

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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 Complaints IN00177116, IN00176994, and IN00176072.</p> <p>Complaint IN00177116 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F282, and F309.</p> <p>Complaint IN00176994 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F309, and F282.</p> <p>Complaint IN00176072- Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F282, and F309.</p> <p>Survey Dates: July 6, and 7, 2015</p> <p>Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930</p> <p>Census bed type: SNF/NF: 96 Total: 96</p> <p>Census payor type: Medicare: 22</p>	F 0000	<p>Kim Rhoades, Director Long Term Care Indiana State Department of Health 2 north Meridian Street Section 4-Bl Indianapolis, IN 46204-3006</p> <p>Dear Ms Rhoades, Enclosed you will find the plan of correction for the complaint survey (Survey ID 04U911: IN00176072, IN00176994, and IN00177116) conducted at our facility on July 7, 2015. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein. The facility requests that this plan of correction be accepted as our allegation of compliance. We further request that our plan of correction be considered for a paper compliance desk review. If you have any further question of the facility, you may reach the facility at 317-347-9501. Peggy Moore Executive Director</p>	
------------------------	--	--------	--	--

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: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254		
(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>Medicaid: 55 Other: 19 Total: 96</p> <p>Sample: 6</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</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).</p> <p>Based on record review and interview,</p>	F 0279	1.Resident B and Resident G	08/06/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254		
(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 facility failed to develop an individualized plan of care for dialysis for 2 of 3 residents reviewed for dialysis care plans (Residents B and G).</p> <p>Findings include:</p> <p>1. Resident B's record was reviewed on 7/6/15 at 1:20 p.m. Resident B had diagnoses, which included but were not limited to, end stage renal disease.</p> <p>A physician's order, dated 6/20/15, indicated orders for dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>The record did not indicate a care plan to address Resident B's diagnosis of end stage renal disease and did not address the need for dialysis.</p> <p>During an interview on 7/7/15 at 1:45 p.m., the Director of Nursing indicated Resident B did not have an individualized plan of care which addressed end stage renal disease and/or dialysis.</p> <p>2. Resident G's record was reviewed on 7/6/15 at 3:00 p.m. Resident G had a diagnoses, which included but were not limited to, end stage renal disease.</p>		<p>have discharged from the facility.</p> <p>2.All other residents receiving dialysis have the potential to be affected. An audit of the care plan has been completed for all residents residing in the facility and currently receiving dialysis. All care plans have been revised if needed and developed to address the patients' individual immediate need for dialysis.</p> <p>3.All Licensed nursing staff have been educated on developing the initial plan of care to address the patients' initial individual immediate needs until the interdisciplinary team completes the Initial Minimum Data Set.</p> <p>4.The DNS/Designee will complete an audit of all residents initial plan of care within 24 hours of admission to validate the Initial Plan of care addresses the patient's initial individual and immediate needs. This will be completed daily for 30 days, then five times a week for 30 days, then three times a week for 30 days. Monitoring will continue Quarterly and annually for all dialysis residents. All findings from the audit will be reviewed in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if less then 100% compliance how monitoring will continue.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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 6/27/15, indicated orders for dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>The record did not indicate a care plan to address Resident G's end stage renal disease and did not address the need for dialysis.</p> <p>During an interview on 7/7/15 at 1:40 p.m., Licensed Practical Nurse (LPN) #5 indicated the admitting nurse initiated the admission care plan and entered it into the computer. She indicated the facility did not have standardized guidelines for what needs should have been addressed in the initial care plan and indicated it was left to "nursing judgement." She further indicated dialysis was a need that should have been addressed on the admission care plan.</p> <p>During an interview on 7/7/15 at 1:45 p.m., the Director of Nursing indicated Resident G did not have an individualized plan of care which addressed end stage renal disease and/or dialysis.</p> <p>A policy titled "Residents Receiving Dialysis," identified as current by the Director of Nursing on 7/6/15 at 10:15 a.m., indicated, "...Licensed nurses</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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>evaluate the resident's for signs and symptoms of infection/bacterium, bleeding/hemorrhage, septic shock and /or excess deficient fluids... Plan of care include directives for managing the resident's needs end-stage renal disease...."</p> <p>A policy titled "Initial Plan of Care," identified as current by the Director of Nursing, on 7/7/15 at 2:33 p.m., indicated, "...An initial plan of care is initiated within 24 hours of admission that addresses the patient's initial individual and immediate needs until the interdisciplinary team completes the initial Minimum Data Set (MDS)... Review the initial patient information taking into consideration the following areas... Health Maintenance: monitoring of disease processes that are currently being treated... Develop an individualized initial care plan based on the patient's immediate needs. Focus upon the patient's immediate needs... Place the initial plan of care in the patient's active medical record... Care plan identifies: Patient diagnoses and conditions... Patient centered measurable goals with established completion dates...."</p> <p>This Federal tag relates to Complaints IN00177116, IN00176994, and IN00176072.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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>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 record review and interview, the facility failed to monitor vitals signs as ordered for 1 of 3 dialysis patients reviewed for plan of care (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 7/6/15 at 1:20 p.m. Resident B had diagnoses, which included but were not limited to, end stage renal disease.</p> <p>A physician's order, dated 6/20/15, indicated an order for monitoring vital signs every day for dialysis monitoring</p>	F 0282	<p>1.Resident B has discharged from the facility.</p> <p>2.All residents with a Physician's order for monitoring vital signs have the potential to be affected. An audit has been completed of all residents with a physician's order for monitoring vital signs and any findings have been addressed with the Physician and family or resident.</p> <p>3.All Licensed nursing staff have been educated on monitoring vital signs per physician orders and/ or per plan of care.</p> <p>4.The DNS/Designee will audit all residents' medical record to validate vital signs were obtained</p>	08/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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=G Bldg. 00	<p>related to end stage renal disease.</p> <p>The record did not indicate Resident B's pulse, temperature, oxygen saturation, or respirations were monitored as ordered on 6/26/15.</p> <p>During an interview on 7/7/15 at 1:45 p.m., the Director of Nursing indicated documentation was not available which indicated Resident B's vitals were assessed as ordered on 6/26/15.</p> <p>This Federal tag relates to Complaints IN00177116, IN00176994, and IN00176072.</p> <p>3.1-35(G)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to ensure a resident who refused dialysis was monitored and</p>	F 0309	<p>and recorded for residents with physician's orders for monitoring or per plan of care. This audit will be completed daily for 30 days, then five times a week for 30 days, then three times a week for 30 days. Monitoring will continue Quarterly and annually for all dialysis residents All findings from the audit will be reviewed in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if less then 100% compliance how monitoring will continue.</p> <p>1.Resident B has discharged from the facility. Resident B was admitted to the hospital on 6/29/2015 due to respiratory</p>	08/06/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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>educated of the risks to health, resulting in altered mental status and hospital admission for respiratory failure for 1 of 7 residents reviewed for quality of care (Resident B).</p> <p>Findings include:</p> <p>Resident B's record was reviewed on 7/6/15 at 1:20 p.m. Resident B had diagnoses, which included but were not limited to, end stage renal disease. A 6/27/15, Minimum Data Set (MDS) assessment tool indicated Resident B was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15 out of 15.</p> <p>A physician's order, dated 6/20/15, indicated dialysis three times a week on Monday, Wednesday, and Friday.</p> <p>A physician's order, dated 6/20/15, indicated monitor vital signs every day for dialysis monitoring related to end stage renal disease.</p> <p>A dialysis communication record, dated 6/24/15, indicated Resident B was dialyzed on 6/24/15.</p> <p>A dialysis communication record, dated 6/26/15, indicated Resident B refused dialysis on that date. The record</p>		<p>failure.</p> <p>2.All residents receiving dialysis that refuse dialysis services have the potential to be affected. An audit has been completed of all residents receiving dialysis services to validate treatment was received and if treatment was declined that monitoring and education of the risks to health were implemented. Any findings were communicated to the physician.</p> <p>3.All Licensed nursing staff have been educated on Residents Receiving Dialysis, Refusal of Care and rescheduling dialysis services.</p> <p>4.The DNS/designee will validate dialysis services were rendered or declined and ongoing monitoring, physician notification, re-scheduling, and patient or family education completed as appropriate per plan of care and physician's orders. This audit will be completed daily for 30 days, then five times a week for 30 days, then three times a week for 30 days. Monitoring will continue Quarterly and annually for all dialysis residents All findings from the audit will be reviewed in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if less then 100% compliance how monitoring will continue.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/07/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK			STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254		
(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>indicated the physician and the dialysis center was notified of the resident's refusal.</p> <p>The record did not indicate Resident B's health was adequately monitored for decline related to prolonged time between dialysis and did not indicate the facility attempted to reschedule the missed dialysis. The record did not indicate education was provided to Resident B regarding risk to health due to refusing dialysis.</p> <p>A progress note, dated 6/27/15 at 12:45 p.m., indicated, "Seen hyperventilating, grasping for breath. She appears to be experiencing panic attack, unable to sit still. She was showing all the s/s of anxiety. Be informed resident refused to go for her dialysis the previous day...." This note indicated her vitals signs and breath sounds were assessed and were within normal limits.</p> <p>A progress note, dated 6/29/15 at 7:19 a.m., indicated Resident B was verbally unresponsive. The facility called her dialysis service provider and the dialysis service provider wanted her transported to them for dialysis. The record indicated the transportation provider was "concerned" and instead transported the resident to the hospital.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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>An emergency room progress note, dated June 29, 2015 at 7:11 a.m., indicated, "...MWF HD (Monday, Wednesday Friday Hemodialyzed) patient, coming from ECF (Extended Care Facility), EMS (Emergency Medical Service) called for altered mental status. Upon my arrival pt (patient) was somnolent, gagging, and making incomprehensible words. She is on Hydrocodone (narcotic pain medication) and Tramadol (pain medication) for pain. Last known HD was last Monday. Don't know how much they take off or what her dry weight is. her weight today was 132 kg (kilograms). We gave Narcan (narcotic reversal) 0.4 mg IV (intravenous) with little improvement. We planned on intubating her for airway protection... Potassium found to be high. Admitted to (physician named) due to respiratory failure...."</p> <p>During an interview on 7/7/15 at 1:40 p.m., Licensed Practical Nurse (LPN) #5 indicated if dialysis patients refused dialysis they were at increased risk for complications and should have been monitored for health status decline. She indicated urine (if they produced any), vitals, mental status, and fluid intake should have been monitored. She further indicated dialysis should have been rescheduled to ensure the missed session</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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>was "made up as soon as possible."</p> <p>During an interview on 7/7/15 at 1:51 p.m., Contracted Dialysis Staff #6 indicated the facility should have attempted to reschedule the dialysis appointment and indicated if the dialysis center was not able to accommodate the schedule, an appointment would have been arranged at another facility.</p> <p>During an interview on 7/7/15 at 1:45 p.m., the Director of Nursing (DON) indicated the facility did not have procedures in place which ensured residents who went prolonged periods without dialysis were consistently monitored to ensure health status did not decline. She indicated attempts were not made to reschedule missed dialysis appointments. The DON indicated, with the exception of 6/26/15, vitals were obtained daily as ordered to monitor Resident B's health status. She indicated documentation was not available to indicate the resident was monitored for complications due to prolonged periods without dialysis. The DON further indicated documentation which indicated Resident B was educated regarding the risks of missing dialysis or offered another appointment for dialysis was not available.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/07/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
--	--

(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 policy titled "Residents Receiving Dialysis," identified as current by the Director of Nursing on 7/6/15 at 10:15 a.m., indicated, "...Licensed nurses evaluate the resident's for signs and symptoms of infection/bacterium, bleeding/hemorrhage, septic shock and /or excess deficient fluids... Plan of care include directives for managing the resident's needs end-stage renal disease...."</p> <p>This Federal tag relates to Complaints IN00177116, IN00176994 , and IN00176072</p> <p>3.1-37(a)</p>			