

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/22/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R-C 12/20/2011
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	
{F 000}	<p>INITIAL COMMENTS</p> <p>This visit was for a Post Survey Revisit (PSR) to the PSR completed on November 17, 2011 to the Investigation of Complaint IN00097219 completed on September 30, 2011.</p> <p>Complaint IN00097219:Corrected</p> <p>This visit was in conjunction with Investigation of Complaint IN00100378.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the Investigation of Complaint IN00099339 completed on November 17, 2011.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on November 17, 2011 to the Recertification and State Licensure Survey completed on September 6, 2011.</p> <p>This visit was in conjunction with a Post Survey Revisit (PSR) to the PSR completed on November 17, 2011 to the Investigation of Complaint IN00097871 completed on October 20, 2011.</p> <p>Survey dates: December 19 & 20, 2011</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Janet Adams, RN, TC Kathleen Vargas, RN Susan Bruck, RN</p>	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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.

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{F 000}	Continued From page 1 Census bed type: SNF/NF: 121 Total: 121 Census payor type: Medicare: 26 Medicaid: 73 Other: 22 Total: 121 Sample: 10 Kindred Transitional Care and Rehabilitation was found to be compliance with 42 CFR Part 483, Subpart B and 410 IAC 16.2 in regard to Post Survey Revisit (PSR) to the PSR to the Investigation of Complaint IN00097219. Quality review 12/21/11 by Suzanne Williams, RN	{F 000}			