

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/04/2015
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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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K 0000  Bldg. 03	<p>A Life Safety Code Preoccupancy Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).</p> <p>Survey Date: 08/04/15</p> <p>Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740</p> <p>At this Life Safety Code survey, Dyer Nursing and Rehabilitation Center addition was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire, the 2000 edition of NFPA (National Fire Protection Association) 101, LSC (Life Safety Code) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18, New Health Care Occupancies.</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 has a capacity of 161 and had a census of</p>	K 0000	<p>Dyer Nursing and Rehabilitation Center respectfully requests adesk 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.</p>	
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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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K 0022 SS=E Bldg. 03	<p>130 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>NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 Based on observation and interview, the facility failed to ensure 3 of 3 doors likely to be mistaken for a way of exit was identified as "No Exit". LSC 7.10.8.1 requires any door that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads: NO Exit. This deficient practice could affect staff and up to 24 residents in the new addition. Findings include: Based on observation with the Maintenance Director, Administrator, and the Housekeeping Supervisor on 08/05/15 between 4:05 p.m. and 4:37 p.m. the following doors lacked a sign</p>	K 0022	<p>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.</p> <p><b>DYER NURSING &amp; REHABILITATION CENTER</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>LIFE SAFETY SURVEY</b> <b>AUGUST 2015</b></p> <p>Please accept the following as the facility's credible allegation of compliance. This plan of</p>	08/18/2015
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	<p>that identified the door either as an exit or not an exit:</p> <p>a. Therapy exterior door b. Sitting room exterior door c. Courtyard Hallway exterior door</p> <p>Based on interview at the time of each observation, with the Maintenance Director, Administrator, and the Housekeeping Supervisor acknowledged the aforementioned conditions. 3.1-19(b)</p>		<p>correction does not constitute an admission of guilt or liability by the facility and is submitted only in response to the regulatory requirement.</p> <p><b>K-022</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The therapy exterior door, the sitting room exterior door and the courtyard hallway exterior door have been identified with a sign that reads No Exit.</p> <p><b>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;</b></p> <p>All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Maintenance Director/Designee to check all doors for proper</p>	

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K 0025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD		<p>identified signs monthly.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance Supervisor/Designee to check all doors for proper identified signs monthly.</p> <p><b>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;</b></p> <p>Maintenance Supervisor/Designee to present checklist at monthly Safety Committee meeting x 3 months.</p> <p><b>Date by which systemic corrections will be completed:</b> <b>August 18, 2015</b></p>		

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Bldg. 03	<p>Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3</p> <p>Based on observation, the facility failed to ensure openings through 1 of 2 smoke barriers in the Therapy addition were protected to maintain the smoke resistance of each smoke barrier. LSC Section 8.3.6.1 requires the passage of building service materials such as pipe, cable or wire to be protected so that the space between the penetrating item and the smoke barrier shall be filled with a material capable of maintaining the smoke resistance of the smoke barrier or be protected by an approved device designed for the specific purpose. This deficient practice could affect staff and up to 24 residents.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director, Administrator, and the Housekeeping Supervisor on 08/04/15 at 4:35 p.m. two separate two</p>	K 0025	<p>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.</p> <p><b>DYER NURSING &amp; REHABILITATION CENTER</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>LIFE SAFETY SURVEY</b> <b>AUGUST 2015</b></p> <p>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.</p>	08/18/2015			

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	inch penetrations were in the smoke barrier wall. Based on interview at the time of observation, the Maintenance Director acknowledged the aforementioned condition.  3.1-19(b)		<p><b>K-025</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The penetration in the smoke barrier wall was caulked with fire caulk.</p> <p><b>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;</b></p> <p>All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Maintenance Director/Designee will inspect any new passage of building material such as pipe, cable or wire to ensure there is no penetration.</p> <p><b>What measures will be put into place or what systemic</b></p>	

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K 0051 SS=E Bldg. 03	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is		<p><b>changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance Supervisor/Designee to inspect any new passage of building material such as pipe, cable or wire to ensure there is no penetration.</p> <p><b>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;</b></p> <p>Maintenance Supervisor/Designee to present results monthly to the Safety Committee Meeting x 3 months.</p> <p><b>Date by which systemic corrections will be completed: August 18, 2015</b></p>	

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	<p>installed according to NFPA 72, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection, or extinguishing system operation. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72, National Fire Alarm Code, and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 18.3.4, 9.6</p> <p>Based on record review and interview, the facility failed to provide documentation for 1 of 1 fire alarm systems. LSC 9.6.2.10 refers to NFPA 72, National Fire Alarm Code. NFPA 72, Chapter 7 Inspection, Testing, and Maintenance lists the requirements for initial installation. This deficient practice could affect staff and 24 all clients in the Therapy addition.</p> <p>Findings include:</p> <p>Based on record review and interview with the Maintenance Director, Administrator, and the Housekeeping Supervisor on 8/4/15 at 4:45 p.m. no fire alarm documentation was available for review.</p> <p>3.1-19(b)</p>	K 0051	<p>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.</p> <p><b>DYER NURSING &amp; REHABILITATION CENTER</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>LIFE SAFETY SURVEY</b> <b>AUGUST 2015</b></p> <p>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</p>	08/18/2015

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			<p>the facility and is submitted only in response to the regulatory requirement.</p> <p><b>K-051</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The fire alarm system is scheduled for inspection Tuesday August 18, 2015.</p> <p><b>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;</b></p> <p>All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. The fire alarm system is scheduled for inspection Tuesday August 18, 2015.</p>	

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K 0056	NFPA 101		<p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The fire alarm system is scheduled to be inspected Tuesday August 18, 2015. Maintenance Director/Designee to ensure quarterly inspections are completed as required.</p> <p><b>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;</b></p> <p>Maintenance Supervisor/Designee to present quarterly inspection results to the Safety Committee Meeting.</p> <p><b>Date by which systemic corrections will be completed:</b> <b>August 18, 2015</b></p>	

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SS=F Bldg. 03	<p><b>LIFE SAFETY CODE STANDARD</b></p> <p>There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5.</p> <p>Based on observation and interview, the facility failed to provide documentation for the acceptance tests required for new sprinkler systems. LSC 9.7.1 requires automatic sprinkler systems shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. NFPA 13, 1999 edition, 10-2.2 requires a hydrostatic test and 10-2.3 requires an air pressure leakage test. This deficient practice could affect staff and up to 24 residents.</p> <p>Findings include:</p> <p>Based on interview and record review with the Maintenance Director, Administrator, and Housekeeping Supervisor on 08/04/15 at 4:45 p.m., no sprinkler documentation was available for review.</p>	K 0056	<p>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.</p> <p><b>DYER NURSING &amp; REHABILITATION CENTER</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>LIFE SAFETY SURVEY</b> <b>AUGUST 2015</b></p> <p>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</p>	08/18/2015			

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	3.1-19(b)		<p>the facility and is submitted only in response to the regulatory requirement.</p> <p><b>K-056</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;</b></p> <p>The sprinkler system is scheduled for inspection Tuesday August 18, 2015.</p> <p><b>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;</b></p> <p>All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. The sprinkler system is scheduled for inspection Tuesday August 18, 2015.</p>	

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K 0130	NFPA 101		<p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>The sprinkler system is scheduled to be inspected Tuesday August 18, 2015. Maintenance Director/Designee to ensure quarterly inspections are completed as required.</p> <p><b>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;</b></p> <p>Maintenance Supervisor/Designee to present quarterly inspection results to the Safety Committee Meeting.</p> <p><b>Date by which systemic corrections will be completed:</b> <b>August 18, 2015</b></p>		

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SS=D Bldg. 03	<p><b>MISCELLANEOUS</b> <b>OTHER LSC DEFICIENCY NOT ON 2786</b></p> <p>Based on observation and interview, the facility failed to ensure 1 of 2 smoke barrier door sets held open by devices arranged to automatically close would self close and latch into the door frame once the fire alarm system is activated. LSC 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed. This deficient practice could affect all residents, staff and visitors.</p> <p>Findings include:</p> <p>Based on observation with the Maintenance Director, Administrator, and the Housekeeping Supervisor on 08/15/15 at 4:08 p.m., the smoke barrier door set near resident room 140 in the Therapy addition which is held open by magnetic hold devices and arranged to automatically close did not latch into the door frame when the fire alarm system was activated. Based on interview at the time of observation, the Maintenance Director, Administrator, and the Housekeeping Supervisor acknowledged the aforementioned condition.</p> <p>3.1-19(b)</p>	K 0130	<p>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.</p> <p><b>DYER NURSING &amp; REHABILITATION CENTER</b></p> <p><b>PLAN OF CORRECTION</b></p> <p><b>LIFE SAFETY SURVEY</b> <b>AUGUST 2015</b></p> <p>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.</p> <p><b>K-130</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient</b></p>	08/18/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155220	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>03</u> B. WING _____	X3) DATE SURVEY COMPLETED  08/04/2015
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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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			<p><b>practice;</b></p> <p>The smoke barrier door set near resident room 140 was repaired and now latches.</p> <p><b>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;</b></p> <p>All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Maintenance Director/Designee will inspect smoke barrier doors monthly for proper latching.</p> <p><b>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur;</b></p> <p>Maintenance Supervisor/Designee to inspect smoke barrier doors monthly for proper latching.</p>	

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			<p><b>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;</b></p> <p>Maintenance Supervisor/Designee to present results monthly to the Safety Committee Meeting x 3 months.</p> <p><b>Date by which systemic corrections will be completed: August 18, 2015</b></p>	