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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155193 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>10/17/2013 |
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| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD | STREET ADDRESS, CITY, STATE, ZIP CODE<br>377 WESTRIDGE BLVD<br>GREENWOOD, IN 46142 |
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| F000000            | <p>This visit was for the Investigation of Complaint IN00137710.</p> <p>Complaint IN00137710 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiencies are cited.</p> <p>October 16 &amp; 17, 2013</p> <p>Facility number: 000101<br/>Provider number: 155193<br/>AIM number: 100291290</p> <p>Survey team:<br/>Diana Zgonc, RN-TC</p> <p>Census bed type:<br/>SNF/NF: 139<br/>Total: 139</p> <p>Census payor type:<br/>Medicare: 40<br/>Medicaid: 91<br/>Other: 8<br/>Total: 139</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> | F000000       | <p>Ms. Kim Rhoades Indiana State Department of Health Long Term Care Division 2 North Meridian Street, Section 4B Indianapolis, Indiana 46204 October 25, 2013 RE: Survey Event ID: 243H111 Dear Ms.</p> <p>Rhoades: Attached you will find the completed Plan of Correction and attachments for our Complaint Survey dated October 17, 2013. We request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (317) 888-4948. Sincerely, Steven Tanner HFA</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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|                          | Quality review completed on October 22, 2013; by Kimberly Perigo, RN.  |                     |  |                            |

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| F000223<br>SS=A   | <p>483.13(b), 483.13(c)(1)(i)<br/>FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.<br/>Based on record review and interview, the facility failed to ensure residents were free from abuse for 1 of 3 residents reviewed for abuse in a sample of 6 (CNA #1, CNA #2, and Resident #E).</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 10/16/13 at 1:35 P.M.</p> <p>Diagnoses for Resident #E included, but were not limited to dementia with behavior disturbances, anxiety, reflux, anemia, osteoporosis, depressive disorder, hypothyroidism, and glaucoma.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment indicated the Resident's BIMS (brief interview of mental status) score was a "3" (cognition severely impaired).</p> | F000223   | <p>Resident E had no injury. Resident E had a head to toe assessment completed without findings on 06/05/2013. Resident was interviewed without recollection of the event. Resident E's roommate interviewed without findings. Greenwood police called and event reported. Case number G13L11915. Family and MD notified. Resident E care plan continues with 2 staff for care. C.N.A. #1 was terminated. C.N.A. #2 was given a final written warning related to not reporting immediately an event that constitutes abuse to the ED. C.N.A. # 2 was terminated on 10/13/2013 for unrelated performance issues. All residents receiving care from C.N.A. # 1 on 06/05/2013 were interviewed without findings and head to toe assessments completed for the same residents without findings. All staff were in-serviced on What Constitutes Abuse, Abuse, Event reporting and Resident Rights with emphasis on reporting immediately to the</p> | 10/25/2013   |  |   |  |

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|   | <p>An "Incident Report Form" for an unusual occurrence was provided by the Administrator on 10/16/13 at 9:45 A.M. The report indicated on 6/5/13 at 3:20 A.M., CNA (certified nursing aide) # 2 was providing care for Resident # E with the assistance of CNA # 1. Resident # E has a history of resisting care and combativeness and at the time care was being provided, she struck CNA # 1. CNA # 1 reportedly struck the resident on the left side of her face (cheek) with an open hand in retaliation.</p> <p>Review of CNA # 1's employee record on 10/17/13 at 9:30 A.M., indicated she was terminated on 6/5/13. The CNA was hired on 9/5/12 and had been given orientation for abuse, behavior management, resident rights and dementia training. The CNA has a current and valid certification. Background checks and references were received for the employee prior to hiring. The police were contacted regarding the allegation of abuse to the resident.</p> <p>During an interview with the Administrator, he indicated we notified the State Agency and the police as soon as we found out. The staff had been given all the orientation training per our policy.</p> |   | <p>ED. The DNS/ED will investigate all events that have the potential to constitute abuse. Abuse training and education will be provided in General Orientation for new employees, annually for current employees and as needed. The ED/DNS will continue to complete daily observation rounds throughout the facility to monitor the safety and wellness of the residents. Forty Resident and family interviews will be completed quarterly in an effort to identify any concerns or events that would constitute abuse. All findings will be reviewed in PI monthly and the PI committee will determine when 100% compliance is achieved or if further monitoring is required.</p> |  |  |   |  |

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|                          | 3.1-27(a)(1)   |                     |  |                            |

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| F000225<br>SS=D   | <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br/>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on record review and</p> | F000225   | Resident E had no injury.   | 10/25/2013   |  |   |  |

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|   | <p>interview, the facility failed to ensure abuse of a resident by a staff member was reported to the Administrator immediately according to the facility policy for 1 of 3 residents reviewed for abuse in a sample of 6 (CNA #1, CNA #2, and Resident #E).</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 10/16/13 at 1:35 P.M.</p> <p>Diagnoses for Resident #E included, but were not limited to dementia with behavior disturbances, anxiety, reflux, anemia, osteoporosis, depressive disorder, hypothyroidism, and glaucoma.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment indicated the Resident's BIMS (brief interview of mental status) score was a "3" (cognition severely impaired).</p> <p>An "Incident Report Form" for an unusual occurrence dated 6/5/13 was provided by the Administrator on 10/16/13 at 9:45 A.M. The report indicated on 6/5/13 at 3:20 A.M., CNA #2 was providing care for Resident #E with the assistance of CNA #1. Resident #E has a history of resisting</p> |   | <p>Resident E had a head to toe assessment completed without findings on 06/05/2013. Resident was interviewed without recollection of the event. Resident E's roommate interviewed without findings. Greenwood police called and event reported. Case number G13L11915. Family and MD notified. Resident E care plan continues with 2 staff for care. C.N.A. #1 was terminated. C.N.A. #2 was given a final written warning related to not reporting immediately an event that constitutes abuse to the ED. C.N.A. # 2 was terminated on 10/13/2013 for unrelated performance issues. All residents receiving care from C.N.A. # 1 on 06/05/2013 were interviewed without findings and head to toe assessments completed for the same residents without findings. All staff were in-serviced on What Constitutes Abuse, Abuse, Event reporting and Resident Rights with emphasis on reporting immediately to the ED. All staff were educated on Abuse Prevention with emphasis on providing information to residents, families and staff on how and to whom they report concerns, incidents and complaints/concerns without the fear of retribution; and provide feedback regarding the concerns that have been expressed. The DNS/ED will investigate all events that have the potential to</p> |  |  |   |  |

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|   | <p>care and combativeness and at that time, she struck CNA #1. CNA #1 reportedly struck the resident on the left side of her face (cheek) with an open hand. The "Incident Report Form" also indicated CNA # 1 &amp; 2 finished care without further incident. CNA #2 finished her shift at 3:30 A.M.</p> <p>On 6/5/13 at 8:30 P.M., CNA #2 contacted the facility and indicated at that time, CNA #1 had struck Resident #E on the face during care that morning. (approximately 17 hours after the incident)</p> <p>During an interview with the Administrator on 10/17/13 at 8:30 A.M., he indicated the police were contacted and an investigation was conducted. He also indicated CNA #2 failed to report the incident immediately, because she was afraid of CNA #1. All staff were re-inserviced regarding abuse. The CNAs are not currently employed at the facility.</p> <p>A current facility policy dated 7/22/10 and titled "Responding to and Investigating an Abuse Allegation" and provided by the Administrator on 10/16/13 at 9:45 A.M., indicated:<br/>"Procedure ... Alleged Physical Abuse ... 3. Contact the Executive Director</p> |   | <p>constitute abuse. Abuse, Abuse Prevention training, Resident Rights and Privacy and confidentiality education will be provided in General Orientation for new employees, annually for current employees and as needed to include information on how and to whom they report concerns, incidents and complaints/concerns without the fear of retribution; and all persons will remain confidential with regards to reporting. The ED/DNS will continue to complete daily observation rounds throughout the facility to monitor the safety and wellness of the residents and staff. Forty Resident or family interviews and staff interviews will be completed quarterly in an effort to identify any concerns or events that would constitute abuse. All findings will be reviewed in PI monthly and the PI committee will determine when 100% compliance is achieved or if further monitoring is required.</p> |                      |   |

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|   | and Director of Nursing immediately ..."<br><br>3.1-28(c)  |   |   |                      |   |

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| F000226<br>SS=D   | <p>483.13(c)<br/>DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure staff followed the abuse protocol and report an allegation of abuse by a staff member to the Administrator immediately according to the facility policy for 1 of 3 residents reviewed for abuse in a sample of 6 (CNA #1, CNA #2, and Resident #E).</p> <p>Findings include:</p> <p>The clinical record for Resident #E was reviewed on 10/16/13 at 1:35 P.M.</p> <p>Diagnoses for Resident #E included, but were not limited to dementia with behavior disturbances, anxiety, reflux, anemia, osteoporosis, depressive disorder, hypothyroidism, and glaucoma.</p> <p>The most recent Quarterly MDS (Minimum Data Set) assessment indicated the Resident's BIMS (brief interview of mental status) score was a "3" (cognition severely impaired).</p> | F000226   | <p>Resident E had no injury. Resident E had a head to toe assessment completed without findings on 06/05/2013. Resident was interviewed without recollection of the event. Resident E's roommate interviewed without findings. Greenwood police called and event reported. Case number G13L11915. Family and MD notified. Resident E care plan continues with 2 staff for care. C.N.A. #1 was terminated. C.N.A. #2 was given a final written warning related to not reporting immediately an event that constitutes abuse to the ED. C.N.A. # 2 was terminated on 10/13/2013 for unrelated performance issues. All residents receiving care from C.N.A. # 1 on 06/05/2013 were interviewed without findings and head to toe assessments completed for the same residents without findings. All staff were in-serviced on What Constitutes Abuse, Abuse, Event reporting and Resident Rights with emphasis on reporting immediately to the ED. All staff were educated on Abuse Prevention with emphasis on providing information to</p> | 10/25/2013   |  |   |  |

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|   | <p>An "Incident Report Form" for an unusual occurrence dated 6/5/13 was provided by the Administrator on 10/16/13 at 9:45 A.M. The report indicated on 6/5/13 at 3:20 A.M., CNA #2 was providing care for Resident #E with the assistance of CNA #1. Resident #E has a history of resisting care and combativeness and at that time, she struck CNA #1. CNA #1 reportedly struck the resident on the left side of her face (cheek) with an open hand. The "Incident Report Form" also indicated CNA # 1 &amp; 2 finished care without further incident. CNA #2 finished her shift at 3:30 A.M.</p> <p>On 6/5/13 at 8:30 P.M., CNA #2 contacted the facility and indicated at that time, CNA #1 had struck Resident #E on the face during care that morning. (approximately 17 hours after the incident)</p> <p>During an interview with the Administrator on 10/17/13 at 8:30 A.M., he indicated the police were contacted and an investigation was conducted. He also indicated CNA #2 failed to report the incident immediately, because she was afraid of CNA #1. All staff were re-inserviced regarding abuse. Both CNAs had been provided orientation</p> |   | <p>residents, families and staff on how and to whom they report concerns, incidents and complaints/concerns without the fear of retribution; and provide feedback regarding the concerns that have been expressed. The DNS/ED will investigate all events that have the potential to constitute abuse. Abuse, Abuse Prevention training, Resident Rights and Privacy and confidentiality education will be provided in General Orientation for new employees, annually for current employees and as needed to include information on how and to whom they report concerns, incidents and complaints/concerns without the fear of retribution; and all persons will remain confidential with regards to reporting. The ED/DNS will continue to complete daily observation rounds throughout the facility to monitor the safety and wellness of the residents and staff. Forty Resident or family interviews and staff interviews will be completed quarterly in an effort to identify any concerns or events that would constitute abuse. All findings will be reviewed in PI monthly and the PI committee will determine when 100% compliance is achieved or if further monitoring is required.</p> |  |  |   |  |

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|  | <p>on hire regarding abuse, resident rights, behavior management and dementia training.</p> <p>A current facility policy dated 7/22/10 and titled "Responding to and Investigating an Abuse Allegation" and provided by the Administrator on 10/16/13 at 9:45 A.M., indicated:<br/>"Procedure ... Alleged Physical Abuse ... 3. Contact the Executive Director and Director of Nursing immediately ..."</p> <p>3.1-28(a)</p> |  |  |  |
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