STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 05 B. WING ____________	02/27/2024

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
K 000	INITIAL COMMENTS A Life Safety Code Preoccupancy Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a) Removal of an aluminum-framed entrance and sidelights Conversion of a passage and an activity room into a combined dining and activity room Creation of a second locked wing (and possible adjacent locked courtyard) to accomodate twenty (20) residents, in rooms 140-14, to include: Installation of delayed-egress magnetic locks and keypads at an existing cross-corridor door, at the interior and exterior doors of the north exit from the wing, and at the west door of the dining/activity room Installation of a delayed-egress magnetic lock and keypad at the exterior door outside the locked unit serving the north end of the amenities wing Interconnection of all magnetic locks to the existing fire alarm system Survey Date: 02/27/24 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this preoccupancy survey, Dyer Nursing & Rehabilitation Center was found in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR 483 Subpart B and 410 IAC 16.2. This one story facility was determined to be of	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 000	Continued From page 1 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 115 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 02/29/24	K 000		