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	01/22/2026

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 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 observation, record review, and interview, the facility failed ensure residents who were dependent on staff for activities of daily living (ADL's) received bathing at least twice a week and failed to ensure a resident received incontinence care timely, for 3 of 3 residents reviewed for ADL assistance. (Residents C, B, and D)Findings include:1. During an observation on 1/21/26 at 10:12 a.m., Resident C was lying in bed, the bed sheet was not covering the resident, and the incontinence brief was visible and was observed to be saturated with urine. She indicated she was waiting to be cleaned up. The resident's call light had not been activated and when asked, she indicated she thought it was on. The call light was then activated by the resident at 10:13 a.m. RN 1 entered the room at 10:15 a.m. and the resident indicated she needed her incontinence brief changed. RN 1 turned the call light off and indicated the CNA assigned to her would be notified and then left the room. The resident was interviewed while she waited for staff to return and indicated she received bathing, sometimes once in two weeks. and then it just depends. She indicated she had gone six weeks without being bathed. When she had asked the staff in the past to change her brief, they would tell her they would change her after lunch and then they never return to provide care. She indicated the last time she had her brief changed was before the day shift came in around 6:00 a.m. She drank a lot of water due to her kidneys and she had to urinate a lot. At 10:46 a.m., CNA 2 and RN 1 entered the room. CNA 2 indicated she was assigned to care for the resident and had just been informed the resident needed incontinence care. CNA 2 indicated she started her shift at 7:00 a.m. and this was the first time she checked the resident for incontinence. Incontinence care was then provided by CNA 2 and RN 1.The Director of Nursing (DON), Corporate Nurse, and the Administrator were notified of the observation on 1/21/26 at 11:17 a.m. No further information was received.During an interview on 1/21/26 at 11:04 a.m., RN 1 indicated he could not recall who he had informed the resident needed incontinence care when he had turned the call light off and left the room at 10:15 a.m. Resident C's record was reviewed on 1/21/26 at 3:06 p.m. The diagnoses included, but not limited to, chronic kidney disease, history of urinary tract infections, and diabetes mellitus.A Quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, indicated an intact cognitive status, was dependent on staff for bathing and toileting, required maximum assistance with bed mobility, and was always incontinent of bowel and bladder.A Care Plan, last reviewed on 12/15/25, indicated assistance with ADL's was required. The interventions indicated assistance with bathing would be offered at least two times daily and a bed bath would be offered on non-shower days or with shower refusals, assistance would be given with incontinence care.The shower schedule indicated a shower/bathing was to be completed on Tuesday and Friday mornings. The bathing input forms for 11/2025, 12/2025, and 1/2026, received from the DON, indicated the resident received only four of eight scheduled bathing for November 2025, four of nine scheduled bathing for December 2025, and four of six scheduled bathing in January 2026.The DON was informed of the missed bathing days on 1/21/26 at 3:45 p.m., no further information was received.2. Resident B's (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	closed record was reviewed on 1/21/26 at 1:07 p.m. The diagnoses included, but were not limited to, dementia and bipolar disorder.A Care Plan, dated 9/2/25, indicated assistance was required for ADL care. The interventions included assistance would be provided for hygiene care.The Quarterly MDS assessment, dated 12/22/25, indicated an intact cognitive status, no behaviors, was dependent on staff for toileting, bathing, and hygiene, and was always incontinent of bowel and bladder.A Care Plan, dated 1/8/26, indicated the resident was resistive to care. The interventions indicated the resident would be allowed to make decisions about treatment and would be educated of the possible outcome of not complying with the treatment or care.The shower schedule indicated a shower/bathing was to be completed on Monday and Thursday days. The bathing input forms for 11/2025, 12/2025, and 1/2026, received from the DON indicated she received three of the eight scheduled bathing in November 2025. November 3, 17, 27, 2025 were left blank and November 13 and 20 were marked non-applicable. She received one bed bath in December on 12/25/25. December 1, 4, 7, 11, 15, 18, 22, and 29, 2025 were marked with non-applicable. There were no showers or bathing provided in January prior to the resident being discharged from the facility on 1/23/26.There was no documentation that indicated the resident resisted or refused the bathing.During an interview on 1/21/26 at 2:00 p.m., the DON indicated she was unable to locate any documentation the resident refused the bathing. She acknowledged the care plan indicated she resisted care, not refused care, and there was a lack of bathing at least twice a week for the resident.3. During an interview on 1/21/26 at 9:56 a.m., Resident D indicated she only gets bathed if she asked the staff to bathe her.Resident D's record was reviewed on 1/22/26 at 8:39 a.m. The diagnoses included, but were not limited to, diabetes mellitus and schizophrenia.A Care Plan, dated 8/2/25, indicated assistance was required for ADL's. The interventions included assistance would be provided for hygiene.A Quarterly MDS assessment, dated 12/10/25, indicated an intact cognitive status, no behaviors, and dependent for toileting and bathing. The bathing schedule indicated bathing was to be completed on Tuesday and Friday evenings. The bathing input forms for 11/2025, 12/2025, and 1/2026, received from the DON indicated she received four of eight scheduled bathing in November 2025. November 4, 14, 28, and 25, 2025 was marked with non-applicable. She received five of nine scheduled bathing in December 2025. December 2, 5, 16, and 30, 2025 was marked with non-applicable.During an interview with the DON on 1/21/26 at 3:45 p.m., she had no further information about the bathing.During an interview on 1/22/26 at 9:45 a.m., the DON indicated she had not found any other information about the missed bathing.A facility ADL policy, dated 2/26/21 and received from the Administrator as current, indicated a resident who was unable to carry out ADL's would receive the necessary services to maintain personal hygiene.A facility bowel and bladder incontinence policy, dated 2/12/21 and received from the Administrator as current, indicated the staff would provide assistance with incontinence care for residents who were incontinent routinely, including but not limited to brief changes, peri care, clothing and linen changes.This citation relates to Intake 2687036.3.1-38(a)(3)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on record review and interview, the facility failed to ensure a resident received treatment and care in accordance with professional standards of practice, related to blood sugars not completed and medications not administered as ordered by a physician, for 1 of 3 residents reviewed for quality of care and receiving medications as ordered. (Resident G)Finding includes:Resident G's record was reviewed on 1/22/26 at 10:01 a.m. The diagnoses included, but were not limited to, dementia and diabetes mellitus.A Care Plan, dated 2/4/25, indicated the resident had diabetes mellitus. The interventions indicated medication would be administered as ordered.A Care Plan, dated 10/29/25, indicated the resident refused medication. the interventions indicated medications would be crushed as needed and/or when she expresses unable to swallow the medication. The reason for the medication would be explained to the resident.An Annual Minimum Data Set assessment, dated 11/5/25, indicated a severely impaired cognitive status and received insulin and an antipsychotic medications.A Physician's Order, dated 5/25/25, indicated humalog insulin was to be administered at 9:00 a.m. and 5:00 p.m. daily after a blood glucose test was completed. The amount of insulin to be administered was dependent on the results of the blood glucose results (sliding scale).The Medication Administration Record (MAR), dated 12/2025, indicated the blood glucose testing had not been completed on 12/16/25 at 5:00 p.m., 12/17/25 at 9:00 a.m. and 12/26/25 at 9:00 a.m. There were no blood sugar results or documentation the insulin was or was not administered.There were no glucose results documented in the Progress Notes or on the blood glucose listings in the record.A Physician's Order, dated 5/24/25, indicated olanzapine (antipsychotic) 2.5 milligrams (mg), one tablet was to be given three time a day for psychosis. The medication was scheduled for 6:00 a.m., 2:00 p.m., and 6:00 p.m.The MAR, dated 12/2025, indicated the olanzapine was refused at 6:00 a.m. on December 1, 2, 5, 6, 8, 9, 10, 12, 13, 15, 18, 19, 21, 23, 24, 25, and 26, 2025.The MAR, dated 1/2026, indicated the olanzapine was refused at 6:00 a.m. on January 1, 2, 3, 5, 11, and 19, 2026.There was no documentation that indicated the Physician had been notified of the medication not received. There was no documentation that indicated the care plan intervention had been followed of crushing the medication or the reason the olanzapine had been refused.During an interview on 1/22/26 at 12:06 p.m., the Director of Nursing indicated she had spoken to the nurse scheduled for the refusal days and he indicated the resident was agitated in the morning. No other interventions had been attempted.A medication administration policy, dated 10/25/14 and identified as current from the Administrator, indicated medications were to be administered in a safe, accurate, and effective manner.This citation relates to Intake 2706590.3.1-37

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on record review and interview, the facility failed to ensure a urinalysis (UA) with culture and sensitivity (C&S) laboratory test was completed as ordered for 1 of 1 resident reviewed for laboratory testing. (Resident C) Finding includes:During an interview on 1/21/26 at 10:15 a.m., Resident C indicated she has had urinary tract infections and that she has burning with voiding for a while. She indicated they had tried different medications and they could not get rid of the infection.Resident C's record was reviewed on 1/21/26 at 3:06 p.m. The diagnoses included, but were not limited to, chronic kidney disease, history of urinary tract infections, and diabetes mellitus.A Quarterly Minimum Data Set (MDS) assessment, dated 11/20/25, indicated an intact cognitive status, was dependent on staff for bathing and toileting, required maximum assistance with bed mobility, and was always incontinent of bowel and bladder.A Care Plan, last reviewed on 12/15/25, indicated enhanced barrier precautions were required related to a multi-drug resistant organism urinary tract infection. A Nurse's Progress Note, dated 12/29/25 at 1:41 p.m., indicated the resident had complaints of burning with urination. The Nurse Practitioner was notified and an order for a UA with C&S was obtained.A Nurse Practitioner's order, dated 12/30/25, indicated a UA with C&S was to be collected.There was no documentation in the record that indicated the laboratory test had been completed.During an interview on 1/21/26 at 3:45 p.m., the Director of Nursing indicated the UA C&S had not been completed.This citation relates to Intake 2687036.3.1-49(f)(1)