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 02/24/2015

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
F000000	This visit was for the Investigation of Complaints IN00166154 and IN00167772 Complaint IN00166154- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F246 and F314. Complaint IN00167772- Substantiated. Federal/State deficiencies related to the allegations are cited at F157 and F314. Survey dates: February 19, 20, & 24, 2015 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Survey team: Janet Adams, RN-TC Census bed type: SNF/NF: 118 Total: 118 Census payor type: Medicare: 34 Medicaid: 61 Other: 23 Total: 118	F000000	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by	

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.

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	155218	A. BUILDING 00 B. WING	02/24/2015

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	Sample: 6 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on February 28, 2015, by Janelyn Kulik, RN.		the facility.	
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).			

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

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	The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review, and interview, the facility failed to notify the Physician and responsible family member of a resident's weight loss for 1 of 4 residents reviewed for weight loss in the sample of 6. (Resident #C) Finding includes: The record for Resident #C was reviewed on 2/19/15 at 11:15 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer, high blood pressure, congestive heart failure, protein calorie malnutrition, and depressive disorder. The resident's January 2015 and February 2015 weight records were reviewed. The resident's were recorded as follows: 1/08/2015 - 128.3 pounds 1/16/2015 - 129.7 pounds 1/29/2015 - 115.0 pounds 2/05/2015 - 115.5 pounds	F000157	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the	03/24/2015

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	2/11/2015 - 117.5 pounds 2/16/2015 - 117.5 pounds 2/18/2015 - 117.6 pounds Review of the 12/2/14 Minimum Data Set (MDS) quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (13). A score of (13) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident was dependent on staff for eating. A care plan initiated on 11/28/14 indicated the resident had an ADL (Activities of Daily Living) self care deficit related to limited mobility. Care plan interventions included for staff to provide assistance as needed. Another care plan initiated on 11/28/14 indicated the resident was at risk for nutritional decline related to non healing pressure wounds, a diagnosis of malnutrition, and receiving enteral feedings. Care plan intervention included for staff to administer tube feeding as ordered, provide vitamins and supplements as ordered, and notify the RD (Registered Dietitian), Physician, and family of significant weight changes. The 11/19/2014 Medical Nutrition Therapy Assessment was reviewed. The		resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. **F –157 Notification of Change** The facility respectfully requests a desk review for paper compliance with this citation. It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident C's family and physician were notified of the weight loss that occurred in January 2015. RD review completed of this resident. Physician orders obtained and plan of care updated as appropriate. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: A Full audit of all current residents was completed for	

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	assessment was completed by the RD (Registered Dietitian). The assessment indicated the resident's weight was 135.5 pounds and the resident was not on a Physician prescribed weight loss regime. The summary indicated the resident had a history of malnutrition in the hospital and stated he weighed 180 pounds last year. The 1/2015 and 2/2015 Nursing Progress Notes were reviewed. There was no documentation of the resident's Physician or family being notified of the above weight loss. When interviewed on 2/20/15 at 11:40 a.m., the District Nurse indicated the resident had a weight loss at the time. The District Nurse also indicated there was no documentation of the Resident's Physician and family being notified of the resident's weight loss. The facility policy titled "Notifications" was reviewed on 2/20/15 at 1:00 p.m. The release date on the policy was 4/28/13. The District Nurse provided the policy and indicated the policy was current. The policy indicated staff were to inform the patient, their attending Physician, and the patient's surrogates when a significant change occurred in the patient's physical, mental, or psychosocial status.		weight loss over the prior 6 month period. Residents that were noted to have weight loss were added to the Nutritional Assessment Risk “NAR,” IDT meeting. All residents are weighed weekly until deemed loss is resolved. A NAR meeting is held by the IDT to review identified resident’s nutritional status. All new admissions are added to NAR IDT meeting list and are weighed weekly x 4 following admission. New admissions are added to the NAR IDT listing for review if required. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Education provided by the DNS/designee to LN staff and center RD regarding assessment and documentation requirements associated with nutritional status and weight monitoring.. To ensure the deficient practice does not recur, the monitoring system established is: NAR and notification audit performed by DNS/designee weekly x 4 then monthly thereafter. Findings and trends from monitoring will be reported monthly to the center PI until a lesser frequency is deemed appropriate. with PI. POC date:	

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	This Federal tag relates to Complaints IN00166154 and IN00167772. 3.1-5(a)(2)		3/24/15	
F000246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, record review, and interview, the facility failed to ensure the resident's need were accommodated related to call lights not in reach for 1 of 3 residents reviewed for call lights in place in the sample of 6. (Resident #E) Finding includes: On 2/19/15 at 9:30 a.m., Resident #E was observed in bed. The resident was awake and alert. There was a red colored call light pad resting on the resident's chest. The resident bent his head down to attempt to reach the pad with this chin and was unable to as the pad was not in reach. No staff members or visitors were	F000246	The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the	03/24/2015

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	present in the room. On 2/19/15 at 9:58 a.m., the resident was observed in bed. The resident's call light pad remained in the same position. The resident again bent his head down to touch the pad with his chin and was unable to reach it. No staff members or visitors were present in the room. The record for Resident #E was reviewed on 2/19/15 at 10: 30 a.m. The resident's diagnoses included, but were not limited to Multiple Sclerosis, urinary tract infection, malaise and fatigue, insomnia, dysphagia (difficulty swallowing), bladder atrophy, and chronic wounds. The 12/17/14 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, and personal hygiene. The resident required total assistance of staff for bathing and dressing. The resident required extensive assistance of one staff member for eating. The resident had impairment in range of motion in both upper and both lower extremities. When interviewed on 2/19/15 at 10:05 a.m., the Unit Manager indicated the resident's call light device was to be on his chest and he activities it by bending		facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. **F –246 Reasonable Accommodation of needs** The facility respectfully requests a desk review for paper compliance with this citation. It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the resident found to have been affected by the deficient practice was: Resident reassessed and evaluation completed by therapy for use of appropriate and usable call light. Alternative breath	

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	his chin down to touch the device. This Federal tag relates to Complaint IN00166154. 3.1-3(v)(1)		activated call light device obtained to promote ease of use and offered to patient/responsible party, as well as discussed with hospice. Consistently assigned staff provided with resident specific education regarding individual needs associated with call light and validation of appropriate placement for use by the resident. Physician orders obtained and plan of care updated as appropriate. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Full facility audit of current residents was completed by the ED/Interdisciplinary team delegates to ensure all residents are able to utilize call lights as needed. Identified concerns addressed and corrected if indicated. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Angel care rounds will include periodic observations of call light use by the residents served. To ensure the deficient practice does not recur, the monitoring system established is: Education provided by the DNS/Designee to care staff regarding call light accessibility and communication of identified	

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			concerns associated with individual resident needs. *The ED/Designee will complete random observation rounds weekly X 4 weeks to validate call lights are accessible and able to be used by center residents.* On-going monitoring of individual needs associated with call lights will be completed by the DNS/designee in conjunction with MDS assessments. *DNS/Designee will compile the audit results and present to the facility Performance Improvement Committee monthly X 6 months or until a lesser frequency is deemed appropriate.* POC date: 3/24/15	
F000314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on observation, record review, and interview, the facility failed to provide	F000314	The facility requests that this plan of correction be considered its credible allegations of	03/24/2015

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	necessary treatment and services for pressure ulcers related to wound dressings not in place ,wound treatments not completed as ordered, wound treatments not initiated upon identification of pressure ulcers, lack of daily pressure ulcer monitoring, and IDT (Inter Disciplinary Team) reviews not completed as per the policy for residents with pressure ulcers for 4 of 4 residents reviewed for pressure ulcers in the sample of 6. (Residents #C, #D, #E and #H) Findings include: 1. During Orientation Tour on 2/19/15 at 9:30 a.m., Resident #E was observed in bed. A skin assessment was completed by LPN #1 at this time. The resident had area to the side of his right lateral foot. The area was irregularly shaped and measured approximately 2 cm (centimeters) x 1 cm. The area was light purple in the center and no drainage was noted. There was no dressing in place to the area. There was a round intact area on the right outer ankle area. The area was intact and was approximately 1.5 cm in diameter. There was no dressing in place to the area. On 2/19/15 at 10:05 a.m., the resident was observed in bed. A skin assessment		compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. **F –314 Pressure Ulcers** The facility respectfully requests a desk review for paper compliance with this citation.	

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	was performed by the Unit Manager. The resident had a dressing to the right hip area dated 2/16/15. The resident had a dressing in place to the coccyx area also. An irregular shaped light purplish intact area was observed to the right outer/lateral side of the foot. The area was approximately 3 cm. x 1 cm. A round dark area was noted to the right ankle. The area was intact and measured approximately 1 cm. in diameter. There were no dressing in place. The Unit Manager identified the two above areas as new areas. On 2/19/15 at 2:20 p.m., LPN #1 and the Unit Manager were observed rendering wound care to the resident. There were no dressings in place on the right foot or ankle areas. The dressing to the outer right hip area dated 2/16/15 was still in place. The dressing was removed. The area measured 4 cm x 3.5 cm with a brown/black center, no drainage, and the edges were attached. Nursing staff then covered the area with a foam dressing. The dressings to the resident's sacrum area were removed by Nursing staff. An area of redness extended to each side of the sacral/coccyx area. The District RN was present and instructed the Unit Manager and LPN #1 to measure the entire area as one ulcer at this time. The entire area was measured by the Unit		It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Resident's C, D, E, and H were assessed for dressings in place per physician orders. Daily pressure ulcer monitoring sheets were placed in the treatment records of resident C, D, E, and H. The IDT was educated regarding completion of weekly review and evaluation of needs for residents with wounds. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Full facility audit for assessment of skin was completed for current residents. All dressings/treatment orders were reviewed per physician orders. Weekly skin logs and daily monitoring records established/updated for accuracy. Physician orders obtained and plans of care updated as indicated. Weekly skin assessment schedule for current residents reviewed and revised as indicated. IDT meeting log was placed in IDT binder for residents with wounds	

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	Manager and measured 10.9 cm x 6.8 cm. The ulcer to the left proximal thigh area was cleansed and packed with with gauze soaked in Dakins solution by LPN #1. The record for Resident #E was reviewed on 2/19/15 at 10:30 a.m. The resident's diagnoses included, but were not limited to Multiple Sclerosis, urinary tract infection, malaise and fatigue, insomnia, dysphagia (difficulty swallowing), bladder atrophy, and chronic wounds. The 12/17/14 Minimum Data Set (MDS) quarterly assessment indicated the resident required extensive assistance of two staff members for bed mobility, transfers, and personal hygiene. The resident required total assistance of staff for bathing and dressing. The resident required extensive assistance of one staff member for eating. The resident had impairment in range of motion in both upper and both lower extremities. The assessment also indicated the resident was at risk for pressure ulcer development and and currently had Stage III (full thickness tissue loss with no bone, tendon, or muscle exposed) and Stage IV, (full thickness tissue loss with exposed bone, tendon, or muscle exposed) unhealed pressure ulcers. The resident's current care plans were		requiring review at weekly IDT meetings. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Education provided to LN staff and members of the IDT who are involved in the center skin management process, regarding skin assessment, weekly IDT review for residents with wounds, and physician notification. An IDT binder and skin logs were established to track each resident with wounds. To ensure the deficient practice does not recur, the monitoring system established is: The DNS/designee will complete an audit of residents with pressure ulcer wounds weekly x 4. The DNS/designee will review current wound reports monthly ongoing. Trends and patterns will be monitored and necessary changes will be implemented. Findings and trends from monitoring will be reported to the center Performance Improvement Committee monthly until a lesser frequency is deemed appropriate. POC date: **3/24/15**	

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	reviewed. A care plan initiated on 10/9/12 indicated the resident had the potential of skin integrity needs related to high risk for pressure ulcers and a history of pressure ulcers. The care plan was revised last 1/9/15. Care plan interventions included for the resident to have a Low Air Loss mattress, skin assessments weekly, and his arms elevated on pillows. Additional interventions included for treatments to be provided as ordered by the Physician, turning and repositioning every 2 hours and as needed, and use of a thin draw sheet for lifting. A care plan initiated on 7/714 indicated the resident had an actual alteration in skin integrity with pressure ulcers to the left buttock and left thigh related to decreased mobility. The care plan was last revised on 12/8/14. Care plan interventions included for staff to complete Daily Monitoring Pressure Ulcer reports, follow the Physician orders for skin care and treatments, initiate Weekly Pressure Ulcer reports, monitor for signs and symptom of infection, and RD (Registered Dietitian) to monitor and evaluate nutritional intake and condition of wounds and make recommendations as indicated. A care plan initiated on 10/7/14 indicated			

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 02/24/2015
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	the resident had actual alteration in skin integrity to the coccyx, peri area, and right thigh. The care plan was last revised on 10/8/14. Care plan interventions included for staff to follow Physician orders for skin care and treatment, monitor areas for symptoms of infection and report to the Physician, Specialty mattress, and turn/reposition every two hours. The Daily Monitoring/Pressure Ulcer sheets were reviewed. There were January sheets for the left posterior thigh ulcer and the left lateral buttock ulcer. The last entry on the left posterior thigh sheet was entered on 1/20/15. No further entries were made. The January 2015 sheet for the left lateral buttock wound indicated the last entry was made on 1/20/15. No further entries were made. There were no February 2015 Daily Monitoring/Pressure Ulcer sheets for any pressure ulcers available. The 2/2015 Treatment Records were reviewed. There was a Physician's order initiated on 2/11/15 to cleanse the right hip wound, pat dry, and apply a foam dressing every day. The treatment was last signed out as completed on 2/16/15. There was no documentation on the Treatment Record related to the above treatment being signed out as completed			

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

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	on 2/17/15 or 2/18/15. The 2/11/15 Wound Care Specialist Evaluation report was reviewed. The report indicated the resident was immobile, had contractures, and had a diagnoses of Multiple Sclerosis. The resident had a Stage III pressure ulcer to the left lateral buttock area of at least 214 days duration. The report indicated the following Physician assessments of the resident's pressure ulcers: Left Lateral Buttock: Stage III, 3.5 cm x 4.0 cm with 1007 granulation tissue, undermining at 9 o'clock, duration greater then 214 days Left Proximal Thigh: Stage IV, 3.5 cm x 3.5 cm x 2.5 cm, 100 % granulation tissue, duration greater then 120 days Heel (no extremity listed): Unstageable (full thickness tissue loss in which the base of the ulcer is covered by slough (yellow, tan, gray, green , or brown) and/or eschar(tan,brown or black), 1.5 cm x 3.0 cm Right Lateral Hip: Unstageable, 5.5 cm x 3.0 cm Right Buttock: Unstageable, 1.7 cm x 1.5 cm Left Medial Buttock : Unstageable, 1.3 cm x 1.5 cm Right side of the Sacrum: Unstageable,			

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

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	1.5 cm x 2.5 cm The Weekly Pressure Ulcer reports for January and February 2015 were reviewed and the residents wounds were classified as follows per facility Nursing Staff: Left Proximal Posterior Thigh: 1/14/15: 5.5 cm x 3.0 cm x 2.0 Stage IV 1/21/15: 3.5 cm x 3.7 cm x 2.2 Stage IV 1/29/15 : 5.0 cm x 3.5 cm x 1.2 cm Stage IV 2/04/15: 4.0 cm x 3.5 cm x 1.2 cm Stage IV 2/11/15: 3.5 cm x 3.5 cm x 2.5 cm Stage IV Right Heel: 2/11/15: 1.5 cm x 3.0 cm- No stage listed (date of initial observation 2/10/15) 2/22/15 1 cm x 1.2 cm - Unstageable Left Heel: 2/11/15: 3.3 x 2.3 cm Stage II (date of initial observation 2/10/15) 2/20/15 2.5 cm x 2 cm - Suspected Deep Tissue Injury (purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and shear) Right Sacrum 2/11/15: 1.5 cm x 2.5 cm - no Stage			

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

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	listed: (initial observation 2/11/15) Right trochanter: 2/11/15: 5.5 cm x 3.0 cm, - no Stage listed: (initial observation 2/10/15) Right Buttock: 2/11/15: 1.7 cm x 1.5 cm - no Stage listed (initial observation 2/11/15) Left Buttock: 1/07/15: 3.5 cm x 2.3 cm- Stage III 1/14/15: 4.0 cm x 1.6 cm - Stage II 1/21/15: 3.5 cm x 1.2 cm - Stage III 1/28/15 : 3.5 cm x 1.2 cm x 0.1 cm - Stage III 2/04/15: 3.0 cm x 1.0 cm x 0.1 cm- Stage III There were no RD nutritional assessment noted for 1/2015 or 2/2015. A Nutritional Services note was completed by the Registered Dietitian on 11/21/14. The note indicated the resident was under Hospice Care and had an area of skin concern. The resident's medications included multivitamin and Vitamin C. The resident was receiving a regular diet with honey thickened liquids and Boost pudding. When interviewed on 2/20/15 at 2:45 p.m., the Unit Manager indicated she obtained a Physician's order on 2/19/15			

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	for a foam dressing to be applied to new area on the lateral foot sometime between 10:00 a.m. and Lunch time. The Unit Manager indicated the ordered foam dressings were available but she did not initiate the treatment at the time of the order as she was called to feed residents at Lunch. 2. During Orientation Tour on 2/19/15 at 8:25 a.m., Resident #C was observed in bed. LPN #1 removed the sock from the resident's left foot. A pressure ulcer was noted to the resident's left heel. The pressure ulcer was approximately 2 cm (centimeters) in diameter. The center of the ulcer was red in color and no drainage was noted from the wound. No dressing was present on the wound. No dressings were noted in the resident's sock when it was removed from the left foot. No dressings were observed in the resident's bed. The record for Resident #C was reviewed on 2/19/15 at 11:15 a.m. The resident's diagnoses included, but were not limited to, pressure ulcer, high blood pressure, congestive heart failure, protein calorie malnutrition, and depressive disorder. Review of the 12/2/14 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief			

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	Interview for Mental Status) score was (13). A score of (13) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff members for bed mobility and transfers. The assessment indicated the resident required extensive assistance of one staff member for personal hygiene and had impairment in range of motion in one upper extremity and both lower extremities. The assessment also indicated the resident was at risk for the development of pressure ulcers and had one Unstageable ulcer (ulcer with full thickness tissue loss in which the base was covered by slough (yellow,tan, green, or brown) and or eschar(tan, brown or black). The most severe tissue damage on on the resident's ulcer was noted to be slough. A Braden Scale for predicating pressure ulcer development was completed on 2/16/15. The resident's score indicated he was at high risk for pressure ulcer development. The resident's current care plans were reviewed. A care plan initiated on 11/18/14 indicated the the resident had a pressure ulcer related to immobility and			

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	malnutrition. Care plan interventions included for staff to administer treatments as ordered and monitor for effectiveness, and to assess/record/monitor wound healing with measuring the length, width, and depth of wounds. A care plan initiated on 11/28/14 indicated the resident had an ADL (Activities of Daily Living) self care deficit related to limited mobility. Care plan interventions included for staff to provide assistance as needed. Another care plan initiated on 11/28/14 indicated the resident was at risk for nutritional decline related to non healing pressure wounds, a diagnosis of malnutrition, and receiving enteral feedings. Care plan intervention included for staff to administer tube feeding as ordered, provide vitamins and supplements as ordered, and notify the RD (Registered Dietitian, Physician and family of significant weight changes. The 2/2015 Physician orders were reviewed. An order was written on 2/11/15 to cleanse the left heel ulcer with wound cleanser, pat dry, and apply a collagen and foam dressing every three days. Review of the 2/2015 Treatment Records indicated the above the ordered treatment was first signed out as completed on			

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	2/12/15 and last signed out as completed on 2/17/15. The Treatment Records also included the following three treatments were initiated on 2/13/15. 1. Cleanse the coccyx wound with normal saline, pat dry, apply Bactroban (an antibiotic ointment) and Santyl (an ointment to debride necrotic tissue) , pack with a fluff gauze, and cover with dry dressing daily. 2. Cleanse the left posterior thigh, pat dry, apply a Collagen and dressing to the area every day. 3. Cleanse the right posterior thigh, pat dry, apply a Collagen and dressing to the area every day. Continued review of the 2/2015 Treatment Records indicated the following treatments had been in place 2/1/15 through 2/11/15. 1. Cleanse the left heel with normal saline/wound cleanser, apply optyfoam and wrap with Kerlix every day. This treatment was initially ordered on 1/26/15 and discontinued on 2/11/15. 2. Cleanse coccyx wound with normal saline/wound cleanser, apply Santyl/Bactroban mix with 500 milligrams of crushed Flagyl (an antibiotic) to the wound and undermining and cover with foam every day and prn			

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	(as needed). This treatment was initially ordered on 12/31/14 and discontinued on 2/11/15. The resident's treatments for the left heel and the coccyx were circled as not completed on the 6:00 a.m. - 2:00 p.m. shift on 2/5/15. The treatments were not signed out as completed on the 2:00 p.m.- 10:00 p.m. either. The back page of the Treatment Record indicated there were notes completed on 2/5/15 related to the above circled treatment. The first was made on the 6:00 a.m.- 2:00 p.m. shift. This entry indicated the resident was not available and the treatment was not done and the above was "endorsed" to the 2:00 p.m.- 10:00 p.m. Nurse. The second entry was made on the 2:00 p.m.- 10:-00 p.m. This entry indicated the treatment was not completed. The resident's treatments to the coccyx, left posterior thigh, right posterior thigh, and the left heel were all circled as not completed on 2/15/15. There was no documentation addressing or explaining why the treatments were not completed. There were no Daily Monitoring/ Pressure Ulcer records available for January or February 2015. A Daily Monitoring/Pressure Ulcers form was completed for December 2014 for the			

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	pressure ulcer to the resident's coccyx. The Weekly Pressure Ulcer Reports for the left posterior thigh pressure ulcer were reviewed. Reports completed on 1/28/15 and 2/4/15 both indicated the left posterior thigh ulcer was first observed on 1/21/15. The reports both indicated the ulcer was a Stage II and measured 2.0 cm x 1.5 cm. The Weekly Pressure Ulcer Reports for the left heel pressure ulcer were reviewed as follows: 2/11/15- measured 1.0 cm x 2.0 cm with no Stage listed. 2/4/15- measured 1.0 cm x 2.0 cm with no Stage listed. The Weekly Pressure Ulcer Reports for the Coccyx pressure ulcer were as follows: 1/28/14- Unstageable, measuring 4.0 x 3.8 x 0.5 cm 2/4/15 - Stage IV , measuring 5.0 x 5.0 cm x 0.5 cm The 2/18/15 Wound Care Specialist Evaluation record was reviewed. The record was completed by a Physician. The record indicated the resident had pressure ulcers to the sacrum, left posterior thigh, right posterior thigh, and the left heel. The wounds were assessed			

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

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	by the Physician as follows: Sacrum pressure ulcer: Stage IV pressure ulcer (full thickness tissue loss with exposed bone, tendon, or muscle exposed with slough or eschar present) measuring 4.5 cm x 4.5 cm 0.7 cm with undermining of 2.5 cm at 12 o'clock. 20 % yellow necrotic tissue and 80% granulation tissue present. Left Posterior Thigh: Stage II pressure ulcer (partial thickness loss of dermis presenting as a shallow open ulcer with a red pink ulcer bed without slough) measuring 5 cm x 1.0 cm x 0.1 cm with no change in the wound progress. Right Posterior Thigh: Stage II pressure ulcer measuring 1/2 cm x 1.2 cm with improvement noted. Left Heel: Stage III pressure ulcer- Cauterization had been completed on wound and noted to be a Stage III (full thickness tissue loss with no bone, tendon, or muscle exposed, undermining and tunneling may be present) measuring 0.7 cm x 1.0 cm with 100 % granulation tissue with improvement noted by decreased surface area. There were no IDT (Inter-Disciplinary			

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	Team) notes or Nutrition at Risk Notes completed in 1/2015 or 2/2015. A Medical Nutrition Therapy Assessment was completed on 11/19/14. The assessment was an admission assessment and was completed by the RD (Registered Dietitian). The assessment indicated the resident was admitted on 11/15/14 and had a Stage III pressure ulcer. The assessment indicated the resident's current weight was 135.5 pounds, was currently NPO (receiving nothing by mouth), and received tube feedings. The assessment indicated the resident had increased nutrient needs related to malnutrition and a pressure ulcer. The goal was to improve the resident's skin integrity. There were no further RD or nutritional assessments related to the resident's nutrient needs when pressure ulcers developed. 3. On 2/20/15 at 9:55 a.m., Resident #D was observed sitting in a geri-chair in his room. There were no staff members in the room at this time. The resident had yellow non skid slippers on both of his feet and did not have shoes or other foot wear on. The sock on the resident's right foot was rolled down over the ankle and his heel was not completely covered by his sock. There were no bandages or dressings in place to the resident's right			

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	heel or foot. CNA #2 entered the resident's room at 9:59 a.m. and removed the sock from the resident's right foot. There was a round open are to the heel measuring approximately 2.5 cm (centimeters) in diameter. There was pale yellowish tissue on the wound surface. The CNA looked under the geri chair and on the both sides of the seat the resident was sitting in and did not observe any bandages or dressings. CNA #2 indicated the resident had already been to Therapy this morning and had recently returned to his room. The record for Resident #D was reviewed on 2/20/15 at 10:05 a.m. The resident's diagnoses included, but were not limited to, kidney injury, urinary tract infections, gastrostomy tube, and dysphagia (difficultly swallowing). Review of the 12/22/14 Minimum Data Set (MDS) admission assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15) . A score of (15) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff members for bed mobility and transfers. The assessment indicated the			

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	resident required extensive assistance of one staff member for dressing, eating, personal hygiene, and bathing. The assessment also indicated the resident was at risk for the development of pressure ulcers and had no pressure ulcers at the time of the assessment. The resident's current care plans were reviewed. A care plan initiated on 12/23/14 indicated the resident had an ADL (Activities of Daily Living) Self Care performance deficit related to multiple co-morbidities. Care plan interventions included for staff to encourage the resident to participate and praise all efforts at self care. A care plan initiated on 12/23/14 indicated the resident had the potential for pressure ulcer development related to incontinence of bowel. Care plan interventions included for staff to administer treatments as ordered and monitor for effectiveness, and monitor the resident's nutritional status and lab/diagnostic work. Review of the 2/2015 Physician Order Statement indicated there was an order to cleanse the right heel ulcer with normal saline, pat dry gauze, apply a foam dressing, and wrap with Kerlix every day. The order was originally written on 1/15/15.			

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	The 1/2015 Nursing Progress Notes were reviewed. An entry made on 1/15/15 indicated a right heel pressure ulcer was observed. The pressure ulcer was Unstageable and the current treatment was for staff to apply a foam dressing. A 1/15/15 Weekly Pressure Ulcer Progress Report was reviewed. The report indicated the resident had an Unstageable pressure ulcer to the right heel. The ulcer was first observed on 1/15/15 and measured 5 cm x 4.6 cm. The wound was assessed as a Stage III ulcer (full thickness skin loss involving damage or necrosis of subcutaneous tissue). Necrotic adherent soft, black eschar was present and covering 25-50% of the wound bed. The treatment ordered was to apply a foam dressing and cover with a dry dressing. The 1/22/15 Weekly Pressure Ulcer Progress report indicated the right heel ulcer measured 5 cm x 4.6 cm and was Unstageable. Necrotic adherent soft, black eschar was present and covering 25-50% of the wound bed. The 1/29/15 Weekly Pressure Ulcer Progress report indicated the right heel ulcer was Unstageable and measured 5 cm x 4.6 cm. Necrotic adherent soft,			

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	black eschar was present and covering 25-50% of the wound bed The 2/4/15 Weekly Pressure Ulcer Progress report indicated the right heel ulcer was a Stage II and measured 3.5 cm x 3.5 cm. and had loosely adherent slough. A Physician's Progress Note was completed by the Wound Physician on 2/12/15. The note indicated the resident had an ulcer to the left heel. The wound was Unstageable with necrosis present. The ulcer measured 3.5 cm x 2.6 cm. The ulcer had 40% necrotic yellow tissue and 60% granulation tissue with a moderate amount of serous (blood colored) drainage The January Daily Monitoring /Pressure Ulcer report indicated the resident had a pressure ulcer to the right heel. The last entry made on the report was completed on 1/20/15. No further daily monitoring of the right heel ulcer was completed. There were no February 2015 Daily Monitoring/Pressure Ulcer reports for the right heel ulcer available. There were no IDT (Inter-Disciplinary Team) notes or Nutrition at Risk Notes completed in 1/2015 or 2/2015.			

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	When interviewed on 2/19/15 at 8:30 a.m., LPN #3 indicated she was assigned to care for Resident #C. The LPN indicated she was not aware and had not been informed by any staff that the resident did not have a dressing in place to the left heel. The LPN indicated the night shift had gotten the resident out of bed prior to the start of the day shift. LPN #3 indicated the resident had a treatment ordered and should have had a dressing in place to the left heel. 4. The closed record for Resident #H was reviewed on 2/20/15 at 3:15 p.m. The resident's diagnoses included, but were not limited to, anemia, diabetes mellitus, open wounds on the buttock, protein calorie malnutrition, high blood pressure, and left lower lobe amputation. The resident was sent to the hospital Emergency Room on 2/11/15 and had not returned to the facility. The 12/17/14 Quarterly MDS assessment indicated the resident required extensive assistance of two staff members for bed mobility and transfers. The assessment indicated the resident required extensive assistance of one staff member for dressing and had no known weight loss or gain. The assessment also indicated the resident was at risk for the			

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	development of pressure ulcers and had no unhealed ulcers at the time of the assessment. A Braden Scale assessment form for predicting pressure ulcer risk was completed on 12/9/14. The score was (14.0). A score of (14) indicated the resident was at risk for the development of pressure ulcers. The resident's current care plans were reviewed. A care plan initiated on 1/20/15 indicated the resident had a pressure ulcer and the potential for pressure ulcer development related to immobility. Care plan interventions included to monitor the resident's nutritional status and monitor/document/report changes in skin status to the Physician. Review of the 1/2015 and 2/2015 Progress Notes indicated there were no NAR or IDT notes related to pressure ulcer or nutritional status. A Weekly Pressure Ulcer report was initiated on 1/29/15. The report indicated the resident had a Stage III pressure ulcer to the coccyx. The ulcer measured 10 cm x 5 cm x < .01 cm. The wound tissue was noted to have white/grey non viable tissue &/or non - adherent yellow tissue			

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	with a scant amount of exudate. A treatment was obtained to cleanse the wound with wound cleanser, pat dry, and cover with a foam dressing daily. The 2/11/15 Wound Care Specialist Evaluation report was reviewed. The report indicated the pressure ulcer to the bilateral sacrum area measured 8.0 cm x 5.0 cm with Unstageable Necrosis. Surgical excisional debridement was completed . The 2/11/15 Weekly Pressure Ulcer report indicated the Sacrum ulcer was a Stage IV and measured 8.0 cm x 5.0 cm. There was a moderate amount of serosanguineous (thin, watery, pale red/pink) drainage present. A Weekly Pressure Ulcer report was initiated on 1/20/15. The report indicated the resident had an Unstageable pressure ulcer to the right heel. The pressure ulcer measured 6 cm x 4.5 cm with no visible necrotic tissue and no exudate present. The 1/27/15 Weekly Pressure Ulcer report indicated the right heel ulcer measured 6 cm x 4.5 cm and remained Unstageable with no necrotic tissue or exudate noted. The 2/11/15 Weekly Pressure Ulcer report indicated the right heel ulcer measured 4.5 cm x 3.7 cm and remained Unstageable with no visible necrotic			

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	tissue or exudate noted. The 2/11/15 Wound Care Specialist Evaluation report indicated the resident had an Unstageable pressure ulcer to the right heel. The pressure ulcer measured 4.5 cm x 3.7 cm. The treatment ordered was to apply Skin-Prep twice daily. A Weekly Pressure Ulcer report was initiated on 1/29/15. The report indicated the resident had an Unstageable pressure ulcer to the right great toe area. The ulcer measured 2 cm x 1.5 cm with no visible necrotic tissue or exudate noted. The 2/11/15 Weekly Pressure Ulcer report indicated the pressure ulcer was now called right distal medial foot area and measured 2.0 cm x 1.0 cm and remained Unstageable with no visible necrotic tissue or exudate. The 2/11/15 Wound Care Specialist Evaluation report indicated the resident had an Unstageable pressure ulcer to the right distal medial foot. The pressure ulcer measured 2.5 cm x 3.5 cm. The treatment ordered was to apply Skin Prep twice daily. The Daily Monitoring/Pressure Ulcer sheets were reviewed. A sheet for the right great toe area was initiated on 1/28/15. No entries were made on			

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	1/30/14. No Daily Monitoring sheet were available for February 2015. There were no 1/2015 or 2/2015 Daily Monitoring sheets available for the right heel ulcer. There were no 2/2015 Daily Monitoring sheets for the sacral ulcer available. The February 2015 Treatment Records were reviewed. The ordered treatment to the right heel was for Skin Prep and wrap with Kerlix every day. The treatment was circled as not completed on 2/9/15. The treatment to the coccyx was to cleanse the coccyx wound with wound cleanser, pat dry, and apply a foam dressing every day. The treatment was circled as not completed on 2/9/15. An entry was made on the back page of the Treatment Record. The entry indicated "unable to complete dt (due to) time". When interviewed on 2/20/15 at 1:25 p.m., the District Nurse indicated the NAR (Nutrition at Risk)/IDT meets weekly on Thursday. The District Nurse also indicated new admissions, residents on weekly weights, and residents with wounds were to be reviewed at the weekly meetings. The District Nurse also indicated members from all Departments were to be present at the weekly meeting and each team member maintains logs for their disciplines or care area they were in charge of such as skin conditions, falls,			

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	weight loss and other areas. The responsible staff members were responsible for taking notes and and logging the residents and notes in the system. When interviewed on 2/24/15 at 8:50 a.m., the District Nurse indicated there were no ongoing Nutritional assessment or notes for the resident's with pressure ulcers. The facility policy titled "Prevention and Treatment of Pressure Ulcers and Non-Pressure Related Wounds" was reviewed on 2/20/15 at 1:00 p.m. The policy had a release date of 10/27/14. The District Nurse provided the policy and indicated the policy was current. The policy indicated the Nutritional Status of resident at risk for pressure ulcers should be addressed and appropriate referral to the Dietitian were to be made as indicated. The policy also indicated reevaluation of the nutritional status for wound healing should be completed initially and with each condition change. The facility form titled "Daily Monitoring/Pressure Ulcers" was reviewed on 2/2015 at 1:00 p.m. The form had a revised date of 9/30/13. The District Nurse provided the form and indicated the form was currently to be			

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	used for all pressure ulcers. The form indicated the ulcers were to be monitored in five categories to identify changes in the wound's healing process. Columns A, C, D, and E were to be completed if there was no dressing in place. Columns B, C, and E were to be completed if a dressing was present. The five categories were as follows: Column A- note if there was improvement, no change, infected, deteriorated, or healed. Column B- if a dressing was present: note if the dressing was dry and intact, leaking drainage, or not applicable Column C Surrounding Skin of Ulcer - observable with dressing intact- Note if the skin was pink or normal, bright red and/or blanches to touch, white or gray pallor, dark red or purple and/or not bleachable, or black or hyperpigmented, Column D- Peripheral Tissue Edema (Around Wound edges)- note is there was no swelling, minima swelling, non-pitting or pitting edema. Column E- Pain associated with Pressure Ulcer- note if no pain, pain present, pain adequately controlled, or pain not controlled. The Instructions for the use of the form indicated one sheet was to be used for each site This Federal tag relates to Complaints			

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	IN00166154 and IN00167772. 3.1-40(a)(2)			