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		08/12/2015

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 the Investigation of Complaints IN00177327, IN00178680, IN00178864, and IN00179993. Complaint IN00177327-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00178680-Substantiated. No deficiencies related to the allegations are cited. Complaint IN00178864-Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226. Complaint IN00179993-Substantiated. Federal/State deficiencies related to the allegations are cited at F225 and F226. Survey dates: August 11 & 12, 2015 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Census bed type: SNF/NF: 96 Total: 96 Census payor type:	F 0000		

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		08/12/2015

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
	Medicare: 14 Medicaid: 65 Other: 17 Total: 96 Sample: 8 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.			
F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).			

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 08/12/2015
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 facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.			
	Based on record review and interview, the facility failed to report an allegation of abuse to the Administrator and the Indiana State Department of Health (ISDH), related to an allegation of a resident threatening another resident, for 2 of 4 residents reviewed for abuse in a total sample of 8. (Residents #H and #J) Finding includes: Resident #J's record was reviewed on 08/11/15 at 12:32 p.m. The resident's diagnoses included, but were not limited to, dementia and diabetes mellitus. A Social Service Note, dated 06/23/15 at 3:11 p.m., indicated the resident stated he had not felt unsafe and had no concerns regarding his roommate. During an interview on 08/11/15 at 1:10	F 0225	F 225 Investigate/Report Allegations This Plan of Correction constitutes my written allegation ofcompliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission thata deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meetrequirements established by state and federal law. We respectfully request a Desk Review of thisPlan of Correction. 1.For Residents H & J, incident was reportedto Administrator and ISDH. 2.All residents have the potential to be affected.All interviewable residents will be asked questions related to abuse todetermine if allegations of abuse have not yet been reported. All allegationswill be immediately reported to the Administrator with follow-up per policy onall previously unreported allegations of abuse/neglect.	09/08/2015

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 08/12/2015
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
	p.m., the Social Service Director indicated on 06/22/15, she had looked at Resident #H's Nurses' Notes and saw a note which indicated Resident #H had threatened Resident #J. The Social Service Director indicated she was unsure if the Nurse who had written the note had notified the Administrator. She indicated no one had reported the incident to her, and she found out about the threat when she read Resident #H's Nurses' Notes. She indicated she had interviewed Resident #H and he had informed her he had told the staff if resident #J had not quit yelling he would have killed him. She indicated she reported the threat to the Administrator after talking with Resident #H. During an interview on 08/11/15 at 1:18 p.m., the Administrator indicated she had not been notified by the Night Nurse about Resident #H threatening Resident #J, and after she was informed about Resident #H threatening Resident #J by the Social Service Director, she notified the Night Nurse and the Night Nurse had indicated nothing threatening had been voiced by Resident #H. The Administrator indicated she had not reported the allegation to the Indiana State Department of Health. Resident #H's record was reviewed on		3.All staff will be inserviced on abuse reportingpolicy. All allegations of abuse will be immediately reported to theAdministrator and ISDH. 4.Administrator/designee will ask questionsrelated to abuse to 10 residents per month. Results of these interviews will bereviewed monthly in the facility's Quality Assurance Performance Improvementcommittee X 6 months. 5.Completion date September 8, 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 08/12/2015
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
	08/12/15 at 9:06 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A Nurses' Note, dated 06/22/15 at 3:48 a.m., indicated a CNA had reported to the Nurse, Resident #H had made threats to Resident #J and Resident #J had been removed from the room and was at the Nurses' Station for safety reasons. A late entry note, dated 06/23/15 at 12:35 a.m. for 06/22/15 at 5:10 a.m., indicated the Nurse had spoken to Resident #H and the resident indicated Resident #J had been talking very loud and Resident #H had yelled at Resident #J. The note indicated there had been no confrontation between either resident. During an interview on 08/12/15 at 8:00 a.m., the Corporate RN Consultant indicated she had not been at the facility when this occurred and acknowledged an allegation of abuse had been made by the CNA. During an interview on 8/12/15 at 8:57 a.m., Resident #H indicated Resident #J had kept him awake for a couple nights and the night of 06/22/15, the resident was talking loudly and he could not sleep. Resident #H indicated he put the call light on and the CNA answered 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 08/12/2015

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
	light and he told her if Resident #J did not, "shut up", they would find him, "on the floor". Resident #H indicated the CNA left the room and informed her Supervisor and they came and talked to him. He stated, "they made too much out of it." This Federal Tag relates to Complaints IN00178864 and IN00179993. 3.1-28(c) 3.1-28(d) 3.1-28(e)			
F 0226 SS=D Bldg. 00	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Based on record review and interview, the facility failed to ensure the facility's abuse policy was followed, related to not immediately reporting an allegation of abuse to the Administrator of the facility,and the Indiana State Department of Health (ISDH) for 2 of 4 residents reviewed for abuse in a total sample of 8. (Residents #H and #J) The facility also	F 0226	F 226 Develop/Implement Abuse/Neglect Policies This Plan of Correction constitutes my written allegation ofcompliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission thata deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meetrequirements	09/08/2015

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 08/12/2015
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
	failed to ensure their Abuse policy for screening new employees had been followed related to past working references for 3 of 5 employees reviewed, who were hired in the last 120 days. (RN #1, CNA #2, and CNA #3) Findings include: 1. During an interview on 08/11/15 at 1:10 p.m., the Social Service Director indicated on 06/22/15 she had looked at Resident #H's Nurses' Notes and had seen a note which indicated Resident #H had threatened Resident #J. The Social Service Director indicated she was unsure if the Nurse who had written the note had notified the Administrator. She indicated no one had reported the incident to her, and she found out about the threat when she had read Resident #H's Nurses' Notes. She indicated she had interviewed Resident #H and he had informed her he had told the staff if resident #J had not quit yelling he would have killed him. She indicated she reported the threat to the Administrator after talking with Resident #H. During an interview on 08/11/15 at 1:18 p.m., the Administrator indicated she had not been notified by the Night Nurse about Resident #H threatening Resident #J, and after she was informed about		established by state and federal law. We respectfully request a Desk Review of thisPlan of Correction. 1.For Residents H & J, incident was reportedto Administrator and ISDH. 3 staff found to be non-compliant for referencechecks will have reference checks performed. 2.All residents have the potential to be affected.All interviewable residents will be asked questions related to abuse todetermine if allegations of abuse have not yet been reported. All allegationswill be immediately reported to the Administrator with follow-up per policy onall previously unreported allegations of abuse/neglect. All new hires X 90 dayswill be audited for reference checks.Reference checks will be completed as needed. 3.All staff will be inserviced on abuse reportingpolicy. All allegations of abuse will be immediately reported to theAdministrator and ISDH. Staff Development Coordinator and a back-up will beinserviced on policy for completion of reference checks for new hires. 4.Administrator/designee will ask questionsrelated to abuse to 10 residents per month. Results of these interviews will bereviewed monthly in the facility's Quality Assurance Performance Improvementcommittee X 6 months. Staff Development	

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 08/12/2015
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 #H threatening Resident #J by the Social Service Director, she notified the Night Nurse and the Night Nurse had indicated nothing threatening had been voiced by Resident #H. The Administrator indicated she had not reported the allegation to the Indiana State Department of Health. Resident #H's record was reviewed on 08/12/15 at 9:06 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and hypertension. A Nurses' Note, dated 06/22/15 at 3:48 a.m., indicated a CNA had reported to the Nurse, Resident #H had made threats to Resident #J and Resident #J had been removed from the room and was at the Nurses' Station for safety reasons. During an interview on 08/12/15 at 8:00 a.m., the Corporate RN Consultant indicated she had not been at the facility when this occurred and acknowledged an allegation of abuse had been made by the CNA. 2. Employee files of staff hired by the facility in the last 120 days were reviewed on 08/12/15 at 11:48 a.m. RN #1, CNA #2, and CNA #3 did not have past work/personal references in		Coordinator/back-up will track all newhire reference checks. Tracking will be reviewed monthly in the facility'sQuality Assurance Performance Improvement committee X 6 months. 5.Completion date September 8, 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 08/12/2015
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
	their employee files. During an interview on 08/12/15 at 1:15 p.m., the Administrator indicated there were no references located for RN #1, CNA #2, and CNA #3. A facility policy, dated 07/28/14, titled, "Abuse", and received from the Administrator as current, indicated, "...All alleged violations involving mistreatment, neglect, or abuse...are reported immediately to the Administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)...The center implements procedures that include: a. Screening...Investigations into the past histories of a potential employee include...Inquiry of previous and or current employers..." This Federal Tag relates to Complaints IN00178864 and IN00179993. 3.1-28(a)			