STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING / B. WING	X3) DATE SURVEY COMPLETED
	155220	A. BUILDING 01 / B. WING	07/01/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DYER NURSING AND REHABILITATION CENTER	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
K 0000 Bldg. 01	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/01/2015 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 Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. 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 151 and had a census of 138 at the time of this survey.	K 0000	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.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	All areas where residents have customary access and all areas providing facility services were sprinklered.			
K 0025 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half 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 and steel 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. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observation and interview, the facility failed to ensure 1 of 1 ceiling smoke barriers and were maintained to provide a half hour fire resistance rating. LSC 8.3.2 requires smoke barriers shall be continuous from an outside wall to an outside wall. This deficient practice could affect 2 residents in resident room 129 and up to 4 residents in the Library. Findings include: Based on observations with the Maintenance Director and Corporate Property Manager on 07/01/15 from 11:08 a.m. then again at 12:20 p.m., one	K 0025	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	07/15/2015

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	half inch ceiling penetration was discovered in resident room 129 around the sprinkler head escutcheon, then again one half inch ceiling penetration in the Library around a cable wire. Based on interview at the time of observation, the Maintenance Director and Corporate Property Manager acknowledged the aforementioned conditions. 3.1-19(b)		regulatory requirement. **K025** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice. Resident room 129 dry wall mud was applied, and fire caulk was used in Library. 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Maintenance Supervisor/Designee to check sprinkler heads in common areas during monthly PM rounds 3. What measures will be put into place or what systematic changes will be made to ensure that the alleged deficient	

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			practice does not recur. Maintenance Supervisor/Designee to check sprinkler heads in common areas during monthly PM rounds 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place. Maintenance Supervisor/Designee to present PM rounds checklist at monthly Safety Committee x 3 months 5. By what date will the systematic changes be complete. 7/15/15	
K 0062 SS=E Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 1. Based on observation and interview, the facility failed to ensure 1 of 1 sprinkler system was continuously maintained in reliable operating condition	K 0062	Dyer Nursing and Rehabilitation Center respectfully requests a	07/15/2015

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	and inspected and tested periodically. NFPA 25, 2-3.2 requires gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced. This deficient practice affects all occupants in the facility including staff, visitors and residents. Findings include: Based on observation with the Maintenance Director and Corporate Property Manager on 07/01/2015 at 12:10 p.m., the sprinkler system located in the Center Equipment room had one of two pressure gauges with a date indicating the gauges were manufactured in 2005. Based on interview at the time of observation, the Maintenance Director and Corporate Property Manager acknowledged the aforementioned condition. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 1 of 5 sprinkler heads in the Walnut room was maintained. This deficient practice could affect staff only.		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. **K062** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice. Center Equipment room gauge was replaced and contracted with Orr to be checked annually, escutcheon in Walnut room was replaced 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken.	

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	Findings include: Based on observations the Maintenance Director and Corporate Property Manager on 07/01/15 at 12:21 p.m., one sprinkler head escutcheon was missing in the Walnut room. Based on interview at the time of observation, the Maintenance Director and Corporate Property Manager acknowledged the aforementioned condition. 3.1-19(b)		All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Orr is contracted to check gauges annually and replace as needed; Maintenance Supervisor/Designee to check sprinkler heads in common areas during monthly PM rounds 3. What measures will be put into place or what systematic changes will be made to ensure that the alleged deficient practice does not recur. Orr is contracted to check gauges annually and replace as needed; Maintenance Supervisor/Designee to check sprinkler heads in common areas during monthly PM rounds 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place.	

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			Maintenance Supervisor/Designee to present monthly PM rounds checklist at monthly Safety Committee x 3 months 5. By what date will the systematic changes be complete. 7/15/15	
K 0072 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 Based on observation and staff interview, the facility failed to maintain the means of egress free from obstructions in one of seven corridors. This deficient practice could affect 48 residents, staff, and visitors. Findings include: Based on observations with the Maintenance Director and the Corporate Property Manager on 07/01/15 at 10:13 a.m., a queen sized bed frame was stored	K 0072	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	07/15/2015

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	in the West South Hall corridor. Based on interview at the time of observation, the Maintenance Director said the bed frame was stored there for him to work on and fix. 3.1-19(b)		liability by the facility and is submitted only in response to the regulatory requirement. **K130** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice. Hospital bed was removed from hallway outside Maintenance office 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Staff was in-serviced to fill out Maintenance request slips when any equipment, including beds, need repair. Staff is to leave equipment needing repair in an area that does not block egress	

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			3. What measures will be put into place or what systematic changes will be made to ensure that the alleged deficient practice does not recur. Staff was in-serviced to fill out Maintenance request slips when any equipment, including beds, need repair. Staff is to leave equipment needing repair in an area that does not block egress. Safety Committee to monitor during weekly Safety Committee rounds 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place. Safety Committee to present rounds checklist at monthly Safety Committee meeting 5. By what date will the systematic changes be complete. 7/15/15	

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K 0130 SS=E Bldg. 01	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure the penetration in 2 of 6 fire barrier walls was maintained to ensure the fire resistance of the barrier. LSC 19.1.1.3 requires all health care facilities to be maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of the occupants. LSC 8.2.3.2.4.2 requires pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through fire barriers shall be protected as follows: (1) The space between the penetrating item and the fire barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the fire barrier, the sleeve shall be solidly set in the fire barrier, and the space between the item and the sleeve shall meet on of the following conditions: a. It shall be filled with a material that is	K 0130	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. **K130** 1. What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice. Penetrations were filled with 3M brand fire barrier and holes repaired (see pictures) 2. How other residents	07/15/2015

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	capable of maintaining the fire resistance of the fire barrier. b. It shall be protected by an approved device that is designed for the specific purpose. This deficient practice could affect residents in 3 of 5 smoke compartments. Findings include: Based on an observation with the Maintenance Director and Corporate Property Manager on 07/01/15 at 12:14 p.m. then again at 1:23 p.m., there were two separate 3/4 inch fire wall penetrations in the Main Hall by the Theater. Then again two penetrations measuring 24 inches by 48 inches and 15 inches by 48 inches in the East North Hall fire wall. Based on interview at the time of observation, the Maintenance Director and Corporate Property Manager acknowledged the aforementioned conditions. 3.1-19(b)		having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Penetrations were filled with 3M brand fire barrier and holes repaired (see pictures) 3. What measures will be put into place or what systematic changes will be made to ensure that the alleged deficient practice does not recur. Any contracted work will be checked by Maintenance Director/Designee for compliance 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place. Safety Committee to be	

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	155220		07/01/2015

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			notified of any contracted work and compliance at monthly Safety Committee meetings 5. By what date will the systematic changes be complete. 7/15/15	
K 0147 SS=D Bldg. 01	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 Based on observation and interview, the facility failed to ensure 3 of 3 flexible cords were not used as a substitute for fixed wiring to provide power equipment with a high current draw. NFPA 70, National Electrical Code, 1999 Edition, Article 400-8 requires that, unless specifically permitted, flexible cords and cables shall not be used as a substitute for fixed wiring of a structure. This deficient practice affects 2 residents and staff. Findings include: Based on observation with Maintenance Director and Corporate Property Manager on 07/01/2015 the following was discovered: A. At 10:08 a.m., a surge protector was	K 0147	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. **K147 - A, B, and C** 1. What corrective action(s)	07/15/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155220	X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING	X3) DATE SURVEY COMPLETED 07/01/2015
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	discovered powering a refrigerator and microwave in the Maintenance Office B. At 10:09 a.m., an extension cord was discovered powering a television. C. At 10:24 a.m., an extension cord was discovered powering a cell phone charger in resident room 182. Based on interview at the time of observation, the Maintenance Director and Corporate Property Manager acknowledged the aforementioned conditions. 3.1-19(b)		will be accomplished for those residents found to have been affected by the alleged deficient practice. Surge protector and extension cords were removed from A, B, and C 2. How other residents having the potential to be affected by the same alleged deficient practice will be identified and what corrective action(s) will be taken. All residents, visitors, and staff have the potential to be affected by the alleged deficient practice. Surge protector and extension cords were removed from A, B, and C 3. What measures will be put into place or what systematic changes will be made to ensure that the alleged deficient practice does not recur. Maintenance Supervisor/Designee to monitor during weekly PM	

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			rounds using Safety Committee rounds checklist (see attached) 4. How the corrective action(s) will be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put into place. Maintenance Supervisor/Designee to present Safety Committee rounds checklist at monthly Safety meeting x 3 months 5. By what date will the systematic changes be complete. 7/15/15	