AND PLAN OF CORRECTION ID:		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		155220	B. WING		12/28/2022	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD IEFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA 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.		E 0000	The facility kindly requests a converse.	desk	
		impleted on 01/03/23				
K 0000	(a 101 001					
Bldg. 01	Licensure Survey w Department of Heal 483.90(a). Survey Date: 12/28 Facility Number: 0 Provider Number: 100 At this Life Safety of and Rehabilitation of	00125 155220	K 0000	The facility kindly requests a creview.	desk	
LABORATOR	Y DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	IGNATURE	TITLE	(X6) DATE	

(X6) DATE

Natalie Porcaro Administrator 01/13/2023

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	
		155220	B. W	ING		12/28/	/2022
NAME OF D	ROVIDER OR SUPPLIER		•	STREET A	ADDRESS, CITY, STATE, ZIP COD	•	
					EFFIELD AVE		
DYER NU	JRSING AND REHA	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION , 42 CFR Subpart 483.90(a),		TAG	DEFICIENC!)		DATE
		e and the 2012 edition of the					
	•	etion Association (NFPA) 101,					
		SC), Chapter 19, Existing					
	•	ancies and 410 IAC 16.2.					
	This one story facility was determined to be of						
	-	ruction and fully sprinklered.					
		re alarm system with hard wired					
	•	resident rooms, in corridors					
		to the corridors. The facility					
	has a capacity of 16	1 and had a census of 115 at					
	the time of this survey.						
	All areas where resi	dents have customary access					
		ing facility services were					
	sprinklered.						
	Quality Review con	npleted on 01/03/23					
K 0321	NFPA 101						
SS=E	Hazardous Areas	- Enclosure					
Bldg. 01	Hazardous Areas	- Enclosure					
		are protected by a fire					
	-	our fire resistance rating					
	(with 3/4 hour fire	•					
		nguishing system in .7.1 or 19.3.5.9. When the					
		ic fire extinguishing system					
		areas shall be separated					
	•	by smoke resisting					
	•	rs in accordance with 8.4.					
	Doors shall be self-closing or						
	•	and permitted to have					
		pplied protective plates that					
		inches from the bottom of					
the door.							
		and zone locations of hat are deficient in					
	REMARKS.	nat are delicient III					
	I VEIVIALVIVO.						

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Event ID:

JOJW21 Facility ID: 000125

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPLETED
		155220	B. W	ING		12/28/2022
NAME OF I	PROVIDER OR SUPPLIEI)	-	STREET A	ADDRESS, CITY, STATE, ZIP COD	
NAME OF I	FROVIDER OR SUFFEIEI				EFFIELD AVE	
DYER N	URSING AND REH	ABILITATION CENTER	DYER,		IN 46311	
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	·	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY	DATE
	19.3.2.1, 19.3.5.9					
	Aroo	Automatia Enrinklar				
	Area Separation	Automatic Sprinkler				
	I	-Fired Heater Rooms				
		er than 100 square feet)				
	, -	nance, and Paint Shops				
	•	ooms (exceeding 64				
	gallons)	come (executing e i				
	e. Trash Collectio	n Rooms				
	(exceeding 64 gal					
f. Combustible Storage Rooms/Spaces						
	(over 50 square fe	- ·				
	g. Laboratories (if	classified as Severe				
	Hazard - see K32	2)				
	Based on observation	on and interview, the facility	K 0321		Dyer Nursing & Rehabilitation	on 01/10/2023
	failed to ensure 1 o	f 2 hazardous rooms that			Life Safety Code	
		l equipment were separated			Recertification and State	
		by smoke resistant partitions.			Licensure Survey: 12-28-22	
	_	ice could affect 20 residents in			K 321	
	one smoke compart	tment			Please accept the following as	
					facility's plan of correction. Th	is
	Findings include:				plan of correction does not	
	D4 1				constitute an admission of gui	it or
		ons during a tour of the facility ace Director and Corporate			liability by the facility and is	the
		22 between 12:43 p.m. and 2:22			submitted only in response to	uie
		equipment room which			regulatory requirement.	
	_	I hot water heaters had one			What corrective action will b	
		o around a pipe in the ceiling			accomplished for those	
		aters. Based on interview at			residents found to have been	n
	·	ervation, the Corporate			affected by the deficient	
		ere was an unsealed			practice? The penetration in	the
		Boiler Equipment room.			ceiling in the boiler room was	
	1				sealed by UL standard.	
	The finding was re-	viewed with the Maintenance				
	_	Engineer, and Administrator			How will the facility identify	
	during the exit cont	ference.			other residents having the	
					potential to be affected by th	ne
	3.1-19(b)				same deficient practice? The	

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PRINTED: 01/20/2023 FORM APPROVED OMB NO. 0938-039

	OF CORRECTION	IDENTIFICATION NUMBER 155220	A. BUILDING B. WING	01	COMPLE S 12/28/2	ETED
	PROVIDER OR SUPPLIEF	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
				deficient practice has the po to affect all staff, residents, visitors.		
				What measures will the fact take or what systems will the facility alter to ensure that problem will be corrected will not recur? Maintenance educated on ensure there is any penetrations in the ceiling monthly random audit of valuates of the facility will be completed for 3 months to ecompliance.	the the and se was s not ng. A rious	
				How will the corrective action monitored to ensure the definition practice will not recur and with quality assurance program up to put into place? Copy of audie be reviewed at safety commeeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	icient rhat will be dit will nittee	
				Date of Completion: 1-10-2	3	
K 0353 SS=F Bldg. 01	Sprinkler System Automatic sprinkle are inspected, tes accordance with N	- Maintenance and Testing - Maintenance and Testing er and standpipe systems ted, and maintained in NFPA 25, Standard for the g, and Maintaining of				

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JOJW21 Facility ID: 000125

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	LETED
		155220	B. W	ING		12/28	/2022
		<u> </u>	-	STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			IEFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER	_		IN 46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	·ΤΕ	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE
		Protection Systems.					
	1	n design, maintenance,					
	1	sting are maintained in a nd 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 sprinkle	er system.					
	9.7.5, 9.7.7, 9.7.8	, and NFPA 25					
		review, observation and	K 0	353	Dyer Nursing & Rehabilitatio	'n	01/31/2023
		ty failed ensure 1 of 1 backflow			Life Safety Code		
	1 ~	n the sprinkler system piping			Recertification and State		
		in accordance with NFPA 25.			Licensure Survey: 12-28-22		
		for the Inspection, Testing,			K 353		
		Water-Based Fire Protection			Please accept the following as		
	l ⁻	ion, Section 13.6.2.1 states all			facility's plan of correction. Th	is	
	_	s installed in fire protection			plan of correction does not		
		be tested annually by			constitute an admission of gui	It or	1
	_	rd flow test of the system at			liability by the facility and is		
	_	ate, including hose stream			submitted only in response to	the	1
		rants or inside hose stations			regulatory requirement.		
		eam of the backflow preventer.			Milest compacting settings will be		
	the facility.	ice could affect all residents in			What corrective action will b	е	
	ine facility.				accomplished for those residents found to have been	n	
	Findings include:				affected by the deficient	.1	
	i mamga metade.				practice? The backflow		
	Based on record rev	view with the Maintenance			inspection was completed		
		rate Engineer on 12/28/22 at			12-29-22.		
	_	documented backflow annual			The ceiling construction is		
	· ·	d 12/17/21. Based on interview			scheduled to be completed by	,	
	_	e Maintenance Director stated			1.31.23.		
		spection had not been done					
		led to be done later in the			How will the facility identify		
	week				other residents having the		

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	THE TOTAL CONTESTS	THE SERVICES				21.0.0,00	
STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONST	TRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BUILDI	NG	01	COMPL	LETED
		155220	B. WING	•		12/28	/2022
NAME OF P	PROVIDER OR SUPPLIER	Ł			RESS, CITY, STATE, ZIP COD		
					FIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER	DY	ER, IN	46311		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE	ID		DROVIDEDIS DI ANI DE CODDECTIONI		(X5)
PREFIX		CY MUST BE PRECEDED BY FULL	PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	·	R LSC IDENTIFYING INFORMATION	TAG		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
					otential to be affected by th	e	
	Findings were discu	issed with the Maintenance		-	ame deficient practice? The		
	_	Engineer, and Administrator at			eficient practice has the pote		
	exit conference.	Engineer, and Administrator at			affect all staff, residents, an		
	exit conference.				isitors.	u	
	2 Deced on observe	ation and interview, the facility		l VI	Sitors.		
		ntion and interview, the facility		,,,	/hat magaines :::!!! 4ha f!!!	4	
	failed to maintain the ceiling construction in 1 of 6				/hat measures will the facili	-	
	_	ts. The ceiling traps hot air and			ike or what systems will the		
		rinkler and cause the sprinkler			cility alter to ensure that th		
		ified temperature. NFPA 13,		1 -	roblem will be corrected an	d	
	· ·	1.1 states the distance between			'ill not recur? Maintenance		
		tor and the ceiling above shall			epartment was educated on		
	be selected based on the type of sprinkler and the			re	equired inspections and		
	type of construction	n. This deficient practice		fre	equency of those inspections	s. A	
	could affect all staf	f and residents in one smoke		m	onthly audit will be performe	d for	
	compartment.			6	months of all required		
				in	spections to ensure complia	nce.	
	Findings include:						
	D	on with the Maintenance		l.,		L -	
					ow will the corrective action		
		orporate Engineer on 12/28/22			onitored to ensure the defici		
	_	and 2:22 p.m., in the lobby			ractice will not recur and wha		
		eater there was a six foot			uality assurance program wil		
		drywall ceiling had been taken			ut into place? Copy of audit		
		on could delay the activation			e reviewed at safety committ	ee	
	_	stalled in ceiling. Based on			neeting for a duration of 6		
		e of observation, the Corporate			onths. All other deficient		
	_	e of the issue and was in the		pi	ractices will be immediately		
	process of fixing the	e ceiling.		co	orrected upon occurrence.		
	21.10(1)						
	3.1-19(b)						
					ata af Oammirtiana 4 04 00		
				0	ate of Completion: 1-31-23		
K 0355	NFPA 101						
SS=D	Portable Fire Extir	nguishers					
Bldg. 01	Portable Fire Extir						
J. J.		guishers are selected,					
		d, and maintained in					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPL	ETED
		155220	B. W	ING		12/28/	2022
		<u> </u>		STREET	ADDRESS, CITY, STATE, ZIP COD		
NAME OF F	PROVIDER OR SUPPLIEF	8			HEFFIELD AVE		
DYER NI	JRSING AND REH	ABILITATION CENTER			IN 46311		
	Г		1				(V.F.)
(X4) ID PREFIX		STATEMENT OF DEFICIENCIE		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG		ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
1710		NFPA 10, Standard for		1710			DATE
	Portable Fire Extir						
	18.3.5.12, 19.3.5.12, NFPA 10						
		on, record review, and	K 0	355	Dyer Nursing & Rehabilitation	n	01/10/2023
		ty failed to ensure 1 of 12			Life Safety Code		01/10/2023
		uishers was given maintenance			Recertification and State		
		than one year apart. NFPA			Licensure Survey: 12-28-22		
	_	Portable Fire Extinguishers, at			K 355		
	Section 7.3.1.1.1 re	quires that fire extinguishers			Please accept the following as	s the	
	shall be subjected to	o maintenance at intervals of			facility's plan of correction. Th		
		ar, at the time of hydrostatic			plan of correction does not		
	_	ically indicated by an			constitute an admission of gui	It or	
	_	onic notification. Section			liability by the facility and is	·	
		guisher maintenance as a			submitted only in response to	the	
	_	on of the fire extinguisher that			regulatory requirement.		
		maximum assurance that a fire					
		perate effectively and safely			What corrective action will b	е	
		physical damage or condition			accomplished for those		
		ration, if any repair or			residents found to have been	n	
	1 -	essary, and if hydrostatic			affected by the deficient		
	_	naintenance is required. each fire extinguisher shall			practice? The fire extinguish	er in	
		securely attached that			the Maintenance office was	ıto.	
		and year the maintenance was			inspected and is now up to da	uc.	
		es the person performing the			How will the facility identify		
	1 ^	s the name of the agency			other residents having the		
		k. This deficiency could affect			potential to be affected by th	ie	
	Maintenance staff.				same deficient practice? The		
					deficient practice has the pote		
	Findings include:				to affect all staff, residents, and		
	_				visitors.		
	Based on an observ	ation with the Maintenance					
	Director and Corpo	rate Engineer on 12/28/22			What measures will the facil	ity	
	between 12:43 p.m.	and 2:22 p.m., the tag on an			take or what systems will the	e	
	ABC extinguisher in the Maintenance Office was				facility alter to ensure that the	ne	
	dated December 2021. Based on record review, the				problem will be corrected an	ıd	
	contracted company for maintenance of fire				will not recur? Maintenance		
		acted the annual inspection on			department was educated on		
		interview at time of			ensuring all fire extinguishers		
	observation, the Ma	intenance Director agreed			inspected monthly for 3 month	ıs.	

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	T OF DEFICIENCIES DF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 155220	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 12/28/2022
	ROVIDER OR SUPPLIER JRSING AND REHA	ABILITATION CENTER	601 SH	ADDRESS, CITY, STATE, ZIP COD HEFFIELD AVE , IN 46311	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	inspection and miss This finding was re	viewed with the Maintenance Engineer, and Administrator at		How will the corrective action monitored to ensure the defici practice will not recur and what quality assurance program with put into place? Copy of audit be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	ent at II be <i>will</i>
				Date of Completion: 1-10-23	
K 0511 SS=B Bldg. 01	complies with NFF Code, electrical w complies with NFF Code. Existing ins service provided r 18.5.1.1, 19.5.1.1, Based on observation failed to ensure 1 of Lobby Hall was encrequires electrical with NFPA 70, Nat 406.5 (F) states exp shall be enclosed so	Electric gas or related gas piping PA 54, National Fuel Gas iring and equipment PA 70, National Electric tallations can continue in to hazard to life.	K 0511	Dyer Nursing & Rehabilitation Life Safety Code Recertification and State Licensure Survey: 12-28-22 K 511 Please accept the following as facility's plan of correction. The plan of correction does not	s the
	-	dents in the 100 hall.		constitute an admission of gui liability by the facility and is submitted only in response to regulatory requirement.	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER		JILDING	01	l	COMPLETED	
		155220	B. WI	ING		12/28/	2022	
	PROVIDER OR SUPPLIER	ABILITATION CENTER		601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION		TAG	DEFICIENCY)		DATE	
	REGULATORY OF Based on observation Director and Corporate between 12:43 p.m. Lobby Hall attice the that was not enclose terminals. Based or observation, the Cocame off when the in the attic from a version of the composition of the them.	on with the Maintenance rate Engineer on 12/28/22 and 14:22 p.m., in the Main ere was an electrical receptacle ed and had exposed metal interview at time of exporate Engineer stated that it sprinkler company was working			What corrective action will be accomplished for those residents found to have beer affected by the deficient practice? The electrical outlet the Main Lobby was closed winew 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 pote to affect all staff, residents, and visitors. What measures 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 complete for 3 months to ensure compliance. How will the corrective action is monitored to ensure the deficient practice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committe meeting for a duration of 3	e t in th a e ntial d ty e d ng ed. ed be ent tt		
					months. All other deficient practices will be immediately corrected upon occurrence.			

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Event ID:

JOJW21 Facility ID: 000125

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220			 JILDING	nstruction <u>01</u>	(X3) DATE SURVEY COMPLETED 12/28/2022	
	ROVIDER OR SUPPLIER	ABILITATION CENTER	601 SH	NDDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
				Date of Completion: 1-10-23		
K 0923 SS=E Bldg. 01	Storag Gas Equipment - O Storage Greater than or eo Storage locations and ventilated in a and 5.1.3.3.3. >300 but <3,000 o Storage locations enclosure or within space of non- or li construction, with that can be secure stored with flamma from combustibles sprinklered) or enc noncombustible or minimum 1/2 hr. fi Less than or equa ln a single smoke cylinders available patient care areas of less than or equ required to be stor Cylinders must be as specified in 11. A precautionary si on each door or gr room, where the s a minimum "CAUT STORED WITHIN Storage is planner	are outdoors in an an enclosed interior mited- combustible door (or gates outdoors) and. Oxidizing gases are not ables, and are separated by 20 feet (5 feet if closed in a cabinet of construction having a re protection rating. I to 300 cubic feet compartment, individual a for immediate use in with an aggregate volume and to 300 cubic feet are not red in an enclosure. handled with precautions 6.2. gn readable from 5 feet is ate of a cylinder storage ign includes the wording as ION: OXIDIZING GAS(ES)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	î î		(X3) DATE	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER	A. BU	JILDING	01	COMPI	LETED
		155220	B. W	ING		12/28	/2022
NAME OF I				STREET A	ADDRESS, CITY, STATE, ZIP COD		
NAME OF I	PROVIDER OR SUPPLIEF	(601 SH	EFFIELD AVE		
DYER N	URSING AND REH	ABILITATION CENTER		DYER,	IN 46311		
(X4) ID		STATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION	+	TAG	BEFFERET		DATE
		cylinders are segregated . When facility employs					
	_	gral pressure gauge, a					
	threshold pressure considered empty is established. Empty cylinders are marked to						
	avoid confusion. Cylinders stored in the open						
	are protected from	· ·					
	-	.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		K 0	923	Dyer Nursing & Rehabilitatio	n	01/10/2023
					Life Safety Code		
					Recertification and State		
	avoid confusion. This deficient practice could				Licensure Survey: 12-28-22		
	_	lents and staff in one smoke			K 923		
	compartment.				Please accept the following as		
	F' 1' ' 1 1				facility's plan of correction. Th	IS	
	Findings include:				plan of correction does not	14	
	Rased on observativ	ons with the Maintenance			constitute an admission of gui liability by the facility and is	IL OF	
		rate Engineer on 12/28/22			submitted only in response to	the	
		and 2:22 p.m., the oxygen			regulatory requirement.	uic	
		to rooms 107 and 178			regulatory requirement:		
	_	that did not separate full			What corrective action will b	е	
		ty cylinders but on the floor			accomplished for those		
		linders mixed with full and			residents found to have been	n	
	empty and not mark	xed. Based on interview at the			affected by the deficient		
	time of observation	, the Corporate Engineer stated			practice? The proper signage	е	
	there were cylinder	s on the floor that were both			was placed in the oxygen roor	m	
	full and empty.				and all cylinders have been		
					segregated.		
	_	reviewed with the Maintenance					
	_	Engineer, and Administrator			How will the facility identify		
	during the exit conf	ference.			other residents having the	_	
	3 1 10(b)				potential to be affected by the		
	3.1-19(b)				same deficient practice? The		
					deficient practice has the pote to affect all staff, residents, an		
					visitors.	iu	
					7.5.1076.		
					What measures will the facili	itv	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 12/28/2022	
	PROVIDER OR SUPPLIE	L R ABILITATION CENTER	1	601 SH	ADDRESS, CITY, STATE, ZIP COD EFFIELD AVE IN 46311		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADEFICIENCY)	ATE	(X5) COMPLETION DATE
TAG	REGULATORY O	X LSC IDEN HEY FING INFORMATION		IAU	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 oxygent cylinders are segregated based if they are Full or Empty. A weekly audit will be completed 3 months to ensure compliant of the will the corrective action monitored to ensure the deficit practice will not recur and what quality assurance program will put into place? Copy of audit be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	ne nd ed on d for ce. be ient at II be will	DATE
K 0000							
Bldg. 04	Licensure Survey v	000125 155220	K 00	000	The facility kindly requests a creview.	desk	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTII A. BUILDI B. WING		04	(X3) DATE S COMPL 12/28/	ETED		
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 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		PREI	ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
K 0211 SS=E	At this Life Safety Cand Rehabilitation Compliance with Re Medicare/Medicaid, Life Safety from Fir National Fire Protect LSC (Life Safety Constitution Rehabilitation hall a with Chapter 18, New This one story facility Type V (111) constitution that a capacity has a first smoke detection in a rand in spaces open thas a capacity of 16 the time of this survey All areas where resident and all areas provides sprinklered.	Code survey, Dyer Nursing Center was found not in quirements for Participation in , 42 CFR Subpart 483.90(a), re and the 2012 edition of the ration Association (NFPA) 101, ode) and 410 IAC 16.2. The and Therapy was surveyed rew Health Care Occupancies. ty was determined to be of ruction and fully sprinklered. re alarm system with hard wired resident rooms, in corridors to the corridors. The facility 1 and had a census of 115 at rey. dents have customary access ing facility services were						
SS=E Bldg. 04	Means of Egress - Aisles, passagewardischarges, exit lo in accordance with of egress is contin all obstructions to emergency, unless through 18/19.2.1, 18.2.1, 19.2.1, 7.1 Based on observation failed to ensure 1 of means of egresses w free of obstructions.	General ays, corridors, exit cations, and accesses are n Chapter 7, and the means uously maintained free of full use in case of s modified by 18/19.2.2 1.	K 0211		Dyer Nursing & Rehabilitation Life Safety Code Recertification and State Licensure Survey: 12-28-22 K 211	1	01/10/2023	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/28/2022				
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION n.	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) Please accept the following as facility's plan of correction. Th plan of correction does not	DATE s the			
	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			constitute an admission of gui liability by the facility and is submitted only in response to regulatory requirement.				
	boxes placed in the interview at the time Engineer stated the be in the storage roo	ce cart with approximately 10 corridor. Based on an e of observation, the Corporate service cart was supposed to om and the resident beds were or for storage. There wasn't		What corrective action will b accomplished for those residents found to have been affected by the deficient practice? The beds and services art were removed from the	ı			
	was removed from the Findings were discu	in other spots. The service cart the corridor upon observation. assed with the Maintenance Engineer, and Administrator at		corridor. The cardboard boxe were moved from the corridor. How will the facility identify other residents having the				
	exit conference. 3.1-19(b)	Zingineor, and Familia and a		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.	e Intial			
				What measures will the facilitate or what systems will the facility alter to ensure that the problem will be corrected an will not recur? Staff were educated on not storing anyth in the corridors. A random we audit will be performed for 3 months of all corridors.	e le d			
				How will the corrective action monitored to ensure the defici practice will not recur and what	ent			

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AND PLAN OF CORRECTION		IDENTIFICATION NUMBER 155220		ILDING	04 	COMPLI 12/28/	ETED
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
					quality assurance program will put into place? Copy of audit was be reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence.	will	
					Date of Completion: 1-10-23		
K 0754 SS=E Bldg. 04	shall not exceed 3 average density of room or space shat gallons/square feet capacity of 32 gallowithin any 64 squalinen or trash collecapacities greater located in a room parea when not attered to be extracted to be extracted in a room parea when not attered to be extracted to be extracted in a room parea when not attered in a room parea when not attered in a requirements when than or equal to 96 and containers for and listed as meet 6921 or equivalent 18.7.5.7, 19.7.5.7	Trash Containers sh collection receptacles 2 gallons in capacity. The f container capacity in a all not exceed 0.5 et. A total container cons shall not be exceeded are feet area. Mobile soiled ection receptacles with than 32 gallons shall be protected as a hazardous ended. colely for recycling are colled from the above re each container is less 6 gallons unless attended, combustibles are labeled ting FM Approval Standard t.	v oʻ	754	Duor Nursing & Pohabilitation		01/10/2023
	failed to ensure 2 so corridor did not exco within a 64 square for	on and interview, the facility biled linen receptacles in the eed 32 gallons in capacity cot area. This deficient t staff and up to 15 residents	K 07	754	Dyer Nursing & Rehabilitation Life Safety Code Recertification and State Licensure Survey: 12-28-22 K 754	1	01/10/2023

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLETED 04 B. WING 12/28/2022 155220 STREET ADDRESS, CITY, STATE, ZIP COD NAME OF PROVIDER OR SUPPLIER 601 SHEFFIELD AVE DYER NURSING AND REHABILITATION CENTER DYER. IN 46311 (X4) ID SUMMARY STATEMENT OF DEFICIENCIE ID (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PREFIX COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION TAG DEFICIENCY) DATE in the smoke compartment. Please accept the following as the facility's plan of correction. This Findings include: plan of correction does not constitute an admission of guilt or Based on observation with the Maintenance liability by the facility and is Director and the Corporate Engineer on 12/28/22 submitted only in response to the between 12:43 p.m. and 2:22 p.m., there was one regulatory requirement. 33-gallon trash receptacle and one 33-gallon linen receptacle next to each other outside resident What corrective action will be room 146. Based on interview at the time of accomplished for those observation, the Corporate Engineer and residents found to have been Maintenance Director agreed there was over 32 affected by the deficient gallons in one smoke compartment. practice? The soiled linen and trash receptacle carts were This finding was reviewed with the Maintenance removed from the corridor. Director, Corporate Engineer, and Administrator at exit conference. How will the facility identify 3.1-19(b) 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

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monitored to ensure the deficient

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER 155220		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 12/28/2022				
NAME OF PROVIDER OR SUPPLIER DYER NURSING AND REHABILITATION CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 601 SHEFFIELD AVE DYER, IN 46311				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		ΓE	(X5) COMPLETION DATE	
					practice will not recur and what quality assurance program will put into place? Copy of audit with the reviewed at safety committed meeting for a duration of 3 months. All other deficient practices will be immediately corrected upon occurrence. Date of Completion: 1-10-23	be will		

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