire and spread into facility.  What measures will the facili take or what systems will the facility alter to ensure that the	ion the is tor the ed ed ed	09/13/2021

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	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CO A. BUILDING B. WING	onstruction <u>04</u>	(X3) DATE SURVEY COMPLETED 09/07/2021
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP CODE HEFFIELD AVE IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE DATE
				problem will be corrected a will not recur? The Maintena Department was educated or overhangs over 4 feet needin sprinkler coverage. A one tin audit of soffits or any overhal facility will be performed by maintenance to ensure compliance in other areas.	ance n ng ne
				How will the corrective action monitored to ensure the deficient practice will not recur and who quality assurance program who 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.	cient nat vill be its ation ent
				Date of Completion: 9/13/21	
K 0353 SS=F Bldg. 04	Sprinkler System Automatic sprinkle are inspected, tes accordance with N Inspection, Testin Water-based Fire Records of system	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of Protection Systems. In design, maintenance, esting are maintained in a			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155220		(X2) MUL <sup>*</sup> A. BUIL B. WING	DING	NSTRUCTION  04	(X3) DATE : COMPL 09/07/	ETED	
	PROVIDER OR SUPPLIER	ABILITATION CENTER	(		DDRESS, CITY, STATE, ZIP CODE EFFIELD AVE N 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	a) Date sprinkler b) Who provided c) Water system Provide in REMAF coverage for any rautomatic sprinkle 9.7.5, 9.7.7, 9.7.8, Based on observation failed to ensure 1 of maintained with spasprinkler cabinet an premises. NFPA 25 Testing, and Mainter Protection Systems, 5.4.1.4 states a suppfewer than six) shall premises so that any operated or damage replaced. The sprint types and temperature on the property. The cabinet located when they are subjected when they are subjected when they are subjected and staff in the facility from 12:25 Plant Manager and 09/07/21 the follow	supply source  RKS information on non-required or partial or system.  In and NFPA 25 on and interview, the facility of 1 sprinkler systems was are sprinklers, a spare of a sprinkler wrench on the sprinklers (never 1 be maintained on the sprinklers that have been of in any way can be promptly sklers shall correspond to the way the sprinklers we sprinklers shall be kept in a wrench will at no time exceed 100.  A special sprinkler wrench of kept in the cabinet to be and installation of sprinklers ince could affect all residents lity.  The sprinkler with the waintenance Director on the sprinkler with the waintenance was a sprinkler with the waintenance was a sprinkler with the waintenance was a sprinkler was a sprinkler with the waintenance was a sprinkler was a sp	K 035	53	Dyer Nursing & Rehabilitatio Life Safety Code Recertificat K (353) Please accept the following as facility's plan of correction. Th plan of correction does not constitute an admission of gui liability by the facility and is submitted only in response to regulatory requirement.  What corrective action will b 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 boxe located in the kitchen area, receiving area, and maintenar office.  How will the facility identify other residents having the potential to be affected by th same deficient practice? The deficient practice has the potential to affect all staff, residents, and visitors in the	ion s the is thor the e n or s	09/13/2021

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO JILDING	04	(X3) DATE S COMPL		
		155220	B. W	ING		09/07/	2021
	PROVIDER OR SUPPLIER	ABILITATION CENTER	•	601 SH	ADDRESS, CITY, STATE, ZIP CODE EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	located in the kitche b. An adjustable cre wrench, was inside	scent wrench, not a sprinkler the spare sprinkler cabinet			facility in an emergency situati and sprinkler heads needed change out.		
	resident room 150.  Based on interview observations, the M acknowledged the a were inside the spar aforementioned local.  This finding was revenue.	aintenance Director djustable crescent wrenchs e sprinkler cabinets at the			What measures will the facilitake or what systems will the facility alter to ensure that the problem will be corrected an will not recur? Maintenance we ducated on correct wrench needed for all spare sprinkler heads. A one time audit of the spare sprinkler boxes will be performed by maintenance to appure sometimes.	e d vas	
	3.1-19(b)				How will the corrective action I monitored to ensure the deficie practice will not recur and what quality assurance program will put into place? A copy of audi will be reviewed at safety meeting for 3 months. All deficient sprinkler wrenches if any will be changed out immediately.	ent t be it	
K 0711 SS=F Bldg. 04	patients and for th of an emergency. Employees are pe				Date of Completion: 9/13/21		

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	JILDING	04	COMPL	ETED	
		155220	B. W	NG		09/07/	2021	
				STREET	ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIER	8						
DVED NII	IDOING AND DELL	A DIL ITATIONI OFNITED			IEFFIELD AVE			
DYERNO	JRSING AND REH	ABILITATION CENTER		DYEK,	IN 46311			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA'	re	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	plan, and a copy of	of the plan is readily						
	available with tele	phone operator or with						
	security. The plan	addresses the basic						
		l of staff per 18/19.7.2.1.2						
		ill of the fire safety plan						
	components per 1							
		18.7.1.3, 18.7.2.1.2,						
	18.7.2.2, 18.7.2.3							
		.2, 19.7.2.2, 19.7.2.3						
	i e	view and interview; the	K 0	711	Dyer Nursing & Rehabilitatio	n	09/13/2021	
		ovide a written plan that		, 11	Life Safety Code Recertification		07/13/2021	
		onents in 1 of 1 written fire			K (711)			
	plans. LSC 18.7.2.2 requires a written health care				Please accept the following as	the		
	occupancy fire safety plan that shall provide for				facility's plan of correction. Thi			
	the following:				plan of correction does not	Ĭ		
	(1) Use of alarms				constitute an admission of guil	t or		
	` '	alarm to fire department			liability by the facility and is	. 01		
		ne call to fire department			submitted only in response to	the		
	(4) Response to alar	-			regulatory requirement.	uio		
	(5) Isolation of fire	11113			regulatory requirement.			
	(6) Evacuation of in	nmediate area			What corrective action will be	<u> </u>		
	(7) Evacuation of si				accomplished for those	-		
		loors and building for			residents found to have beer			
	evacuation	loors and building for						
	(9) Extinguishment	of fire		affected by the deficient				
		ice could affect all residents,			practice? The facility has amended the fire alarm panel	to		
	staff and visitors.	ice could affect all residents,			· ·	.0		
	starr and visitors.				include the activation of	a.		
	Findings include:				transmission of fire alarm sign			
	i manigo metade.				in required 90 seconds to the	ire		
	Based on review of	'Fire Procedure Plan All			alarm board.			
		on with the Maintenance						
		ord review at 11:39 a.m. on			How will the facility identify			
		n fire safety plan did not			other residents having the			
		Insmission of alarm to fire			potential to be affected by th			
		on interview at the time of			same deficient practice? The			
	_	Maintenance Director			deficient practice has the			
	· ·	of orementioned written fire			potential to affect all staff,			
					residents, and visitors if signal			
		address Transmission of alarm			was not received in required 9	0		
	to fire department.							

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	AND PLAN OF CORRECTION  X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 04 COMPLETED  B. WING 09/07/2021			ETED
	PROVIDER OR SUPPLIE URSING AND REH	R IABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  601 SHEFFIELD AVE  DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	This finding was re	eviewed with the Plant Manager Director at the exit conference.			seconds in a fire and staff was not aware of policy.  What measures will the facilitake or what systems will the facility alter to ensure that the problem will be corrected an will not recur? The staff was educated on the amended fire preparedness plan including transmission of activation of alarm to alarm board in require 90 seconds. Property manage will audit fire drills for a 3 monduration to ensure compliance.  How will the corrective action monitored to ensure the deficipractice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.  Date of Completion: 9/13/21	ed ed er th ee. be ent at I be will	

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