

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 04/13/2016
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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 the Investigation of Complaint IN00194762, IN00195912, IN00196773, IN00197073 and IN00197343.</p> <p>Complaint IN00194762--Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00195912--Substantiated. Federal/state deficiencies are cited at F157 and F323.</p> <p>Complaint IN00196773--Substantiated. Federal/state deficiency is cited at F309.</p> <p>Complaint IN00197073--Substantiated. Federal/state deficiency is cited at F309.</p> <p>Complaint IN00197343--Substantiated. Federal/state deficiencies are cited at F157 and F323.</p> <p>Survey date: April 6, 7, 8, 11, 12 and 13, 2016</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Census bed type:</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. 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.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

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F 0157 SS=D Bldg. 00	<p>SNF: 20 NF: 63 SNF/NF: 16 Total: 99</p> <p>Census payor type: Medicare: 20 Medicaid: 63 Other: 16 Total: 99</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on April 15, 2016.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the 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,</p>			

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	<p>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 the attending physician and the family following two assisted falls to the floor for 1 of 3 residents reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 4-12-16 at 2:40 p.m. Her diagnoses included, but was not limited to, morbid obesity, diabetes, chronic fatigue, dementia, right hip pain, history of alcohol abuse and osteoarthritis. Her</p>	F 0157	<p>F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC) A facility must immediately inform the 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</p>	04/26/2016

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	<p>admission Minimum Data Set assessment, dated 2-5-16, indicated she has moderate cognitive impairment, she required extensive assistance of one person for ambulation, she utilized a walker or wheelchair for mobility, pain assessment indicated she experienced occasional pain of moderate intensity that did not adversely affect her sleep at night or day to day activities, was indicated to be a fall risk, was indicated to have no falls prior to admission to the facility and had one fall without injury after admission to the facility.</p> <p>A nursing progress note, dated 2-4-16 at 3:34 p.m., indicated the resident was assisted to the floor by facility staff as therapy staff observed the resident "low in her chair." It indicated, "Res[ident] is a very large woman, she was to [sic] low in the chair, so the best thing to do was to lower her to the floor. With the help of 4 staff members she was lowered to the floor, so we could get her back into the bed. Res. was a/o [alert and oriented] able to make needs known. No c/o [complaint of] pain, no SOB [shortness of breath], full assessment was done."</p> <p>A nursing progress note, dated 2-12-16 at 6:21 a.m., indicated during an assisted transfer with two staff, the resident's right knee "buckled and pt [patient] was</p>		<p>treatment significantly (i.e., 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). Since the nature of the survey was a complaint, the facility is unable to determine the identity of Resident # B so the facility is unable to provide corrective action. Any other resident that has an assisted fall related event, the physician and family will be promptly notified. The licensed nursing staff have been educated on the notification requirements of an assisted fall event. The clinical management team will review in the Clinical morning meeting Monday through Friday the clinical record of any fall assisted event to ensure that the physician and family have been notified. The weekend supervisor will ensure notification on the weekends. This practice will continue indefinitely. The Director of Nursing will report to the monthly Performance Improvement Committee the results of the daily notification results. The committee will make any recommendations if the results are not at 100%.</p>	

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	<p>unable to stand and bear wt [weight] and staff was unable to keep holding her up. Pt. was lowered to ground in a purposeful and controlled movement and then staff put pt in bed. Pt. did not receive any injuries or complaints [sic]."</p> <p>In an interview with the Executive Director (ED) and the Director of Nursing (DON) on 4-13-16 at 2:30 p.m., the ED indicated it was her understanding that if a resident was assisted to the floor, that was not considered a fall as the event was a controlled event, and as a result, this would not require the event to be investigated as a fall, nor treated as a fall which would require the typical fall investigation and notifications to the physician and family. The DON indicated this information was verified with the Corporate Nurse. The ED indicated all staff have been trained that an "assist to the floor" does not constitute a fall.</p> <p>On 4-6-16 at 10:23 a.m., the ED provided a copy of a policy, entitled, "Resident Rights-Federal." This policy indicated, "...Notification of changes. A Center must immediately inform the 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</p>			

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F 0309 SS=E Bldg. 00	<p>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.)..."</p> <p>On 4-13-16 at 3:50 p.m., the ED provided a copy of a policy, entitled, "Resident Event Response." This policy had a date of 5-15-03 and was indicated to the current policy utilized by the facility. This policy indicated, "Adverse events involving a resident are investigated immediately, corrected as soon as possible after the event, and reported as required...Record the notification of MD and family member/responsible party..."</p> <p>This Federal tag relates to Complaint IN00195912 and Complaint IN00197343.</p> <p>3.1-5(a)(1)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and</p>			

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	<p>psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to ensure call lights are responded to in a timely manner, and failed to ensure care supplies for incontinence care are readily available for 4 of 4 residents reviewed for call lights in a sample of 10, resulting in urinary incontinence and emotional stress. (Resident #C, #D, #G and #L)</p> <p>Findings include:</p> <p>1. Resident #C's clinical record was reviewed on 4-6-16 at 3:05 p.m. It indicated her diagnoses included, but were not limited to Parkinson's disease, fractures of the bones of the foot, diabetes and dementia. Her most recent Minimum Data Set assessment, dated 3-5-16, indicated she requires extensive assistance of two or more persons with transfers, is unable to ambulate, uses a wheelchair for mobility and is frequently incontinent of bowel and bladder.</p> <p>In an interview with a family member on 4-12-16 at 11:45 a.m., he indicated he has witnessed the call light being activated for the purpose of incontinence care and it taking the staff from 30 to 60 minutes to respond to provide care. He indicated</p>	F 0309	<p>F 309 483.25 PROVIDECARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Since the nature of the survey was a complaint, the facility is unable to determine the identity of Residents # C, #D, #G and #L so no corrective measures can be conducted Any resident requiring incontinence supplies have the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice of untimely call light response. Staff, including non-clinical staff, has been educated on answering call lights promptly. The ED/Management team will conduct random call light response time audits across all shifts and weekends three times a week for a month. If improvement is noted, the audit will be decreased to one time a week for a month and then bi-monthly. The supplies closets on each unit have been reorganized and stocked appropriately with briefs to be</p>	04/26/2016

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	<p>this means the resident is sitting in a wet incontinence brief the entire time.</p> <p>2. Resident #D's clinical record was reviewed on 4-7-16 at 11:00 a.m. It indicated her diagnoses included, but were not limited to intestinal fistula and chronic pain. Her most recent Minimum Data Set assessment, dated 3-9-16, indicated she is cognitively intact and independent with her care.</p> <p>In an interview with Resident #D on 4-7-16 at 9:30 a.m., she indicated it can take more than one hour to have her call light responded to, and this has happened on more than one occasion. She explained that due to her health status, she experiences nausea and itching and this is very stressful for her when it takes so long for the staff to respond to her request for medication for these problems. She indicated when she has addressed this issue with some of the CNA's, they have told her that when they see her call light on, they assume it is for her medication, so they will wait for the nurse to answer her call light. She indicated she has resorted to calling the front desk with her cell phone to get assistance when her call light has not been responded to by the staff in a timely manner.</p>		<p>available through a 24 hour period. A nursing supervisor has the code to the main supply room at all times in the case that additional supplies are needed. The ED/designee will randomly audit the supply closets for adequate supplies weekly. The facility conducts at a minimum 10 monthly interviews with the residents surrounding customer service related questions. An additional question will be added to inquire about call light response times and supply availability. Results of the call light response time audits, supply closet audits and resident interview responses will be presented to the monthly Performance Improvement Committee meeting by the ED/designee. The committee will determine if and when the audits can be discontinued.</p>	

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	<p>3. Resident #G's clinical record was reviewed on 4-11-16 at 6:40 a.m. It indicated his diagnoses included, but were not limited to lymphoma, brain tumor and cerebrovascular accident (CVA or stroke). His most recent Minimum Data Set assessment, dated 1-20-16, indicated he required extensive assistance of one person with dressing, eating, bathing, toileting and was frequently incontinent of bowel and bladder.</p> <p>In interview with a family member on 4-8-16 at 1:10 p.m., she indicated the resident requires total care essentially with all aspects of his care due to his health status. She indicated one of the issues she would like improved upon is the supplies of incontinence briefs. She indicated, "Sometimes we have to wait [for staff to locate these items] and they have run out, so we provide a lot of our own."</p> <p>4. Resident #L's clinical record was reviewed on 4-13-16 at 11:35 a.m. It indicated his diagnoses included, but were not limited to liver transplant. His most recent Minimum Data Set assessment, dated 2-29-16 indicated he is cognitively intact, he requires extensive assistance of two or more persons with bed mobility and transfers, requires extensive assistance of one person with</p>			

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	<p>ambulation, dressing, bathing, toileting, is occasionally incontinent of urine and has an ostomy bag utilized for stool.</p> <p>In an interview with CNA #1 on 4-11-16 at 5:45 a.m., she indicated, "One of our biggest problems on nights [night shift] is not having enough supplies, mainly [incontinence] briefs." She explained only two staff have access to the main supply room, in order to access any additional supplies. She indicated staff "do the best we can...sometimes can borrow briefs from other halls, but it makes it hard."</p> <p>In an interview with Resident #L on 4-13-16 at 10:00 a.m., he indicated he has had to wait up to two hours for his call light to be responded to, with "evening and nights or weekends the worst...feel like it is [due to the facility being] understaffed...nursing staff do the best that they can." He indicated another concern is, "Right now, [the facility is] out of [incontinent] briefs."</p> <p>In an interview with the Executive Director on 4-13-16 at 3:45 p.m., she indicated the facility does not have a specific policy related to call light response time. She indicated her expectations are that call lights will be responded to within five to ten minutes.</p>			

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	<p>She indicated a staff meeting was held on 3-31-16 in which this topic was addressed. She indicated during the meeting, it was discussed it is a facility expectation that all staff will answer call lights and that if the person responding to the call light is unable to meet the resident's need, then that person should communicate this to the resident or family and that they will seek out the person who can attend to their needs as soon as possible. She indicated another topic addressed at this meeting was the use of incontinence briefs. She explained the individual resident is not charged for each brief, as this was addressed at the meeting. She explained the briefs are considered a facility supply. She indicated she has requested staff to only obtain 6 or fewer briefs at a time for each resident in order to have the supply in each supply closet last longer. She explained that staff had been takes large amounts of the briefs for their assigned residents and leaving other staff with very limited number of briefs, causing problems with supply and demand.</p> <p>In an interview with the Executive Director (ED) and Director of Nursing (DON) on 4-7-16 at 1:28 p.m., the ED indicated the facility has a central supply room that is kept locked with access by upper management and a supply closet on</p>			

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F 0323 SS=D Bldg. 00	<p>each of the two units in which all staff has access. She indicated each supply closet is restocked on Monday through Friday, with a larger amount of supplies being provided to each supply closet on Friday. She explained the upper management staff always has access to the supply room for any additional supplies.</p> <p>This Federal tag relates to Complaint IN00196773 and Complaint IN00197073.</p> <p>3.1-37(a)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to conduct an investigation into two assisted falls to the floor for 1 of 3 residents reviewed for falls. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 4-12-16 at 2:40 p.m. Her diagnoses included, but was not limited to, morbid obesity, diabetes, chronic</p>	F 0323	F 323 483.25(h) FREE OFACCIDENT HAZARDS/SUPERVISION/DEVI CES The facility mustensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to preventaccidents. Since the nature of the survey was a complaint, the facility cannot determine the identity of Resident #B. Anyresident that has a assisted fall related event will	04/26/2016

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	<p>fatigue, dementia, right hip pain, history of alcohol abuse and osteoarthritis. Her admission Minimum Data Set assessment, dated 2-5-16, indicated she has moderate cognitive impairment, she required extensive assistance of one person for ambulation, she utilized a walker or wheelchair for mobility, pain assessment indicated she experienced occasional pain of moderate intensity that did not adversely affect her sleep at night or day to day activities, was indicated to be a fall risk, to have no falls prior to admission to the facility and had one fall without injury after admission to the facility.</p> <p>A nursing progress note, dated 2-4-16 at 3:34 p.m. indicated the resident was assisted to the floor by facility staff as therapy staff observed the resident "low in her chair." It indicated, "Res[ident] is a very large woman, she was to [sic] low in the chair, so the best thing to do was to lower her to the floor. With the help of 4 staff members she was lowered to the floor, so we could get her back into the bed. Res. was a/o [alert and oriented] able to make needs known. No c/o [complaint of] pain, no SOB [shortness of breath], full assessment was done."</p> <p>A nursing progress note, dated 2-12-16 at 6:21 a.m. indicated during an assisted</p>		<p>have a thorough investigation completed at the time of the event by the licensed nurse at the time of the event and then reviewed by the Interdisciplinary Team (IDT) in the Clinical morning meeting Monday through Friday for causal factors to ensure appropriate interventions are implemented. The Executive Director, Director of Nursing and the clinical staff, including therapy, have been educated on the definition of a fall and that an assisted fall does meet the definition of a fall and an investigation must be completed at the time of the event to determine causal factors and implementation of appropriate interventions to potentially prevent a future event. The resident's careplan and aide assignment sheet will be updated accordingly. Any assisted fall related event will be reviewed in the clinical morning meeting Monday through Friday by the IDT for appropriate interventions. The Director of Nursing/designee will report to the monthly Performance Improvement Committee the tracking and trending of any assisted fall related events indefinitely. It will remain a standing agenda item.</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>transfer with two staff, the resident's right knee "buckled and pt [patient] was unable to stand and bear wt [weight] and staff was unable to keep holding her up. Pt. was lowered to ground in a purposeful and controlled movement and then staff put pt in bed. Pt. did not receive any injuries or complaints [sic]."</p> <p>In an interview with the Executive Director (ED) and the Director of Nursing (DON) on 4-13-16 at 2:30 p.m., the ED indicated it was her understanding that if a resident was assisted to the floor, that was not considered a fall as the event was a controlled event, and as a result, this would not require the event to be investigated as a fall, nor treated as a fall which would require the typical fall investigation and notifications to the physician and family. The DON indicated this information was verified with the Corporate Nurse. The ED indicated all staff have been trained that an "assist to the floor" does not constitute a fall. The DON indicated the facility did not conduct a formal investigation into either event in regards to issues that may have contributed to the event; however, she indicated her medications had been reviewed at great length related to her chronic pain and other medical issues.</p> <p>On 4-6-16 at 10:23 a.m., the ED provided</p>			

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	<p>a copy of a policy, entitled, "Accidents and Supervision to Prevent Accidents." This policy had a revision date of 4-28-11 and was indicated to the current policy utilized by the facility. This policy indicated, "The center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents. This includes systems and processes designed to identify hazards and risks; evaluate and analyze hazards and risks; implement interventions to reduce hazards and risks and monitor of effectiveness and modify approaches when necessary...Falls. Center evaluates the causal factors leading to a patient fall to help support relevant and consistent interventions to try to prevent future occurrences. Proper actions following a fall include: Ascertaining if there were injuries, and providing treatment as necessary; Determining what may have caused or contributed to the fall; Addressing the factors for the fall; Revising the patient's plan of care and/or center practices, as needed to reduce the likelihood of another fall.</p> <p>On 4-13-16 at 3:50 p.m., the ED provided a copy of a policy, entitled, "Resident Event Response." This policy</p>			

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	had a date of 5-15-03 and was indicated to the current policy utilized by the facility. This policy indicated, "Adverse events involving a resident are investigated immediately, corrected as soon as possible after the event, and reported as required..." The accompanying procedure for this policy indicated, "Investigate the cause of the event immediately after emergency care has been given and the resident's condition is stabilized. Assess the resident's risk for future events of the same nature." An example provided included to utilize a "Fall Risk Assessment." "Determine root causes of the event, including, but not limited to: The resident's condition/disease process, Side effects of medication or treatment, Performance failures on the part of a person or entity (resident, staff, visitor, or vendor), Equipment failure, or, Environmental factors. Plan and implement corrective action. Update care plan interventions to address the resident's risks and event outcomes, based on the investigation and risk assessment. Refer equipment failures or environmental hazards to the appropriate department heads for immediate correction...Report the incident to the interdisciplinary team at daily (Monday through Friday) morning meetings, including: Reason for the event,			

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	Preventive interventions, plan of care related to the event and Methods of communicating the plan to caregivers..." This Federal tag relates to Complaint IN00195912 and Complaint IN00197343. 3.1-45(a)(1) 3.1-45(a)(2)				