STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 01/23/12 Facility Number: 000023 Provider Number: 155062 AIM Number: 100289400 Surveyor: Richard D. Schade, Life Safety Code Specialist 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 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2.	K0000	Please accept the following as the facility's credible allegation of compliance. 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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 one story facility was determined to be of Type V (111) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, resident sleeping rooms and areas open to the corridors. The facility has a capacity of 151 and had a census of 139 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 01/27/12. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0018 SS=B	Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.			
	Based on observation and interview, the facility failed to ensure 1 of 77 resident room doors would latch into the door frame or were provided with a device that exerts at least 5 pounds of pressure to keep the door tightly closed. This deficient practice could effect occupants in and near resident room 178, including staff, visitors and residents. Findings include: Based on observation on 01/23/12 at 2:00 p.m. with the maintenance supervisor, the corridor door to resident room number 178 was not	K0018	**K018 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** Room 178 was repaired to meet specifications. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents who have doors that don't latch into the door frame or a device to provide at least 5 pounds of pressure to keep the door closed have the potential to be affected by the alleged deficient practice. Facility doors were inspected to ensure proper equipment to keep doors closed. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance staff have been	02/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	equipped with a latch which latched into the door frame, or a device to provide at least five pounds of pressure to keep the door closed. The maintenance supervisor stated at the time of observation, he was not aware of the problem. 3.1-19(b)		re-educated by Administration/designee on the following: · Facility doors need to latch into the door frame or have a device to provide at least 5 pounds of pressure to keep the door closed. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Maintenance/designee will perform audits monthly on 10 facility doors to ensure proper equipment in place to keep door closed when needed. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0048 SS=E	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1			
	Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in 1 of 1 written fire safety plans for the facility in the event of an emergency. LSC 19.2.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, as well as staff and visitors in the vicinity of the kitchen. Findings include:	K0048	**K048 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** A facility policy was generated to include the use of K rated fire extinguishers. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice. Disaster manual was reviewed for any other necessary update/changes. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** The Quality Assurance team met and reviewed the new policy and approved it to be included in the Disaster Manual. Kitchen and maintenance staff were inserviced regarding the policy describing the use of K extinguisher and to use only after activating the fixed suppression system. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Annually the Quality Assurance committee will review	02/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 a review of the facility's written fire disaster plan on 01/23/12 at 2:25 p.m. with the maintenance supervisor, the fire disaster plan did not include the use of the Class K fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. The maintenance supervisor acknowledged at the time of record review, he was not aware of the missing policy and procedure concerning the extinguisher. 3.1-19(b)		the Disaster manual for any necessary changes or updates. If a situation comes up prior to the annual review, the committee with discuss the needed change/update and incorporate it into the Disaster manual at that time. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
K0064 SS=B	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10			
	Based on observation and interview, the facility failed to ensure 1 of 1 ABC portable fire extinguishers in the kitchen was readily accessible. NFPA 10, 1-6.3 requires fire extinguishers shall be conspicuously located where they will be readily accessible and immediately available in the event of fire. Preferably they shall be located along normal paths of travel, including exits from areas. NFPA 10, 1-6.6 requires fire extinguishers shall not be obstructed or obscured from view. This deficient practice affects staff in and near the kitchen. Findings include: Based on observation with the maintenance supervisor on 01/23/12 at 2:05 p.m., access to the ABC portable fire extinguisher located in the kitchen, was blocked from access and view by a beverage cart. The maintenance supervisor	K0064	**K064 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The beverage cart was moved so the fire extinguisher located in the kitchen was in view and easily accessible. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice if a fire extinguisher cannot be easily seen or accessible. Facility was inspected to ensure there were no objects blocking the other fire extinguishers. **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Kitchen staff have been re-educated by Administration/designee on the following: · All facility fire extinguishers need to be easily seen and accessible · No objects can be placed in front of or under a fire extinguisher **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance programs will be put into place;** Maintenance/Dietary	02/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 at the time of observation the cart was blocking the fire extinguisher and instructed kitchen staff not to obstruct fire extinguishers. 3.1-19(b)		manager/designee will perform audits weekly to ensure the fire extinguishers were in view and accessible. If a fire extinguisher is noted to be out of site or blocked the object will be moved immediately. A summary of the audits will be presented to the Quality Assurance committee monthly by Administration/designee for three months. Thereafter, if determined by the Quality Assurance Committee, auditing and monitoring will be done quarterly and present quarterly at the QA meeting. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012

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 PERCEDED 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
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on record review and interview, the facility failed to ensure emergency task lighting in and around 1 of 1 generator sets was in accordance with NFPA 101, 2000 Edition, Life Safety Code. LSC Section 7.9.3 requires an annual functional test to be conducted on emergency battery lighting systems for not less than 90 minutes. NFPA 110, Section 5-3.1 requires EPS (Emergency Power Supply) equipment locations shall be provided with battery powered emergency lighting. This deficient practice could affect all residents, staff and visitors in the facility. Findings include: Based on record review with the maintenance supervisor on 01/23/12 at 1:40 p.m., the maintenance supervisor acknowledged he had no record of	K0144	**K144 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;** The generator company was called and scheduled to come out on February 10 th and perform the needed tests. **How the facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;** All residents and staff have the potential to be affected by the alleged deficient practice. The generator tests are scheduled for February 10 th . **What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;** Maintenance staff have been re-educated by Administration/designee on the following: · Annually the battery powered lighting at the generator must be tested for 90 minutes and recorded for evidence. · Annually the generator must be tested at 30 percent of capacity of the nameplate rating and recorded for evidence. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance**	02/15/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 battery powered lighting at the generator being tested for 90 minutes annually. The maintenance supervisor stated at the time of record review, he was not aware of the requirement. 3.1-19(b) 2. Based on record review and interview, the facility failed to ensure the generator ran for at least 30 minutes at 30% of the nameplate rating for 12 of 12 months. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of generators serving the emergency electrical system to be in accordance with NFPA 110. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised at least once monthly, for a minimum of 30 minutes, using one of the following methods: a. Under operating temperature conditions or at not less than 30 percent of the EPS (Emergency Power Supply) nameplate rating.		**programs will be put into place;** Maintenance/designee will add the necessary generator tests to the maintenance calendar to ensure the necessary tests are completed. If any scheduled testing is not completed at the recommended time period, the specific company will be contacted to perform as soon as possible to meet requirements to maintain safety. Monitoring will be on going.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
	b. Loading that maintains the minimum exhaust gas temperatures as recommended by the manufacturer. The date and time of day for required testing shall be decided by the owner, based on facility operations. This deficient practice could affect all residents, staff and visitors. Findings include: Based on review of monthly load test record documentation with the maintenance supervisor at 1:50 p.m. on 01/23/12, monthly logs for the period of December 2010 through January 2012 show the emergency generator was not tested at 30 percent of capacity of the nameplate rating for the last year. Based on interview at the time of record review, the maintenance supervisor stated he was not aware of the requirement. 3.1-19(b)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 01/23/2012

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 PERCEDED 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