

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/29/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00128441.</p> <p>Complaint IN00128441 Substantiated. Federal/state deficiencies related to the allegations are cited at F279.</p> <p>Survey dates: August 22, 23, 24, 25, 26, 27, 28, and 29, 2013.</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Survey team: Diana Sidell RN, TC Sunny Jungclaus RN (August 22, 23, 25, 26, 27, 28, and 29, 2013) Jennifer Carr RN (August 22, 23, 26, 27, and 28, 2013)</p> <p>Census bed type: SNF/NF: 144 Total: 144</p> <p>Census payor type: Medicare: 16 Medicaid: 110 Other: 18</p>	F000000	<p>September 19, 2013 Kim Rhoades, Director Long Term Care Indiana State Department of Health 2 North Meridian Street Indianapolis, Indiana 46204 Re: Survey Event ID IFSO11 Dear Kim Rhoades, On August 29, 2013 a Recertification and State Licensure with complaint (In00128441) Survey was conducted at Kindred Transitional Care and Rehabilitation - Columbus and this serves as our letter of credible allegation of compliance as of September 27, 2013 and we are requesting a desk review in lieu of a revisit Kindred Transitional Care and Rehabilitation – Columbus asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of action. The staff of Kindred Transitional Care and Rehabilitation – Columbus is committed to delivering high quality care to its residents to obtain their highest level of physical, mental and psychological functioning. Sincerely, Sherry E. Harrison RN HFA 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.

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	Total: 144 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.				

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F000156 SS=D	<p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes:</p>						

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	<p>A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,</p>						

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	<p>and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure liability and appeal notices were given in a timely manner for 1 of 3 residents in a sample of 3 who fit the criteria for liability notices. (Resident #147)</p> <p>Findings include:</p> <p>RN #1 provided the Notice of Medicare Provider Non - Coverage for resident #147 on 8/27/13 at 9:15 a.m. The notice indicated Resident #147's services would end 07/18/13. The form was signed and dated on 07/18/13 by Resident # 147's relative. Attached to the notice was a letter titled SNF (Skilled Nursing Facility) Determination on Continued Stay dated 07/18/13. The beginning sentences of this letter read, "On 07/17/2013, we reviewed your medical information and found that the services furnished (Resident #147) no longer qualified as covered under Medicare beginning 07/18/2013. The reason is: DC (discharge) home w/3d (with 3 days) left in benefit period...." A further sentence in the letter reads, "We regret that this may be your first notice of the noncoverage of services</p>	F000156	<p>This Plan of Correction is the center's credible allegation of compliance. The Facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Notice of Rights, Rules, Services, ChargesThe facility ensures liability and appeal notices are given in a timely manner. Resident # 147 was discharged from facility on 7/18/2013. Residents receiving Medicare coverage have the potential to be affected by this alleged deficient practice. A review was completed on the medical information andthe Notice of Medicare Provider Non-Coverage letters for Medicare residents residing in facility. The Executive Director re-educated the Nurse Case Manager and Social Service department on The Notice of Medicare Provider Non-Coverage Letter and the SNF Determination on Continued Stay letter on 9/17/2013. The Case Manager will weekly bring the letters of Notice of Medicare Provider Non-coverage to the Medicare</p>	09/27/2013			

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	<p>under Medicare."</p> <p>On 8/27/13, at 9:15 a.m., RN #1 indicated that the notice was given late to the resident due to being given to RN#1 late.</p> <p>On 08/29/13, at 11:24 a.m., RN #1 provided the facility policy table used for notifications for Medicare Part A and Part B services. Under the Notes section is the following, "1. Expedited Determination (ED) - SNFs must deliver the Generic Notice, when required, not later than 2 days before the effective date the Medicare coverage ends...."</p> <p>3.1-4(f)(3)</p>		<p>Meeting for review to ensure timely accurate distribution to Medicare Residents. The Executive Director will randomly audit 2 Notices of Medicare provider Non-Coverage letters weekly x 8, then monthly x 4, then quarterly until compliance is achieved. Results will be reviewed in PI Committee and action plans implemented as necessary. Date of compliance 09/27/2013</p>		

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F000244 SS=E	<p>483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Based on record review and interview, the facility failed to effectively act on grievances brought to administration, in that residents continued to have complaints about call lights not being answered timely. This affected 32 residents and had the potential to affect all 144 residents who resided in the facility. (Residents #6, 8, 9, 12, 19, 28, 38, 39, 46, 48, 49, 56, 61, 65, 67, 61, 70, 87, 92, 101, 110, 114, 128, 138, 144, 148, 149, 152, 155, 158, 161, and 186)</p> <p>Findings include:</p> <p>During an interview on 08/23/13 at 10:02 a.m., Resident #92 indicated that when the call button is pushed to ask a question or request care services - the CNA's will come in and turn the button off and then not ask for what they need or listen to their requests. Resident #92 also indicated that the staff don't listen to what we say and then got teary eyed</p>	F000244	<p>This Plan of Correction is the center's credible allegation of compliance. The facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Listen/Act on Group Grievances/Recommendations T he facility effectively acts on grievances/recommendations brought to administration Residents # 6, 8 9, 12, 19, 28, 38, 39, 46, 48, 49, 56, 61, 65, 67, 70, 87, 92, 101, 110, 114, 128, 138, 144, 148, 149, 152, 155, 158, 161 and 186. The facility residents have been individually educated by the Social Service Department on the facility policy for Use of Call Lights and expectations of staff timeliness and responsiveness. Residents residing in the facility have the potential to be affected by this</p>	09/27/2013			

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	<p>and also indicated that this happens about every day. The roommate of Resident #92, Resident #158, also indicated that this was correct information from Resident #92.</p> <p>During an interview on 08/23/13, at 2:18 p.m., Resident #39 indicated that the CNA's are not usually timely with answering the call buttons with waiting time for an answer ranging from 10 minutes to 30 minutes. Resident #39 indicated that 10 minutes was too long a wait.</p> <p>During an interview on 8/23/13 at 9:19 a.m., Resident #114 indicated she has to wait 15 to 20 minutes for her call light to be answered.</p> <p>During an interview on 8/23/13, at 3:26 p.m., Resident #46 indicated she turned on her call light yesterday morning and it was never answered.</p> <p>During an interview on 08/23/13 at 2:56 p.m., Resident #19 indicated that sometimes has had to wait 30 minutes for assist when uses his call button. He indicated that this can happen approximately 50% of the time he uses his call button.</p> <p>During an interview on, 8/29/13 at 10:20 a.m., Resident #61 indicated</p>		<p>alleged deficient practice. Activity Director will be re-educated on 9/25/2013 by Lacy Beyl & Co. on the appropriate procedures for communicating follow up on concerns identified during Resident Council. Call light responsiveness and timeliness will be addressed monthly during Resident Council and concerns will be brought to the ED/designee and be addressed within 3 days. The DNS/designee will complete a Resident Council Follow Up form with a written plan of action and deliver 1 copy to the resident council president, 1 copy to the PI Committee and original to the Activity Director. A facility staff in-service is scheduled for 9/24/2013 to review the policy on Use of Call Light and the facility expectations for timeliness and addressing needs as requested. Any staff member found to turn off call and not address the resident needs will receive – re-education with disciplinary actions to include termination. DNS/Designee will complete a call light study form on 10 residents weekly x 12, then monthly thereafter. The Executive Director will review Call Light Study with the DNS and management team weekly during clinical am meeting to address compliance and update action plan and provide re-education as needed. Results of the Resident Council Follow Up form's plan of action and the Call Light Study</p>				

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	<p>that despite the continued past several months of complaints during the Resident Council meetings about timeliness of answering call lights, he indicated that nothing has changed. The problem is still going on. Resident #61 indicated that they (the CNA's) will come in and turn off the light and then tell them (residents) that they have to turn off the lights but then they leave without asking what the resident needs and the residents will have to put the light on again and also indicated that on occasion they may have to wait 45 minutes for assist. Resident #61 also indicated that usually the Activities Director takes the minutes and forwards concerns noted to the appropriate department. Resident # 61 also indicated that the only response they get back about their concerns is "no comment".</p> <p>Review of Resident Council monthly meeting minutes indicated a meeting was held on 05/21/13 at 2:30 p.m., with 6 residents attending. During this meeting, the Nursing concern noted in the minutes indicated, "1. Please make sure CNA's are timely with patient care." (Residents #6, #38, #46, #49, #61, #87)</p> <p>Review of Resident Council monthly</p>		<p>form will be reviewed in PI Committee monthly and action plans implemented and updated as necessary. Date of compliance 09/27/2013</p>				

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	<p>meeting minutes, of a meeting that was held on 06/24/13 at 2:30 p.m., indicated 10 residents attended. During this meeting, the Nursing concern noted in the minutes indicated, "1. Please make sure the CNA's are timely with call lights." (Residents #8, #38, #46, #48, #49, #61, #65, #67, #110, #138)</p> <p>Resident Council monthly meeting minutes indicated a meeting was held on 07/08/13 at 2:30 p.m., with 13 residents attending. During this meeting, the Nursing concern noted in the minutes indicated, "(1) 200 hall call lights need to be timely... Comments: Call lights need to be louder." (Residents #8, #28, #38, #46, #49, #61, #65, #70, #87, #144, #149, #152, #155)</p> <p>Resident Council monthly meeting minutes indicated a meeting was held on 08/12/13 at 2:30 p.m., with 15 residents attending. During this meeting, the Nursing concern noted in the minutes indicated, "(1) We want the CNA's to make us the first priority. (2) Call light response takes longer at times." (Residents #9, #12, #38, #46, #49, #56, #61, #87, #101, #128, #138, #148, #149, #161, #186)</p> <p>During an interview on 08/29/13 at</p>						

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	11:00 a.m., with the Activities Director #2 (AD#2), who indicated that she does attend the Resident Council monthly meetings and also types up the meeting minutes and follows up for the concerns identified in the meetings. She has each department address any concerns identified for them with a Resident Council Follow Up form for a written Plan of Correction (POC). POC for Nursing for 05/21/13 was signed by DON on 06/03/13 with no other documentation. POC for Nursing for 06/24/13 indicated, "staff inserviced about concerns regarding call lights and signed by the DON on 07/01/13. POC for Nursing for 07/08/13 indicated, "Staff inserviced about call light response times on 07/16/13 and signed by the DON on 07/16/13. POC for Nursing for 08/12/13 indicated, "will complete call light audits randomly et educate staff during in-service on 08/27/13 and signed by DON on 08/20/13. AD#2 also indicated that she will read the POC's at the next Resident Council meeting and offers to give them a copy of the POC's. She also indicated that the 'no comments' on the minutes are noted if that is what the Residents report to her about a department during the meeting.						

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	<p>During a follow up interview, on 08/29/13 at 11:07 a.m., Resident #61 indicated that the AD#2 has not read the follow up/POC information to them at the next meeting and she was unaware that the Resident Council could have copy of the response from the departments about their concerns. She also indicated that AD#2 is new and they are trying to get her trained to give them the information they need.</p> <p>Staff inservice attendance records received from the DON, on 08/29/13 at 5:36 p.m., indicated: For concern from 05/21/13 - Resident Council follow up inservice 06/04/13 with typed information, "1. Please answer call lights in a more efficient manner. Remember that it is anyone's responsibility." (DON also updated POC documentation to include "Staff inservices to be completed on RCFU (Resident Council Follow up) on 06/04/13.) For concern from 06/24/13 - Inservice 07/02/13 with typed information, "1. Call lights must be answered timely. All staff is responsible for answering call lights. It is nursing's main focus to ensure these lights are being answered timely. We have recent complaints from the residents that our call light timeliness is too long. Please ensure</p>						

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	<p>we are meeting their needs quickly." For concern from 07/08/13 - Nursing issues Inservice 07/16/13 with typed information, "1. Call light times need to quicker. We have complaints of call lights exceeding what our expectations are. Please answer timely." For concern from 08/12/13 - Lab Req, briefs, Resident Council Follow up inservice 08/27/13 (no typed information attached).</p> <p>Call light audit information, dated 08/15/13 at 5:00 a.m., 9:00 a.m., 4:00 p.m., received from the DON on 08/29/13 at 5:36 p.m. noted times for answering 5 lights at 5:00 a.m. ranged from 1 to 4 minutes; 7 lights at 9:00 a.m. ranged from 2 to 5 minutes; and 8 lights at 4:00 p.m. ranged from 18 seconds to 3 minutes. The DON further explained that these audits are conducted by him and 2 unit managers in a random manner when they are on the units doing other work - without staff knowledge of the audit.</p> <p>3.1-3(l)</p>				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on interview and record review, the facility failed to ensure a resident received notice prior to a roommate change for 1 of 2 residents who fit the criteria for notification of roommate changes. (Resident #24)</p> <p>Findings include:</p> <p>During an interview with Resident #24, on 8/23/13 at 10:32 a.m., she indicated she did not receive a notice when a roommate was moved in, that they "just moved her in, [she] found out the day she moved in."</p> <p>During an interview, on 8/29/13 at 11:02 a.m., Employee #5, Social Services, indicated Resident #24's roommate came in on 9/14/12, and there is no documentation of anyone coming in and letting the family or resident know the roommate was coming in.</p> <p>A policy for "Room-to-Room Transfer" was provided by the Director of Nursing on 8/29/13 at 2:58 p.m. The policy indicated but was not limited to:</p>	F000247	<p>This Plan of Correction is the center's credible allegation of compliance. The facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Right to Notice Before Room/Roommate Change Resident # 24 has had no further roommate changes. Residents having a roommate change have the potential to be affected by this alleged deficient practice. Social Service has completed an audit of the last 3 months of room transfers to ensure appropriate documentation and procedures were followed. An in-service for nursing staff and social services will be completed on 9/20/2013 on the facility policy "Room To Room Transfers" and appropriate documentation to reflect notices of transfers and roommate changes.. Executive Director/ designee will complete an audit of resident room transfer weekly x 8</p>	09/27/2013			

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	"Centers complete room-to-room transfers to provide residents with a room of their choice whenever possible and to provide specialized nursing care. Compliance Guidelines 1. Center discusses transfer with resident, family and/or responsible party in advance to explain rationale...3. Residents are introduced to the new roommate prior to a room move. 3.1-3(v)(2)		weeks then monthly x 4 and then quarterly until compliance is achieved.. Results of the audit will be reviewed in PI Committee monthly with action plans implemented as necessary.Compliance Date of 9/27/2013		

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F000279 SS=D	<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, the facility failed to develop a care plan that addressed tracheostomy care and oxygen use for 1 of 33 residents reviewed for care planning. (Resident #A)</p> <p>Findings include:</p> <p>Resident #A's closed record was reviewed on 8/27/13 at 1:21 p.m. The record indicated Resident #A was admitted on 10/22/12 with diagnoses that included, but were not limited to,</p>	F000279	This Plan of Correction is the center's credible allegation of compliance. The facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Develop Comprehensive Care Plans Resident # A was unable to be identified.. Residents having a	09/27/2013			

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	<p>fever, constipation, headache, low potassium, heart disease, anxiety state, esophageal reflux, sleep disturbance, generalized pain, atrial fibrillation, cardiac dysrhythmias, diastolic heart failure, acute respiratory failure, congestive heart failure, and had a tracheostomy.</p> <p>Physician's telephone orders dated 10/24/12 indicated: "Trach[eostomy] care Q (every) day and PRN (as needed) per protocol. Suction is PRN..."</p> <p>An admission Minimum Data Set Assessment (MDS), dated 10/29/12, indicated the resident had a tracheostomy and required oxygen therapy.</p> <p>Review of interim care plans, initiated after admission, and care plans initiated after the admission MDS, failed to indicate a care plan that addressed the services required for tracheostomy care, and failed to address the services required for oxygen therapy.</p> <p>This Federal tag relates to Complaint IN00128441.</p> <p>3.1-35(a)</p>		<p>tracheostomy and/or oxygen use have the potential to be affected by this alleged deficient practice. The DNS/designee has completed an audit on residents receiving oxygen and on residents with tracheostomy and care plans have been reviewed and updated accordingly.</p> <p>Licensed Nurses will be re-educated 9/24/2013 by the SDC/designee on the facility policy for "Initial Plan of Care" and "Comprehensive Plan of Care. The admitting nurse will develop the initial plan of care addressing patient immediate needs at admission. The Interdisciplinary Team will develop a comprehensive plan of care on admission, quarterly annually and with a significant change in condition and PRN to address areas identified and ensure each plan of care is individualized.</p> <p>Director of Nursing/designee will review new admission records for initial care plan implementation during am clinical meeting (Monday through Friday) and weekend manager will review on (Saturday, Sunday and holidays). The Interdisciplinary Team will utilize the audit tool "Review of Process Measures – Care Planning" during care plan conferences for residents to ensure care plans are accurate and reflect the resident correct condition. Results of the audit will be reviewed in PI Committee monthly with action plans</p>		

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	3.1-35(b)(1)		reviewed and updated as necessary. Compliance Date of 9/27/2013		

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F000281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.</p> <p>Based on record review and interview, the facility failed to ensure physician's orders were followed related to labwork for 1 of 33 residents reviewed. (Resident #46)</p> <p>Findings include:</p> <p>A record review of Resident #46 was conducted on 8/27/13 at 1:57 p.m. Diagnoses included, but were not limited to, hypopotassemia, congestive heart failure and hypertension.</p> <p>A physician's order dated 8/5/13 indicated, "D/C (discontinue) Potassium Chloride 10 meq (milliequivalents), 7.5 ml (milliliters) liquid PO (by mouth) QD (once daily). N.O. (new order) Potassium Chloride 20meq, 15ml liquid PO (by mouth) QD (once daily). Recheck K+ (potassium) level 8/9/13."</p> <p>No result report for the lab ordered 8/9/13 was located in the resident's record.</p>	F000281	<p>This Plan of Correction is the center's credible allegation of compliance. The facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Services Provided Meet Professional Standards Resident # 46 had a potassium level obtained on 8/27/2013 with results within normal limits. MD and family notified. Resident with physicians orders for labs have the potential to be affected by this alleged deficient practice. A facility audit was completed 8/27/2013 on physician's orders for labs to ensure compliance; any non-compliance issues identified were addressed. An in-service for licensed staff will be completed on 9/20/2013 on the facility policy "Physician Orders" and on responsibility for lab tracking. Unit Managers will review physician's orders during am clinical meeting (Monday</p>	09/27/2013	

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	<p>In an interview with the Medical Records Coordinator on 8/27/13 at 5:15 p.m., she indicated that she was unable to locate the lab result.</p> <p>In an interview with the Director of Nursing (DoN) on 8/28/13 at 8:45 a.m., he indicated, "We missed it." He further indicated that a stat (short turnaround time) potassium level was drawn and resulted 8/27/13 at 7:00 p.m., and that the results were within the normal range. A review of lab results from 8/27/13 at 7:00 p.m., and provided by the DoN on 8/28/13 at 8:45 a.m., indicated that Resident #46's potassium level was 4.0mmol/L and within normal limits.</p> <p>3.1-35(g)(1)</p>		<p>through Friday) and review lab binder from each unit to ensure labs obtained and results reported to physician. Physician will be notified immediately for any needed clarification of lab orders. Any non-compliance issues identified will result in re-education &/or disciplinary action up to and including termination. The DNS / Designee will audit for following physician's orders for labs utilizing the "Review of Process Measures – Monitoring Labs", weekly x 12, monthly x 4 and then quarterly until compliance is achieved.. Results of the audit will be reviewed in PI Committee monthly with action plans implemented as necessary. Compliance Date of 09/27/2014</p>		

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F000371 SS=E	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview, and record review, the facility failed to ensure that food is stored, prepared, distributed, and served under sanitary conditions for 3 of 4 observations.</p> <p>Findings include:</p> <p>During an initial kitchen tour on 8/22/13 at 8:15 a.m., the soap dispenser at the only hand washing sink was observed to be cracked and broken. The Dietary Manager and Dietary Employee #4 were both observed pushing the dispenser multiple times and manipulating the left corner of the dispenser before soap was dispensed. When this surveyor attempted hand washing and no soap was dispensed, the dietary manager manipulated the dispenser 2-3 times before soap was dispensed.</p> <p>During the same initial kitchen tour, the dietary manager was observed washing her hands for only 8</p>	F000371	<p>This Plan of Correction is the center's credible allegation of compliance. The facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Food Procure, Store/Prepare/Serve – Sanitary Soap Dispenser in the kitchen at the hand washing sink was replaced on 8/22/2013. On 8/26/2013 all the milk in the 2 milk refrigerators were checked for expiration dates and any milk with expired dates was removed. Residents receiving meals at the facility have the potential to be affected by this alleged deficient practice. Dietary employee # 4 received disciplinary action for using her bare hands to remove a spoon from pureed meat and was individually re-educated on facility policy for "Principles of Safe Food Handling." The Dietary Manager</p>	09/27/2013			

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	<p>seconds. Dietary Employee #4 was observed washing her hands for 7 seconds before indicating, "I'm in a hurry. I have to get the trays out." She was then observed transporting a cart of trays out of the kitchen.</p> <p>On 8/22/13 at 9:30 a.m. and in the presence of the kitchen manager, Dietary Employee #4 indicated she was preparing pureed barbeque chicken for approximately 20 residents for the noon meal. She did not wash her hands prior to beginning the procedure, nor was she observed performing hand washing at anytime throughout the observation. She was observed to perform the entire task with her bare hands. During the observation, the large metal spoon she was using to stir the meat fell into the pureed barbecue chicken. The entire handle was submerged in the meat. Dietary Employee #4 was observed lifting the handle out with her bare hands and continuing to mix the meat. She then covered the pot with foil and indicated she would store the pureed meat in the pre-heated oven until ready to serve.</p> <p>On 8/22/13 at 9:52 p.m., Dietary Employee #4 was observed in the dirty dish area handling chemical solution strips before walking back to</p>		<p>re-educated the dietary staff on "Principles of Safe Food Handling, Hand Hygiene / Handwashing and On Procedures for identifying and returning expired milk" on 8/26/2013. The Staff Development Coordinator re-educated the Dietary staff on "Principles of Safe Food Handling" and Procedures for identifying and returning milk with expired dates on 9/18/2013 with return demonstrations completed on Handwashing Technique.. An in-service for facility staff will be completed 9/24/2013 on "Hand Hygiene / Handwashing" with return demonstrations completed. The Registered Dietician / designee will complete weekly quick rounds, any identified issues will be addressed and the plan of correction reviewed and updated with results reviewed at PI Committee monthly. Executive Director/ designee will complete monthly sanitation rounds with results reviewed during monthly PI Committee for compliance with action plans updated as needed. Department managers will complete an audit for Appropriate Handwashing Technique and Procedures on 5 staff members, weekly x 8, monthly x 4 and then quarterly. Results of the audit will be reviewed in PI Committee monthly with action plans implemented as necessary. Compliance Date of 9/27/2013</p>		

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	<p>the food preparation area, retrieving a bag of cabbage from the refrigerator, and then donning clean gloves. She indicated that she was preparing cole slaw.</p> <p>In an interview with the Kitchen Manager, on 8/22/13 at 10:02 a.m., she was asked what the hand washing policy for kitchen staff included. She indicated, "Whenever they come in after being out...whenever they go out to smoke...." She further indicated that she has a "blanket policy" that staff is required wear gloves whenever they handle food. When asked to clarify, she indicated, "It keeps it simple if they're required to wear them all the time." When asked if she would have preferred that Dietary Employee #4 wear gloves while preparing the pureed food during the earlier observation, she indicated, "Yes."</p> <p>During a kitchen tour with the Kitchen Manager on 8/26/13 at 2:47 p.m., 3 single-serve whole milk cartons with an expiration date of 8/23/13 were observed in the left and middle sections of one of two milk refrigerators. The Kitchen Manager removed the cartons from the refrigerator and indicated she would return them to the vendor for a</p>						

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	<p>refund.</p> <p>A review of the "Principles of Safe Food Handling" policy provided by the Director of Nursing (DoN) on 8/28/13 at 12:15 p.m., partially indicated the following:</p> <ol style="list-style-type: none"> 1. "Wash hands regularly following proper hand washing procedures." 2. "Avoid bare-hand contact with food that is cooked or ready-to-eat." 3. "Wear latex-free gloves when direct contact with food in necessary...." 4. "Wash hands before putting on a new pair of gloves." 5. "Wash hands and/or change gloves each time a new task is started, and especially after handling raw food." 6. "Discard food that has been contaminated." 7. "Handle utensils used for food preparation and service as follows: <ol style="list-style-type: none"> a. Such that the handle is not in food." <p>A review of the "Hand Hygiene/Hand washing" policy was provided by the DoN on 8/28/13 at 12:15 p.m. and partially indicated the following for all employees:</p> <ol style="list-style-type: none"> 1. "Hand hygiene is to be performed: <ul style="list-style-type: none"> - Before donning gloves for 						

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	<p>working with food; - Before or during food preparation; as often as necessary to remove soil and contamination and to prevent cross-contamination when changing tasks;"</p> <p>2. "Rub hands together with vigorous friction for 20 seconds (The amount of time it takes to sing "Happy Birthday" through twice)."</p> <p>3.1-21(i)(1)</p>			

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F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to</p>	F000441	This Plan of Correction is the center's credible allegation of	09/27/2013			

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	<p>prevent the spread of infection by requiring staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice for 2 of 2 observations that affected 2 residents. (Resident #42)</p> <p>Findings include:</p> <p>During an observation on 8/23/13 at 3:39 p.m., LPN #3 was observed passing medications to several residents sitting in a common area. She was observed coughing into her bare hand before dispensing and administering medication to Resident #42. She did not perform hand washing, nor did she use hand sanitizer before dispensing or administering the medication.</p> <p>During an interview immediately following the incident, LPN #3 introduced herself and indicated, "I'm the one with the sniffles." She was then observed to dispense and administer medication to another resident.</p> <p>A review of the "Hand Hygiene/Handwashing" policy provided by the Director of Nursing (DoN) on 8/28/13 at 12:15 p.m. indicated that hand hygiene is to be</p>		<p>compliance. The facility is requesting a desk review in lieu of a revisit. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Infection Control, Prevent Spread, Linens Resident # 42 has exhibited no adverse effects Residents residing in the facility have the potential to be affected by this alleged deficient practice. LPN # 3 was re-educated along with disciplinary actions on facility policy "Respiratory Hygiene/Cough Etiquette," "Infection Control Work Practices" and "Hand Hygiene / Handwashing." An in-service for facility staff will be completed on 9/24/2013 on the facility policies "Respiratory Hygiene/Cough Etiquette," "Infection Control Work Practices," "Employee Symptom Screen for Acute Illness" and "Hand Hygiene / Handwashing." Department managers are responsible for identifying and monitoring employees exhibiting cold symptoms to ensure infection control work practices are being followed. Employees exhibiting signs and symptoms of infection will report to charge nurse for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/29/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201		
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	performed "...After coughing, sneezing, or blowing the nose." 3.1-18(l)		completion of an Employee Symptom Screen for Acute Illness with appropriate actions followed. Any non-compliance issues identified will result in re-education &/or disciplinary action up to and including termination. The Staff Development Coordinator / Designee will audit for infection control practices utilizing the "Review of Process measures – Preventing, Monitoring and Tracking Infections, weekly x 12, monthly x 4 and then quarterly until compliance is achieved.. Results of the audit will be reviewed in PI Committee monthly with action plans implemented as necessary. Compliance Date of 09/27/2014		