STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155312	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-INDIAN CREEK	240 BEECHMONT DR CORYDON, IN 47112

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F000000	This visit was for a Recertification and State Licensure Survey. Survey dates: October 27, 28, 29, 30 and 31, 2014 Facility number: 000206 Provider number: 155312 AIM number: 100284940 Survey team: Trudy Lytle, RN-TC Joshua Emily, RN (10-27, 28, 30 & 31, 2014) Gwen Pumphrey, RN (10-29, 30 and 31, 2014) Gloria Reisert, MSW Jennifer Sartell, RN Census bed type: SNF/NF: 121 Total: 121 Census payor type: Medicare: 13 Medicaid: 81 Private: 19 Other: 8 Total: 121 These deficiencies reflect state findings	F000000	Attached you will find the completed Plan of Correction and attachments for the recertification and state licensure survey dated October 31, 2014. The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.We respectfully request that our plan of correction, be accepted as our allegation of compliance. We further request that our plan of correction, monitoring tools and review of systemic changes we have made, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 738-8127.Sincerely,Bonnie FallinExecutive Director	

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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	cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 6, 2014 by Randy Fry RN.			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to revise the resident's care plan for psychiatric medication usage to reflect the current medications the resident was taking. This deficient practice affected 1 of 5 residents reviewed for unnecessary medications. (Resident #132).	F000280	F280 DESK REVIEW REQUESTED1) Care plan corrected for resident #132.2) All psychotropic medication usage care plans audited for accuracy and corrected as needed.3) Staff Development Coordinator, or designee, in serviced social services and licensed nurses on completing psychotropic	11/21/2014

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	Findings included: Review of the clinical record for Resident #132 on 10/30/14 at 10:00 a.m., indicated the resident had diagnoses which included, but were not limited to: dementia, psychosis and depression. A 9/26/14 care plan reflected "Resident uses psychotropic medications r/t (related to) Celexa (an Anti-depressant) and Risperdal (an anti-psychotic drug)". This care plan was initiated on 3/20/14 with review dates of 4/21, 7/1 and 9/26/14. The resident was initially admitted to the facility on 3/11/14 on Celexa, but it was discontinued on 4/15/14 when the psychiatrist changed it to Lexapro (an Anti-depressant). The Risperdal was also discontinued on 6/17/14 per the 6/19/14 Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review. On 10/30/14 at 12:13 p.m. The Director of Nursing (DON) presented a printed copy of the resident's Psychotropic care plan from the computer. Review of this care plan noted a revision date of 10/30/14 in which the care plan was		medication care plans.4) Social Services Director, or designee, will audit psychotropic medication care plans for accuracy after admission, MDS completion, scheduled care plan review and psychotropic medication change, daily for 1 week, 3 times a week for 3 weeks, weekly for 3 weeks, monthly for 3 months, and quarterly during scheduled care plan reviews as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee.	

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	revised to take off the use of Celexa and Risperdal due to medications being discontinued months prior. The DON indicated that she was unable to explain why the computer still showed the old care plan when the care plan she printed off now had the changes. On 10/30/14 at 12:24 p.m., the LPN Supervisor indicated this care plan had just now been updated and what the computer was showing was the old one before the changes. On 10/30/14 at 12:25 p.m., the LPN Supervisor presented a copy of the facility's current policy titled "Care Plans". Review of this policy at this time included, but was not limited to: "Policy: A comprehensive care plan is developed consistent with the patient's specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to meet the patient's needs as identified in the patient's assessment or as identified in relation to the patient's response to the interventions or changes in the patient's conditions...Components:...3. The team of qualified persons monitors the patient's condition and effectiveness of the care plan interventions and revises the care plan quarterly, annually, with a			

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	significant change assessment or more frequently as needed with the input by the patient and/or the representative, to the extent possible...6. The plan of care includes directives for managing:...b. Revised and updated as necessary to reflect the individual's current status..." 3.1-35(d)(2)(B)			
F000315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. Based on record review and interview, the facility failed to attempt a toileting program for 2 of 4 residents reviewed for urinary incontinence. (Resident #75 and #78) Findings include: 1. The Clinical Record for Resident #75 was reviewed on 10/29/14 at 10:47 a.m. Diagnoses included, but were not limited	F000315	F 315 DESK REVIEW REQUESTED1) A 3 day voiding pattern and bladder assessment was completed on residents #75 and #78. Care plans updated and toileting program or incontinence care implemented as indicated from assessment. Physician and family notification and summary note written.2) Toileting program and incontinence care audited for accuracy on all residents in center. Bladder assessments	11/21/2014

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	to, dementia and hypertension. On 10/29/14 at 10:40 a.m., the Minimum Data Set assessment, dated 8/27/14, for Resident #75 was reviewed. It indicated no mood or behavior and extensive assist of 2 with bed mobility, transfers and toilet use. It also indicated a toileting program was not attempted for Resident #75. Review of the document titled Bladder Voiding Pattern Record dated 5/2/14 through 5/5/14 indicated Resident #75 was continent 7 times during a 72 hour period. Review of the document titled Bladder Status Evaluation included, but was not limited to the following: "History...1. Duration of Urinary Incontinence: sence (sic) admition (sic) on 5/2/14 2. Has Bladder Voiding Pattern been completed? a. Yes...3. Current urinary status: incont. (incontinent) of B&B (bowel and bladder)...Cognition: 1. Resident able to communicate toileting needs. a. Yes. 2. Resident is able to follow directions to participate in training program. a. Yes...Functional Incontinence:...Symptoms...2a. (check mark) Resident is aware of the need to urinate - Unable to reach toilet." The		initiated as indicated from audit. Toileting programs, incontinence care, summary notes, physician and family notification completed as needed. Residents will have Bladder Status Screening for continence status on admission, annually, and with change in condition affecting residents' continence status. Bladder Status Screening will be followed by a 3 day voiding pattern, Bladder Status Evaluation, and toileting program as indicated.3) Staff Development Coordinator or designee in serviced licensed nurses on Assessing and Implementing Toileting Programs or Incontinence Care for residents as indicated from Assessment.4) Director of Nursing Services, or designee, will audit toileting programs, as well as assessments and outcomes on new admissions, annual evaluations and significant changes, daily for 1 week, 3 times a week for 3 weeks, weekly for 3 weeks, monthly for 3 months, to monitor effectiveness or changes, and correct any issues. Director of Nursing Services or designee will review quarterly assessment accuracy and ensure any discrepancies are corrected as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee.	

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	clinical record lacked documentation as to why Resident #75 was not started on a toileting program. During an interview with LPN#1 on 10/29/14 at 11:30 a.m., she indicated it was not documented as to why a Toileting Program was not attempted for Resident #75. 2. The Clinical Record for Resident #78 was reviewed on 10/30/14 at 8:55 a.m. Diagnoses included, but were not limited to dementia, edema and hypertension. The Minimum Data Set assessment for Resident #78, dated 10/1/14, was reviewed on 10/29/14 at 3:31 p.m. It indicated extensive assist of one person for bed mobility and toileting. It also indicated a toileting program was not attempted for Resident #78. The document titled Bladder Voiding Pattern Record, dated 7/3/14 through 7/5/14 indicated Resident #78 was continent 9 times in a 72 hour period. The document titled Bladder Status Evaluation, dated 7/11/14, included, but was not limited to the following: "History...1. Duration of Urinary Incontinence: years 2. Has Bladder Voiding Pattern been completed? a.			

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	Yes...3. Current urinary status: Incontinent...Cognition: 1. Resident is able to communicate toileting needs. a. Yes...". During an interview on 10/31/14 at 9:10 a.m. with LPN #2, she indicated toileting programs are based on the 3 day bowel and bladder assessment. She indicated staff would toilet Resident #78 and at times she would go and at other times she would not. She also indicated Resident #78 can, at times, tell you if she has to go and, at other times, she cannot. On 10/31/14 at 1:30 p.m., the Director of Nursing indicated she could not find a policy and procedure on toileting programs. 3.1-41(a)(2)			
F000465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation and interview, the facility failed to ensure a clean and sanitary environment for 9 of 40 resident's rooms (102,104, 105, 108, 111, 116, 125, 216 and 324) which were	F000465	F465 DESK REVIEW REQUESTED1) Maintenance repairs and cleaning completed on resident rooms 102, 104, 105, 108, 111, 116, 125, 216, 324, hallway and dining rooms.2) All residents rooms, dining rooms,	11/21/2014

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	observed, one hallway, and 21 of 32 light covers in three of five dining rooms. Findings include: During an observation, on 10/27/2014 at 10:07 a.m., in the shared bathroom for resident rooms 102 and 104, the sink leaked underneath when the water was turned on. A trash can was observed under the sink, catching the leaking water, with one inch of standing water and with black particles floating in the standing water. The bathroom sink was missing the nozzle. When the sink was turned on, water from the sink splashed out far enough to hit the clothes of the person turning on the water. During an observation, on 10/27/2014 at 11:31 a.m., in room 116 the wallpaper had a tear, fifty inches in length running from floor to ceiling in between the resident's beds. The room also had a second tear in the wallpaper in between the resident's beds running in the direction of the base board to the ceiling, which was thirty six inches in length. The room also had a crack in the plaster running above the entire width of the rooms air unit top. To the right side of the air unit, on the base of the unit, a four inch by two inch hole was observed underneath the base.		and hallways were audited for disrepair and cleanliness and any identified concerns resolved. Schedules developed for resident rooms, dining rooms, and hallways maintenance rounds/repairs and housekeeping cleaning schedule. 3) Staff Development Coordinator, or designee, in serviced staff on General Environmental Conditions Policy and completion process for maintenance requests.4) Executive Director, or designee, will audit resident rooms, dining rooms and hallways for maintenance/cleaning needs and address, daily for 1 week, 3 times a week for 3 weeks, weekly for 3 weeks, and monthly as an ongoing process of this facility. Audit results will be reviewed in monthly Quality Assurance meeting to achieve 100% compliance as determined by Quality Assurance committee.	

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	During an observation, on 10/27/2014 at 12:06 p.m., in room 216 the bathroom faucet was dripping and was unable to be turned off by hand. The bathroom had a strong urine odor at that time. The caulking around the front of the toilet was rusty brown in color. During an observation, on 10/27/2014 at 2:00 p.m., in the bathroom of room 125, the base board to the left of the sink was pulled away from the wall in a three inch area with a brown substance in between the wall and the base board. During an observation, on 10/27/2014 at 2:20 p.m., in room 324 the wallpaper was torn in a two inch by eight inch area next to bed "A". To the right of the window, was a dark colored, scuff mark on the wall measuring two inches by ten inches. During an interview, on 10/30/2014 at 10:25 a.m., with the Maintenance Director, he confirmed all the above issues existed at the time of the observations, and at the time of the interview being conducted on 10/30/14. The Maintenance Director indicated he does rounds once a week in each room along with the Housekeeping Supervisor. The Maintenance Director indicated he would do maintenance requests, as issues			

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	were identified to him, and as he would find the issues during his weekly round. During an observation, on 10/31/2014 at 11:45 a.m., in the 100 hall dining room, there were 6 of 9 light covers above the residents eating area, in which numerous dead insects were inside the light covers, while the residents were eating. A crack in the wall was observed on the top left of the entrance to the 100 hall dining room, eighteen inches in length. Also observed was a one inch by one inch piece of wall plaster missing above the entrance entering into the 100 hall dining room. During an observation, on 10/31/2014 at 11:50 a.m., in the 100 hall, a crack was observed running from the top of the door seal to the ceiling above room 111. Also observed in the 100 hall was a crack in the ceiling running from room 105 across the hall to room 108. The crack was observed to be ranging in sizes from one quarter of an inch to one inch in width. The plaster was observed to be flaking, cracking, and hanging from the ceiling. During an observation, on 10/31/2014 at 12:30 p.m., in the main dining room, there were 11 of 17 light covers, above the residents eating area, in which			

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	numerous dead insects were inside the light covers, while residents were eating. During an observation, on 10/31/2014 at 12:37 p.m., in the south dining hall, there were 4 of 6 light covers, above the residents eating area, in which numerous dead insects were inside the light covers, while residents were eating. During an interview, on 10/31/2014 at 11:55 a.m., the Maintenance Director confirmed the above issue of dead insects in the light fixtures in the dining rooms, existed at the time of the observations, and at the time of the interview being conducted on 10/31/2014. The Maintenance Director indicated he had cleaned out the light fixtures on Monday of that week. He indicated the dead insects accumulate that quickly. He indicated that the Housekeeping Supervisor informs him of when to clean out the light fixtures. Later in the interview the Maintenance Director indicated that he does not wait to be told by the Housekeeping Supervisor, he cleans the light covers out every week. He indicated he had no policy or log for cleaning the light covers, he just cleaned them every week. During an interview, on 10/31/2014 at 12:00 p.m., with the Housekeeping			

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	Supervisor, she confirmed the above issue of dead insects in the light fixtures in the three dining rooms. She indicated that it was not her responsibility to keep the light covers clean and free of dead insects. She indicated that she would help the Maintenance Director sweep up the bugs when he cleaned them out, but was unsure if she had done so for the week. 3.1-19(f)			