STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING -- B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
E 0000 Bldg. --	An Emergency Preparedness Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.73. Survey Date: 12/28/22 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Emergency Preparedness survey, Dyer Nursing and Rehabilitation Center was found in compliance with Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers, 42 CFR 483.73. The facility has a capacity of 161 and had a census of 115 at the time of this survey. Quality Review completed on 01/03/23	E 0000	The facility kindly requests a desk review.	
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/28/22 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740 At this Life Safety Code survey, Dyer Nursing and Rehabilitation Center was found not in compliance with Requirements for Participation in	K 0000	The facility kindly requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Natalie Porcaro	Administrator	01/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Medicare/Medicaid, 42 CFR Subpart 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 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 01/03/23			
K 0321 SS=E Bldg. 01	NFPA 101 Hazardous Areas - Enclosure Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) Based on observation and interview, the facility failed to ensure 1 of 2 hazardous rooms that contained fuel fired equipment were separated from other spaces by smoke resistant partitions. This deficient practice could affect 20 residents in one smoke compartment Findings include: Based on observations during a tour of the facility with the Maintenance Director and Corporate Engineer on 12/28/22 between 12:43 p.m. and 2:22 p.m., in the boiler equipment room which contained fuel fired hot water heaters had one 1-inch unsealed gap around a pipe in the ceiling by the hot water heaters. Based on interview at the time of the observation, the Corporate Engineer agreed there was an unsealed penetration in the Boiler Equipment room. The finding was reviewed with the Maintenance Director, Corporate Engineer, and Administrator during the exit conference. 3.1-19(b)	K 0321	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification and State Licensure Survey: 12-28-22** K 321 Please accept the following as the facility's plan of correction. 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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The penetration in the ceiling in the boiler room was sealed by UL standard.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The*	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			deficient practice has the potential to affect all staff, residents, and visitors. **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance was educated on ensure there is not any penetrations in the ceiling. A monthly random audit of various areas of the facility will be completed for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 1-10-23**	
K 0353 SS=F Bldg. 01	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 1. Based on record review, observation and interview, the facility failed ensure 1 of 1 backflow prevention device in the sprinkler system piping was tested annually in accordance with NFPA 25. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 2011 Edition, Section 13.6.2.1 states all backflow preventers installed in fire protection system piping shall be tested annually by conducting a forward flow test of the system at the designed flow rate, including hose stream demand, where hydrants or inside hose stations are located downstream of the backflow preventer. This deficient practice could affect all residents in the facility. Findings include: Based on record review with the Maintenance Director and Corporate Engineer on 12/28/22 at 11:15 a.m., The last documented backflow annual inspection was dated 12/17/21. Based on interview at record review, the Maintenance Director stated that the backflow inspection had not been done yet, but was scheduled to be done later in the week.	K 0353	**Dyer Nursing & Rehabilitation** **Life Safety Code** **Recertification and State Licensure Survey: 12-28-22** K 353 Please accept the following as the facility's plan of correction. 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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The backflow inspection was completed 12-29-22.* *The ceiling construction is scheduled to be completed by 1.31.23.* **How will the facility identify other residents having the**	01/31/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Findings were discussed with the Maintenance Director, Corporate Engineer, and Administrator at exit conference. 2. Based on observation and interview, the facility failed to maintain the ceiling construction in 1 of 6 smoke compartments. The ceiling traps hot air and gases around the sprinkler and cause the sprinkler to operate at a specified temperature. NFPA 13, 2010 edition, 8.5.4.1.1 states the distance between the sprinkler deflector and the ceiling above shall be selected based on the type of sprinkler and the type of construction. This deficient practice could affect all staff and residents in one smoke compartment. Findings include: Based on observation with the Maintenance Director and the Corporate Engineer on 12/28/22 between 12:43 p.m. and 2:22 p.m., in the lobby corridor near the theater there was a six foot opening where the drywall ceiling had been taken down. This condition could delay the activation of the sprinklers installed in ceiling. Based on interview at the time of observation, the Corporate Engineer was aware of the issue and was in the process of fixing the ceiling. 3.1-19(b)		**potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on required inspections and frequency of those inspections. A monthly audit will be performed for 6 months of all required inspections to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 6 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 1-31-23**	
K 0355 SS=D Bldg. 01	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 Based on observation, record review, and Interview, the facility failed to ensure 1 of 12 portable fire extinguishers was given maintenance at periods not more than one year apart. NFPA 10, the Standard for Portable Fire Extinguishers, at Section 7.3.1.1.1 requires that fire extinguishers shall be subjected to maintenance at intervals of not more than 1 year, at the time of hydrostatic test, or when specifically indicated by an inspection or electronic notification. Section 3.3.15 defines extinguisher maintenance as a thorough examination of the fire extinguisher that is intended to give maximum assurance that a fire extinguisher will operate effectively and safely and to determine if physical damage or condition will prevent its operation, if any repair or replacement is necessary, and if hydrostatic testing or internal maintenance is required. Section 7.3.3 states each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed, identifies the person performing the work, and identifies the name of the agency performing the work. This deficiency could affect Maintenance staff. Findings include: Based on an observation with the Maintenance Director and Corporate Engineer on 12/28/22 between 12:43 p.m. and 2:22 p.m., the tag on an ABC extinguisher in the Maintenance Office was dated December 2021. Based on record review, the contracted company for maintenance of fire extinguishers conducted the annual inspection on 12/13/22. Based on interview at time of observation, the Maintenance Director agreed	K 0355	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification and State Licensure Survey: 12-28-22** K 355 Please accept the following as the facility's plan of correction. 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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The fire extinguisher in the Maintenance office was inspected and is now up to date.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance department was educated on ensuring all fire extinguishers are inspected monthly for 3 months.*	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	that the fire extinguisher was overdue for inspection and missed. This finding was reviewed with the Maintenance Director, Corporate Engineer, and Administrator at the exit conference. 3.1-19(b)		How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 1-10-23**	
K 0511 SS=B Bldg. 01	NFPA 101 Utilities - Gas and Electric Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 Based on observation and interview, the facility failed to ensure 1 of 1 electrical outlets in the Main Lobby Hall was enclosed and protected. LSC 9.1.2 requires electrical wiring and equipment to comply with NFPA 70, National Electrical Code. Article 406.5 (F) states exposed terminals and receptacles shall be enclosed so that live wiring terminals are not exposed to contact. This deficient practice could affect 20 residents in the 100 hall. Findings include:	K 0511	**Dyer Nursing & Rehabilitation** **Life Safety Code** **Recertification and State** **Licensure Survey: 12-28-22** K 511 Please accept the following as the facility's plan of correction. 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.	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	Based on observation with the Maintenance Director and Corporate Engineer on 12/28/22 between 12:43 p.m and 14:22 p.m., in the Main Lobby Hall attic there was an electrical receptacle that was not enclosed and had exposed metal terminals. Based on interview at time of observation, the Corporate Engineer stated that it came off when the sprinkler company was working in the attic from a water pipe bursting. Findings were discussed with the Maintenance Director, Corporate Engineer, and Administrator at exit conference.		**What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The electrical outlet in the Main Lobby was closed with a new outlet cover.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Maintenance staff were educated on ensuring all electrical outlets are covered. A weekly audit will be completed for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.*	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			Date of Completion: 1-10-23	
K 0923 SS=E Bldg. 01	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99)			
	Based on observation and interview, the facility failed to ensure 7 of 7 empty cylinders are segregated from full cylinders and are marked to avoid confusion. This deficient practice could affect up to 15 residents and staff in one smoke compartment. Findings include: Based on observations with the Maintenance Director and Corporate Engineer on 12/28/22 between 12:43 p.m. and 2:22 p.m., the oxygen storage rooms next to rooms 107 and 178 contained one rack that did not separate full cylinders from empty cylinders but on the floor there were seven cylinders mixed with full and empty and not marked. Based on interview at the time of observation, the Corporate Engineer stated there were cylinders on the floor that were both full and empty. The findings were reviewed with the Maintenance Director, Corporate Engineer, and Administrator during the exit conference. 3.1-19(b)	K 0923	**Dyer Nursing & Rehabilitation** **Life Safety Code Recertification and State Licensure Survey: 12-28-22** K 923 Please accept the following as the facility's plan of correction. 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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The proper signage was placed in the oxygen room and all cylinders have been segregated.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents, and visitors.* **What measures will the facility**	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			take or what systems will the facility alter to ensure that the problem will be corrected and will not recur? *Staff were educated on ensuring oxygen cylinders are segregated based on if they are Full or Empty. A weekly audit will be completed for 3 months to ensure compliance.* How will the corrective action be monitored to ensure the deficient practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 1-10-23**	
K 0000 Bldg. 04	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana Department of Health in accordance with 42 CFR 483.90(a). Survey Date: 12/28/22 Facility Number: 000125 Provider Number: 155220 AIM Number: 100266740	K 0000	The facility kindly requests a desk review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	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 483.90(a), Life Safety from Fire and the 2012 edition of the National Fire Protection Association (NFPA) 101, LSC (Life Safety Code) and 410 IAC 16.2. The Rehabilitation hall and Therapy was surveyed with Chapter 18, New Health Care Occupancies. 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 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 01/03/23.			
K 0211 SS=E Bldg. 04	NFPA 101 Means of Egress - General Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 Based on observation and interview, the facility failed to ensure 1 of 1 rehabilitation corridor means of egresses were continuously maintained free of obstructions. This deficient practice affects 15 residents using the rehabilitation hall	K 0211	**Dyer Nursing & Rehabilitation Life Safety Code Recertification and State Licensure Survey: 12-28-22** K 211	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	during an evacuation. Findings include: Based on observation during a tour of the facility with the Maintenance Director and Corporate Engineer on 12/28/22 between 12:43 p.m. and 2:22 p.m., there were four resident beds along the corridor and a service cart with approximately 10 boxes placed in the corridor. Based on an interview at the time of observation, the Corporate Engineer stated the service cart was supposed to be in the storage room and the resident beds were placed in the corridor for storage. There wasn't any available room in other spots. The service cart was removed from the corridor upon observation. Findings were discussed with the Maintenance Director, Corporate Engineer, and Administrator at exit conference. 3.1-19(b)		Please accept the following as the facility's plan of correction. 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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The beds and service cart were removed from the corridor. The cardboard boxes were moved from the corridor.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents in the event of an emergency evacuation.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Staff were educated on not storing anything in the corridors. A random weekly audit will be performed for 3 months of all corridors.* How will the corrective action be monitored to ensure the deficient practice will not recur and what	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 1-10-23**	
K 0754 SS=E Bldg. 04	NFPA 101 Soiled Linen and Trash Containers Soiled Linen and Trash Containers Soiled linen or trash collection receptacles shall not exceed 32 gallons in capacity. The average density of container capacity in a room or space shall not exceed 0.5 gallons/square feet. A total container capacity of 32 gallons shall not be exceeded within any 64 square feet area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gallons shall be located in a room protected as a hazardous area when not attended. Containers used solely for recycling are permitted to be excluded from the above requirements where each container is less than or equal to 96 gallons unless attended, and containers for combustibles are labeled and listed as meeting FM Approval Standard 6921 or equivalent. 18.7.5.7, 19.7.5.7 Based on observation and interview, the facility failed to ensure 2 soiled linen receptacles in the corridor did not exceed 32 gallons in capacity within a 64 square foot area. This deficient practice could affect staff and up to 15 residents	K 0754	**Dyer Nursing & Rehabilitation** **Life Safety Code** **Recertification and State** **Licensure Survey: 12-28-22** K 754	01/10/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
	in the smoke compartment. Findings include: Based on observation with the Maintenance Director and the Corporate Engineer on 12/28/22 between 12:43 p.m. and 2:22 p.m., there was one 33-gallon trash receptacle and one 33-gallon linen receptacle next to each other outside resident room 146. Based on interview at the time of observation, the Corporate Engineer and Maintenance Director agreed there was over 32 gallons in one smoke compartment. This finding was reviewed with the Maintenance Director, Corporate Engineer, and Administrator at exit conference. 3.1-19(b)		Please accept the following as the facility's plan of correction. 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. **What corrective action will be accomplished for those residents found to have been affected by the deficient practice?** *The soiled linen and trash receptacle carts were removed from the corridor.* **How will the facility identify other residents having the potential to be affected by the same deficient practice?** *The deficient practice has the potential to affect all staff, residents in the event of an emergency evacuation.* **What measures will the facility take or what systems will the facility alter to ensure that the problem will be corrected and will not recur?** *Staff were educated on not storing receptacles near each other, receptacles must not exceed 32 gallons. A random weekly audit will be performed for 3 months of all corridors.* How will the corrective action be monitored to ensure the deficient	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 04 B. WING	12/28/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
DYER NURSING AND REHABILITATION CENTER	601 SHEFFIELD AVE DYER, IN 46311

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (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
			practice will not recur and what quality assurance program will be put into place? *Copy of audit will be reviewed at safety committee meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.* **Date of Completion: 1-10-23**	