STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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 0000 Bldg. 00	This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00186499. Complaint IN00186499-Substantiated. Federal/State deficiencies related to the allegations are cited at F282. Survey dates: November 16, 17, 18, 19, and 20, 2015 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census bed type: SNF/NF: 97 Total: 97 Census payor type: Medicare: 17 Medicaid: 61 Other: 19 Total: 97 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 26143, on	F 0000	This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a Desk Review of this Plan of Correction for paper compliance.	

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	November 25, 2015.			
F 0164 SS=D Bldg. 00	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.			
	Based on observation, record review, and interview, the facility failed to ensure privacy was provided related to	F 0164	F 164 Resident#85 was interviewed and is now noted on care plan area of preference	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	performing a blood sugar check and stating the results aloud in the Dining Room during a meal service for 1 of 1 residents reviewed for privacy. (Resident #85) Finding includes: The Lunch meal service in the West Unit Dining Room was observed on 11/16/15 at 11:45 a.m. Resident #85 was seated at a table with her meal tray. Other residents and staff members were present in the Dining Room. The Speech Therapist was at the table with the resident. LPN #2 entered the Dining Room and told the resident he needed to test her blood sugar. The LPN did not ask the resident if it she wanted her blood sugar tested in the Dining Room or in private. The LPN proceeded to put on a pair of disposable gloves and performed a glucometer (blood stick to a finger) on the resident's left hand. LPN #2 then stated the results of the blood glucose level out loud. The record for Resident #85 was reviewed on 11/19/15 at 8:16 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, ischemic heart disease, glaucoma, and high blood pressure.		when doing blood glucose monitoring is identified. LPN #2 was immediately counseled and teachable moment given. All residents can be affected bythis practice. Angels have completed rounds on their residents, and no other residents have privacy concerns. Nursing staff have been re-inserviced regarding providing care with privacy, especially regarding blood glucose monitoring. Monitoring dining areas audits for privacy will be completed 3X per week by assigned management staff. Angel rounds are completed 2x/wk for any other privacy issues. These audits will be given to DON for follow-up. These audits will be reviewed monthly X 6 months by the QI committee for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	The 11/2015 Physician Order Statement was reviewed. There was an order for Accu-checks (blood sugar tests) to be completed three times a day at 7:00 a.m., 11:00 a.m., and 4:00 p.m. The 10/31/15 Minimum Data Set (MDS) Quarterly assessment, indicated the resident's BIMS (Brief Interview for Mental Status) score was (12). A score of (12) indicated the resident's cognitive patterns were moderately impaired. When interviewed on 11/19/15 at 1:20 p.m., the resident stated she preferred to have her blood sugars tested in "private." When interviewed on 11/19/15 at 2:45 p.m., the Administrator indicated the LPN should not have performed the blood glucose test in the Dining Room and should not have verbalized the results out loud. 3.1-3(p)(4)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	Based on observation, record review and interview, the facility failed to follow Physician Orders and/or the care plan related to the administration of pain medication and the application of geri sleeves (a protective garment used for resident's skin) for 1 of 5 residents reviewed for unnecessary medications and for 1 of 3 residents reviewed for non pressure related skin conditions of the 7 residents who met the criteria for non pressure related skin conditions. (Residents #B & #C) Findings include: 1. On 11/17/15 at 9:04 a.m., Resident #C was observed with an area of dark reddish discoloration to the left forearm. On 11/17/15 at 3:07 p.m., the resident was observed in bed. At that time, she was dressed in a hospital gown with her arms not covered. The resident was not wearing any geri sleeves to either of her arms. On 11/18/15 at 10:00 a.m. and 11:45 a.m., the resident was observed in bed. At that time, she was dressed in a hospital gown with her arms not covered. The resident was not wearing any geri sleeves to either of her arms.	F 0282	F 282 Resident C is now wearing geri-sleeves as ordered. Resident B had received seven of theprescribed Norco as were signed out. However, the medication was not indicated on medication record. This cannot be corrected as the resident hasbeen discharged. All residents with physician'sorders can be affected by this practice. All orders and care plans have been reviewed to ensure they are being followed with corrections made as needed forclarity. Nurses will be in-serviced on following physician's orders and care plans. Geri-sleeves will be placed on the treatment administration record to increase monitoring of placement as ordered. Medication orders with scheduled and PRN components will be written separately for clarity. The Unit Manager/designee will monitor physician's orders 3X a week for following orders. Angels will monitor for care planned interventions in place as ordered 2x/wk. DNS/designee will present the results of these audits to QI committee monthly X 6 months for any recommendations.	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	On 11/18/15 at 3:15 p.m., the resident was observed sitting in a wheelchair dressed in street clothes with short sleeves. At that time, there were no geri sleeves noted to her arms. The record for Resident #C was reviewed on 11/18/15 at 11:16 a.m. The resident's diagnoses included, but were not limited to, stroke, and high blood pressure. The Admission Minimum Data Set (MDS) assessment dated 8/24/15, indicated the resident was severely impaired for decision making. The current care plan dated 11/1/15 indicated "Resident has a bruise on her left lower forearm." The Nursing approaches were to apply protective garments such as geri sleeves to her arms. Physician Orders dated 11/1/15, indicated to monitor the bruise to the left lower arm and apply geri sleeves to arms daily. Interview with the East Unit Manager on 11/19/15 at 11:14 a.m., indicated the resident should be wearing geri sleeves to both arms. 2. The closed record for Resident #B was reviewed on 11/18/15 at 1:33 p.m. The resident's diagnoses included, but were not limited to, Alzheimer dementia,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	femur fracture, high blood pressure, and CVA (stroke). The May 2015 Physician orders were reviewed. There was an order written on 5/29/15 for the resident to receive Norco (a narcotic medication) 5/325 milligrams. The order indicated the resident was to receive one tablet via gastrostomy tube one hour prior to PT (Physical Therapy) and to hold the dose for sedation. There was another order written on 5/29/15 for the resident to receive Norco 5/325 milligrams every six hours as needed (prn) for pain via the gastrostomy tube. The May 2015 Medication Administration Record indicated no doses of the Norco were signed out as given. The 6/4/15 Minimum Data Set (MDS) Admission assessment, indicated the resident received scheduled pain medications. The assessment also indicated the resident required extensive assistance of staff for bed mobility, eating, dressing, and personal hygiene. The resident's Care Plans were reviewed. A Care Plan initiated on 5/29/15, indicated the resident had acute hip pain related to a fracture. Care plan interventions included, but were not			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	limited to, administer medications as ordered, monitor for effectiveness of the medications, and anticipate the resident's need for pain relief and respond to any complaints of pain. The June 2015 Medication Administration Record, indicated the resident received Norco 5/325 milligrams every 6 hours prn on the following dates/times: 6/2/15 at 8:00 p.m. 6/3/15 at 6:30 p.m. 6/4/15 at 7:30 p.m. No doses of the Norco were signed out as given one hour prior to Physical Therapy as ordered. The Pharmacy Controlled Substance Record for Hydrocodone-apap (Norco) 5-325 milligrams was reviewed. A total of (30) tablets were delivered from the Pharmacy on 5/29/15. The record indicated (23) of the (30) tablets were returned to the Pharmacy on 7/7/15. The resident was discharged on 6/19/15. The 5/2015 Physical Therapy logs indicated the resident received Physical Therapy on 5/29/15. The 6/2015 Physical Therapy logs indicated the resident received Physical Therapy 6/1/15-6/5/15, 6/8/15-6/12/15, and 6/15/15 & 6/16/15. There was no			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	documentation of the resident being sedated in the 5/2015 or the 6/2015 Physical Therapy logs. When interviewed on 11/19/15 at 9:30 a.m., the Administrator indicated the resident should have received the pain medication one hour before Physical Therapy as ordered by the Physician. This Federal tag relates to Complaint IN00186499. 3.1-35(g)(2)			
F 0309 SS=E Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on observation, record review and interview, the facility failed to ensure bruises were assessed and monitored for 3 of 3 residents reviewed for skin conditions non pressure related of the 7 residents who met the criteria for skin conditions non pressure related. The facility also failed to ensure a resident's	F 0309	F 309 For Resident #71, documentation including assessment and care planning was completed for the areas of discoloration to the top of the left forearm. For Resident #C, documentation including assessment and care planning was completed for the area of dark reddish discoloration of the	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	dialysis fistula was monitored for 1 of 1 residents reviewed for dialysis and the facility also failed to ensure pacemaker checks were completed for 1 of 5 residents reviewed for unnecessary medications. (Residents #C, #5, #71, #101, and #127) Findings include: 1. On 11/17/15 at 9:53 a.m., Resident #71 was observed with areas of reddish purple discoloration to the top of his left forearm. . The record for Resident #71 was reviewed on 11/18/15 at 3:13 p.m. The resident's diagnosis included, but was not limited to, dermatitis. The weekly skin check sheet dated 11/11/15, indicated the resident had no new open areas and his skin turgor was within normal limits. The skin observation sheets dated 11/7-11/20/15, indicated there was no documentation related to red areas or discoloration. Interview with the Interim Director of Nursing on 11/20/15 at 11:00 a.m., indicated that she saw the purpura to the resident's left wrist area, however, she		left forearm. Resident #101, documentation including assessment and care planning was completed for the areas of bruising to forearms. Resident #127 had his dialyisis access site assessed for patency. Resident #5 has an order to be seen by a cardiologist to initiate pacemaker evaluation. All residents with discolored areas, orders for protective devices such as geri-sleeves, those with accesses devices for dialysis and those with pacemakers can be affected by this practice. A whole-house skin sweep was performed to determine if other undocumented skin impairments are present. Corrections were made as needed for compliance. Nursing staff have been in serviced regarding bruising (discoloration) documentation including assessment and care planning, application of protective devices such as geri-sleeves, documentation of assessment of access sites for dialysis residents, and maintenance of pacemakers. Nurses will complete documentation of assessment of skin impairments at the time the impairment is noted. Nurses will assess all dialysis fistulas daily. Nurses will ensure that all residents that have pacemakers will maintain an active order for pacemaker checks. UnitManager/designee will validate 5 skin assessments weekly for complete	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	was not aware of the areas of discoloration to the top of the resident's left forearm. 2. On 11/17/15 at 9:04 a.m., Resident #C was observed with an area of dark reddish discoloration to the left forearm. The record for Resident #C was reviewed on 11/18/15 at 11:16 a.m. The resident's diagnoses included, but were not limited to, stroke and high blood pressure. The Admission Minimum Data Set (MDS) assessment dated 8/24/15, indicated the resident was severely impaired for decision making. Nurses' Notes dated 11/1/15 at 10:44 a.m., indicated the resident's family and Nurse Practitioner (NP) were notified of a bruise to the resident's left lower arm. A new order was obtained to monitor the bruise and apply geri sleeves to arms. The current care plan dated 11/1/15, indicated "Resident has a bruise on her left lower forearm." The Nursing approaches were to apply protective garments such as geri sleeves to her arms. Physician Orders dated 11/1/15, indicated to monitor the bruise to the left lower arm and apply geri sleeves to arms daily.		documentation of skin impairments. Unit Manager/designee will audit dialysis fistula assessment 3x/wk. Unit Manager/designee will audit residents with pacemakers monthly to ensure active orders are present for pacemaker checks. DNS/designee will present the results of these audits to the QI committee monthly X 6 months for any recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	The non pressure skin condition report dated 10/30/15, indicated an area on the right gluteal fold and next to the drop down box "left lower arm" was documented. The measurement was 5 centimeter (cm) by 2 cm and the area was red. Continued review of non pressure skin condition report sheets dated for the month of 11/2015, indicated there were no other weekly measurements of the bruise to the left lower arm. The left lower arm bruise was measured by the East Unit Manager on 11/19/15 at 11:15 a.m. The bruise measured 1 cm by 1.2 cm and the color was red. Interview with the East Unit Manager on 11/19/15 at 1:28 p.m., indicated the nurse documented right gluteal fold in the drop down box, but it should have been documented as a bruise on the left lower arm. She further indicated the initial measurements were documented but no other weekly measurements of the bruise to the left lower arm were documented after 10/30/15. 3. On 11/16/2015 at 12:06 p.m., Resident #101 was observed in her room seated in a wheelchair. She had geri sleeves (skin protectors) in place on both arms. An observation at the time,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	indicated multiple areas of purple bruising to both of the resident's arms and hands. The record for Resident #101 was reviewed on 11/17/2015 at 2:53 p.m. The resident's diagnoses included, but were not limited to, adult failure to thrive, hypertension, and anorexia. The Weekly Skin Assessment sheets dated 9/3/2015-11/17/2015 indicated no documentation of bruising. The electronic Daily Skin Observation charting for the past 30 days indicated no skin concerns. The current care plan indicated: senile pupura and fragile skin. The interventions included, but were not limited to, geri sleeves as tolerated, monitor bruise every shift, and monitor/document location, size and treatment of bruise. The September, October, and November 2015 Medication Administration Records (MAR's) and Treatment Administration Records (TAR's) were reviewed. There was no documentation related to the bruising to the resident's bilateral hands and arms.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	An interview with the Interim Director of Nursing (DON) on 11/18/2015 at 2:43 p.m., indicated the multiple areas of purple bruising to Resident #101's bilateral hands and arms had not been identified and the nursing staff should have charted weekly assessments of the bruising. Continued interview also indicated the electronic Daily Skin Observations should have also identified the bruising to the resident's bilateral hands and arms. Observation with LPN #4 on 11/18/2015 at 3:05 p.m., indicated there was purple bruising underneath the resident's geri sleeves and they should have been identified, monitored, and documented on the resident's Weekly Skin Assessment sheets. Further interview at the time, indicated staff would assess and measure the areas. Review of the Weekly Non-Pressure Skin Condition Report dated 11/18/2015 provided by the West Unit Manager on 11/19/2015 at 11:00 a.m., indicated the following areas of purple bruising: -right side of forearm measuring 1.8 centimeters (cm) x 1 cm -slightly above right wrist measuring 6 cm x 4 cm -above left wrist measuring 1.5 cm x 1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	cm -lower left arm measuring 3 cm x 2 cm -side of left elbow measuring 0.8 cm x 0.8 cm -under left elbow measuring 1.8 cm x 1.2 cm -right forearm measuring 1.5 cm x 0.8 cm -right hand measuring 5 cm x 3 cm The current Measuring and Documenting Pressure Ulcer/Non-Pressure Ulcer facility policy dated 5/15/2013, provided by the East Unit Manager on 11/19/2015 at 10:00 a.m., indicated "Completion of measuring and document pressure/non-pressure ulcers upon admission, weekly follow up, as needed when there is change in wound status, new wound, and as part of the discharge assessment." 4. The record for Resident #127 was reviewed on 11/17/2015 at 2:43 p.m. The resident's diagnoses included, but were not limited to, end stage renal disease (ESRD) with dialysis, diabetes, and cardio vascular disease. The Physician's Orders dated 11/2015 indicated dialysis on Monday, Wednesday, and Friday. There were no orders related to assessing and or monitoring the resident's right dialysis access site every shift or at least daily.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	The November 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed. There was no documentation related to assessing and/or monitoring the resident's right dialysis access site every shift or at least daily. The November 2015 Dialysis Log was reviewed. The log indicated the resident's access site was assessed weekly on Monday, Wednesday, and Fridays. The current care plan indicated: the resident needs hemodialysis related to ESRD. The interventions included, but were not limited to, monitor shunt site by palpating for thrill and auscultating for bruit daily. Interview with the West Unit Manager on 11/18/2015 at 9:15 a.m., indicated the resident's access site was not being monitored and/or assessed daily. Interview with the Interim Director of Nursing on 11/18/2015 at 2:51 p.m., indicated the nursing staff should have been monitoring and/or assessing the resident's dialysis access site at least daily. The current Residents Receiving Dialysis			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	policy dated 10/31/09 indicated, "Licensed nurses manage dialysis access site to maintain patency and adequate blood flow for dialysis." 5. The record for Resident #5 was reviewed on 11/19/2015 at 8:35 a.m. The resident's diagnoses included, but were not limited to, chronic obstructive pulmonary disease, pace maker, and diabetes. The Physician's Orders dated September, October, and November 2015, indicated no orders related to pacemaker checks. The September, October, and November 2015 Medication Administration Record (MAR) and Treatment Administration Record (TAR) were reviewed. There was no documentation related to the resident's pacemaker being checked. The current care plan indicated: the resident has a pacemaker. The interventions included, but were not limited to, pace maker checks as ordered. Interview with the Interim Director of Nursing on 11/20/2015 at 10:10 a.m., indicated the resident's pacemaker had not been checked and there were no current orders for pacemaker checks.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	3.1-37(a)			
F 0318 SS=D Bldg. 00	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Based on observation, record review, and interview, the facility failed to ensure services were provided to prevent a decline in range of motion related to splint and cone devices not in place for 1 of 3 residents reviewed for contractures of the 7 who met the criteria for contractures. (Resident #85) Finding includes: On 11/17/15 at 2:40 p.m., Resident #85 was observed in bed. The resident was not receiving care. The resident's right index finger was bent over the right middle finger. The other three fingers were bent at the knuckles. There were no splints or anti contracture devices in place to the right hand or fingers. The resident was not receiving care at this time. Four fingers of the left hand were bent at the knuckles. There were no	F 0318	F 318 For Resident #85, the order for splints was discontinued while the resident received occupational therapy for contracture. Any resident with a splint who is receiving therapy for contracture can be affected by this practice. Therapy manager will audit all residents with splint orders who are receiving therapy for contracture to ensure splint orders are discontinued while receiving therapy. Therapy staff will be inserviced on discontinuation of splint orders while receiving therapy for contracture. Therapy manager will audit all residents receiving therapy for contracture weekly to ensure that splint orders are discontinued while receiving therapy. Therapy manager/designee will present the results of these audits to the QI committee monthly X 6 months for recommendations.	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	splints or anti contracture devices in place to the left hand or fingers. Staff were not providing care to the resident at the above time. On 11/18/15 at 9:59 a.m., 10:23 a.m., 10:50 a.m., 11:09 a.m., and 12:55 p.m., the resident was observed sitting in a wheelchair in the hallway across from the Nursing Station. The fingers of the resident's right hand were closed. No splint or any other anti contracture devices were in place to the right hand at the above times. The thumb and the first three fingers of the left hand were open and the last two fingers were closed in a fist. No splint or any other devices were in place to the resident's left hand or fingers. Staff were not providing care to the resident at the above times. The record for Resident #85 was reviewed on 11/19/15 at 8:16 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus, heart disease, glaucoma, and high blood pressure. The 10/31/15 Minimum Data Set (MDS) quarterly assessment, indicated the resident's BIMS (Brief Interview for Mental Status) was (12). A score of (12) indicated the resident's cognitive patterns were moderately impaired. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	assessment also indicated the resident required extensive assistance of one staff member for dressing and personal hygiene. The assessment also indicated the resident had impairment in range of motion on both of her upper extremities. The 11/2015 Physician Order Statement, indicated there was an order for the resident to have a carrot splint in place with the narrow side towards the small finger on her right hand. The order also indicated the carrot splint was to be on in the morning and off at night. There was also an order for the resident to have a functional resting hand splint in place to the left hand. The order also indicated the splint was to be on in the morning and off at night. The resident's current Care Plans were reviewed. A Care Plan initiated on 1/6/15, indicated the resident had contractures to both of her hands. The Care Plan was last updated with a target goal date of 11/20/16. Care plan interventions included, but were not limited to, apply a left hand functional resting splint in the morning and remove the splint at night. The current CNA assignment sheet indicated the resident was to have a right carrot splint and a left hand splint. The			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	assignment sheet indicated both were to be on in the morning and off at night. When interviewed on 11/19/15 at 1:05 p.m., CNA #1 indicated she was assigned to care for the resident. The CNA indicated she was not aware the resident was to wear any splints or braces during the day. When interviewed on 11/19/15 at 1:13 p.m., Occupational Therapist #1 indicated the resident was to have a cone splint in her right hand during the day and the splint to her left hand at night. When interviewed on 11/19/15 at 1:57 p.m., the Unit Manager indicated the resident should have had the splints on as ordered. 3.1-42(a)(2)			
F 0329 SS=D Bldg. 00	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.			
	Based on observation, record review and interview, the facility failed to ensure blood pressure and blood glucose monitoring was completed as ordered as well as ensuring indications for the use of narcotics, antianxiety medications and antipsychotic medications was completed for 3 of 5 residents reviewed for unnecessary medications. (Residents #2, #62, and #187) Findings include: 1. The record for Resident #2 was reviewed on 11/18/15 at 8:58 a.m. The resident's diagnoses included, but were not limited to, high blood pressure and diabetes.	F 0329	F 329 For Resident #2, MD/NP was notified of blood sugars not obtained as ordered. For Resident#62, MD/NP was notified of blood pressures not obtained as ordered. For Resident#187, indications for use were obtained for xanax and hydrocodone. All residents with medication orders can be affected by this practice. All physician's orders will be reviewed to ensure no unnecessary medications are being used. Nurses will be in serviced regarding compliance with all orders regarding unnecessary medications. The Unit Manager/designee will audit all medication administration records 3X per week for unnecessary medications. DNS/designee will present the results of these audits to the QI	12/23/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	A Physician's order dated 7/29/15, indicated the resident's blood sugar was to be checked before meals and at bedtime. The Physician was to be notified if the resident's blood sugar was less than 70 or greater than 300. The diabetic flowsheet for the month of September 2015 was reviewed. There were no blood sugars documented for the following dates: None documented on 9/2/15. 9/5/15 no blood sugar documented at 5:00 p.m. and 8:00 p.m. 9/7/15 no blood sugar documented at 7:30 a.m. and 11:00 a.m. 9/8/15 no blood sugar documented at 5:00 p.m. 9/16/15 no blood sugar documented at 8:00 p.m. 9/17/15 no blood sugar documented at 11:00 a.m. and 8:00 p.m. 9/21/15 no blood sugar documented at 8:00 p.m. 9/24/15 no blood sugar documented at 5:00 p.m. and 8:00 p.m. 9/27/15 no blood sugar documented on 5:00 p.m. and 8:00 p.m. Interview with the Interim Director of Nursing on 11/20/15 at 10:55 a.m., indicated the resident's blood sugar was not monitored as ordered.		committee monthly X 6 months for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	2. The record for Resident #62 was reviewed on 11/17/15 at 2:54 p.m. The resident's diagnosis included, but was not limited to, hypertension (high blood pressure). A Physician's order dated 10/17/13 and listed on the November 2015 Physician's Order Summary (POS), indicated the resident's blood pressure was to be obtained and recorded weekly. The Physician was to be notified if the resident's blood pressure was less than 100/60 or greater than 160/100. The October 2015 Medication Administration Record (MAR) was reviewed. The resident's blood pressure was not monitored weekly for the entire month. The September 2015 MAR indicated the resident's blood pressure was not monitored weekly on 9/1, 9/7, and 9/22/15. The August 2015 MAR indicated the resident's blood pressure was not monitored weekly on 8/11 and 8/25/15. Interview with Interim Director of Nursing on 11/20/15 at 10:55 a.m., indicated the resident's blood pressures			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	were not monitored as ordered. 3. On 11/17/15 at 2:56 p.m., Resident #187 was observed sitting in a wheelchair. The resident was displaying no anxiety or behaviors at that time. The record for Resident #187 was reviewed on 11/18/15 at 10:21 a.m. The resident was newly admitted to the facility on 11/13/15. The resident's diagnoses included, but were not limited to, atrial fibrillation, diabetes, dementia, high blood pressure, cardiomegaly, depression, ascites, septic shock, dementia without behavioral disturbance, congestive heart failure, and encephalopathy. Physician Orders dated 11/13/15, indicated Xanax (an Antianxiety medication) 0.25 milligrams (mg) 1 tab nightly as needed for anxiety and Xanax 0.25 mg 1 tab four times a day as needed for anxiety. Another order dated 11/13/15, indicated Seroquel (Antipsychotic medication) 50 mg every night. One other order dated 11/13/15, indicated Hydrocodone (a pain medication) 5-325 mg two tabs by mouth every 4 hours as needed for pain. Social Service Progress Notes dated 11/17/15, indicated no documentation of any indication for the use of the Seroquel			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	medication. The Minimum Data Set (MDS) assessment was not ready for preview as the resident had only been at the facility for 5 days. The controlled substance sheet was reviewed. The resident received the Xanax on 11/14 at 3:00 a.m., 11/14 at 9:00 p.m., 11/15 at 2:00 p.m., and on 11/16/15 at 1:00 a.m. Nursing Progress Notes for the above mentioned dates indicated there was no documentation of an indication for the use of the as needed Xanax. There was no documentation of any anxiety or any interventions tried first before the administration of the Xanax. The controlled substance record for the medication of Hydrocodone 5-325 mg indicated the resident had received the medication on 11/14 at 2:00 p.m., 11/15 at 2:00 p.m., and on 11/16/15 at 1:00 a.m. Nursing Progress Notes for the above mentioned dates indicated there was no indication for the use of the Hydrocodone or an assessment of the resident's pain. Continued review of the Nursing Progress Notes indicated there was no documentation or indication of why the			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	as needed Hydrocodone and the as needed Xanax were given at the same on 11/15 at 2:00 p.m., and on 11/16/15 at 1:00 a.m. The Medication Administration Record (MAR) for the above mentioned medication was reviewed. There was no documentation on the back of the MAR as to why the Xanax and Hydrocodone were given. Interview with the East Unit Manager on 11/18/15 at 4:00 p.m., indicated there was no pain assessment in the resident's chart or any documentation of why the resident received the pain medication. She further indicated there was no documentation of why the resident received the as needed Xanax on those days as well. The East Unit Manager indicated the only diagnoses for the Seroquel that she could find was depression and she had found that information in the hospital notes. She further indicated there was no indication or documentation on why the resident received both the Xanax and the Hydrocodone together on 11/15 and 11/16/15. 3.1-48(a)(3) 3.1-48(a)(4)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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 0333 SS=D Bldg. 00	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on observation, record review and interview, the facility failed to ensure 1 of 1 resident observed for insulin administration were free from a significant medication error related to the wrong dose of insulin being administered. (Resident #2) Finding includes: On 11/18/15 at 5:09 p.m., LPN #5 was observed to administer 8 units of Novolog insulin to Resident #2. The label on the vial of insulin indicated the resident was to receive 6 units of insulin. The record for Resident #2 was reviewed on 11/18/15 at 8:58 a.m. The resident's diagnosis included, but was not limited to, diabetes. A Physician's order dated 9/17/15, indicated the resident was to receive Novolog insulin, inject 8 units subcutaneously (sq) twice a day at lunch and dinner.	F 0333	F 333 Resident #2 had their medication administration record corrected immediately. The physician and family have been notified. All residents with order changes have the potential to be affected by this practice. All physician's orders have been reviewed for accuracy through the monthly recapitulation of physician's orders process with correction made as needed. Nurses will be in-serviced regarding transcription of physician's order changes. Nurses who complete monthly recapitulation of physician's orders have been inserviced on the procedure for monthly recapitulation of orders. 3 random charts will be audited weekly by Director of Nursing/designee for accuracy of monthly recapitulation of orders with corrections made as needed for compliance. Results of these audits will be presented to the QI committee monthly X 6 months for recommendations.	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	A Physician's order dated 10/26/15, indicated the Novolog insulin was to be decreased to 6 units at 11:00 a.m. and 5:00 p.m. The October 2015 Medication Administration Record (MAR), indicated the order was updated and the resident received the 6 units of Novolog twice a day 10/27-10/31/15. The November 2015 MAR, indicated the order had not been updated and indicated the resident was to receive 8 units of Novolog insulin twice a day. The eight units of insulin had been signed out twice a day 11/1-11/18/15. Interview with the Administrator on 11/20/15 at 12:00 p.m., indicated the resident's Physician had been notified and a medication error report completed. She indicated the resident had been receiving the wrong dose of insulin for the month of November 2015. 3.1-48(c)(2)			
F 0371 SS=E Bldg. 00	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to serve food and/or beverages under sanitary conditions related to passing beverages in uncovered cups down the hallway for 1 of 2 units observed during meal time. (The East Unit) Finding includes: On 11/16/15 at 12:05 p.m., the enclosed meal tray carts were placed at the East Unit Nurse's station. At that time, CNA #4 was observed pouring lemonade into plastic cups and placing them directly on the resident's trays inside the enclosed carts. CNA's #4, #5, and #6 were all observed passing the room trays down the hallway to the residents in their rooms. All three CNA's were observed passing the room trays down the hallways. There were 12 lunch trays that were passed and observed with cups of lemonade that were not covered with lids. The current 2/28/14 Tray line set up, service and meal delivery policy provided	F 0371	F 371 The three CNA's involved in passing drinks on the unit on 11/16/15 were inserviced on proper infection control when passing drinks on the unit. All residents who receive fluids with meals can be affected by this practice. No other observations were made during the survey of drinks being passed uncovered. Staff involved in meal service will be in serviced on proper infection control when passing drinks on the unit. The dietician/designee will monitor tray passing on each unit weekly forcompliance. These audits will be presented monthly X 6 months to the QI committee for recommendations.	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	by Dietary Food Manager (DFM) on 11/20/15 at 10:00 a.m., indicated food transported to a dining room or nursing unit that does not have direct access to the kitchen or to a patient's room must be in an enclosed cart or appropriately covered. Interview with the Dietary Food Manager on 11/20/15 at 10:15 a.m., indicated the beverages were to be covered at all times while transporting trays down the hall to the resident rooms. 3.1-21(i)(3)			
F 0441 SS=E Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, record review, and interview, the facility failed to ensure infection control practices were maintained related to wash basins, cylinders, bed pans, and tooth brushes stored uncovered or on the floor in resident rooms on 2 of 2 units (The East and West units). The facility also failed to ensure Tuberculin (TB) skin tests were completed at the time of hire for 5 employees. (Employees #1, #2, #3, #4, and #5) Findings include: 1. The facility Employee Health records were reviewed on 11/20/15 at 11:24 a.m. TB (Tuberculin) skin tests were not completed at the time of hire for the	F 0441	F441 Employee #1 has received a TB risk assessment and chest x-ray related to being PPD+. Employee #2 has received her second step for TB skin test Employee #3 has received her TB skin test Employee #4 has received her TB skin test Employee #5 has received her TB skin test Room 134 had no wash basin noted on the floor. Room 127 had no bed pan found on the floor. Room 231 has no bath basin on the floor. Room 212 has no bath basin on the floor. Room 130 toothbrush noted on the floor sink has been replaced. There is no washbasin on the floor of room 106. There are no wash basins, urine collection containers and bed pans on the floor in room 228. There is no bedpan on the floor of room 217. There is no	12/18/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	following employees: Employee #1- Dietary Aide hired on 5/4/15 . No first or second TB test documented. Employee #2- Registered Dietitian hired on 6/3/15. First step TB administered on 10/7/15 and not read. No second step TB test documented. Employee #3- CNA hired on 10/13/15. No first or second step TB tests documented. Employee #4- LPN hired on 10/6/15. No first or second step TB tests documented. Employee #5- CNA hired on 9/23/15 - No first or second step TB tests documented. When interviewed on 11/20/15 at 11:24 a.m., the Interim Director of Nursing indicated there were no records of the above employees having TB tests upon hire as required. When interviewed on 11/20/15 at 1:05 p.m., the Nurse Consultant indicated the above employees TB testing should have been completed as required. The facility policy titled "Employee		washbasin on the floor of room 121. There is no washbasin in room 227 on the floor. There are no wash basins on the floor in room 233. There are no wash basins on the floor in room 229. All residents using reusable equipment can be affected by this practice. Rounds of the building show no other reusable equipment stored improperly in bathrooms. All staff can be affected by this practice. All staff hired within the last 3 months will be reviewed for the presence of TB. Corrections will be made as needed for compliance. Nursing staff and housekeeping staff have been in-serviced regarding proper care and storage of reusable care equipment. Staff Development Coordinator and back-up have been inserviced on policy for TB testing of new employees. Angels will complete their assigned rounds 2x/wk to ensure proper storage of reusable equipment. DNS/designee will review all new hires weekly for TB testing per policy. Results of the angel rounds will be presented by the ED and Results of the TB testing for new hires will be presented monthly X 6 months to the QI committee for recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	Health Program" was reviewed on 11/20/15 at 12:05 p.m. The policy was dated 10/5/2011. The Nurse Consultant provided the policy and indicated the policy was current. The policy indicated baseline TB (tuberculin) skin tests were to be administered to employees using the two-step method for employees not having a documented negative TB skin test result in the preceding 12 months. Initial and follow up TB test information was to be documented. 2. a. On 11/16/2015 at 11:45 a.m., Room 134 was observed. There was a wash basin on the bathroom floor and the closet floor not covered by a plastic bag. Two residents shared this bathroom. b. On 11/17/2015 at 9:06 a.m., Room 127 was observed. There was a bed pan on the bathroom floor behind the toilet not covered by a plastic bag. Two residents shared this bathroom. c. On 11/17/2015 at 9:20 a.m., Room 231 was observed. There was a wash basin on the bathroom floor underneath the sink not covered by a plastic bag. One resident resided in this room. d. On 11/17/2015 at 9:06 a.m., Room 212 was observed. There was a wash basin on the floor next to the resident's bed not covered by a plastic bag. One			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/20/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER		STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311	

(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
	resident resided in this room. e. On 11/17/2015 at 10:38 a.m., Room 130 was observed. There was a tooth brush on the back of the sink uncovered and a tooth brush in a toiletry rack open to air touching the wall. Two residents shared this bathroom. f. On 11/17/2015 at 9:55 a.m., Room 106 was observed. There was a wash basin on the floor underneath the bathroom sink not covered by a plastic bag. There was also a graduated cylinder uncovered on the back of the toilet. Two residents shared this bathroom. g. On 11/17/2015 at 9:05 a.m., Room 228 was observed. There was a wash basin, bed pan, and urine collection container stacked on top of each other on the bathroom floor next to the toilet not covered by a plastic bag. Two residents shared this bathroom. h. On 11/17/2015 at 9:10 a.m., Room 217 was observed. There was a bed pan on the bathroom floor not covered by a plastic bag. One resident resided in this room. i. On 11/16/2015 at 11:58 a.m., Room 121 was observed. There was a wash basin on the bathroom floor not covered			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155218		11/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DR DYER, IN 46311

(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
	by a plastic bag. Two residents shared this bathroom. j. On 11/17/2015 at 9:00 a.m., Room 227 was observed. There was a wash basin on the bathroom floor not covered by a plastic bag. Two residents shared this bathroom. k. On 11/19/2015 at 9:50 a.m., Room 233 was observed. There were two wash basins stacked on top of each other on the bathroom floor by the toilet not covered by a plastic bag. One resident resided in this room. l. On 11/19/2015 at 8:30 a.m., Room 229 was observed. There was a wash basin on the floor next to the resident's bed not covered by a plastic bag. one resident resided in this room. Interview with the Housekeeping Director on 11/20/2015 at 10:00 a.m., indicated all of the above should have been stored in tooth brush holders or plastic bags on a shelf or in a drawer. 3.1-18(a) 3.1-18(j)			