

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

PRINTED: 04/01/2025  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>155220</b>		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>03/26/2025</b>	
NAME OF PROVIDER OR SUPPLIER  <b>DYER NURSING AND REHABILITATION CENTER</b>				STREET ADDRESS, CITY, STATE, ZIP CODE <b>601 SHEFFIELD AVE</b> <b>DYER, IN 46311</b>			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for the Investigation of Nursing Home Complaints IN00453758, IN00454225, and IN00455534. This visit included the Investigation of Residential Complaint IN00455516.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey and the PSR to the Investigation of Complaints IN00450533 and IN00451791 completed on 2/11/25. This visit included the PSR to the State Residential Licensure Survey completed on 2/11/25.</p> <p>Complaint IN00453758 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00454225 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00455534 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00455516 - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00450533 - Corrected</p> <p>Complaint IN00451791 - Corrected</p> <p>Survey dates: March 25 and 26, 2025</p> <p>Facility number: 000125 Provider number: 155220 AIM number: 100266740</p> <p>Census Bed Type: SNF/NF: 118</p>			F 000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	<p>Continued From page 1</p> <p>Residential: 35 Total: 155</p> <p>Census Payor Type: Medicare: 16 Medicaid: 92 Other: 10 Total: 118</p> <p>Dyer Nursing And Rehabilitation Center was found to be in compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2-3.1 in regard to the to the Investigation of Complaints IN00453758, IN00454225, and IN00455534.</p> <p>Quality review completed on 3/31/25.</p>	F 000			