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	06/03/2026

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 - Some	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 to ensure activities of daily living (ADLs) were completed for dependent residents related to assistance with shaving, hair washing, checking for incontinence, oral care, nail care and providing assistance with eating for 14 of 16 residents reviewed for ADLs. (Residents F, G, B, P, Q, R, S, T, N, J, K, H, L, and M) Findings include:1. On 5/27/26 at 9:46 a.m., Resident F was observed with a growth of facial hair. During an interview at that time, the resident indicated he wanted to be shaved. On 5/27/26 at 2:56 p.m., the resident's facial hair remained. On 5/28/26 at 9:06 a.m., 11:14 a.m., and 1:45 p.m., the resident's facial hair remained. During an interview on 5/28/26 at 1:45 p.m., the resident indicated he was still waiting to be shaved. The record for Resident F was reviewed on 5/28/26 at 2:57 p.m. Diagnoses included, but were not limited to, stroke and lack of coordination. A Care Plan, dated 8/8/25 and reviewed on 5/1/26, indicated the resident required assistance with ADLs (activities of daily living) including bed mobility, eating, transfers, toileting, and bathing related to the diagnoses of right above the knee amputation, left below the knee amputation, history of stroke, and incontinence. Interventions included, but were not limited to, assist with personal hygiene including dressing and grooming as needed. Encourage self participation as able. The Quarterly Minimum Data Set (MDS) assessment, dated 5/5/26, indicated the resident was moderately impaired for daily decision making and he was dependent on staff for bathing and personal hygiene. The May 2026 Bath and Skin Reports provided by the facility indicated the resident was shaved on 5/7, 5/21, 5/25, and 5/28/26. During an interview on 5/28/26 at 4:30 p.m., the Administrator and Nursing Consultant 1 indicated the resident would be shaved. 2. On 5/26/26 at 11:00 a.m., Resident G was observed in her room in bed. Her hair was greasy in appearance. On 5/27/26 at 10:38 a.m., the resident's hair remained greasy. During an interview at that time, the resident indicated she needed her hair washed. At 3:04 p.m., the resident's hair remained greasy. On 5/28/26 at 9:10 a.m. and 2:40 p.m., the resident's hair remained greasy. (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 - Some	On 5/31/26 at 7:45 a.m. and 9:15 a.m., the resident's hair remained greasy. On 6/1/26 at 9:15 a.m., the resident was observed with greasy hair. The record for Resident G was reviewed on 6/1/26 at 1:22 p.m. Diagnoses included, but were not limited to, stroke and hemiplegia/hemiparesis (muscle weakness and paralysis) following a stroke affecting the left non-dominant side. The Quarterly Minimum Data Set (MDS) assessment, dated 4/24/26, indicated the resident was cognitively intact and dependent on staff for bathing and personal hygiene. A Care Plan, dated 5/1/26, indicated the resident required assistance with ADLs (activities of daily living) including bed mobility, transfers, toileting and bathing related to diagnoses of hemiplegia, metabolic encephalopathy (altered brain function), weakness, incontinence, and impaired mobility. Interventions included, but were not limited to, assist with personal hygiene including dressing and grooming as needed. Encourage self participation as able. The May 2026 Bath and Skin Report provided by the facility indicated there was no documentation of the resident's hair being washed on 5/4, 5/7, 5/11, 5/14, 5/18, 5/21, 5/25, and 5/28/26. On 6/2/26 at 8:55 a.m., the resident was observed in her room in bed. Her hair had been washed and was clean in appearance. During an interview on 6/2/26 at 4:04 p.m., the Administrator indicated the resident's hair should have been washed in a more timely manner. 3. During a confidential interview on 5/29/26 at 1:29 p.m., it was indicated the resident was always wet and never changed every two hours. When visiting, for example from 9:00 a.m. to 2:00 p.m., the resident was not changed. During a return visit at 4:00 p.m. the same day, the resident was soaked and had still not been changed. During a continuous observation on 6/1/26 beginning at 9:25 a.m., Resident B was seated in a broda chair in the East Unit dining room. At 11:10 a.m., the resident was moved from the dining room and positioned across from the nurse's station. At 11:45 a.m., the resident was taken back into the East Unit dining room for lunch. At 11:58 a.m., the resident was being fed lunch. During this time frame, the resident was not taken back to his room and checked for incontinence. During a continuous observation on 6/2/26 beginning at 8:57 a.m., the resident was again seated in his broda chair in the East Unit dining room. At 12:15 p.m., the resident was being served lunch. During this time frame, the resident remained in the unit dining room and was not taken back to his room and checked for incontinence. The record for Resident B was reviewed on 6/1/26 at 2:57 p.m. Diagnoses included, but were not limited to, dysphagia (difficulty swallowing), stroke, and dementia without behavior disturbance. A Care Plan, dated 12/15/23 and reviewed on 4/3/26, indicated the resident required assistance with ADLs (activities of daily living) including bed mobility, eating, transfers, toileting and bathing related to hemiplegia and hemiparesis (muscle weakness and paralysis). Interventions included, but were not limited to, assist with toileting as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Significant Change Minimum Data Set (MDS) assessment, dated 4/13/26, indicated the resident had short and long term memory problems and was severely impaired for daily decision making. The resident was incontinent of bowel and bladder and was dependent on staff for toileting. During an interview on 6/3/26 at 8:43 a.m., CNA 7 indicated the residents were to be checked and/or changed every two hours and as needed. During an interview on 6/3/26 at 10:00 a.m., Nurse Consultant 1 indicated the residents should be checked for incontinence at least every two hours and as needed. 4. During random observations on 5/26/26 at 10:55 a.m. and 5/27/26 at 10:15 a.m., Resident P was observed sitting in a wheelchair in the memory care dining room. At those times, the resident was unshaven and had long fingernails. During random observations on 5/28/26 at 8:55 a.m., 10:50 a.m., 1:25 p.m., and 2:10 p.m., on 5/29/26 at 7:39 a.m., 8:03 a.m., and 10:25 a.m., and on 5/31/26 at 7:35 a.m., Resident P was observed with a large amount of facial hair. During an interview on 5/28/26 at 1:25 p.m., the resident indicated he liked to be clean-shaven. On 5/31/26 at 9:04 a.m., CNA 1 was observed shaving the resident in the shower room. The record for Resident P was reviewed on 5/28/26 at 2:05 p.m. Diagnoses included, but were not limited to, type two diabetes, dementia, major depressive disorder, bipolar disorder, and anxiety disorder. The 2/23/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed substantial to maximal assistance with personal hygiene. A Care Plan, revised on 1/7/26, indicated the resident required assistance with ADLs including bathing. The approaches were to assist with personal hygiene including grooming as needed. The resident was scheduled for a shower every Wednesday and Saturday on the evening shift. The shower sheets indicated the resident was not shaved on 5/2, 5/13, 5/16, 5/18, and 5/20/26. There was nothing documented on 5/6 and 5/27/26. During an interview on 6/1/26 at 11:00 a.m., the Director of Nursing had no additional information to provide. 5. During an interview on 5/27/26 at 11:50 a.m., Resident Q indicated he had very bad tremors in both hands and it was very difficult to eat sometimes. He indicated that on 5/26/26, he did not eat lunch or dinner because his tremors were too bad and no staff offered to help him. During a meal observation on 5/29/26 at 12:00 p.m., the resident was observed eating lunch. Both hands were observed with mild to moderate tremors and he had to lean all the way forward by the plate to eat so the food would not fall off of the silverware. He was served mashed potatoes, a piece of meat, vegetables, and pink lemonade. The meat was not cut up for him and the lid was still on the lemonade. He did not have his Kennedy cup (a specialized, spill-proof adaptive drinking cup designed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	for individuals with mobility challenges, arthritis, or Parkinson's) for his drink. During a meal observation on 5/31/26 at 8:14 a.m., the resident was observed sitting straight up in the bed. He was eating his food with regular silverware and the built up silverware was not on the tray. He had a cup of orange juice and the Kennedy cup was not observed. He was observed to eat his food with mild to moderate tremors in both hands. The record for Resident Q was reviewed on 5/28/26 at 9:34 a.m. Diagnoses included, but were not limited to, stroke, type two diabetes, major depressive disorder, and anxiety disorder. The 4/24/26 Quarterly Minimum Data Set (MDS) assessment, indicated the resident was cognitively intact for daily decision making, and needed partial to moderate assistance with eating. The resident weighed 145 pounds and has had a significant weight loss. The Care Plan, revised on 7/18/25, indicated the resident required assistance with ADLs including eating. The approaches were to assist with meal consumption, eating and drinking as needed. The Care Plan, revised on 5/26/26, indicated the resident was at risk for impaired nutritional status due to dialysis. The approaches were to provide a Kennedy cup and built up silverware at each meal and provide assistance with meal intake as needed. Provide diet/supplements as ordered by the physician. A Physician's Order, dated 4/24/26, indicated the resident was to receive a liberal renal diet, regular texture, regular thin consistency with a plate guard, a Kennedy cup and built up utensils at meals. During an interview on 6/1/26 at 11:00 a.m., Nurse Consultant 1 was unaware the resident needed help with eating and that he needed a special cup for drinking. She had no additional information to provide. 6. During random observations on 5/26/26 at 10:24 a.m. and 5/27/26 at 11:30 a.m., Resident R was observed in bed with long dirty fingernails. During random observations on 5/28/26 at 8:40 a.m., 10:50 a.m. and 3:15 p.m., the resident was observed in bed with long dirty fingernails and a large amount of food debris in her teeth. On 5/28/26 at 1:26 p.m., Resident R was observed in bed, with long dirty fingernails and food debris in her teeth. Her lunch tray was observed on the over bed table, completely untouched. On 5/29/26 at 8:15 a.m. CNA 3 delivered two breakfast trays to the room, one for Resident R and one for her roommate. The CNA placed Resident R's tray on the over bed table, and moved to the other side of the privacy curtain with the roommate's tray. She then sat down to feed the roommate. At 8:25 a.m., Resident R's tray was still untouched and on the over bed table. At 8:27 a.m., the CNA left the room with the roommate's tray and placed it on the cart. She walked back into the room and prepared Resident R's tray and at 8:28 a.m. began feeding the resident. At that time, the resident's fingernails were still dirty and long and there was a large amount of food in her teeth. On 5/29/26 at 12:00 p.m., Resident R was observed in bed. Her nails were long and dirty and her teeth were full of food debris. At 12:13 p.m. CNA 3 brought the roommate's tray and sat down to feed her. During an interview at 12:16 p.m., CNA 3 indicated Resident R was going to eat after she was finished (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	feeding her roommate. She had left it on the cart so it would stay warm. At 12:18 p.m., the fire alarm went off and the CNA left the room and closed the door. At 12:22 p.m., the Code Red was all clear. The CNA went back into the room to finish feeding the roommate. She finished feeding the roommate at 12:24 p.m., and removed her tray out of the room. At 12:28 p.m., the CNA started to feed Resident R and she was receptive of the food. On 5/29/26 at 2:20 p.m., CNA 3 was asked if she had completed oral care for the resident that morning. She indicated No she had not. She also indicated she had not performed nail care or trimmed her nails. The record for Resident R was reviewed on 5/27/26 at 3:01 p.m. Diagnoses included, but were not limited to, stroke, major depressive disorder, vascular dementia, anxiety disorder, and aphasia (difficulty speaking). The 5/5/26 Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for bathing, oral care, eating, and personal hygiene. A Care Plan, revised on 5/12/26, indicated the resident required assistance with ADLs including eating and bathing. The approaches were to assist with with meal consumption, eating and drinking as needed, assist with oral care as needed and assist with personal hygiene as needed. During an interview on 5/29/26 at 2:30 p.m., the Administrator indicated she was going to address the issues with staff and had no additional information to provide. 7. During random observations on 5/26/26 at 10:55 a.m. and 5/27/26 at 10:17 a.m., Resident S was observed seated in a wheelchair dressed in street clothes. At those times, he had a large amount of facial hair observed to his face, chin and neck areas. The record for Resident S was reviewed on 5/28/26 at 3:40 p.m. Diagnoses included, but were not limited to, type two diabetes, dementia, and depression. The 3/3/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and was dependent on staff for personal hygiene. A Care Plan, revised on 3/8/26, indicated the resident had an ADL self care performance deficit related to dementia. The approaches were to assist with care as needed. The resident received a shower on Tuesday and Friday mornings. The shower sheets indicated the resident was shaved on 5/1 and 5/12/26. The resident was not shaved on 5/5, 5/7, 5/15, 5/19, and 5/21/26. There was no documentation on 5/26/26. During an interview on 6/1/26 at 11:00 a.m., the Director of Nursing had no additional information to provide. 8. During random observations on 5/26/26 at 10:50 a.m. and 12:05 p.m., on 5/27/26 at 10:59 a.m., on 5/28/26 at 8:55 a.m., 10:50 a.m., 1:30 p.m. and 3:00 p.m., on 5/29/26 at 7:38 a.m., 10:30 a.m. and 11:50 a.m., Resident T was observed in bed. At those times, his fingernails were long and dirty with a brown like substance underneath them. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The record for Resident T was reviewed on 5/29/26 at 2:40 p.m. Diagnoses included, but were not limited to, dementia with behaviors, major depressive disorder, and anxiety disorder. The 3/18/26 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed partial to moderate assistance with personal hygiene. A Care Plan, dated 3/27/26, indicated the resident had an ADL self care performance deficit related to dementia. The approaches were to assist as needed. The shower sheets indicated the resident's nails were last trimmed on 5/14/26. Nail care was not completed on 5/5, 5/7, 5/12, 5/19, and 5/21/26. During an interview on 6/1/26 at 11:00 a.m., the Director of Nursing had no additional information to provide. 9. During an interview on 5/27/26 at 9:41 a.m., Resident N indicated her nails were dirty and long and in need of trimming. During random observations on 5/28/26 at 8:50 a.m., 10:50 a.m., on 5/29/26 at 10:30 a.m., and on 5/31/26 at 8:17 a.m., the resident's fingernails were long and dirty. The record for Resident N was reviewed on 6/1/26 at 9:05 a.m. Diagnoses included, but were not limited to, type two diabetes, morbid obesity, and major depressive disorder. The admission Minimum Data Set (MDS) assessment, dated 4/10/26, indicated the resident was cognitively intact for daily decision making and had a functional limitation of range of motion on one side to the upper extremity. The resident needed substantial to max assist with personal hygiene. The Care Plan, revised on 5/19/26, indicated the resident required assistance with ADLs including bathing. The approaches were to assist with personal hygiene as needed. During an interview on 6/1/26 at 10:50 a.m., Nurse Consultant 1 indicated the resident's nails were cleaned and cut on 5/31/26 and she had no additional information to provide. 10. During observations on 5/26/26 at 10:16 a.m., 5/27/26 at 2:38 p.m., 5/28/26 at 8:58 and 4:17 p.m., and 5/29/26 at 10:21 a.m., Resident J's face was unshaven, hair greasy and uncombed, and his shirt dirty with food debris. The resident was wearing the same shirt each day of the observations. The resident's record was reviewed on 5/28/26 at 11:00 a.m. Diagnoses included, but were not limited to, respiratory failure and dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 5/7/26, indicated the resident had moderate cognitive impairment and required moderate assistance with ADLs. There was no documentation of refusal of care since 5/12/26. A Care Plan, revised on 5/18/26, indicated the resident required assistance with ADLs. Interventions included assisting with personal hygiene including dressing/grooming as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 5/28/26 at 4:33 p.m., the Director of Nursing (DON) and the Administrator were informed of the findings. No additional information was received. 11. During observations on 5/26/26 at 10:29 a.m., 5/27/26 at 3:52 p.m., and 5/28/26 at 10:44 a.m., Resident K's face was unshaven, fingernails were long and dirty, and hair greasy and uncombed. The resident's record was reviewed on 6/1/26 at 1:31 p.m. Diagnoses included, but were not limited to, hemiplegia (weakness on one side of the body) following a stroke, and Alzheimer's disease. The Quarterly Minimum Data Set (MDS) assessment, dated 3/16/26, indicated the resident had moderate cognitive impairment, and was dependent for ADLs (activities of daily living). There was no documentation of refusal of care since 5/2/26. A Care Plan, revised 7/14/25, indicated the resident required assistance with ADLs, including bathing. During an interview on 5/28/26 at 4:33 p.m., the Director of Nursing (DON) was informed of the findings. No additional information was received. 12. During random observations on 5/26/26 at 10:52 a.m., 5/27/26 at 3:41 p.m. and 5/28/26 at 10:19 a.m., Resident H's face was unshaven, and his hair was greasy and uncombed. The resident's record was reviewed on 5/29/26 at 11:49 a.m. Diagnoses included, but were not limited to, diabetes, unstageable pressure ulcer of right heel, and foot drop (inability to lift the front part of the foot). The Quarterly Minimum Data Set (MDS) assessment, dated 3/9/26, indicated the resident had moderate cognitive impairment and required substantial/maximal assistance with activities of daily living (ADLs). A Care Plan, revised on 3/15/26, indicated the resident had an ADL self-care performance deficit. There was no documentation of resident refusal of ADL care. During an interview on 5/28/26 at 4:33 p.m., the Director of Nursing (DON) was informed of the findings. No additional information was received. 13. On 5/26/26 at 10:55 a.m., Resident L was observed in his wheelchair, he was unshaven. On 5/27/26 at 10:20 a.m., and 11:22 a.m., the resident was observed in the dining room and was unshaven. The record for Resident L was reviewed on 5/29/26 at 10:22 a.m. Diagnoses included, but were not limited to, heart failure, weakness, dysphagia (difficulty swallowing) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS) assessment, dated 3/2/26, indicated the resident was (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	severely impaired for daily decision making and was dependent with all activities of daily living (ADLs). A Care Plan, dated 7/10/25, indicated the resident had impaired cognitive function related to dementia. A Care Plan, dated 3/6/26, indicated the resident required assistance with ADLs. Interventions were to assist with personal hygiene, which included dressing/grooming as needed. During an interview on 6/1/26 at 2:00 p.m., the Administrator indicated she understood the ADLs concern and had no additional information to provide. 14. On 5/26/26 at 3:21 p.m., Resident M was observed asleep in bed. The resident was unshaven and his hair had not been cut. During an interview at the time, the resident's spouse/roommate and emergency contact indicated the staff does not offer to trim the resident's hair or beard and he was in need of both. On 5/29/26 at 10:25 a.m., and 12:11 p.m., the resident was observed asleep in bed, and he was unshaven and his hair was not cut. The record was reviewed for Resident M on 5/26/26 at 3:30 p.m. Diagnoses included, but were not limited to, dementia, diabetes, anxiety, and heart failure. The Annual Minimum Data Set (MDS) assessment, dated 4/1/26, indicated the resident was severely impaired for daily decision making and was impaired on both sides of the upper and lower extremities. Shower/bathing and personal hygiene required dependent care. A Care Plan, dated 1/3/25, indicated the resident had impaired cognitive function related to dementia. A Care Plan, dated 3/6/26, indicated the resident required assistance with ADLs. Interventions were to assist with personal hygiene, which included dressing/grooming as needed. During an interview on 6/1/26 at 2:00 p.m., the Administrator indicated she understood the ADLs concern and had no additional information to provide. This citation relates to Intakes 2984104, 3010389, and 3026073. 410 IAC (Indiana Administrative Code) 16.2-3.1-38(a)(2)(A) 410 IAC 16.2-3.1-38(a)(3)(B) 410 IAC 16.2-3.1-38(a)(3)(C) 410 IAC 16.2-3.1-38(a)(3)(D) 410 IAC 16.2-3.1-38(a)(3)(E)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview the facility failed to ensure residents who were admitted with or re-admitted with pressure ulcers received a timely assessment and treatment orders for 2 of 6 residents reviewed for pressure ulcers. (Residents C and N) Findings include: 1. On 6/3/26 at 10:29 a.m., the Interim Wound Care Nurse was observed completing treatments to Resident C's right foot, right heel, and sacrum. There was an area of dark skin to the resident's right heel. During an interview at the time, the Interim Wound Nurse indicated the resident's foot and heel were getting better and that the resident was seen weekly by the Wound Physician. The record for Resident C was reviewed on 6/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Parkinson's, type two diabetes, stroke, and hemiparesis/hemiplegia (muscle weakness and paralysis) following a stroke affecting the left non-dominant side. The 3/17/26 Annual Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and he was dependent on staff for bed mobility. The resident had no pressure ulcers at the time of the assessment. The 5/11/26 Discharge Return Anticipated MDS assessment indicated the resident had no open areas. A Care Plan, dated 5/22/26, indicated the resident had a pressure ulcer or potential for pressure ulcer development related to immobility. The resident had actual impairment to his right heel, right medial foot, coccyx, left ear, and right plantar foot. Interventions included, but were not limited to, administer treatments as ordered and monitor for effectiveness and follow the the facility policies/protocols for the prevention/treatment of skin breakdown and weekly treatment documentation to include measurement of each area of skin breakdown's width, length, depth, type of tissue and exudate. A Nurse's Note, dated 4/28/26 at 2:12 p.m., indicated staff had informed the writer (Interim Wound Nurse) that the resident had an open area to his right heel. Upon assessment, the right heel was noted with purple and yellow discoloration, no drainage noted, and the peri wound (area of skin surrounding wound) was pink. The right heel was tender to touch. The physician and the resident's Power of Attorney (POA) were notified and a new treatment was put in place. A Physician's Order, dated 4/28/26, indicated the resident's medial heel was to be cleansed with normal saline, pat dry, apply skin prep and leave open to air. The April 2026 Treatment Administration Record (TAR) indicated the treatment was signed out on 4/29/26 and then it was discontinued on 4/29/26. A Nurse's Note, dated 4/29/26 at 1:43 p.m., was completed by the previous Wound Care Nurse. The entry indicated the writer was notified of possible skin breakdown. Upon assessment, the writer did not observe any skin breakdown. The resident's right heel was intact and no discoloration noted. The writer implemented prevalon boots to bilateral heels. No complaints of pain were voiced and no signs or symptoms of distress noted. Resident's POA notified of boots. A Physician's Order, dated 5/3/26, indicated the resident's right medial heel was to be cleansed with normal saline, pat dry, apply skin prep and leave open to air (LOTA) daily. The treatment was (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discontinued on 5/5/26. There was no skin assessment and measurements of the resident's heel wound on 5/3/26. A Physician's Order, dated 5/5/26, indicated the resident's right medial heel and right medial ankle were to be cleansed with normal saline/wound cleanser, paint with betadine (a topical antiseptic), allow to dry. Cover with one 4 x 4 and secure with a thin layer of rolled gauze daily. The May 2026 TAR indicated the treatments to the right medial heel and right medial ankle were signed out as being completed 5/5-5/11/26. There was no skin assessment and measurements of the resident's heel and ankle wounds on 5/5/26. There was also no documentation indicating the resident's POA was notified of the treatment orders. The resident was sent to the emergency room for evaluation of altered mental status on 5/11/26 and he returned to the facility on 5/18/26. A Nurse's Note, dated 5/18/26 at 7:20 p.m., indicated the resident arrived to the facility via ambulance accompanied by two paramedics and family at the bedside. The resident was alert to person, and place. The resident was able to make needs known. Respirations were even and unlabored. Abdomen soft and non-tender. Skin warm, and dry. The resident had multiple pressure injuries with treatments in place. All orders received and verified with hospice nurse and physician. Per the hospice nurse, a low air loss mattress and frame had been ordered. Documentation in the Wound Rounds section of the resident's record indicated no assessment of the resident's wounds had been completed by facility staff on the resident's readmission on [DATE]. Wound Rounds documentation, completed on 5/22/26, indicated the resident was admitted with a unstageable (a pressure ulcer where the true depth and severity can't be assessed because the wound bed is obscured by dead tissue) pressure ulcer to to the right heel that measured 4 centimeters (cm) in length by 4 cm in width by undetermined depth. A Physician's Order, dated 5/23/26, indicated the resident's right heel and right medial foot were to be cleansed with normal saline or wound cleanser. Apply a thin layer of betadine and LOTA daily. These were the first documented treatment orders since the resident was readmitted on [DATE]. Physician's Orders, dated 5/27/26, indicated the resident's right distal medial foot, right medial foot, right medial heel, and right medial ankle were to be cleansed with normal saline or wound cleanser, pat dry. Apply thin layer of betadine and LOTA every day shift for wound care. The areas were assessed in Wound Rounds on 5/27/26 and identified as being present on admission. This was the first documented assessment of the areas except for the right heel since being readmitted on [DATE]. During an interview on 6/1/26 at 10:10 a.m., the Director of Nursing (DON) indicated they parted ways with the wound nurse due to not documenting wound treatments and not completing assessments. They identified there was a problem with pressure ulcers and developed a Performance Improvement (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan (PIP), however, the facility was not specifically monitoring new admissions or readmissions for wounds. The DON indicated they would just be caught on the random audits they would be doing weekly. The PIP was initiated on 5/7/26 and wounds were to be monitored through 6/4/26. During an interview on 6/3/26 at 2:45 p.m., Nurse Consultant 1 indicated the resident's wounds were assessed by the hospice nurse during his readmission assessment on 5/18/26 and treatments were ordered. Review of the hospice documentation, dated 5/18/26 and provided by the Nurse Consultant, indicated the wounds were staged but not measured. Treatment orders were also given, but not addressed by facility staff. The treatment orders were not listed on the May 2026 TAR on 5/18/26. During a interview on 6/3/26 at 2:50 p.m., Nurse Consultant 1 indicated there was no documentation of the hospice treatment orders on the TAR starting 5/18/26. All of the resident's wounds were assessed by the Wound Physician on 5/27/26 and new orders received. 2. During an interview on 5/27/26 at 10:11 a.m., Resident N indicated she had pressure ulcers but had not seen. The resident was observed lying in bed and wearing heel boots to both feet. During a wound treatment observation on 6/1/26 at 11:25 a.m., the Interim Wound Nurse and LPN 1 donned the appropriate personal protective equipment and entered the resident's room. The right heel boot was removed from the resident's foot. At that time, there was a deep tissue injury (a severe form of pressure ulcer) observed. The area was intact and dark purple in color. The resident's skin to both of her feet was very dry and scaly with skin peeling away. During an interview at that time, the Interim Wound Nurse indicated the wound physician would be seeing the resident on 6/2/26 and would stage the ulcer. The record for Resident N was reviewed on 6/1/26 at 9:05 a.m. Diagnoses included, but were not limited to, chronic respiratory failure, cervical cancer, type two diabetes, morbid obesity, anemia, dyspnea (difficulty breathing), heart disease, high blood pressure, and, major depressive disorder. The resident was admitted to the hospital on [DATE] and returned to the facility on 5/16/26. The admission Minimum Data Set (MDS) assessment, dated 4/10/26, indicated the resident was cognitively intact for daily decision making and had a functional limitation of range of motion on one side to the upper extremity. The resident was at risk for pressure ulcers and currently had none. The Care Plan, revised on 4/15/26, indicated the resident had the potential for pressure ulcer development related to impaired mobility. The approaches were to monitor, document, and report any changes in skin status. The Care Plan, revised on 5/27/26, indicated the resident had a pressure ulcer to the right heel. A Hospital Note, dated 5/15/26, indicated the resident had a deep tissue injury to the right heel that (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was clean and intact and was purple and red in color. A Nurse's Note, dated 5/15/26 at 10:49 p.m., indicated the resident returned from the hospital. A complete head to toe assessment was completed and she had wounds that had dressings that were clean, dry, and intact. The admission Assessment, dated 5/16/26, indicated, DTI (deep tissue injury) bilateral heels. There were no measurements and no assessment of the wounds. A Nurse's Note, dated 5/26/26 at 11:09 a.m., indicated the nurse was notified of the resident having potential skin breakdown. Upon assessment, there was discoloration to her right heel. The physician was notified of the new open area and new orders were received. A Physician's Order, dated 5/27/26, indicated cleanse the right heel with normal saline and apply skin prep every morning. There were no physician's orders for any type of wound treatments prior to 5/26/26 for the right heel. The Weekly Wound Round Assessment indicated the right heel DTI measured 3 centimeters (cm) in length, by 3 cm in width, by unknown. The pressure ulcer was 100% maroon and intact. During an interview on 6/1/26 at 10:10 a.m., the Director of Nursing (DON) indicated they parted ways with the wound nurse due to not documenting wound treatments and not completing assessments. They identified there was a problem with pressure ulcers and developed a Performance Improvement Plan (PIP), however, the facility was not specifically monitoring new admissions or readmissions for wounds. The DON indicated they would be just caught on the random audits they would be doing weekly. The PIP was initiated on 5/7/26 and wounds were to be monitored through 6/4/26. During an interview on 6/1/26 at 11:00 a.m., Nurse Consultant 1 indicated they were getting a new wound nurse and she would look to see if there was any information that a treatment was obtained at the time of admission for the right heel. During an interview on 6/2/26 at 9:30 a.m., the Interim Wound Nurse indicated the wound physician saw the resident on 6/2/26 and assessed the right heel pressure ulcer. The Wound Physician Note, dated 6/2/26, indicated the resident had a DTI to the right heel that measured 1.5 cm in length by 2 cm in width by unknown, was intact, and dark purple and maroon in color. The treatment of skin prep remained the same. This citation relates to Intake 3026073. 410 IAC (Indiana Administrative Code) 16.2-3.1-40(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided related to dining and diet orders for 6 of 6 residents reviewed for accident hazards. (Residents V, D, C, T, U, and E) Findings include:1. On 5/31/26 at 8:11 a.m., Resident V was observed in the East dining room eating her breakfast in front of two other residents. There were no staff members in the dining room while the resident ate her breakfast. The resident ate all of her meal with no staff supervision. The record for Resident V was reviewed on 6/3/26 at 3:45 p.m. Diagnoses included, but were not limited to, Alzheimer's, schizophrenia, and dementia with behavior disturbance. The 4/22/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and required set up or clean up assist with eating. The resident was also identified as having a weight loss. A Care Plan, reviewed on 4/22/26, indicated the resident was at risk for malnutrition. Interventions included, but were not limited to, provide supervision during meals. During an interview on 6/2/26 at 4:04 p.m., the Administrator indicated the resident should have been supervised while eating her breakfast. 2. On 6/1/26 at 11:55 a.m., Resident D was overheard coughing in the East dining room. The resident was holding a cookie in her left hand after taking a bite and she indicated she couldn't eat the cookie. The resident was served mashed potatoes, creamed corn, and ground meat with gravy. Observation of the resident's tray card at the time indicated the resident was to receive a mechanical soft diet with nectar thick liquids. The record for Resident D was reviewed on 6/1/26 at 9:58 a.m. Diagnoses included, but were not limited to, dementia without behavior disturbance and protein-calorie malnutrition. The 3/4/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was cognitively impaired for daily decision making and required supervision or touching assistance with eating. The resident received a mechanically altered diet and had episodes of loss of liquids or solids from her mouth when eating or drinking and holding food in her mouth/cheeks or residual food in her mouth after meals. A Care Plan, reviewed on 2/25/26, indicated the resident required assistance with activities of daily living (ADLs) related to eating. Interventions included, but were not limited to, assist with meal consumption, eating, and drinking as needed. A Physician's Order, dated 5/22/26, indicated the resident was to receive mechanical soft texture pleasure feeds with nectar consistency liquids with a Magic Cup (a nutritional supplement) at lunch. During an interview on 6/2/26 at 4:04 p.m., the Administrator and Nurse Consultant 1 indicated the resident should not have received the cookie. 3. On 6/2/26 at 12:04 p.m., Resident C was observed in the East dining room. The resident received (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	lemonade on his lunch tray which was not thickened. The resident's caregiver brought this to the Social Service Director's attention and asked for a glass of thickened lemonade. The record for Resident C was reviewed on 6/2/26 at 11:05 a.m. Diagnoses included, but were not limited to, Parkinson's and dysphagia (difficulty swallowing). The Annual Minimum Data Set (MDS) assessment, dated 3/17/26, indicated the resident was cognitively impaired for daily decision making and he was dependent on staff for eating. A current Care Plan indicated the resident required assistance with activities of daily living (ADLs) related to eating. Interventions included, but were not limited to, assist with meal consumption, eating and drinking as needed. A Care Plan, dated 5/27/26, indicated the resident was at risk for malnutrition. Interventions included, but were not limited to, provide diet as ordered and one to one feed assist. A Physician's Order, dated 5/18/26, indicated the resident was to receive a pureed diet with honey thickened liquids. During an interview on 6/2/26 at 4:04 p.m., the Administrator and Nursing Consultant 1 indicated the resident's lemonade should have been thickened when he received it. 4. During a breakfast meal observation on 5/31/26 at 7:54 a.m., the meal trays arrived to the [NAME] Memory Care Unit dining room. At that time, Resident T and Resident U were observed sitting at the assistance feeding table. Resident U received her tray first and was assisted with set up and she started to feed herself. Resident T was one of the last resident's to be served as he had to be fed. The CNA sat down and started to assist Resident T to eat. At 9:04 a.m., both Residents T and U were still eating their food. CNA 1 and CNA 2 both left the room to take residents out and the nurse was passing medication on the unit, so that left no staff in the room while the resident's were still eating At 9:06 a.m., another staff member brought another resident a bowl of [NAME] Krispie's, but left because she accidentally put sugar on the cereal and the resident did not want it. CNA 2 came back into the room at 9:06 a.m. and gave Resident T another bite of food and walked away from him and out of the room. He proceeded to chew the food in his mouth over some time. CNA 2 came back into the room at 9:08 a.m. and started to ask other residents if they needed to use the bathroom, however, Resident T was still chewing his food and Resident U was picking at her food and drinking her milk. At 9:10 a.m., she gave Resident T another bite of food and left the room while he was still chewing his food. CNA 2 came back into the room at 9:12 a.m. and looked around and left right away, then came back in again at 9:14 a.m. and left again. Resident T was still chewing his food in his mouth and Resident U was drinking her milk. a. The record for Resident T was reviewed on 5/29/26 at 2:40 p.m. Diagnoses included, but were not limited to, dementia with behaviors, major depressive disorder, and anxiety disorder. The 3/18/26 admission Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making. During an interview on 5/31/26 at 9:06 a.m., CNA 2 indicated the resident has had several falls in the last month and has declined in walking and eating, because staff have to assist him to eat now. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	b. The record for Resident U was reviewed on 6/2/26 at 9:00 a.m. Diagnoses included, but were not limited to, Alzheimer's disease and protein calorie malnutrition. The 2/23/26 Quarterly Minimum Data Set (MDS) assessment indicated the resident was not cognitively intact for daily decision making and needed supervision and cueing for eating. During an interview on 6/1/26 at 11:00 a.m., Nurse Consultant 1 indicated staff should be in the room while the residents were eating. 5. During an observation of the lunch meal in the North Memory Care Dining Room on 5/26/26 at 12:00 p.m., CNA 6 was feeding Resident E. After CNA 6 had fed Resident E approximately half of the regular diet tray, LPN 3 told her it was the wrong tray, and Resident E was supposed to be on a mechanical soft diet. During an interview on 5/26/26 at 12:14 p.m., CNA 6 indicated she was told to feed the resident from that tray. She did not normally work on that unit, and did not know the residents. She fed the resident small pieces of the meatballs and the resident did fine with it. The resident's record was reviewed on 5/29/26 at 9:47 a.m. Diagnoses included, but were not limited to, dementia, diabetes, and heart failure. The Quarterly Minimum Data Set (MDS) assessment, dated 3/4/26, indicated the resident had severe cognitive impairment, and was dependent in activities of daily living (ADLs). A Physician's Order, dated 3/5/26, indicated mechanical soft textured diet. The Special Instructions in the resident's electronic medical record indicated, MECHANICAL SOFT TEXTURED DIET. 1 to 1 feed assist. A Care Plan, revised on 3/2/26, indicated the resident had a nutritional problem or potential for nutritional problem. Interventions included providing and serving the diet as ordered. During an interview on 5/29/26 at 2:32 p.m., the Administrator and Nurse Consultant 1 were informed of the findings. No additional information was received. This citation relates to Intakes 2984104 and 3010389. 410 IAC (Indiana Administrative Code) 16.2-3.1-45(a)(1) 410 IAC 16.2-3.1-45(a)(2)