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	06/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Dyer Nursing and Rehabilitation Center	601 Sheffield Ave Dyer, IN 46311

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to food spillage on the clothing and a shirt raised up exposing the resident's back for 1 of 3 residents reviewed for dignity. (Resident E) Finding includes: During a random observation on 6/18/25 at 9:42 a.m., Resident E was observed sitting in a wheelchair at a table. The resident's shirt was raised up exposing his abdomen, the incontinent brief, and his back and side. There was a wet red stain on the front of the shirt and scrambled eggs were observed on his shorts and lower abdomen. During a random observation on 6/18/25 at 1:15 p.m., the resident was observed sitting in his wheelchair in the main lobby after eating ice cream. There was a white towel over the front of the white shirt. The white shirt was the same one as above and it was still raised up in the back, exposing the resident's sides and back. The red stain was now dried. On 6/18/25 at 1:27 p.m., the resident was observed sitting in his wheelchair in the east unit dining room. The white towel was still in place over the front of him and the white shirt was still lifted up, exposing his side and back. On 6/18/25 at 1:45 p.m., CNA 1 pushed the resident back to his room and was going to lay him down and provide incontinence care. During an interview at that time, the resident indicated he was able to feed himself. During an interview on 6/18/25 at 2:00 p.m., CNA 1 indicated after he was showered and before breakfast, he had a blow out so he was changed. She was aware that his white shirt had a dried red stain on it and saw the dried scrambled eggs in his brief. The record for Resident E was reviewed on 6/18/25 at 3:12 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia, Parkinson's disease, major depressive disorder, high blood pressure, anxiety disorder, and need for assistance with personal care. The 4/3/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had a limited range of motion impairment on one side for both upper and lower extremities. The resident was dependent on staff for toileting, bathing, and dressing and needed substantial to maximum assist with eating. (continued on next page)

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Care Plan, revised on 4/14/25, indicated the resident required assistance with ADLs including eating, and toileting. The approaches were assist with toileting, personal hygiene, and dressing as needed. During an interview on 6/18/25 at 4:15 p.m., the Director of Nursing indicated the resident's shirt should have been pulled down and at least changed. This citation relates to Complaint IN00459057. 3.1-3(t)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on record review and interview, the facility failed to ensure activities of daily living (ADLs) were completed for dependent residents related to incontinence care for 1 of 3 residents reviewed for ADLs. (Resident E) Finding includes: During a random observation on 6/18/25 at 9:42 a.m., Resident E was observed sitting in a wheelchair at a table. The resident's shirt was raised up exposing his abdomen, the incontinent brief, and his back and side. There was a wet red stain on the front of the shirt and scrambled eggs were observed on his shorts and lower abdomen. On 6/18/25 at 1:45 p.m., CNA 1 pushed the resident back to his room and was going to lay him down and provide incontinence care. CNA 2 entered the room with the hoyer lift and assisted CNA 1 with the resident as they put him in the bed. CNA 1 indicated at that time, that she had given the resident a shower before breakfast that morning. She then proceeded to remove the resident's shorts and incontinent brief. The brief was heavily soiled with urine and bowel movement and had the remnants of dried scrambled eggs near his pubic area. During an interview on 6/18/25 at 2:00 p.m., CNA 1 indicated after he was showered and before breakfast, he had a blow out so he was changed, but he had not been changed since then. She was aware and saw the dried scrambled eggs in his brief. The record for Resident E was reviewed on 6/18/25 at 3:12 p.m. Diagnoses included, but were not limited to, stroke, left side hemiplegia, Parkinson's disease, major depressive disorder, high blood pressure, anxiety disorder, and need for assistance with personal care The 4/3/25 Annual Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and had a limited range of motion impairment on one side for both upper and lower extremities. The resident was dependent on staff for toileting, bathing, and dressing and needed substantial to maximum assist with eating. A Care Plan, revised on 4/14/25, indicated the resident was at risk for complications related to bowel and bladder incontinence. The approaches were to check and change as required for incontinence. A Care Plan, revised on 4/14/25, indicated the resident required assistance with ADLs including eating, and toileting. The approaches were assist with toileting, personal hygiene, and dressing as needed. The Bladder Incontinence section in the CNA task section indicated the resident was incontinent of bladder as follows: - 5/23/25: documented at 9:56 a.m. and 9:59 p.m. - 5/25/25: documented at 9:32 a.m. and 9:59 p.m. - 5/26/25: documented at 4:14 a.m. as not applicable and 10:37 a.m. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- 5/31/25: documented at 1:15 a.m. and 11:07 a.m. - 6/1/25: documented at 10:18 a.m. - 6/2/25: documented at 10:48 a.m. and 8:23 p.m. - 6/6/25: documented at 9:23 a.m. and 9:59 p.m. - 6/10/25: documented at 12:41 p.m. and 9:59 p.m. - 6/11/25: documented at 12:40 a.m. and 1:59 p.m. - 6/14/25: documented at 9:39 a.m. and 9:59 p.m. - 6/16/25: documented at 12:06 a.m. and 1:26 p.m. During an interview on 6/18/25 at 4:15 p.m., the Director of Nursing (DON) indicated the CNAs should have provided incontinence care in a more timely manner. The 2/12/21 Incontinence Bowel/Bladder policy, provided by the DON as current on 6/19/25 at 12:14 p.m., indicated a resident who was incontinent of bladder should receive appropriate treatment and services to maintain bladder function. Clinical staff would provide assistance with incontinence care for residents who were incontinent of bladder routinely, including but not limited to brief changes, peri care, clothing changes, and bed linen changes. This citation relates to Complaint IN00459314. 3.1-38(a)(2)(C)