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	11/25/2025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on record review and interview, the facility failed to establish and/or maintain a system that accounted for, periodically reconciled, and ensured the disposition of all controlled drugs, related to lack of documentation of narcotic medication administration for 1 of 1 resident reviewed for misappropriation of property. (Resident M) Finding includes: A Facility Reported Incident (FRI), dated 8/8/25 at 5:01 p.m., indicated an employee was unable to locate scheduled analgesic medication for Resident M. The search was initiated, and the facility was unable to locate the medication. The facility administrator, Director of Nursing (DON), Medical Director, and the resident's responsible party were notified. The resident was assessed and as needed Tylenol was given for pain management. The follow-up indicated that the employee was unable to locate the scheduled analgesic medication for Resident M. A search of all medication carts and medication rooms was initiated. The facility was unable to locate Resident M's medication. A full house narcotic count was conducted at this time. The pharmacy was contacted, and Resident M's medication was re-ordered and the cost was billed to the facility. The drug delivery manifests were reviewed, and staff were working from the date of receipt of medication until current date were interviewed. As a result of staff interviews conducted, the discrepancy with the medication was determined to have occurred between the day shift and evening shift on 8/6/25. Staff working during that timeframe were immediately sent for drug testing and suspended pending test results. One staff member's test result was still in a pending status with the lab. That staff member remains suspended until the results were available. Resident M had been receiving her medications as prescribed. Other residents were interviewed and reported no issues with receiving their medications. The facility's investigation report indicated LPN 8 was interviewed on 8/8/25. LPN 8 reported that she took care of Resident M on 7/30/25 from 12:00 p.m. until 11:00 p.m. The employee reported that she remembered the resident having two cards of Norco (narcotic pain medication) on that day. One card was untouched, and the other had approximately 12-16 pills left. The employee indicated that she worked again on 8/6/25 and received the keys from the unit manager LPN 9. LPN 8 and LPN 9 were about to count the cart and LPN 9 indicated there were only two medication cards in the narcotic box. LPN 8 thought that was odd because when she last worked there were four cards in total in the narcotic box. There were no cards of Norco for Resident M at the time, so she assumed the orders had been changed. When it was time to pass medications, LPN 8 realized Resident M still had active orders for Norco. LPN 8 attempted to get the medication out of the emergency drug kit (EDK), but she was told by the pharmacy that she could not pull a dose from the emergency box. The employee reported that she gave the resident Tylenol for pain at that time. LPN 9 was interviewed by facility staff on 8/8/25. The employee reported that she took care of Resident M on 8/6/25. The employee reported that when she received the medication cart, Resident M had two medication cards of Norco, one of which was full, and the other had about 8 pills left. She reported that she gave Resident M one dose of Norco during her shift. LPN 9 reported off to LPN 8, who was the nurse for the day. LPN 9 initially reported there were two medication cards for another resident in the narcotic box when she handed over the keys to LPN 8. When asked what happened to the cards for Resident M, LPN 9 responded that there were four medication cards left in (continued on next page)

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.

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the cart. LPN 10 was interviewed by facility staff on 8/8/25. The employee reported that she worked from 3:00 p.m. until 11:00 p.m. on 8/3/25. During the shift she recalled there being two cards of Norco for Resident M. She indicated that one card was full and the other was the card they were pulling medications from. Resident M's medications were all available and given during her shift. RN 7 was interviewed by facility staff on 8/9/25. The employee reported that she remembered receiving Resident M's Norco from pharmacy. She recalled that there were still a few pills left in the current card, and she received 2 more cards from pharmacy. She had placed them in the narcotic box. A Packing Slip Proof of Delivery, dated 7/29/25, indicated two hydrocodone-acetaminophen (Norco) tablets 7.5-325 milligram medication cards containing 21 pills each were delivered on 7/29/25. RN 7 signed on the signature page. Resident M's record was reviewed on 11/25/25 at 12:56 p.m. A Physician's Order, dated 7/16/25, indicated hydrocodone-acetaminophen tablet 7.5-325 milligrams (mg) give 1 tablet by mouth three times a day for pain.The August 2025 Medication Administration Record (MAR) indicated the hydrocodone-acetaminophen 7.5-325 mg was not administered on 8/6/25 at 10:00 p.m., 8/7/25 at 10:00 p.m., and 8/8/25 at 2:00 p.m. Each dose was marked 9 - other/see progress notes. On 8/7/25 at 2:00 p.m., the MAR was left blank. There were no narcotic count sheets available for Resident M. During an interview on 11/25/25 at 12:37 p.m., the Nurse Consultant indicated LPN 8 had worked and realized a medication card was missing since the last shift she worked. The medication was not available in the narcotic box, so she went to pull the medication from the EDK, however the pharmacy told her that the medication had just been filled, and she was unable to pull the medication. Once they were notified of the missing medication cards, they started to interview staff that had taken care of Resident M. There were no identified problems with narcotics until the interviews occurred with LPN 8 and LPN 9. LPN 8 indicated when she arrived for her shift, there were no Norco medication cards in the cart. When LPN 9 was interviewed she had said there were two medication cards in total in the narcotic box, and they belonged to another resident. When LPN 9 was asked where Resident M's Norco pills were, she then changed her story and said there was a total of four medication cards in the box. There was a full house sweep to determine if any other resident's medications were missing which included reviewing all of the narcotic count sheets. The medication cards for Resident M were not in the narcotic box and the narcotic count sheet was also missing. Both LPN 8 and LPN 9 were sent for drug testing. It appeared that LPN 9 had tampered with the urine test completed on 8/8/25 and had a rescheduled test again on 8/14/25. Based off the inconsistency with LPN 9's interview and the appearance of her tampering with the drug test, she was then immediately terminated. After this occurred, a new procedure was put into place. During change of shift hand-off, the nursing staff must fill out a count sheet that now includes how many total cards are in the narcotic box as well as an actual count of the medication pills. During a follow-up interview on 11/25/25 at 1:50 p.m., the Nurse Consultant indicated it was standard of care for the nursing staff to do a change of shift narcotic count and fill out the narcotic count sheet. They did not have any policies related to narcotic counts. The staff did not have a formal in-service for their nursing staff related to the new procedure of the narcotic count. This citation relates to Intake 2593183. 3.1-25(b)(3)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure a resident's blood pressure was monitored per Physician's Orders, for a resident who was receiving multiple medications for hypertension. (Resident B)Finding includes:Resident B's record was reviewed on 11/24/25 at 9:56 a.m. The diagnoses included, but were not limited to, hypertensive heart disease and chronic kidney disease.The following Physician's Orders indicated medications that affect the blood pressure:8/20/25, spironolactone (anti-hypertensive/heart failure medication) 50 milligrams (mg) daily.8/29/25, midodrine (treatment of orthostatic hypotension) 5 mg three times a day for major side effect systolic supine hypertension.8/29/25, a Physician's Order indicated vital signs were to be checked every shift.9/2/25, metoprolol tartrate (beta-blocker to treat hypertension) 25 mg twice a day.9/4/25, bumetanide (diuretic) 1 mg twice a day.The Medication Administration Record, dated 11/2025, indicated the vital signs had not been ochecked every shift as ordered by the physician.During an interview, on 11/25/25 at 12:18 p.m., the Director of Nursing indicated the order had not been transcribed to the Medication Administration Record.A facility medication administration policy, dated 10/2014 and received as current from the RN Nurse Consultant, indicated, .Monitoring of side effects or medication-related problems occurs continually.This citation relates to Intake 2617694.3.1-48(a)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure correct Personal Protective Equipment (PPE) was used by staff members (CNA 1 and CNA 2) when providing care to residents who were in Enhanced Barrier Precautions (EBP) and Contact Isolation, for 2 random observations. (Residents E and L) Findings include: 1. During an observation on 11/24/25 at 4:52 a.m., CNA 1 responded to Resident E's call light and the resident indicated she needed her incontinence brief changed. There was a sign on the outside of the entry door that indicated Contact Isolation and EBP precautions were required. CNA 1 completed hand hygiene, applied gloves and prepared the supplies for the care. She indicated she was ready to start the care and was stopped prior to the administration of care. CNA 1 walked to the entry door and observed the sign on the door and then donned a gown. Resident E's record was reviewed on 11/25/25 at 10:32 a.m. The diagnoses included, but were not limited to, diabetes mellitus, urinary tract infection (UTI), and Klebsiella Pneumoniae (bacteria). An admission Minimum Data Set (MDS) assessment, dated 10/24/25, indicated maximum assistance was required for toileting and bathing and she was occasionally incontinent of bowel and bladder. A Care Plan, dated 11/3/25, indicated EBP for Klebsiella Pneumoniae was required. The interventions indicated the facility protocol for EBP would be followed. A Physician's Order, dated 11/3/25, indicated EBP was required due to Klebsiella Pneumoniae in the urine. A gown and gloves were to be used for high contact resident care activities. 2. During an observation on 11/24/25 at 5:09 a.m., CNA 2 was in Resident's L room. The resident was lying in bed and the covers were off the resident. CNA 2 indicated she had just completed incontinence care and there was a soiled brief in the waste basket. CNA 2 was wearing gloves but no gown. The entry door had a sign that indicated both residents of the room required EBP. CNA 2 indicated she was unsure of the facility's EBP policy and then read the EBP sign on the door.Resident L's record was reviewed on 11/25/25 at 11:59 a.m. The diagnoses included, but were not limited to, spinal stenosis and urinary tract infection.An Annual MDS assessment, dated 10/3/25, indicated maximum assistance was required for toileting and bed mobility, was dependent on staff for bathing, and moderate assistance was required for hygiene. The resident was frequently incontinent of bowel and bladder.A Physician's Order, dated 11/12/25, indicated EBP was required related to multidrug-resistance organisms (MDROs)in the urine. Gown and gloves were required for high contact resident care activities.During an interview on 11/25/25 at 2:18 p.m., the RN Nurse Consultant indicated CNA 2 was a new employee and was still in orientation.A facility EBP policy (Centers for Clinical Standards and Quality, Safety & Oversight Group Memorandum. Reference: QSP-24-08-NH), dated 3/2024 and received from the RN Nurse Consultant as current, indicated EBP was required for residents with any MDROs. EBP was to be for, but not limited to, dressing, bathing, hygiene, changing briefs.3.1-18(b)