

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F 0000 Bldg. 00	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00192823 and IN00192911.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00194430.</p> <p>Complaint IN00192823 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00192911 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 23rd thru March 1, 2016.</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Census bed type: SNF/NF: 95 Total: 95</p> <p>Census payor type: Medicare: 16 Medicaid: 57 Private: 7</p>	F 0000		
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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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F 0156 SS=A Bldg. 00	<p>Other: 15 Total: 95</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by #02748 on March 7, 2016.</p> <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</p>				

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	<p>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: 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</p>			

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	<p>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, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on interview and record review, the facility failed to timely issue a Medicare beneficiary notice of noncoverage for 1 of 3 residents reviewed for liability and appeal notices. (Resident #45)</p> <p>Findings include:</p> <p>The 2/1/16 SNF (Skilled Nursing Facility) Determination On Continued Stay notice for Resident #45 was provided by the Case Manager (CM) on 2/25/16 at 11:28 a.m. The notice indicated her medical information was reviewed on 2/1/16, and it was found that she no longer qualified as covered under Medicare beginning 2/1/16. The notice</p>	F 0156	<p>F 156-</p> <p>1. Resident #45 no longer resides at facility and was given notice 2/1/16 per summary statement.</p> <p>2. Case Manager and Minimum Data Set Coordinator were inserviced on Medicare beneficiary notice of noncoverage guidelines.</p> <p>3. Systemic changes are a back-up plan has been put in place for when Case Manager is out of office. Back-up team will provide, print, and deliver timely notice of non-coverage for Medicare beneficiary.</p>	03/22/2016

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F 0157 SS=D Bldg. 00	<p>indicated Resident #45 would discharge home on 2/2/16. The notice was signed by Resident #45, but there was no indication as to the date of her signature.</p> <p>An interview was conducted with the CM on 2/25/16 at 11:37 a.m. She indicated the notice was not timely given to Resident #45, as it was given on 2/1/16, the same day as her last day of Medicare covered services. She indicated she was on vacation at the time of Resident #45's discharge, and Resident #45's notice was "missed" by the department who was responsible for issuing notices in her absence.</p> <p>The Medicare Services policy was provided by the CM on 2/25/16 at 1:50 a.m. It indicated, "The Center notifies the patient in advance of denial of continued Medicare coverage, the reason for the denial of coverage and of the patient's right to appeal the denial for Medicare Part A and B."</p> <p>3.1-4(f)(3)</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the</p>		<p>4. When the Case Manager is out of office, the Executive Director, Minimum Data Set Coordinator and/or Director of Social Services/ designees will be responsible for reviewing records for residents no longer qualified for Medicare coverage. They will print, deliver, and get resident's signature per Medicare Services policy. The non-coverage letters will be reviewed weekly by the Executive Director and the results of this review will be presented every month to the Performance Improvement Committee for any further recommendations. This will be monitored every month indefinitely.</p>		

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	<p>resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a Physician of a missed laboratory test, and the facility also failed to notify a Physician of the results of a lab test for 1 of 6 residents reviewed for unnecessary medication (Resident #185).</p>	F 0157	F 157- 1. Labs for Resident #185 were given to doctor on 3/1/16. 2. A lab audit was completed for all residents to ensure labs and notification was completed and there were no missed labs. The licensed nursing staff was inserviced on proper notification of missed labs and lab results. 3. Facility	03/22/2016

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	<p>Findings include:</p> <p>The clinical record for Resident #185 was reviewed on 2/29/16 at 11:30 a.m. The diagnoses for Resident #185 included, but were not limited to, atrial fibrillation (irregular heart rate), sick sinus syndrome (heart rhythm disorder), acute kidney failure, and cardiac pacemaker.</p> <p>The Hospital Discharge Instructions, dated 2/13/16, indicated to draw a PT/INR (lab to determine blood clotting time) lab every 2 days until stable due to atrial fibrillation and history of PE (pulmonary embolism).</p> <p>A Progress Note, dated 2/18/16, indicated a Physician Order, "...PT/INR in the morning every 2 day(s) for a-fib until INR 2-3 [lab results] then can space testing interval [sic] done by lab...."</p> <p>Lab results for 2/16/16 and 2/20/16 were located in the clinical record. The results for 2/18/16 PT/INR lab and Physician Notification of the missed lab were not located in the clinical record</p> <p>During an interview with Unit Manager #2, on 3/1/16 at 10:20 a.m., she indicated the 2/18/16 PT/INR was not drawn as ordered.</p> <p>A Progress Note for Resident #185, dated 2/20/16, indicated the following PT/INR lab results, "...PT=15.1, INR=1.3..."</p> <p>There was no Physician notification of</p>		<p>systemic changes are a lab log will be utilized by the nursing management team. The nursing management team will review lab orders in the daily clinical meeting, Monday through Friday, where labs will be monitored for order, order entry, results back and notification. The Weekend Supervisor will followup on the lab orders on the weekends. The unit manager/designee will also complete a chart audit to ensure the lab results are present on chart with MD notification. 4.</p> <p>The Director of Nursing Services/designee will review the audits for any trends and implement any necessary new processes based on findings. The review of these audits will be presented to the Performance Improvement Committee monthly until the committee determines compliance has been met.</p>	

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	<p>the 2/20/16 PT/INR results located in the clinical record.</p> <p>During an interview with Physician #3 (Resident #185's primary physician), on 3/1/16 at 11:00 a.m., Physician #3 indicated if he was notified of the above lab results he would've changed the current warfarin (blood thinner) dosage from 3 milligrams daily to 5 milligrams daily.</p> <p>On 3/1/16 at 12:02 p.m., the District Nurse indicated the facility was not able to determine if the Physician was notified of the missed PT/INR on 2/18/16. The District Nurse further indicated the facility was not able to locate physician notification of the lab results from the 2/20/16 PT/INR lab draw for Resident #185.</p> <p>A policy titled, Notifications dated 4/28/13, was received from the District Nurse on 3/1/16 at 1:00 p.m. The policy indicated, "...Staff informs the patient, consults with their attending physician, and notifies the patient's surrogates when:...Treatment needs to be altered significantly; or Laboratory results or any other testing results returned from a contracted laboratory or an outside laboratory...."</p>			

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F 0241 SS=D Bldg. 00	<p>3.1-5(a)(3)</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a resident's dignity, regarding the placement of his catheter tubing, for 1 of 3 residents reviewed for urinary catheter use, and the facility also failed to maintain a cognitively impaired resident's dignity that was wearing a dress for 1 of 1 residents observed in a dining observation. (Resident #14 and Resident #19)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #19 was reviewed on 2/24/16 at 10:00 a.m. The diagnoses for Resident #19 included, but were not limited to cerebral palsy, epilepsy, intellectual disabilities, and</p>	F 0241	<p>F 241-</p> <p>1. Resident #19 the catheter was properly placed through the pants. Resident #14 had a dress on, her dress was immediately pulled down and sweat pants were put on underneath dress. Staff members involved were immediately counseled.</p> <p>2 All other residents with foley catheters have been observed for proper placement of the foley catheter through the bottom of the pants leg. All other residents have been observed to be properly attired while in public areas.</p> <p>3. Facility systemic changes will include</p>	03/22/2016	

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	<p>retention of urine.</p> <p>The February, 2016 physician's orders for Resident #19 indicated the use of a suprapubic catheter.</p> <p>The 1/16/16 Quarterly MDS (minimum data set) assessment indicated Resident #19 required extensive assistance of one person for dressing and toilet use (including managing of a catheter).</p> <p>An observation of Resident #19 sitting in his wheel chair at a table in the activity room was made on 2/25/16 at 3:03 p.m. His catheter tubing was coming out from under his shirt, down the outside of his pant leg, and around the wheel of his wheel chair.</p> <p>An interview was conducted with Unit Manager #7 on 2/25/16 at 3:27 p.m. She indicated Resident #19's catheter tubing should run along the inside of his pant leg, not the outside.</p> <p>The Quality of Life policy was provided by the Director of Nursing on 3/1/16 at 1:00 p.m. It indicated, "Refrain from practices demeaning to patients such as keeping urinary catheter bags uncovered..."2.) The clinical record for Resident #14 was reviewed on 2/22/16 at 2:00 p.m.</p>		<p>roundingby facility management validating foley catheters are in proper position andresidents are dressed appropriately in public places. . The nursing staffwas inserviced on proper dress, proper placement of Foley catheters and theresident's dignity involving appropriate attire while in public area.</p> <p>4. The Executive Director, Director of Nursing/or designees will round daily, Monday through Friday for resident dignity andchecking Foley catheters for proper placement. Results of the audit willreviewed by the monthly Performance Improvement committee for 90 days or until100% compliance achieved.</p>	

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	<p>The diagnosis for Resident #14 included, but was not limited to: mild cognitive impairment.</p> <p>The Annual Minimum Data Set (MDS) dated 11/19/15, indicated Resident #14's Brief Interview for Mental Status (BIMS) score was a score of 6 out of possible score of 15. This score indicated Resident #14 was not cognitively intact. It also indicated Resident #14 needed extensive assistance with dressing.</p> <p>A random observation was made on 2/22/16 at 12:35 p.m. Resident #14 was pushed in her wheelchair by the staff into the main dining room. It was observed Resident #14 had a white blanket draped over her shoulders and arms. Resident #14 was sitting on an additional blanket that was draped over her hips. Resident #14's legs were exposed from the top portions of her thighs to the bottom of her legs with the exception of her ankles and feet which were covered by her socks and shoes.</p> <p>An observation was made of Resident #14 with the Unit Manager #2 in the dining room on 2/22/16 at 12:37 p.m. She indicated Resident #14 was wearing a dress, and it looked like it had "hiked" up.</p>			

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	<p>An observation was made of Resident #14 in her bed with the Social Services Coordinator (SSC) on 2/25/16 at 2:22 p.m. She indicated at that time, Resident #14 was wearing a blouse not a dress. SSC indicated Resident #14 normally wears dusters that are longer in length.</p> <p>An observation was made of Resident #14 in her wheelchair with the Business Office Manager (BOM) on 2/25/16 at 2:51 p.m. It was observed Resident #14 had a dress on that covered her mid thighs. She also was wearing sweat pants on her lower extremities. BOM indicated Resident #14 was wearing that dress not a blouse in the dining room. She indicated it was possible, Resident #28's dress was hiked up in the dining room, so she would not urinate on it.</p> <p>A Quality of Life policy was provided by Medical Records #21 on 3/1/16 at 12:06 p.m. It indicated, "Policy Care is provided in a manner and in an environment that maintains or enhances each patient's dignity and respect in full recognition of his or her individuality. Rationale: Patient choices and/or preferences are respected to maintain the patient's psychosocial and physical individuality. Definitions: Dignity In the staff's interactions with patients, they carry out activities that assist the patient</p>			

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F 0250 SS=D Bldg. 00	<p>to maintain and enhance his/her self esteem and self-worth. Components:...7. Patient's privacy of body is maintained including keeping patients sufficiently covered, such as with a robe, while being taken to areas outside their room,...".</p> <p>3.1-3(t)</p> <p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to follow up on a recommendation for a guardian on a Pre-Admission Screening and Resident Review (PASRR) for 1 of 1 residents reviewed for PASRR Level II Services. (Resident #128)</p> <p>Findings include:</p> <p>The clinical record for Resident #128 was reviewed on 2/29/16 at 11:24 a.m. The diagnosis for Resident #128 included, but was not limited to: profound intellectual disabilities. Resident #128 was admitted on 11/26/14.</p>	F 0250	<p>F 250-</p> <p>1. Guardianship process has been initiated through Kindred Legal Department for Resident #128.</p> <p>2. Social Services Director was inserviced on PASRR Level II and guardianship recommendations. An audit was completed to identify additional facility residents who would benefit from guardianships and PASSR recommendations that have not been acted upon.</p> <p>3. The facility</p>	03/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>The Admission Minimum Data Set (MDS) dated, 12/3/14, and the Annual MDS dated, 11/21/15, indicated Resident #128's Brief Interview for Mental Status (BIMS) score was unable to be assessed due to, "resident is rarely/never understood" (cognitively impaired).</p> <p>The PASRR for Resident #128 dated, 11/19/14, indicated on the recommendations, "(Name of Resident #128) may benefit from a legal guardian to protect his interests, personally, financially, and medically".</p> <p>The PASRR for Resident #128 dated, 10/8/15, indicated on the recommendations, "(Name of Resident #128) may benefit from exploration of Guardianship alternatives".</p> <p>A social services progress note dated, 2/18/16, at 8:27 a.m., indicated Resident #128 was "alert and oriented to self/place only. disoriented to time...res. (Resident #128) not able to verbalize, current month, year, day of week. he is severely impaired in daily decision making skills ie. he is not able to communicate his wants or needs. he is unable to ask or answer questions...he is not able to hold a conversation. he can follow limited 1 step commands. he can not read or write. staff</p>		<p>systemic changes will include the Social Services Director reviewing facility population weekly to identify if any additional guardianships that should be initiated. The Social Services Director will also review all PASSR recommendations have been acted upon</p> <p>4. The Executive Director and Social Services Director will meet weekly regarding newly identified residents who would benefit from guardianships/ newly received PASSR recommendations and provide updates on current residents going through guardianship process and a PASSR recommendations. Results of the audit will reviewed by the monthly Performance Improvement committee for 90 days or until 100% compliance achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>anticipates his needs. dx (diagnosis) of mrdd (mental development disabilities)...".</p> <p>A social services progress note dated, 2/18/16, at 8:31 a.m., indicated Resident #128 had a family that lived in Texas. Resident #128 was emancipated, and signs his own paperwork.</p> <p>An interview was conducted with the Social Services Coordinator (SSC) on 2/29/16 at 12:22 p.m. She indicated she took care of recommendations on the PASRR Level II services. SSC indicated Resident #128 had previously come from a group home in 2014 prior to this facility. Resident #128 was emancipated at that time. SSC indicated she does speak with Resident #128's family in Texas by phone, since he was Resident #128's "next of kin". She indicated the facility had not addressed the recommendations to look into guardianship for Resident #128. The SSC at that time, indicated Resident #128 does not have a Guardian or Power of Attorney (POA) on file.</p> <p>An interview was conducted on 2/29/16 at 2:37 p.m., with the Administrator. She indicated it could not be determined at that time, if Resident's family was the guardian or POA.</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F 0278 SS=A Bldg. 00	<p>A Social Services policy was provided by Medical Records #21 on 3/1/16 at 12:06 p.m. It indicated, "Policy Medically related social services are provided in order to attain or maintain the highest practicable physical, mental, and psychosocial well being of the resident. Compliance Guidelines..1. Attempts are made to obtain needed services even if the state's Medicaid plan does not cover the services. 2. The physical, mental, and psychosocial needs of the resident must be identified and those needs met by the appropriate disciplines. 3. Conditions that would require social service interventions include:..h. Presence of legal or financial problems;.."</p> <p>3.1-34(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure accuracy of the MDS (minimum data set) assessments regarding an explicit terminal prognosis and hospice for 1 of 1 residents reviewed for hospice. (Resident #95)</p> <p>Findings include:</p> <p>The clinical record for Resident #95 was reviewed on 2/25/16 at 11:30 a.m. The diagnoses for Resident #95 included, but were not limited to, degenerative disease of nervous system and early onset cerebellar ataxia .</p>	F 0278	<p>F 278-</p> <p>1. Resident #95 MDS has been modified and the accurate coding to J1400 Prognosis Code has been changed to Yes. .</p> <p>2. All other MDS of those residents receiving hospice services have been reviewed for accurate coding. The MDS coordinator and back-up Case Manager have been inserviced on proper coding of the MDS for hospice.</p> <p>3. The facility completed an</p>	03/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>A Physician's Order, dated 6/5/15, indicated readmit to hospice.</p> <p>During an interview with Unit Manager #1, on 2/25/16 at 10:44 a.m., she indicated Resident #95 had been on hospice services for a "long time."</p> <p>A 12/7/15 Significant Change MDS (minimum data set) assessment did not indicate Resident #95 was receiving hospice in Section O. Section J, for the question, "Does the Resident have a condition or chronic disease that may result in a life expectancy of less than 6 month...." the question was marked "no."</p> <p>A review of the RAI Manual received from the MDS Coordinator, on 2/26/16 at 10:15 a.m., indicated, "...O0100K, Hospice Care Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions....J1400 Prognosis...Code 1, yes: if...2) the resident is receiving hospice services...."</p> <p>During an interview with the MDS Coordinator at 10:15 a.m., on 2/26/16, the MDS Coordinator indicated the above MDS assessment for Resident #95 was</p>		<p>audit of all current hospice residents to verify J1400 Prognosis Code 1 of "Yes" has been entered.</p> <p>4. The MDS coordinator and the Case Manager will review hospice coding for accuracy in daily clinical meeting, Monday through Friday. The results will be reported to the monthly Performance Improvement committee indefinitely.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F 0282 SS=D Bldg. 00	<p>coded incorrectly and she just submitted a correction.</p> <p>3.1-31(d)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure weekly weights were obtained, as ordered by a physician, for 1 of 3 residents reviewed for nutrition, and the facility also failed to ensure a Physician's Order for daily blood pressures was completed for 1 of 6 residents reviewed for unnecessary medication. (Resident #64 and Resident #108)</p> <p>Findings include:</p> <p>1.) The clinical record for Resident #64 was reviewed on 2/24/16 at 9:30 a.m. The diagnoses for Resident #64 included, but were not limited to, dementia. Resident #64 was admitted to the facility</p>	F 0282	<p>F 282-</p> <p>1. Resident #64 weekly weight order was discontinued. Resident #108 had his blood pressure immediately taken and was within normal limits. The physician's order was changed to weekly blood pressure and corrected in the electronic medication system.</p> <p>2. An audit of the electronic medical orders was completed and there were no other issues related to weekly weights or blood pressure checks. The nursing staff has been in-serviced on the policy for</p>	03/22/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>on 1/1/16.</p> <p>The 1/4/16 Physician's Order for Resident #64 indicated weekly weights for 4 weeks every evening shift every Sunday.</p> <p>The 1/7/16 Medical Nutrition Therapy Assessment indicated, "(Name of Resident #64) is on weekly weights to establish baseline."</p> <p>The Weight Summary indicated the following weights for Resident #64:</p> <p>1/1/16 = 195.6 1/10/16 = 191.6 2/7/16 = 192 2/8/16 = 185 2/14/16 = 184.5 2/22/16 = 181</p> <p>An interview was conducted with the Dietician on 2/29/16 at 9:56 a.m. She indicated she thought nursing was responsible for obtaining weights.</p> <p>An interview was conducted with the District Nurse on 2/29/16 at 2:35 p.m. She indicated no weekly weights could be located for Resident #64, and the only one within 4 weeks of the 1/4/16 order for weekly weights, was the weight from 1/10/16.</p>		<p>inputting and following physician's orders.</p> <p>3. All orders related to weights or blood pressure will be reviewed in the daily clinical meeting Monday through Friday and reported to our Performance Improvement committee for 90 days or until 100% compliance achieved.</p> <p>4. The DNS or designee will audit 3 resident records weekly Monday through Friday to ensure ongoing compliance with physician order entry. Results of the audit will be reviewed by the monthly Performance Improvement committee for 90 days or until 100% compliance achieved.</p>	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>The Weight Measurement policy was provided by the Administrator on 3/1/16 at 9:09 p.m. It indicated, "Weight measurement is scheduled as follows: Nursing Centers/Subacute's...Weight with 4 hr (hours) of admission, Weekly for 4 weeks, Monthly thereafter or ore frequently if deemed necessary by Interdisciplinary Team."</p> <p>2.) The clinical record for Resident #108 was reviewed on 2/29/16 at 1:30 p.m. The diagnoses for Resident #108 included, but were not limited to, diabetes mellitus, atrial fibrillation (irregular heart rate), and chronic kidney disease.</p> <p>A Nurse Practitioner note, dated 2/1/16, indicated, "...The pt [patient] seen acutely due to sick sinus syndrome dx'd [diagnosed] by cardiology. The pt refuses a pacemaker. He has uncontrolled BP [blood pressure]...Vital Signs...Blood Pressure: 190/82...Diagnosis, Assessment, Plan...Monitor BP daily for now...."</p> <p>A Physician's Order, dated 2/1/16, indicated, "...BP daily...."</p> <p>The February 2016 MAR (medication administration record) and the clinical record indicated blood pressures were</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250		
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F 0315 SS=D Bldg. 00	<p>missing for the following days: 2/2/16, 2/3/16, 2/4/16, 2/5/16, 2/6/16, 2/7/16, 2/8/16, 2/9/16, 2/11/16, 2/12/16, 2/13/16, 2/14/16 & 2/16/16.</p> <p>During an interview with the District Nurse, on 3/1/16 at 12:35 p.m., the District Nurse indicated the facility was not able to locate the above missing blood pressures. The District Nurse further indicated the order for daily blood pressures was incorrectly coded in the electronic medication system, so the order was not completed as written.</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p>				

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>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.</p> <p>Based on interview and record review, the facility failed to consider an urology consult for a resident with the continued use of an indwelling catheter for 1 of 3 residents reviewed for indwelling catheters. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record for Resident #2 was reviewed on 2/29/16 at 1:30 p.m. The diagnoses for Resident #2 included, but were not limited to, female intestinal-genital tract fistula, colostomy, and rheumatoid arthritis.</p> <p>A Physician's Progress Note, dated 2/21/11, indicated "...s/p [status post] hosp [hospital] colovaginal fistula...s/p repair colostomy f/c [Foley catheter] in place...."</p> <p>During a staff interview with LPN #22, on 2/24/16 at 11:11 a.m., LPN #22 indicated Resident #2 had an indwelling</p>	F 0315	<p>F 315-</p> <p>1. Resident#2 has a urology appointment at Urology of Indiana with Doctor Martin at 10:30am 3.30.16.</p> <p>2. A house wide audit was completed to ensure all residents with foley catheters have had an initial urology consult in place.</p> <p>3. Facility systemic changes will include a foley catheter tracking tool. The nursing management team will review in the daily clinical meeting, Monday through Friday, the tracking tool will monitor resident initial urology consult, the foley catheter care is signed off in MAR/TAR, the justification is completed, and the foley has been care planned. The nursing staff has</p>	03/22/2016

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>catheter. LPN #22 indicated the reason for the catheter was for a female genital fistula.</p> <p>The February 2016 Physician's Orders, indicated orders for a Foley catheter; monitor Foley catheter output and change as needed for occlusion/dislodgment due to the diagnosis of colovaginal fistula.</p> <p>During an interview with Medical Records #21, on 3/1/16 at 11:15 a.m., Medical Records #21 indicated the facility was not able to locate an urology consult for Resident #2 and the facility reviewed the clinical records since 2011.</p> <p>During an interview with MD #3 (Resident #2's primary physician), on 3/1/16 at 11:20 a.m., MD #3 indicated (after reviewing her clinical record) Resident #2 initially had the diagnosis of colovaginal fistula for the indwelling catheter. MD #3 also indicated Resident #2 should've seen a urologist to determine if the indwelling catheter was still needed or if the current care/treatment for the indwelling catheter was appropriate. MD #3 further indicated an order for an urology consult was an oversight.</p> <p>A policy titled, Evaluation of Medical Justification for Indwelling Catheter Use,</p>		<p>been educated on all of the components for justification of a foley catheter.</p> <p>4. The Director of Nursing Services/ Designee and clinical team will review the audits for any trends and implement any necessary new processes based on findings. Results of the audit will be reviewed by the monthly Performance Improvement committee for 90 days or until 100% compliance is achieved.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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F 0425 SS=D Bldg. 00	<p>dated 11/18/05, was received from the District Nurse on 3/1/16 at 1:05 p.m. The policy indicated, "...An indwelling catheter is only used when there is a valid justification. A resident is assessed for and provided the care and treatment needed to reach his or her highest level of continence possible...Catheter Justified 4. Notify the physician of the need to initiate a catheter or continued need for a catheter and obtain order [sic] and a written progress note to support the use of the catheter...."</p> <p>3.1-37(a)</p> <p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 03/01/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview, and record review, the facility failed to dispose of expired insulin prior to administration for 1 of 3 residents that received insulin from the medication cart (Resident #108).</p> <p>Findings include:</p> <p>During an observation of a medication cart with LPN #20, on 3/1/16 at 12:25 p.m., a Novolog flexpen (insulin) for Resident #108 was marked with a sticker as opened on 1/28/16, with another sticker indicating "do not use" after 2/27/16. No other insulin for Resident #108 was observed in the medication cart with LPN #20.</p> <p>During an interview with LPN #20, on 3/1/16 at 12:27 p.m., LPN #20 indicated Novolog expired 28 days after opening and she will retrieve another Novolog flexpen from the medication refrigerator for administration of insulin. LPN #20 further indicated she believed 3 residents</p>	F 0425	<p>F425-</p> <p>1.Resident #108 was observed for adverse reactions. There were no negative outcomes noted. The insulin was discarded immediately.</p> <p>2.All of medication carts were audited for any expired medications. No other medications were identified. Nursing staff was inserviced on expired medication and the policy was posted on nursing carts.</p> <p>3.Systemic changes include nursing management will complete 1 audits per cart every week and Omnicare pharmacy technician will audit every cart once a month. The nursing staff was re-inserviced on ensuring that the medication that is being administered in not expired.</p> <p>4.The Director of Nursing Services/ designee and clinical</p>	03/22/2016

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>received insulin out the medication cart.</p> <p>The clinical record for Resident #108 was reviewed on 2/29/16 at 1:30 p.m. The diagnoses for Resident #108 included, but were not limited to, diabetes mellitus, atrial fibrillation (irregular heart rate), and chronic kidney disease.</p> <p>The February and March 2016 MARs (medication administration records) indicated Resident #108 received 6 units of Novolog on the following days: 2/27/16 at 8:00 a.m., 2/27/16 at 12:00 p.m., 2/28/16 at 8:00 a.m., 2/28/16 at 12:00 p.m., 2/29/16 at 12:00 p.m., 2/29/16 at 5:00 p.m., 3/1/16 at 12:00 p.m.</p> <p>A policy titled, Injectable Medications, dated 9/29/15, was received from the Executive Director on 3/1/16 at 1:30 p.m. The policy did not specify an expiration date for insulin pens, but to follow "... [name of pharmacy] Insulin Storage Recommendations...." The policy also indicated, "...Insulin vials...all vials should be dated when opened and discarded 28 days after opening...."</p> <p>During an interview with Executive Director, 3/1/16 at 1:31 p.m., the</p>		<p>team will review the audits for any trends and implement any necessary new processes based on findings. Results of the audit will reviewed by the Performance Improvement committee for 90 days or until 100% compliance achieved.</p>	

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F 0514 SS=A Bldg. 00	<p>Executive Director indicated she just called the pharmacy and the pharmacy indicated insulin vials and pens had the same timeframe for expiration.</p> <p>3.1-25(o)</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure complete documentation of the MAR (medication administration record) for 1 of 5 residents reviewed for unnecessary medications. (Resident #124)</p> <p>Findings include:</p> <p>The clinical record for Resident #124 was</p>	F 0514	<p>F 514-</p> <p>1. The clinical record for Resident #124 was audited for missed documentation of medication delivery and was updated accordingly.</p> <p>2. Other resident's medication administration records were audited for missed documentation. If applicable, a</p>	03/22/2016

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	<p>reviewed on 2/24/16 at 11:53 a.m. The diagnoses for Resident #124 included, but were not limited to: atrial fibrillation, congestive heart failure, anxiety disorder, neuropathy, hyperlipidemia, chronic obstructive pulmonary disease, hypertension, and cough.</p> <p>The February, 2015 Order Summary Report for Resident #124 indicated the following medications:</p> <p>Coumadin 5 mg daily Furosemide 20 mg daily Lorazepam 0.25 mg daily Neurontin 300 mg at bedtime Pravastatin 20 mg in the evening Albuterol 1 Unit twice daily Metoprolol 12.5 mg every 12 hours Mucinex 600 mg twice daily Nebulizer treatment twice daily Neurontin 100 mg twice daily</p> <p>The February, 2015 MAR for Resident #124 did not indicate the following medications were administered or a reason for nonadministration:</p> <p>Coumadin 5 mg at 5 p.m. on 2/11/16 and 2/19/16 Furosemide 20 mg at 5 p.m. on 2/11/16 and 2/19/16 Lorazepam 0.25 mg at 8 p.m. on 2/11/16, 2/14/16, 2/19/16, and 2/20/16</p>		<p>late entry was made to validate medication administration.</p> <p>The specific nurse was counseled on insufficient documentation. The licensed nursing staff was in-serviced on proper medications sign-off and policy.</p> <p>3. Systemic changes are nursing management team will review 3 residents in daily clinical meeting, Monday through Friday. The Weekend Supervisor will audit for sufficient documentation on the weekend.</p> <p>4. The Director of Nursing Services/ designee and clinical team will review MAR for accuracy in daily clinical meeting, Monday through Friday. Results of the audit will be reviewed by the Performance Improvement committee for 90 days or until 100% compliance achieved.</p>	

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	<p>Neurotin 300 mg at 8 p.m. on 2/11/16 and 2/19/16</p> <p>Pravastatin 20 mg at 6 p.m. on 2/11/16 and 2/19/16</p> <p>Albuterol 1 unit at 8 p.m. on 2/9/16, 2/11/16, 2/13/16, 2/14/16, 2/19/16, and 2/20/16</p> <p>Metoprolol at 8 p.m. on 2/11/16, 2/13/16, 2/14/16, 2/19/16, and 2/20/16</p> <p>Mucinex at 8 p.m. on 2/11/16, 2/13/16, 2/14/16, 2/19/16, and 2/20/16</p> <p>Nebulizer at 8 p.m. on 2/11/16, 2/13/16, 2/14/16, 2/19/16, and 2/20/16</p> <p>Neurotin 100 mg at 2 p.m. on 2/5/16 and 2/16/16</p> <p>An interview was conducted with the District Nurse on 2/29/16 at 2:40 p.m. She indicated they identified the nurse who was responsible for the insufficient documentation of Resident #124's MAR. She indicated it was the expectation that medications are signed off per policy.</p> <p>The General Dose Preparation and Medication Administration policy was provided by the Administrator on 3/1/16 at 9:09 a.m. It indicated, "Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN [as needed] medications,</p>			

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	application sight) on appropriate forms." 3.1-50(a)(1)				