

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
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F000000	<p>This visit was for the Investigation of Complaint IN00150129 and Complaint IN00150405.</p> <p>Complaint IN00150129 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F272 and F353.</p> <p>Complaint IN00150405 -- Substantiated. Federal/state deficiencies related to the allegations are cited at F272 and F353.</p> <p>Survey date: June 6 and 9, 2014</p> <p>Facility number: 000099 Provider number: 155188 AIM number: 100291140</p> <p>Survey team: Penny Marlatt, RN</p> <p>Census bed type: SNF/NF: 125 Total: 125</p> <p>Census payor type: Medicare: 12 Medicaid: 85 Other: 28 Total: 125</p> <p>Sample: 3</p>	F000000	<p>June 20, 2014</p> <p>Indiana State Department of Health 2 N. Meridian Indianapolis, IN 46204</p> <p>RE: Kindred Transitional Care and Rehabilitation-Greenfield Plan of Correction Credible Allegation of Compliance, and</p> <p>Request for Desk Review</p> <p>Dear Kim Rhoades,</p> <p>On June 9, 2014, surveyors from the Indiana State Department of Health completed an inspection at Kindred Transitional Care and Rehabilitation-Greenfield. As a result of the inspection, the surveyors alleged that the Center was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the HCFA-2567L with the Center's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Center of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.</p> <p>Please also consider this letter and the Plan of Correction to be the Center's credible allegation of compliance. The center will achieve</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000272 SS=D	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 13, 2014 by Cheryl Fielden, RN.</p> <p>483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p>		<p>substantial compliance with the applicable certification requirements on June 23, 2014. Please notify me immediately if you do not find the Plan of Correction to be written credible evidence of the Center's substantial compliance with the applicable requirements as of this date. In that event, I will be happy to provide you with additional evidence of compliance so you may certify that the center is in substantial compliance with the applicable requirements.</p> <p>This letter is also our request for a desk review to verify that the Center achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.</p> <p>Thank you for your assistance with this matter. Please call me if you have any questions.</p> <p>Sincerely,</p> <p>Monica Jill Pearson, HFA Administrator (317) 462-3311</p>	

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	<p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>Based on interview and record review, the facility failed to ensure the correct coding and documentation of anticoagulant (blood thinner) medication therapy for an annual Minimum Data Set (MDS) assessment for 1 of 3 residents reviewed for bruises and skin tears in a sample of 3. (Resident #A)</p> <p>Findings include:</p>	F000272	<p>F 272 483.20(b)(1) Comprehensive Assessments</p> <p>1. Resident A has had a follow up MDS assessment completed which reflected the use of an anticoagulant. There was a care plan in place that reflected resident A was on anticoagulant therapy and the resident continued to receive the anticoagulant during the time it did not show on the MDS assessment.</p>	06/23/2014

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	<p>Resident #A's clinical record was reviewed on 6-6-14 at 10:55 a.m. Her diagnoses included, but were not limited to, atrial fibrillation, congestive heart failure and cerebrovascular accident (stroke).</p> <p>Review of the current physician's recapitulation orders for June, 2014 indicated on 5-1-14, Resident #A's orders for Coumadin, an anticoagulant, were modified to indicate to administer 3.5 milligrams (mg) orally daily on Monday, Wednesday, Friday, Saturday and Sunday, as well as administer Coumadin 3 mg daily on Tuesday and Thursday. Updated orders were received on 6-6-14 to discontinue all Coumadin orders.</p> <p>Review of Resident #A's annual MDS assessment, Section N0400-E, dated 1-31-14, did not indicate the resident received anticoagulant therapy during the 7-day look-back period. Review of the Medication Administration Record (MAR) for January, 2014 indicated Coumadin therapy was received 7 days during the look-back period.</p> <p>In an interview with the MDS Coordinator on 6-9-14 at 3:10 p.m., she indicated Resident #A did receive Coumadin during the look-back period in</p>		<p>1.All residents on anticoagulants have the potential to not have anticoagulants marked on the MDS assessment. An audit of the MDS assessments for residents on anticoagulants was completed on June 9. All of these MDS assessments reflected the use of anticoagulants.</p> <p>1.Reeducated MDS coordinator to follow the RAI and CMS guidelines for completion of MDS and to ensure accurate information for each resident is current and up to date on June 9.</p> <p>1.DNS and/or designee will randomly audit one MDS assessment per week for accuracy and completed assessment for 4 months. Results of these audits will be discussed at monthly PI meetings until the committee determines 100% compliance.</p> <p>1.Compliance Date: June 23, 2014</p>		

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	<p>January, 2014 for the annual MDS assessment conducted in January, 2014. She indicated there had been several dosage changes during that time frame, but it had not been discontinued. She indicated she could not explain why the computer program did not alert staff to the particular change as this area on the MDS assessment as it had triggered on previous MDS assessments. She indicated it was an error on the part of the facility.</p> <p>The Centers for Medicare and Medicaid Services's <i>Long Term Care Facility Resident Assessment Instrument User's Manual, Version 3.0</i> (July, 2010) indicated the following coding instructions for Section N0400, "Check E, anticoagulant (e.g., warfarin [generic version of Coumadin], heparin, or low-molecular weight heparin): if anticoagulant medication was received by the resident at any time during the 7-day look-back period (or since admission/reentry if less than 7 days)..."</p> <p>This Federal tag related to Complaint IN00150129 and IN00150405.</p> <p>3.1-31(c)(13)</p>			

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F000353 SS=D	<p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>Based on interview, the facility failed to ensure adequate staffing to prevent a resident from waiting greater than 15 minutes for a response to a call light which resulted in the resident having an episode of urinary incontinence which was embarrassing to the resident for 1 of 3 residents reviewed for incontinence in a sample of 3. (Resident #C)</p> <p>Findings include:</p>	F000353	<p>F 353 483.30(a) Sufficient 24-hour Nursing Staff Per Care Plans</p> <p>1.Resident C was interviewed by social services and unit manager and was encouraged to use her call light when ever she needs to. Resident C has no further complaints of call light being answered promptly and has had no further incidents of incontinence related to call light issues.</p> <p>1.All residents have the</p>	06/23/2014

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	<p>Resident #C's clinical record was reviewed on 6-9-14 at 2:55 p.m. It indicated her diagnoses included, but were not limited to, COPD (chronic obstructive pulmonary disease), chronic pain, osteoporosis and history of pneumonia.</p> <p>Resident #C's admission Minimum Data Set (MDS) assessment, dated 4-1-14, indicated she was cognitively intact, required extensive assistance of one person with transfers, bed mobility, ambulation, hygiene, and toilet use. It indicated she was occasionally incontinent of urine. It indicated she used a walker or wheelchair for mobility. She was identified as a reliably interviewable resident by the facility on 6-6-14.</p> <p>In an interview on 6-9-14 at 2:12 p.m., Resident #C indicated she usually has to wait 15 to 20 minutes to have her call light responded to by facility staff. She indicated she thought the facility could probably use more staff as the staff "always seems to work hard and are very busy. I try not to use my call light much because of that." She indicated she has had "a few times where I've wet myself waiting on them to help me to the bathroom...will say it's somewhat embarrassing to have a bathroom</p>		<p>potential to be affected. Director of Nursing and Unit Manager met with resident council on June 18, to encourage continued use of call lights by residents even when they feel that staff is busy and to discuss any concerns related to staffing. The Director of Nursing and/or designee will provide adequate numbers of staff to carry out interventions to fully meet the needs of those residents identified through this process.</p> <p>1.Nursing will be educated on Call Light, Use of, with emphasis on staff identifying the location of the light and answering the resident promptly by June 23. Random call light audits will be performed by the IDT team to ensure prompt call light response by all staff and resident needs are met timely with any discrepancies reported to the ED/DNS immediately. Social Service will interview 10 residents for concerns related to call light response and staffing weekly for 4 months.</p> <p>1.The Director of Nursing and/or designee will perform call light audits randomly on alternating shifts to assure call lights are being answered promptly by all staff, and the residents needs are met timely five times a week for four weeks, then three times a week for four weeks, then weekly for eight</p>		

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	<p>accident, but it was just because the girls [nursing staff] are so busy tending to other residents."</p> <p>In interview with the Director of Nursing on 6-9-14 at 5:30 p.m., she indicated she was rather surprised with any concerns related to staffing. She indicated the staffing on the unit on which Resident #C resides has been better recently than it has been in a while.</p> <p>In interview with the Executive Director on 6-9-14 at 5:30 p.m., she indicated she had received no concerns regarding staffing from residents or families in the last several weeks.</p> <p>The Executive Director provided a copy of policy entitled, "Call Light, Use of" [sic] on 6-9-14 at 7:10 p.m. This policy indicated, "The call light is a communication tool for the resident to request assistance." It indicated when a call light is activated by a resident, facility staff should, "Identify the location of the light, and answer the resident promptly..."</p> <p>This Federal tag related to Complaint IN00150129 and IN00150405.</p> <p>3.1-17(a)</p>		<p>weeks with findings reported to the ED/DNS daily. Social Service will interview 10 residents for concerns related to call light response and staffing weekly for four months. Results of these audits will be communicated immediately with staff, and discussed in the monthly PI meetings until the committee determines 100% compliance is met.</p> <p>1.Compliance Date: June 23, 2014</p>		

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

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FORM APPROVED

OMB NO. 0938-0391

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