

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

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
F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00182198.</p> <p>Complaint IN00182198- Substantiated. Federal/State deficiency related to the allegations were cited at F279, F282, F309, F312, and F314.</p> <p>Survey dates: September 22 and 23, 2015</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Census bed type: SNF/NF: 111 Total: 111</p> <p>Census payor type: Medicare: 23 Medicaid: 65 Other: 23 Total: 111</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000		

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.

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 09/23/2015	
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			
F 0279 SS=D Bldg. 00	<p>Quality review completed by 26143, on September 27, 2015.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, record review, and interview, the facility failed to develop a</p>	F 0279	<p>F 279 1.Resident had her care plan immediately updated during the</p>	10/16/2015			

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 09/23/2015
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>resident care plan, related to a skin condition, for 1 of 3 residents reviewed for skin conditions in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>During an observation on 09/22/15 at 10:11 a.m., with LPN #1 present, Resident #B was lying in bed. LPN #1 assisted the resident to turn onto her left side. Resident #B's buttock area had a large pink/red area which started at the coccyx area and went into both the right and left buttocks. There was a small open area on the upper area of the right buttock, which had red drainage coming from the area.</p> <p>Resident #B's record was reviewed on 09/23/15 at 9:27 a.m. The resident's diagnosis included, but were not limited to, vascular dementia, diabetes mellitus, and cutaneous (skin) candidacies (yeast).</p> <p>A Weekly Non-Pressure Skin Condition Report, dated 03/26/15 at 9:08 a.m., indicated the skin condition was not new and was first observed on 10/29/14. The report indicated the area was moisture associated incontinent dermatitis, which measured 1.4 cm (centimeters) by 0.5 cm by 0.1 cm and had open areas of excoriation on the resident's coccyx.</p>		<p>survey.</p> <p>2.All residents will be assessed for presence ofwounds. All care plans with would careconcerns will be audited for accuracy.</p> <p>3.Nursing staff will be inserviced regardingimmediate notification of any new skin concern. Staff nurse once identifying concern will update care plan.</p> <p>All skin carechanges will be reviewed at least 3X per week during clinical meeting. All care plans will be evaluated and orupdated at this time.</p> <p>TheDON/designee will audit these records 2X a week for 30 days or until 100%compliance is achieved then a minimum of weekly. DON will report to Quality improvementresults of audits monthly for 6 months. Committee will assess for recommendations.</p> <p>CompletionOctober 16, 2015</p>		

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 09/23/2015
--	---	--	---

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>The Physician's Recapitulation Orders, dated 03/15, indicated an order dated 07/17/13, for Ketoconazole (used for fungal skin infections) 2% cream to the groin, buttocks and neck two times a day and as needed for one tube of cream.</p> <p>A Physician's Order, dated 06/07/15, indicated an order for Zeasorb Powder (anti-fungal) to the neck, buttocks and redness to right and left arm pit, to times a day as needed.</p> <p>The TAR (Treatment Administration Record), dated 08/15, indicated the ketoconazole 2% cream was still being applied two times a day, until 08/05/15, when the treatment order had been changed.</p> <p>A Physician's Progress Note, written by the Wound Care Specialist, dated 08/05/15, indicated the resident had a rash of unknown duration, was diagnosed with candidacies of the perineum, and would be treated with fluconazole (for yeast infections) 150 mg (milligrams) with a repeated dose in seven days for extensive intertriginous (two skin areas touch or rub together) candidacies, BNZ (fungal infections) cream every shift and as needed.</p>			

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 09/23/2015
--	---	--	---

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>A Physician's Order, dated 08/19/15, indicated the Wound Specialist had signed off on the resident's care.</p> <p>A Physician's Order, dated 08/21/15, indicated an order for Lotrimin (anti-fungal) 2% Powder, to apply to the coccyx and sacrum every shift and as needed.</p> <p>A Weekly Skin Check, dated 08/27/15, indicated the resident had skin conditions or changes and the condition was not new since the last documented skin check.</p> <p>A Weekly Skin Check, dated 09/10/15, indicated the resident had skin conditions or changes and the condition was not new since the last documented skin check and to continue the current treatment.</p> <p>The TARs, dated 08/15 and 09/15, indicated the orders for ketoconazole 2% cream from 08/01/15 through 08/07/15, BNZ cream from 08/05/15 through 08/20/15, and Lotrimin 2% Powder from 08/21/15 through present.</p> <p>The resident's care plans indicated there was no care plan for the resident's dermatitis.</p> <p>During an interview on 09/23/15 at 11:33 a.m., RN #3 indicated there had not been</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218		X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/23/2015	
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			
F 0282 SS=D Bldg. 00	<p>a care plan for the dermatitis and one had just been written.</p> <p>This Federal Tag relates to Complaint IN00182198.</p> <p>3.1-35(a)</p> <p>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.</p> <p>Based on observation, record review and interview, the facility failed to follow orders as written by the Resident's Physician, related to the treatment of moisture dermatitis, for 1 of 3 residents reviewed for skin conditions, in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>During an observation on 09/22/15 at 2:56 p.m., with LPN #5 and CNA #6, Resident #B was lying in bed. The resident was turned onto the left side, and LPN #5 indicated the resident had flaking</p>	F 0282	<p>F 282</p> <p>1.Resident had her treatment record reviewed. 2.All treatment records will be reviewed foraccuracy. Counseling for allnon-compliance will be conducted. 3.All nurses will be re-inserviced on completionof treatment record.</p> <p>All treatmentrecords will be reviewed a minimum of 3X per week by nurse managers. These auditswill be reviewed at the next clinical meeting. Any counseling will occur until 100% compliance is achieved. These audits will be done weekly for 4 weeksand then</p>	10/16/2015			

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 09/23/2015	
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>of the skin on the buttock and had contact dermatitis from moisture.</p> <p>During an interview on 09/22/15 at 2:56 p.m. Resident #B's husband, who was in the room while care was being provided, indicated the resident's skin condition on her buttock was not getting better. He continued to indicate he did not think the treatment was being administered correctly and as ordered.</p> <p>Resident #B's record was reviewed on 09/23/15 at 9:27 a.m. The resident's diagnosis included, but were not limited to, vascular dementia, diabetes mellitus, and cutaneous (skin) candidacies (yeast).</p> <p>A Physician's Order, dated 08/05/15, indicated an order for BNZ Cream (anti-fungal) to the coccyx/sacrum area every shift and with episodes of incontinence.</p> <p>The Treatment Administration Record (TAR), dated 08/15, indicated by the lack of initials, the treatment of the BNZ Cream had not been completed on August 6, 7, and 12, 2015 on the 10 p.m.-6 a.m. shift, August 6, 7, 8, 12, an 19, 2015 on the 6 a.m.-2 p.m. shift, and August 6, 7, 10, 12 ,15, an 19, 2015 on the 2 p.m.-10 p. m. shift.</p>		<p>bi-weekly. DNS will report onthese audits monthly with the quality improvement committee until 100%compliance is achieved for 6 months.</p> <p>Completion October16, 2015</p>				

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 09/23/2015
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	
F 0309 SS=D Bldg. 00	<p>A Physician's Order, dated 08/21/15, indicated an order to discontinue the BNZ Cream and start Lotrimin (anti-fungal) 2% powder to the coccyx and sacrum every shift and as needed.</p> <p>The TAR, dated 09/15, indicated by the lack of initials, the treatment was not completed on the 10 p.m.-6 a.m. shift on September 12, 2015, not completed on the 6 a.m.-2 p.m. shift on September 8, 10, 17, and 21, 2015, and not completed on the 2 p.m.-10 p.m. shift on September 1,2,4,5,8,11,12,13,17,and 21, 2015.</p> <p>During an interview on 09/22/15 at 3:30 p.m., LPN #5 indicated if the treatment had been completed, the Nurse would have initialed the treatment was administered. LPN #5 acknowledged the treatment had not been initialed as completed for several days.</p> <p>This Federal Tag relates to Complaint IN00182198.</p> <p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

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>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.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received the necessary treatment and services, related to the monitoring and thoroughly assessing a skin condition for 1 of 3 resident reviewed for skin conditions in a total sample of 3. (Resident #B)</p> <p>Finding includes:</p> <p>During an observation on 09/22/15 at 10:11 a.m., with LPN #1 present, Resident #B was lying in bed. LPN #1 assisted the resident to turn onto her left side. Resident #B's buttock area had a large pink/red area which started at the coccyx area and went into both the right and left buttocks. There was a small open area on the upper area of the right buttock, which had red drainage coming from the area. During the observation, LPN #1 indicated the open area had not been there before and it had appeared to happen when the incontinent pad was removed from the buttock area.</p> <p>Resident #B's record was reviewed on</p>	F 0309	<p>F 309</p> <p>1. Resident had a head to toe assessment immediately. Documentation, including assessment, was completed for area of concern.</p> <p>2. All residents will be assessed for presence of skin impairments. Impairment assessments will be documented.</p> <p>3. Nursing staff has been reinserviced on completion of skin checks and documentation of assessments R/T skin impairments.</p> <p>All skin checks have been redistributed and will now be documented by CNA and Licensed Nurse. All skin checks must be completed as scheduled.</p> <p>Nurse managers will audit these sheets 2X per week for completion.</p> <p>These audits will be presented at the clinical meeting weekly for evaluation by the DON/designee. This will continue minimally of 100% compliance for 30 days. These audits will be presented by DNS to quality improvement committee for recommendations monthly for 6 months.</p>	10/16/2015

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 09/23/2015
--	---	--	---

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>09/23/15 at 9:27 a.m. The resident's diagnosis included, but were not limited to, vascular dementia, diabetes mellitus, and cutaneous (skin) candidacies (yeast).</p> <p>A Weekly Non-Pressure Skin Condition Report, dated 03/26/15 at 9:08 a.m., indicated the skin condition was not new and was first observed on 10/29/14. The report indicated the area was moisture associated incontinent dermatitis, which measured 1.4 cm (centimeters) by 0.5 cm by 0.1 cm and had open areas of excoriation on the resident's coccyx. The summary of the assessment indicated to continue the current treatment as ordered and notify with changes.</p> <p>The Physician's Recapitulation Orders, dated 03/15, indicated an order dated 07/17/13, for Ketoconazole (used for fungal skin infections) 2% cream to the groin, buttocks and neck two times a day and as needed for one tube of cream.</p> <p>The Weekly Skin Check forms, from 03/16/15 to 06/04/15, did not indicate a thorough assessment of the area on the resident's buttocks had been assessed. The forms indicated to continue the treatment.</p> <p>A Nursing Evaluation, dated 06/04/15, indicated the resident skin was normal,</p>		Completion October 16, 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 09/23/2015
--	---	--	---

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>supple and free of open areas.</p> <p>A Physician's Order, dated 06/07/15, indicated an order for Zeasorb Powder (anti-fungal) to the neck, buttocks and redness to right and left arm pit, to times a day as needed.</p> <p>A Nursing Evaluation, dated 07/16/15 at 3:48 a.m., indicated the resident's skin was normal, supple and free from open areas.</p> <p>A Weekly Skin Check, dated 07/30/15, indicated the resident had no skin conditions or changes.</p> <p>The TAR (Treatment Administration Record), dated 08/15, indicated the ketoconazole 2% cream was still being applied two times a day, until 08/05/15, when the treatment order had been changed. The TAR also indicated by no initials present, the Zeasorb Powder had not been administered.</p> <p>A Physician's Progress Note, written by the Wound Care Specialist, dated 08/05/15, indicated the resident had a rash of unknown duration, was diagnosed with candidacies of the perineum, and would be treated with fluconazole (for yeast infections) 150 mg (milligrams) with a repeated dose in seven days for</p>			

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 09/23/2015
--	---	--	---

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>extensive intertriginous (two skin areas touch or rub together) candidacies, BNZ (fungal infections) cream every shift and as needed.</p> <p>The Nurses' Progress Notes prior to 08/05/15 had not indicated the resident had a skin condition.</p> <p>A Nurses' Progress Note, dated 08/05/15 at 9:43 p.m., indicated the resident had new orders for the fluconazole, the BNZ cream, and to discontinue the ketoconazole cream when the BNZ cream arrived.</p> <p>A Weekly Skin Check, dated 08/06/15, indicated the resident had no skin conditions or changes.</p> <p>A Weekly Skin Check, dated 08/13/15, indicated the resident had no skin conditions or changes and no new open areas were noted.</p> <p>A Physician's Order, dated 08/19/15, indicated the Wound Specialist had signed off on the resident's care.</p> <p>A Weekly Skin Check, dated 08/20/15, indicated the resident had no skin conditions or changes and no new skin areas.</p>			

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 09/23/2015
--	---	--	---

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>A Physician's Order, dated 08/21/15, indicated an order for Lotrimin (anti-fungal) 2% Powder, to apply to the coccyx and sacrum every shift and as needed.</p> <p>There was no assessment of the resident's skin condition in the Nurses' Progress Notes for August 1-21, 2015.</p> <p>A Weekly Skin Check, dated 08/27/15, indicated the resident had skin conditions or changes and the condition was not new since the last documented skin check. There was no assessment of the area completed.</p> <p>A Weekly Skin Check, dated 09/10/15, indicated the resident had skin conditions or changes and the condition was not new since the last documented skin check and to continue the current treatment. There was no assessment of the area completed.</p> <p>A Weekly Skin Check, dated 09/17/15, indicated there was no skin conditions or changes, and no new open areas.</p> <p>The TARs, dated 08/15 and 09/15, indicated the orders for ketoconazole 2% cream from 08/01/15 through 08/07/15, BNZ cream from 08/05/15 through 08/20/15, and Lotrimin 2% Powder from 08/21/15 through present.</p>			

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 09/23/2015
--	---	--	---

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>The Nurses' Progress Notes and Weekly Skin Checks indicated there had not been a thorough assessment of the resident's moisture associated incontinent dermatitis from 03/26/15 until the Wound Care Specialist completed an assessment on 08/05/15.</p> <p>The Nurses' Progress Notes and Weekly Skin Checks indicated there had not been a thorough assessment of the resident's moisture associated incontinent dermatitis from 08/06/15 through 09/23/15.</p> <p>There were no Nurses' Progress Notes for 09/22/15 to indicate an assessment of the resident's buttocks and open areas had been completed after LPN #1 had found the open area on 09/22/15. An assessment of the buttock area had not been completed until 09/23/15 at 2:03 p.m.</p> <p>During an interview on 09/23/15 at 9:53 a.m., the Wound Care Specialist indicated the resident had a lot of moisture in the area and the resident had moisture associated dermatitis and he had signed off the resident's case after ordering a new treatment for the area. (A Physician's Order, dated 08/19/15, indicated the Wound Specialist had</p>			

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 09/23/2015
--	---	--	---

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>signed off on the resident's care.)</p> <p>During an observation on 09/23/15 at 10:33 a.m., with RN #3 and CNA #4, the resident was transferred onto her left side, the resident had a white substance on the skin of the buttocks. RN #3 acknowledged the resident had an open area. CNA #4 indicated the resident's buttocks was excoriated and bleeds and indicated the open area was present on 09/22/15. CNA #4 indicated the Nurse had applied powder to the area this morning.</p> <p>During an interview on 09/23/15 at 10:50 a.m., RN #3 indicated an assessment of the resident's skin condition could not be found.</p> <p>During an interview on 09/23/15 at 11:30 a.m., RN #3 indicated she was still looking for an assessment of the area.</p> <p>During an interview on 09/23/15 at 12:21 p.m., RN #3 indicated she was unaware of the open area and the redness of the resident's buttocks. She indicated she was not the resident's Nurse today.</p> <p>LPN #2 (resident's Nurse) assessed the resident's skin condition on 09/23/15 at 2:03 p.m., with the following assessments:</p>			

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 09/23/2015
--	---	--	---

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>Right buttock was assessed as being new and first observed on 09/23/15, open with bloody drainage, and measured 1 cm x 0.4 cm x 0.1 cm.</p> <p>Right buttock was assessment as being new, first observed on 09/23/15, open with bloody drainage, and measured 0.5 cm x 0.5 cm x 0.1 cm.</p> <p>Right buttock was assessed as being new, first observed on 09/23/15, open with bloody drainage, and measured 2 cm x 1 cm x 0.1 cm.</p> <p>Bilateral buttocks was assessed as a new non-pressure area, first observed 09/23/15, had red flaky skin, and measured 32.5 cm x 20 cm x 0.1 cm.</p> <p>During an interview on 09/23/15 at 2:07 p.m., LPN #2 indicated the resident's bilateral buttock was red and had three separate open areas on the right buttock with bloody drainage. She indicated she had notified the Nurse Practioner and at this time she had not changed the resident's treatment orders.</p> <p>A facility policy, dated 04/28/07, titled, "Weekly Non-Pressure Skin Condition Report", received from the Administrator as current on 09/23/15, indicated, "...To</p>			

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 09/23/2015
--	---	--	---

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
F 0312 SS=D Bldg. 00	<p>record on first observation, and then on a weekly schedule, a complete description of a skin condition other than a pressure sore, the response to treatment, and any recommended treatment changes...At least weekly reassess the skin condition by checking the appropriate boxes that best describes the wound for: a. date b. Size in cm 1) Length 2) Width 3) Depth c. Color...g. Progress..."</p> <p>This Federal Tag relates to Complaint IN00182198.</p> <p>3.1-37(a)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. Based on observation, interview, and record review, the facility failed to ensure a resident who was extensive assistance with toileting and always incontinent of bowels received care to maintain good personal hygiene, related to incontinence care, for 1 of 3 residents observed for care, in a total supplemental sample of 3. (Resident #C)</p>	F 0312	<p>F 312</p> <ol style="list-style-type: none"> 1. Resident was cleaned immediately when noted. 2. All residents needing assistance with incontinence care have the potential to be affected. No other residents were noted to have care needs during the survey. 3. All staff will be re-inserviced on communicating care needs to 	10/16/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

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>Finding includes:</p> <p>During an interview on 09/22/15 at 10:17 a.m., LPN #1 indicated Resident #C had a pressure area, a urinary catheter, and was incontinent of bowel movement.</p> <p>An observation immediately after the interview indicated the resident was lying in bed and had been incontinent of soft bowel movement. LPN #1 indicated she would let the CNA's know the resident required incontinence care. LPN #1 then reapplied the resident's brief.</p> <p>During an observation with LPN #7, on 09/22/15 at 11 a.m., Resident #C was lying in bed. The resident's brief was opened by LPN #7 and the bowel movement remained in the resident's brief. LPN #7 administered incontinent care to the resident.</p> <p>During an interview at the time of the observation, Resident #C indicated no one had come in to provide care to her after we left the room earlier.</p> <p>During an interview on 09/22/15 at 11:08 a.m., CNA #8 and CNA #9, who were assigned to the hallway the resident was on, indicated they had not been informed the resident needed incontinence care.</p>		<p>the caregiver.</p> <p>Angel rounds have been adjusted and expanded to other managers so more residents can be observed 2X/week.</p> <p>The nursing managers/supervisors/designee will make additional rounds observing each resident. These rounds will be noted on specific sheets on each day they are assigned.</p> <p>These sheets will be given to the DNS/designee.</p> <p>These audit sheets will be reviewed with the DNS/designee. The DON/designee will audit these records weekly for 30 days or until 100% compliance is achieved then a minimum of weekly. DON will report to Quality improvement results of audits monthly for 6 months. Committee will assess for recommendations.</p> <p>Completion October 16, 2015</p>	

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 09/23/2015
--	---	--	---

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>During an interview on 09/22/15 at 11:10 a.m., LPN #1, who had just returned from a work break, indicated she could not remember who she told about the resident needing incontinence care. LPN #1 then indicated she must have told LPN #7.</p> <p>During an interview on 09/22/15 at 11:12 a.m., LPN #7 indicated she had not been informed the resident required incontinence care. She indicated she had not spoke with LPN #1 because LPN #1 had gone on break.</p> <p>Resident #C's record was reviewed on 09/22/15 at 1:24 p.m. The resident's diagnoses included, but were not limited to, stroke and hypertension.</p> <p>The Quarterly Minimum Data Set assessment, dated 06/29/15, indicated the resident's cognition was moderately impaired with a score of 12, required extensive assistance of two staff for transfers and mobility, toileting, and hygiene, and was always incontinent of bowel.</p> <p>This Federal Tag relates to Complaint IN00182198.</p> <p>3.1-38(a)(3)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/23/2015
--	---	---	---

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
F 0314 SS=D Bldg. 00	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with pressure ulcers received necessary treatment and services to promote prevention of further pressure areas, related to not following care planned interventions, for 1 of 2 residents reviewed for pressure ulcers in a total sample of 3. (Resident #C)</p> <p>Finding includes:</p> <p>During an observation on 09/22/15 at 2:47 p.m., LPN #5 and CNA #6 were in the resident's room. LPN #5 indicated the resident's ankles were not offloaded and the resident's right ankle was resting on the resident's mattress. The resident</p>	F 0314	<p>F 314</p> <p>Resident had heels off loaded as per care plan during the survey.</p> <p>All residents with skin concerns have the potential for this concern.</p> <p>All residents are being audited with regard to skin prevention devices. All care plans and care cards are noted for current accuracy.</p> <p>All staff has been re-inserviced on communication and execution of ulcer prevention intervention.</p> <p>All skin prevention interventions will be noted on care cards through routine clinical meeting. Angels will observe for compliance 2X/week.</p> <p>The DNS/PM supervisor/weekend supervisor will</p>	10/16/2015

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 09/23/2015	
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>had non-skid socks on both feet. LPN #5 indicated the resident had a pressure area on the right ankle.</p> <p>Resident #C's record was reviewed on 09/22/15 at 1:24 p.m. The resident's diagnoses included, but were not limited to, stroke and hypertension.</p> <p>The Quarterly Minimum Data Set assessment, dated 06/29/15, indicated the resident's cognition was moderately impaired with a score of 12, required extensive assistance of two staff for transfers and mobility, had unhealed pressure areas, two stage 4 pressure areas (deep sore reaching muscle and bone) and one unstagable pressure ulcer (unable to determine how deep the sore is due to a thick covering).</p> <p>A care plan, dated 09/11/15, indicated the resident had a stage 4 pressure area on the right outer ankle. The interventions included, "...Prevalon boots (anti-pressure boots) at all times remove for hygiene..."</p> <p>A care plan, dated 06/25/15, indicated the resident had a stage 4 pressure ulcer to the right hip. The interventions included, "...Heels Up to be applied while in bed..."</p> <p>A care plan, dated 09/04/14, indicated the</p>		<p>monitor for compliance. Reports will be given to quality improvement per DNS. All reports will be reviewed monthly for 6months and recommendations given until 100% compliance is achieved.</p> <p>Completion October 16, 2015</p>				

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 09/23/2015
--	---	--	---

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>resident had a potential for pressure ulcers. The interventions included, "...Heel boots on while in bed..."</p> <p>The 09/17/15 Weekly Skin Assessment, indicated the resident had a stage 4 area on the right ankle, which measured 0.1 centimeters (cm) by 0.1 cm by 0.1 cm with 100% granulation tissue present, and to continue off loading and skin prep treatment.</p> <p>This Federal Tag relates to Complaint IN00182198.</p> <p>3.1-40(a)(2)</p>			