

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/31/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 03/29/2022
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 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	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaints IN00365165, IN00368066, IN00368649, IN00369641, IN00371602, and IN00371776. This visit included a PSR to the COVID-19 Focused Infection Control Survey completed on 2/2/22.</p> <p>This visit was done in conjunction with the PSR to Complaint IN00372860 completed on 2/24/22.</p> <p>Complaint IN00365165 - Corrected.</p> <p>Complaint IN00368066 - Corrected.</p> <p>Complaint IN00368649 - Corrected.</p> <p>Complaint IN00369641 - Corrected.</p> <p>Complaint IN00371602 - Corrected.</p> <p>Complaint IN00371776 - Corrected.</p> <p>Complaint IN00372860 - Corrected.</p> <p>Survey dates: March 28 and 29, 2022</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Census Bed Type: SNF/NF: 105 Residential: 35 Total: 140</p> <p>Census Payor Type: Medicare: 25</p>	{F 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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{F 000}	Continued From page 1 Medicaid: 65 Other: 15 Total: 105 Dyer Nursing and Rehabilitation Center was found to be in compliance with 42 CFR Part 483 Subpart B and 410 IAC 16.2-3.1 in regard to the PSR to the Investigation of Complaints IN00365165, IN00368066, IN00368649, IN00369641, IN00371602, and IN00371776 and the PSR to the COVID-19 Focused Infection Control Survey. Quality review completed on 3/30/22.	{F 000}			