

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 06/26/2014
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NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 601 SHEFFIELD AVE DYER, IN 46311
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K010000	<p>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).</p> <p>Survey Date: 06/26/14</p> <p>Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740</p> <p>Surveyor: Bridget Brown, Life Safety Code Specialist</p> <p>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.</p> <p>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</p>	K010000	Dyer Nursing and Rehabilitation Center respectfully requests a desk review in place of a follow-up visit. 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.	
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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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K010038 SS=E	<p>has a capacity of 151 and had a census of 138 at the time of this survey.</p> <p>All areas where residents have customary access and all areas providing facility services were sprinklered.</p> <p>Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 07/03/14.</p> <p>The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>1. Based on observation and interview, the facility failed to ensure 2 of 7 exits were arranged to be accessible. LSC 19.2.1 requires compliance with LSC 7.1, Means of Egress. LSC 7.1.3.2.3 requires an exit enclosure shall not be used for any purpose with the potential to interfere with its use as an exit. LSC 7.1.10.1 "Means of egress shall be continuously free of all obstructions or impediments to full instant use in case of fire or other emergency use." This deficient practice</p>	K010038	<p>K038 <u>1-A</u></p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Construction company removed concrete and debris, poured gravel and</p>	07/18/2014

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	<p>affects staff, visitors and 20 or more residents on the east and north wings of the East Unit.</p> <p>Findings include:</p> <p>a. Based on observation with the maintenance director on 06/26/14 at 1:35 p.m., an addition was being added to the 100 hall on the East Unit. A temporary wall had been constructed across the corridor near room 138 to separate the construction site from the health care center. The wall blocked the original exit to the outside for this smoke compartment. A new exit had been created by eliminating room 136 as a resident room, adding an exit door to the outside, adding an illuminated exit sign directing occupants to the exit through the former resident room, and a concrete discharge sidewalk which discharged to the gravel construction roadway. The sidewalk terminated 12 feet from the exit doorway, had a six inch high accumulation of concrete debris, dirt and gravel across the end of the sidewalk and then an eight inch drop into a rutted roadway. The ruts had an accumulation of water approximately two to three inches deep. The maintenance director acknowledged at the time of observation, the exit discharge and was not safe and accessible for evacuation purposes.</p>		<p>leveled it so there is a continuous safe exit from doorway to roadway</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All staff, visitors, residents would be affected by alleged deficient practice. Construction company removed concrete and debris, poured gravel and leveled it so there is a continuous safe exit from doorway to roadway</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Supervisor/Designee to check exits for safety during daily door alarm audits (see attached)</p>		

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	<p>b. Based on observation with the maintenance director on 06/26/14 at 1:40 p.m., wheelchair leg rests and a blue pad were lying in the middle of the exit corridor two feet from the exit door near room 124. The maintenance director agreed at the time of observation, the equipment effectively blocked the exitway. The surveyor asked CNA # 1 who passed by at the time of observation and went into room 124 if she knew how the equipment came to be lying on the corridor floor. "Yes" she replied, and walked away. The maintenance director agreed at the time of observation and exchange with CNA # 1, the practice of leaving equipment in the middle of an exit corridor was unnecessary and could interfere with the accessibility of the exit. He removed the obstructions immediately himself.</p> <p>3.1-(19)</p> <p>2. Based on observation and interview, the facility failed to ensure 2 of 3 kitchen exit doors were provided with door knobs readily operated under all lighting conditions. LSC 7.2.1.5.4. requires where a latch or other similar device is provided, the method of operation of its releasing device must be obvious, even in the dark. The intention of this requirement is the method of release be</p>		<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Supervisor/Designee to present alarm/exit audit to monthly Safety Committee x 3 months</p> <p><u>1-B</u></p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Staff in-serviced on importance of not obstructing exits and hallways so as not to impede means of egress (see</p>				

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	<p>one which is familiar to the average person. For example, a two step release, such as a knob and independent dead bolt, is not acceptable. In most occupancies, it is important that a single action unlatch the door. This deficient practice could affect visitors and 3 or more kitchen staff.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/14 at 2:05 p.m., two doors separated the dining room from the kitchen. Each had a door knob and independent dead bolt. The maintenance director said at the time of observation, the deadbolt was not locked while staff were in the kitchen but he acknowledged if it were, the deadbolt and doorknob would each have to be opened to exit the kitchen.</p> <p>3.1-19(b)</p>		<p>attached)</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All staff, visitors, residents would be affected by alleged deficient practice. Staff in-serviced on importance of not obstructing exits and hallways so as not to impede means of egress</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance</p>		

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			<p>Supervisor/Designee to check corridors and exits during weekly PM rounds (see attached)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Supervisor/Designee to present rounds checklist to Safety Committee at monthly Safety meeting x 3 months K038 - 2 1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice. Deadbolts removed and latching doorknobs were installed with push button locks which release when knob is turned. 2. How other residents</p>		

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			<p>having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Deadbolts removed and latching doorknobs were installed with push button locks which release when knob is turned.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Supervisor in-serviced Maintenance Asst. on not installing deadbolt locks on doors, only install doorknobs with a single action unlatching mechanism.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Supervisor/Designee to present Safety rounds checklist to</p>	

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K010046 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.19.2.9.1.</p> <p>Based on observation and interview, the facility failed to ensure the exterior exit discharge path for 1 of 7 emergency exits was provided with emergency powered egress lighting. LSC 7.9.1.1 requires emergency lighting be provided for means of egress, including walkways leading to a public way. This deficient practice affects visitors, staff and 10 or more residents on the north wing of the East Unit.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/14 at 1:30 p.m., the exit discharge path from the newly created exit through room 136 had no exit discharge lighting. The maintenance director agreed at the time of observation, exit discharge lighting had not been installed.</p> <p>3.1-19(b)</p>	K010046	<p>Safety Committee at monthly Safety meeting x 3 months</p> <p>K046</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>2 exit discharge lights (both with 2 bulbs) installed outside newly created exit through room 136. One discharge light has battery backup of 90 minutes, other light is connected to emergency generator.</p> <p>2. How other residents having the potential to be affected by the same deficient practice</p>	07/18/2014	

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			<p>will be identified and what corrective action(s) will be taken.</p> <p>All staff, visitors, residents would be affected by alleged deficient practice. 2 exit discharge lights (both with 2 bulbs) installed outside newly created exit through room 136. One discharge light has battery backup of 90 minutes, other light is connected to emergency generator.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Supervisor/Designee runs a generator test monthly to ensure all equipment connected to generator is in good working order (see attached)</p>		

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K010056 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>Based on observation and interview, the facility failed to insure resident room 138 had 2 of 2 sprinkler heads installed in accordance with NFPA 13, Section 5-1.1</p>	K010056	<p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Supervisor/Designee to present Generator Log to Safety Committee x 3 months.</p>	07/18/2014	

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	<p>and 5-6.3.4 which requires sprinklers be located no closer than six feet measured on center. NFPA 101, 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect staff, visitors, and 10 or more residents on the north wing of the East Unit.</p> <p>Findings include:</p> <p>Based on an observation with the maintenance director on 06/26/14 at 1:30 p.m., two sprinkler heads were located eighteen inches from one another in resident room 138. One sprinkler was the recessed type like those installed in other parts of the building and the second, an upright sprinkler head located on exposed piping. The maintenance director said at the time of observation, one of the sprinkler heads was disabled and the other installed due to the construction going on in an adjacent area. He had no documentation of a sprinkler head installation and disabling of another in the room. In any event, he acknowledged a sprinkler head observed in the room would be expected to operate.</p> <p>3.1-19(b)</p>		<p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Disabled recessed sprinkler head was removed from room 138 which resulted in existing sprinkler head to be in accordance with Life Safety Code Standard</p> <p>2. How other residents having the potential to be affected by the same deficient practice</p> <p>will be identified and what corrective action(s) will be taken.</p> <p>All staff, visitors, residents would be affected by alleged deficient practice. Disabled recessed sprinkler head was removed from room 138 which resulted in existing sprinkler head to be in accordance with</p>				

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			<p>Life Safety Code Standard</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Supervisor/Designee to monitor installation of sprinkler heads to ensure compliance.</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Supervisor/Designee to monitor installation of sprinkler heads to ensure</p>		

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K010147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>Based on observation and interview, the facility failed to ensure 4 of 4 flexible cords and multitap adapters were not used as a substitute for fixed wiring. NFPA 70 National Electrical Code, 1999 Edition, Article 400-8 requires, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice could affect staff, visitors and 20 or more residents in the north West Unit smoke compartment and center and north smoke compartments which included the main dining room.</p> <p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/14 between 11:30 a.m. and 3:30 p.m., power strip extension cords or multi tap adapters were used to supply power in:</p> <ul style="list-style-type: none"> a. The MDS office to a microwave and refrigerator; b. The ADON office to a microwave and refrigerator; c. The East Unit Clean utility room to 	K010147	<p>compliance.</p> <p>K147 – A, B, C, and D</p> <p>-</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>Power strip extension cords and multi tap adapters were removed from A, B, C, and D.</p> <p>2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken.</p> <p>All residents, visitors, and staff</p>	07/18/2014
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	<p>charge Hoyer Lift batteries; d. Resident room 164 under the head of the bed. The maintenance director said at the time of observation, he was unaware power strips were not permitted for use for the equipment described.</p> <p>3.1-19(b)</p>		<p>have the potential to be affected by the deficient practice. Power strip extension cords and multi tap adapters were removed from A, B, C, and D.</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Supervisor/Designee to monitor during weekly PM rounds using Safety Committee rounds checklist (see attached)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p>		

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K010211 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 <p>Based on observation and interview, the facility failed to ensure 1 of 2 alcohol based hand sanitizers in the laundry was not installed over an ignition source.</p> <p>NFPA 101, in 19.1.1.3 requires all health facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect visitors and 2 or more staff in the laundry.</p>	K010211	<p>Maintenance Supervisor/Designee to present Safety Committee rounds checklist at monthly Safety Committee x 3 months</p> <p>K211</p> <p>1. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.</p>	07/18/2014			

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 06/26/2014
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	<p>Findings include:</p> <p>Based on observation with the maintenance director on 06/26/14 at 1:50 p.m., an alcohol based hand sanitizer was located just above a light switch in the laundry near the washers. The maintenance director confirmed at the time of observation, the hand sanitizer was alcohol based.</p> <p>3.1-19(b)</p>		<p>Hand sanitizer was relocated to an area away from light switch</p> <p>2. How other residents having the potential to be affected by the same deficient practice</p> <p>will be identified and what corrective action(s) will be taken.</p> <p>All staff, visitors, residents would be affected by alleged deficient practice. Hand sanitizer was relocated to an area away from light switch</p> <p>3. What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur.</p> <p>Maintenance Supervisor in-serviced Maintenance Asst.</p>		

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			<p>on installing additional hand sanitizers away from electrical sources (see attached)</p> <p>4. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place.</p> <p>Maintenance Supervisor inspected all mounted hand sanitizers for compliance (see attached)</p>		