

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/13/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
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F0000	<p>This visit was for Investigation of Complaint IN00109195.</p> <p>Complaint: IN00109195- Substantiated, Federal/State deficiencies related to the allegations are cited at F157 and F309.</p> <p>Unrelated deficiencies cited.</p> <p>Survey dates: June 11 & 13, 2012</p> <p>Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930</p> <p>Survey Team: Mary Jane G. Fischer, RN</p> <p>Census Bed Type: SNF/NF: 105 Total: 105</p> <p>Census Payor Type: Medicare: 43 Medicaid: 37 Other: 25 Total: 105</p> <p>Sample: 6</p> <p>These deficiencies reflect state findings</p>	F0000	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on June 11th-13th 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated committment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request.</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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	cited in accordance with 410 IAC 16.2 Quality review completed on June 19, 2012 by Bev Faulkner, RN				

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F0157 SS=D	<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, 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 record review and interview, the facility failed to ensure the physician or interested family member was notified when a resident began to exhibit tremors and change in level of consciousness</p>	F0157	Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on June 11th-13th 2012. The facility respectfully requests a desk review of our plan of	07/09/2012			

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	<p>(Resident "A") and failed to notify the physician as ordered when a resident exhibited blood glucose reading of 45 (Resident "C"). The affected 2 of 6 residents reviewed for notification and change of condition.</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-11-12 at 11:00 a.m. Diagnoses included but were not limited to recent cerebral vascular accident, diabetes mellitus, left sided paralysis, hypertension, atrial fibrillation, obesity, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>Review of the Nurses Notes indicated the following:</p> <p>"05-11-12 [4:00 p.m.]," indicated the resident was admitted to the facility, accompanied by family. The resident was assessed as "A & O [alert and oriented] pleasant et [and] cooperative ... had a CVA [cerebral vascular accident] affecting left side, leaving [resident] requiring extensive assistance with ADL's [activities of daily living]."</p> <p>"05-14-12 [documented as a late entry] 6 [a.m.] to 2 [p.m.]," indicated the resident</p>		<p>correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure the physician or interested family member to be notified when a resident has a change of condition. 1. Resident A no longer at facility. Resident C was immediately assessed and no concerns identified. The physician and family were notified of accucheck results that were outside of parameters on 6/5/12 occurrence. Although no notification was done on 6/5/12, upon review Physician and family were notified 6/4/12 and 6/6/12 when accucheck was outside call parameters. The Director of Nursing and/or designee will monitor resident daily and review chart, and accucheck flowsheets during clinical meeting to ensure any changes and necessary notifications have been made to help ensure continued compliance. 2. The Director of Nursing and Assistant Director of nursing reviewed current residents receiving accuchecks to ensure notification to physician and family have been made when accuchecks are outside call parameters. No trends were identified. The Nurse for resident C has been counseled and</p>				

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	<p>now appeared "alert to self and others. Forgetful of name of place and time. Unable to obtain BP [blood pressure] HR [heart rate] 102, temp. [temperature] 99.2, O2 [oxygen] 94 %. Resp. [respirations] even and unlabored."</p> <p>"05-15-12 6 [a.m.] to 2 [p.m.] Resp. even and unlabored."</p> <p>"05-16-12 [documented as a late entry for 05-15-12 at 5:30 p.m.] ... attempted to assist resident with eating d/t [due to] tremors in BUE [bilateral upper extremities], family at bedside ... resp. even non - labored, lungs clear." The Nurse Report Sheet for 05-15-12 also indicated the resident had "bilateral upper tremors."</p> <p>"05-16-12 [documented as late entry for 05-15-12] Nsg. [nursing] Resident RIB [remains in bed] at this time with eyes closed. Resp. even non labored. Resident without s/sx [signs or symptoms] distress <sic>... ."</p> <p>"05-16-12 4:00 a.m. - Resident in bed when the CNA [Certified Nurses Aide] informed the charge nurse that resident was shaking hard. Oxygen level 89 %. Resident put on oxygen at 3 L [liters] and 96 % O2 [oxygen] sat. [saturation] achieved. Heart rate at 94. Temp at 99.4.</p>		<p>individually inserviced regarding proper documentation on accucheck flow sheets and physician/family notification when accucheck results are outside call parameters.3. The Staff Development Coordinator re-inserviced staff on 6/12, 6/13, 6/26, and 6/27 to ensure notification of family and physician with resident change in condition and notification of physican /family when accucheck/blood glucose results are outside call paramaters. The Director of Nursing and/or designee will review medication administration records and new orders five times a week to ensure accurate and timely documentation and notifications when necessary have been made to help ensure continued compliance. The systemic changes made, all blank orders have been updated to include physician and family notification line added, orders are then reviewed during daily clinical meeting. Any nurse found to be non compliant will be held accountable and educated /counseled as this will not be tolerated at this facility to help ensure physician and family notification are being done timely. 4. The Director of Nursing and/or designee will review 10% of current residents for 100% compliance related to physican and family notification thru medication administration</p>				

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	<p>Unable to get BP [blood pressure] at this time. Tried later - noted error." Resident stabilized on [sic] 96% oxygen sat. Resident checked every 30 minutes by nurse [illegible word] CNA that went in at interval for patient care. By 6:10 a.m. CNA called me into the room and resident in distress for air/oxygen ? [sic] Crash cart brought in, liquid oxygen and help sought from other nurse. Resident oxygen increased to 15 liters and 911 called. Resident breathing though labored at this time."</p> <p>During interview on 06-11-12 at 12:00 p.m., an interested family member expressed concern that [resident] began to "shake, like [resident] was real cold. On Tuesday [05-15-12] [resident] shook during my entire visit. The nurse took her blood sugar and it was 186 or 187, but she couldn't get a blood pressure because [resident] was shaking so badly. The nurse said the doctor would check [resident] the next day. I don't know why they didn't call the doctor. Then when [resident] got bad during the night and required oxygen at 4:00 a.m. they didn't call me either."</p> <p>The concerns related to Resident "A" were shared with the Assistant Director of Nurses and Executive Director during the Daily Exit conference on 06-11-12 at 1:00</p>		record and any new orders reveiwed for the 10% residents audited in monthly Quality Assurance meeting for the next three months and quarterly thereafter to ensure and monitor quality compliance.				

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	<p>p.m., in regard to the nursing documentation, the concern of a resident with tremors, a significant change in condition with eventual decline on 05-16-12 and lack of physician notification.</p> <p>During interview on 06-13-12 at 9:30 a.m., the Assistant Director of Nurses indicated "After this happened the family came in to talk with us."</p> <p>The Assistant Director of Nurses indicated once she reviewed the resident record she found that the nurse had not documented the resident's condition not only for the late entries, but another nurse did not provide full documentation of the details the morning of 05-16-12. "I had the nurse come in and document as late entries. After I read what she wrote is when I found out about the resident. What we found was the nurses were documenting for the full shift and just writing like 6 [a.m.] to 2 [p.m.]. They never wrote the exact time of an occurrence. We already had an Inservice scheduled, but after this we decided to include change in condition and physician notification for the nursing staff."</p> <p>When interviewed at the time of the Exit Conference on 06-13-12 at 3:15 p.m., the Executive Director and Assistant Director</p>						

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	<p>of Nurses indicated they were unable to provided further documentation related to Resident "A."</p> <p>2. The record for Resident "C" was reviewed on 06-13-12 at 11:15 a.m. Diagnoses included but were not limited to hypoglycemia, altered mental status, hypoxia, hyperglycemia, congestive heart failure, and insulin dependent diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 05-21-12, for sliding scale insulin with Accuchecks [a method to check a resident's blood sugar level] four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The orders instructed the nursing staff to call the doctor if the Accucheck was less than 70 or greater than 350.</p> <p>In addition the resident received scheduled insulin at 8:00 a.m., of Humulin 70/30- 35 units subcutaneous before breakfast, and at 5:00 p.m. Humulin 70/30- 20 units subcutaneous before dinner.</p> <p>Review of the nurses notes, dated 06-05-12 at 8:00 p.m., indicated the resident was A/O [alert and oriented] times three - blood sugar 45. Res.</p>			

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	<p>[illegible word] no s/s [signs or symptoms] of decreased BS [blood sugar]. Res. given OJ [orange juice] times 2, BS increased to 65 then drank Ensure and BS increased to 85."</p> <p>During the Exit Conference on 06-13-12 at 3:00 p.m., the Assistant Director of Nurses verified the nurse should have documented the original reading of 45, notified the physician, and then documented the subsequent readings of the resident's blood sugars until the blood sugar reached 85, which would not have required physician notification.</p> <p>The nursing staff failed to notify the physician of the resident's decreased blood sugar, the intervention the nursing staff provided to the resident and further monitoring of the resident.</p> <p>3. Review of facility policy on 06-13-12 at 8:30 a.m., titled "Notifications," and dated 10-31-07 indicated the following:</p> <p>"Policy [bold type] - Staff informs the resident, consults with their attending physician, and notified the resident's surrogates when:</p> <p>* A significant change occurs in the resident's physical, mental or psychosocial status;</p>						

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	<p>* Treatment needs to be altered significantly; or</p> <p>* A decision is reached to transfer or discharge the resident from the center."</p> <p>4. Review of facility policy on 06-13-12 at 8:30 a.m., titled "Condition Change of a Resident," dated 10-31-06 indicated the following:</p> <p>"Rationale [bold type] Resident change of condition is identified for proper treatment implementation. The physician is informed of resident events and/or change in resident's condition."</p> <p>"Definitions [bold type] Immediate Notification [underscored] - the physician should be informed at the time the event occurs either directly or by pager."</p> <p>"Non-Immediate Notification [underscored] - The physician should be informed of the problem or event during office hours and generally no later than the next regular office day. The nurse should not hesitate to contact the physician at any time for a problem that in their judgment requires immediate medical attention."</p> <p>5. Review of the Kindred "Guidelines for</p>						

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	<p>Physician Notification of Change of Condition/Clinical Problems in Center Residents," on 06-13-12 at 2:30 p.m., and dated 03-11-11, indicated the following guidelines:</p> <p>"Item - Complaint, medical by family or resident. Immediate (High Alert - within 1 hour). Demand to speak to a physician or have a medical assessment without delay."</p> <p>"Diabetes, poorly controlled. Immediate (High Alert - within 1 hour). Any diabetic with altered mental status, LOC [loss of consciousness] or acute infections OR Hypoglycemia episode in someone on hypoglycemic medication or not responding to additional glucose."</p> <p>"Dyspnea. Immediate (High Alert - within 1 hour). Acute onset of change from usual pattern, OR With chest pain, labored respirations, or unstable vital signs, OR Recent intermittent change form usual pattern OR Only partial response to usual treatment regimen."</p> <p>"Glucose. Immediate (High Alert - within 1 hour). Any high or low blood sugar accompanied by persistent change from usual LOC, function, or responsiveness, OR Less than 70 mg [milligram] / dL [deciliter] in a diabetic resident."</p>				

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	<p>"Respiratory Rate. Immediate (High Alert - within 1 hour). Any increase in rate with dyspnea, pain, fever or respiratory distress."</p> <p>"Shortness of breath (dyspnea). Immediate (High Alert - within 1 hour). Abrupt onset of SOB [shortness of breath] with pain, fever or respiratory distress."</p> <p>This Federal tag relates to Complaint IN00109195.</p> <p>3.1-5(a)(2) 3.1-5(a)(3) 3.1-5(a)(4)</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>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 record review and interview, the facility failed to ensure a physician order was followed for 2 of 2 residents who had physician orders related to glucose monitoring (Accuchecks) and/or insulin coverage in a sample of 6. [Residents "A" and "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-11-12 at 11:00 a.m. Diagnoses included but were not limited to recent cerebral vascular accident, diabetes mellitus, left sided paralysis, hypertension, atrial fibrillation, obesity, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders for Glipizide [an oral diabetic medication] 10 mg at 8:00 a.m., and 5 mg at 5:00 p.m. daily for diabetes mellitus. The resident also had admission physician orders for Accuchecks [a method to check a resident's blood sugar level] TID [three times a day] and PRN [as needed] with</p>	F0282	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on June 11th-13th 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure physician orders are followed. 1. Resident A no longer resides at facility. Resident C was immediately assessed and no concerns identified. The Director of Nursing and/or designee will monitor resident daily and review medication administration record and accucheck flowsheets during clinical meeting to ensure any changes and necessary notifications have been made and that accucheck results have been recorded appropriately. 2. The Director of Nursing and Assistant Director of nursing reviewed current residents receiving accuchecks to ensure compliance with recording accucheck results. No trends</p>	07/09/2012			

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	<p>sliding scale insulin coverage of no treatment if the resident's blood sugar was 0 - 200. However, if the resident's blood sugar was 201 - 250 the nurse was instructed to administer 2 units of insulin, 251 - 300 4 units of insulin, 301 - 350 6 units of insulin and to notify the physician if the Accuchecks was less than 70 or greater than 350.</p> <p>Review of the "Accucheck/Sliding Scale Record" for May 2012 indicated the resident's blood sugar was 202 on 05-13-12 at 4:00 p.m. The record lacked documentation the resident received the insulin coverage as indicated in the physician orders.</p> <p>During a review of the resident's "Accucheck/Sliding Scale Record," on 06-13-12 at 2:00 p.m., the Assistant Director of Nurses verified the resident should have received the insulin as ordered by the physician.</p> <p>2. The record for Resident "C" was reviewed on 06-13-12 at 11:15 a.m. Diagnoses included but were not limited to hypoglycemia, altered mental status, hypoxia, hyperglycemia, congestive heart failure, and insulin dependent diabetes mellitus. These diagnoses remained current at the time of the record review.</p>		<p>were identified. The Nurse for resident C has been counseled and individually inserviced regarding proper documentation on accucheck flow sheets and physician/family notification when accucheck results are outside call parameters.3. The Staff Development Coordinator re-inserviced staff on 6/12, 6/13, 6/26, and 6/27 to ensure appropriate documentation is completed daily. The Director of Nursing and/or designee will review medication administration records, accucheck flowsheets and new orders five times a week to ensure accurate and timely documentation to help ensure continued compliance.4. The Director of Nursing and/or designee will review 10% of current residents for 100% compliance related to physician orders are being followed thru medication administration records, accucheck flowsheets and new orders for the 10% of current residents audited in monthly Quality Assurance meeting for the next three months and quarterly thereafter to ensure and monitor quality compliance.</p>				

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	<p>The resident had physician orders, dated 05-21-12, for sliding scale insulin with Accuchecks four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The orders instructed the nursing staff to call the doctor if the Accucheck was less than 70 or greater than 350.</p> <p>In addition the resident received scheduled insulin at 8:00 a.m., of Humulin 70/30- 35 units subcutaneous before breakfast, and at 5:00 p.m. Humulin 70/30- 20 units subcutaneous before dinner.</p> <p>In addition, review of the "Accucheck/Sliding Scale Record," for the month of May 2012, also lacked an Accucheck for 8:00 p.m. on 05-24-12.</p> <p>During the Exit Conference on 06-13-12 at 3:00 p.m., the Assistant Director of Nurses verified the nurse should have documented the original reading of 45, notified the physician, and then documented the subsequent readings of the resident's blood sugars until the blood sugar reached 85, which would not have required physician notification.</p> <p>3.1-35(g)(2)</p>			

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F0309 SS=D	<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 psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to provide nursing care in regard to a full and comprehensive assessment and ongoing monitoring of a resident's condition, in that when resident's condition changed or declined the nursing staff failed to implement nursing measures and provide further intervention as needed for 2 of 6 residents sampled for nursing assessments and change in condition. [Resident's "A" and "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-11-12 at 11:00 a.m. Diagnoses included but were not limited to recent cerebral vascular accident, diabetes mellitus, left sided paralysis, hypertension, atrial fibrillation, obesity, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>Review of the Nurses notes dated</p>	F0309	Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on June 11th-13th 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure and provide nursing care in regards to a full and comprehensive assessment and ongoing monitoring of a resident's condition. 1. Resident A no longer at facility. Resident C was immediately assessed and no concerns identified. The physician and family were notified of accucheck results that were outside of parameters on 6/5/12 occurrence. Although no notification was done on 6/5/12, upon review Physician and family were notified 6/4/12 and 6/6/12 when accucheck was outside call parameters. The Director of	07/09/2012			

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	<p>"05-11-12 [4:00 p.m.]," indicated the resident was admitted to the facility, accompanied by family. The resident was assessed as "A & O [alert and oriented] pleasant et [and] cooperative ... had a CVA [cerebral vascular accident] affecting left side, leaving [resident] requiring extensive assistance with ADL's [activities of daily living]." The admission vital signs documented on the "96 hour vital sign" record indicated the resident's blood pressure was 127/90, pulse 97, temperature 98 and oxygen saturation level at 94%.</p> <p>Review of the Occupational and Physical Therapy Evaluation data, dated 05-12-12, indicated the resident had a "defibrillator - no modalities." During interview on 06-13-12 at 2:20 p.m., the Therapist employee #17 indicated "When I did my assessment, actually I did it in the dining room, [name of resident] told me [resident] had one."</p> <p>Further review of the nurses notes indicated: "05-14-12 [documented as a late entry] 6 [a.m.] to 2 [p.m.]," indicated the resident now appeared "alert to self and others. Forgetful of name of place and time. Unable to obtain BP [blood pressure] HR [heart rate] 102, temp. [temperature] 99.2, O2 [oxygen] 94 %. Resp. [respirations]</p>		<p>Nursing and/or designee will monitor resident daily, review chart, and accucheck flowsheets during clinical meeting to ensure any changes, continued monitoring and necessary notifications have been made to help ensure continued compliance.2. The Director of Nursing and Assistant Director of nursing reviewed current residents receiving accuchecks to ensure monitoring, notification to physician and family have been made when accuchecks are outside call parameters. No trends were identified. The Nurse for resident C has been counseled and individually inserviced regarding monitoring of a resident, proper documentation on accucheck flow sheets and physician/family notification when accucheck results are outside call parameters.3. The Staff Development Coordinator re-inserviced staff on 6/12, 6/13, 6/26, and 6/27 to ensure proper resident monitoring, notification of family and physician with resident change in condition and notification of physician /family when accucheck/blood glucose results are outside call parameters. The Director of Nursing and/or designee will review medication administration records and new orders five times a week to ensure accurate and timely documentation and notifications when necessary</p>	

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	<p>even and unlabored."</p> <p>"05-15-12 6 [a.m.] to 2 [p.m.] Resp. even and unlabored."</p> <p>"05-16-12 [documented as a late entry for 05-15-12 at 5:30 p.m.] ... attempted to assist resident with eating d/t [due to] tremors in BUE [bilateral upper extremities], family at bedside ... resp. even non - labored, lungs clear."</p> <p>"05-16-12 [documented as late entry for 05-15-12] Nsg. [nursing] Resident RIB [remains in bed] at this time with eyes closed. Resp. even non labored. Resident without s/sx [signs or symptoms] distress [sic]... "</p> <p>"05-16-12 4:00 a.m. - Resident in bed when the CNA [Certified Nurses Aide] informed the charge nurse that resident was shaking hard. Oxygen level 89 %. Resident put on oxygen at 3 L [liters] and 96 % O2 [oxygen] sat. [saturation] achieved. Heart rate at 94. Temp at 99.4. Unable to get BP [blood pressure] at this time. Tried later - noted error." Resident stabilized on [sic] 96% oxygen sat. Resident checked every 30 minutes by nurse [illegible word] CNA that went in at interval for patient care. By 6:10 a.m. CNA called me into the room and resident in distress for air/oxygen ? Crash</p>		<p>have been made to help ensure continued compliance.4. The Director of Nursing and/or designee will review 10% of current residents for 100% compliance related to proper resident monitoring of a resident's condition thru medication administration records, new orders and flowsheets recieved for the 10% residents audited in monthly Quality Assurance meeting for the next three months and quarterly thereafter to ensure and monitor quality compliance.</p>				

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	<p>cart brought in, liquid oxygen and help sought from other nurse. Resident oxygen increased to 15 liters and 911 called. Resident breathing though labored at this time."</p> <p>The record indicated the Emergency Medical Technicians arrived at the facility, assessed the resident with pulseless electrical activity, intubated the resident and transported the resident to the hospital Emergency Department, where the resident was pronounced deceased upon arrival.</p> <p>Review of the Emergency Department documentation - patient care record, dated 05-16-12, indicated "Per ECF [Extended Care Facility] provider and EMS [Emergency Medical Services] patient with decreased LOC [level of consciousness] and low O2 Sat [saturation] change since early this A.M."</p> <p>During interview on 06-11-12 at 12:00 p.m., an interested family member expressed concern that [resident] began to "shake, like [resident] was real cold. On Tuesday [05-15-12] [resident] shook during my entire visit. The nurse took her blood sugar and it was 186 or 187, but she couldn't get a blood pressure because [resident] was shaking so badly. The nurse said the doctor would check</p>				

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	<p>[resident] the next day. I don't know why they didn't call the doctor."</p> <p>Interview on 06-13-12 at 1:15 p.m., Licensed Practical Nurse employee #14 indicated "if you can't get a blood pressure with the electronic blood pressure cuff, we go to the old fashion way and use the manual [in regard to a manual blood pressure cuff]."</p> <p>Interview on 06-13-12 at 2:25 p.m. Licensed Practical Nurse employee #12 indicated "If I can't get it [in regard to a resident's blood pressure] I use a manual cuff, that's why I carry my own."</p> <p>Interview on 06-13-12 at 2:45 p.m., the Staff Development Coordinator indicated "The nurses are instructed during orientation to use the Dinamap, but if they are unable to get a resident's blood pressure they are taught to use the manual cuff and they're available on the Units."</p> <p>2. Review of facility policy on 06-13-12 at 2:10 p.m., titled "Oxygen Administration," and dated 08-31-11, indicated the following:</p> <p>"Rationale [bold type] Administer oxygen when a patient has an insufficient amount of oxygen."</p>			

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	<p>"Procedure - 32.) Leave patient in comfortable position with call light within reach. 35.) At regular intervals, check liter flow, fluid level in humidifier and assess the patient's respiratory status for adequate oxygenation."</p> <p>"Documentation Guidelines - 1. Date, time, method of administration and liter flow."</p> <p>"2. Patient's response, as related to the initiation of oxygen therapy and as needed there on: a.) Effectiveness of oxygen therapy, b.) Vital signs before and after therapy."</p> <p>"3. Adverse effects noted, as well as: a 2.) Decreased level of consciousness, confusion, drowsiness, altered concentration, a 3.) Increased pulse rate, a 4.) Increased rate and depth of respiration or irregular respiratory patterns, a 5.) Decreased lung sounds, adventitious lung sounds, a 6.) Elevated blood pressure evolving to decreased blood pressure, a 7.) Dyspnea, a 8.) Use of accessory muscles of respiration, rib retractions, a 9.) Pallor, cyanosis, a 10.) Increased fatigue,</p>			

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	<p>a 11.) Dizziness."</p> <p>"3 b.) Date and time of physician notification, d.) Nursing interventions."</p> <p>"4.) Notification of family member/responsible party of any adverse effects noted."</p> <p>3. The record for Resident "C" was reviewed on 06-13-12 at 11:15 a.m. Diagnoses included but were not limited to hypoglycemia, altered mental status, hypoxia, hyperglycemia, congestive heart failure, and insulin dependent diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 05-21-12, for sliding scale insulin with Accuchecks [a method to check a resident's blood sugar level] four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The orders instructed the nursing staff to call the doctor if the Accucheck was less than 70 or greater than 350.</p> <p>In addition, the resident received scheduled insulin at 8:00 a.m., of Humulin 70/30- 35 units subcutaneous before breakfast, and at 5:00 p.m. Humulin 70/30- 20 units subcutaneous before dinner.</p>			

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	<p>Review of the nurses notes, dated 06-05-12 at 8:00 p.m., indicated the resident was A/O [alert and oriented] times three - blood sugar 45. Res. [illegible word] no s/s [signs or symptoms] of decreased BS [blood sugar]. Res. given OJ [orange juice] times 2, BS increased to 65 then drank Ensure and BS increased to 85."</p> <p>The nursing staff failed to notify the physician of the resident's decreased blood sugar, the intervention the nursing staff provided to the resident and further monitoring of the resident.</p> <p>During the Exit Conference on 06-13-12 at 3:00 p.m., the Assistant Director of Nurses verified the nurse should have documented the original reading of 45, notified the physician, and then documented the subsequent readings of the resident's blood sugars until the blood sugar reached 85, which would not have required physician notification.</p> <p>4. Review of facility policy on 06-13-12 at 8:30 a.m., titled "Condition Change of a Resident," dated 10-31-06 indicated the following:</p> <p>"Rationale [bold type] Resident change of condition is identified for proper</p>			

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	<p>treatment implementation. The physician is informed of resident events and/or change in resident's condition."</p> <p>"Definitions [bold type] Immediate Notification [underscored] - the physician should be informed at the time the event occurs either directly or by pager."</p> <p>"Non-Immediate Notification [underscored] - The physician should be informed of the problem or event during office hours and generally no later than the next regular office day. The nurse should not hesitate to contact the physician at any time for a problem that in their judgment requires immediate medical attention."</p> <p>5. Review of the Kindred "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents on 06-13-12 at 2:30 p.m., and dated 03-11-11, indicated the following guidelines:</p> <p>"Item - Complaint, medical by family or resident. Immediate (High Alert - within 1 hour). Demand to speak to a physician or have a medical assessment without delay."</p> <p>"Diabetes, poorly controlled. Immediate (High Alert - within 1 hour). Any</p>			

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	<p>diabetic with altered mental status, LOC [loss of consciousness] or acute infections OR Hypoglycemia episode in someone on hypoglycemic medication or not responding to additional glucose."</p> <p>"Dyspnea. Immediate (High Alert - within 1 hour). Acute onset of change from usual pattern, OR With chest pain, labored respirations, or unstable vital signs, OR Recent intermittent change form usual pattern OR Only partial response to usual treatment regimen."</p> <p>"Glucose. Immediate (High Alert - within 1 hour). Any high or low blood sugar accompanied by persistent change from usual LOC, function, or responsiveness, OR Less than 70 mg [milligram] / dL [deciliter] in a diabetic resident."</p> <p>"Respiratory Rate. Immediate (High Alert - within 1 hour). Any increase in rate with dyspnea, pain, fever or respiratory distress."</p> <p>"Shortness of breath (dyspnea). Immediate (High Alert - within 1 hour). Abrupt onset of SOB [shortness of breath] with pain, fever or respiratory distress."</p> <p>This Federal tag relates to Complaint IN00109195.</p>			

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F0329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on record review and interview, the facility failed to ensure adequate monitoring of a medication, in that when a resident received anticoagulation therapy, which required laboratory testing for therapeutic levels, the facility failed to ensure the resident received the laboratory test, and continued to administer the medication for 1 of 3 residents who received anticoagulation therapy in a sample of 6. [Resident "A"].</p> <p>Findings include:</p>	F0329	Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on June 11th-13th 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure that appropriate lab levels will be obtained and	07/09/2012

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK				STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254			
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	<p>The record for Resident "A" was reviewed on 06-11-12 at 11:00 a.m. Diagnoses included but were not limited to recent cerebral vascular accident, diabetes mellitus, left sided paralysis, hypertension, atrial fibrillation, obesity, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>The resident was admitted to the facility on 05-11-12, a Friday afternoon at "4:00 p.m. from the home setting" with a "Patient Medication List," noted as "updated" on "05-04-12."</p> <p>The admission orders [from a local area hospital home health care service] indicated the resident received anticoagulation therapy [Warfarin] and while at home had "erratic INR [International Normalized Ratio] and the last INR was 1.7." INR is a blood test for monitoring warfarin.</p> <p>The orders were verified with the physician office on 05-11-12 and transcribed by Licensed Nurse employee #12, who made a handwritten notation for "PT/INR times 1 on Monday (05-14)."</p> <p>Physician orders at the time of admission included "Warfarin [an anticoagulant] 5</p>		<p>evaluated when required.1. Resident A longer at facility.2. All current residents who are currently recieving anticoagulant medication were reviewed by Director of Nursing and Assistant Director of Nursing to make sure appropriate lab monitoring was in place. All new admission's charts are reviewed upon admission in daily a.m clinical meeting to ensure proper orders are present to monitor lab values, and if not baseline labs ordered immediately.3. The Staff Development Coordinator re-inserviced staff on 6/12, 6/13, 6/26 and 6/27 on compliance with residents having appropriate labs ordered on admit and throughout stay, thus ensuring staff and physician can affectively monitor lab levels to identify any abnormal results. Assitant Director of Nursing maintains lab binder of current residents and each unit manager maintains lab logs of residents on their units respectively. Assistant Director of Nursing and Unit Managers meet during a.m clincial meeting and compare lab logs to ensure all labs have been drawn as ordered and notifications have been made.4. The Director of Nursing and/or designee will review 10% of current residents for 100% compliance related to ordered labs for the 10% residents audited in monthly quality assurance meeting for the next three months and quarterly</p>				

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	<p>mg [milligrams] every Mon. [Monday], Wed. [Wednesday] and Fri. [Friday] and 2.5 mg every Tues. [Tuesday], Thurs. [Thursday], Sat. [Saturday] and Sun. [Sunday] by mouth at 17:00 [5:00 p.m.] for an INR goal of 2 - 3."</p> <p>The Nurse Practitioner came in to the facility on Monday (05-14), reviewed the orders and ordered additional labs including the PT/INR. The facility then scheduled the labs for the following Monday (05-21).</p> <p>Review of the Medication Administration Record for May 2012, indicated the resident received the Warfarin as ordered on 05-12, 05-13, 05-14 and 05-15.</p> <p>The record lacked documentation the blood work was ordered as directed.</p> <p>During interview on 06-13-12 at 9:30 a.m., the Assistant Director of Nurses indicated an additional physician order was received on 05-14-12 for the blood work, but the specimen had not been obtained and was scheduled for the following week as it was thought to be routine.</p> <p>The resident received the anticoagulation therapy without adequate monitoring.</p>		thereafter to ensure and monitor quality compliance.		

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	3.1-48(a)(3)				

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCE SSIBLE 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 record review and interview, the facility failed to ensure complete and accurate clinical records for 2 of 6 sampled residents. [Residents "A" and "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "A" was reviewed on 06-11-12 at 11:00 a.m. Diagnoses included but were not limited to recent cerebral vascular accident, diabetes mellitus, left sided paralysis, hypertension, atrial fibrillation, obesity, and congestive heart failure. These diagnoses remained current at the time of the record review.</p> <p>Review of the Occupational and Physical Therapy Evaluation data, dated 05-12-12, indicated the resident had a "defibrillator -</p>	F0514	<p>Enclosed, please find our plan of correction for the deficiencies as identified during the complaint survey on June 11th-13th 2012. The facility respectfully requests a desk review of our plan of correction. We believe that historically we have demonstrated commitment to our plans of correction and that we have delivered consistent quality outcomes. We would appreciate your consideration of this request. It is the practice of this facility to ensure clinical records are complete and accurate. 1. Resident A no longer resides at facility. Resident C was immediately assessed and no concerns identified. The Director of Nursing and/or designee will monitor resident daily and review medication administration record and accucheck flowsheets during clinical meeting to ensure any changes and necessary</p>	07/09/2012

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	<p>no modalities."</p> <p>During interview on 06-13-12 at 2:20 p.m., the Therapist employee #17 indicated "When I did my assessment, actually I did it in the dining room, [name of resident] told me [resident] had one." The record lacked communication between the therapy department and the nursing department in regard to the resident's defibrillator in order to have a complete and accurate clinical record for the resident.</p> <p>The resident had physician orders for Glipizide [an oral diabetic medication] 10 mg at 8:00 a.m., and 5 mg at 5:00 p.m. daily for diabetes mellitus. The resident also had admission physician orders for Accuchecks [a method to check a resident's blood sugar level] TID [three times a day] and PRN [as needed] with sliding scale insulin coverage of no treatment if the resident's blood sugar was 0 - 200. However if the resident's blood sugar was 201 - 250 the nurse was instructed to administer 2 units of insulin, 251 - 300 4 units of insulin, 301 - 350 6 units of insulin and to notify the physician if the Accucheck was less than 70 or greater than 350.</p> <p>Review of the "Accucheck/Sliding Scale Record" for May 2012 indicated the</p>		<p>notifications have been made and that accucheck results have been recorded appropriately.2. The Director of Nursing and Assistant Director of nursing reviewed current residents receiving accuchecks to ensure compliance with recording accucheck results. No trends were identified. The Nurse for resident C has been counseled and individually inserviced regarding proper documentation on accucheck flow sheets and physician/family notification when accucheck results are outside call parameters.3. The Staff Development Coordinator re-inserviced staff on 6/12, 6/13, 6/26, and 6/27 to ensure appropriate documentation is completed daily. The Director of Nursing and/or designee will review medication administration records, accucheck flowsheets and new orders five times a week to ensure accurate and timely documentation to help ensure continued compliance.4. The Director of Nursing and/or designee will review 10% of current residents for 100% compliance related to clinical records on accucheck flowsheet are complete and accurate for the 10% residents audited in monthly Quality Assurance meeting for the next three months and quarterly thereafter to ensure and monitor quality compliance.</p>				

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	<p>resident's blood sugar was 202 on 05-13-12 at 4:00 p.m. The record lacked documentation the resident received the insulin coverage.</p> <p>Review of the resident's record on 06-13-12 at 2:00 p.m., the Assistant Director of Nurses verified the resident should have received and the nurse should have documented the resident received the insulin as ordered.</p> <p>2. The record for Resident "C" was reviewed on 06-13-12 at 11:15 a.m. Diagnoses included but were not limited to hypoglycemia, altered mental status, hypoxia, hyperglycemia, congestive heart failure, and insulin dependent diabetes mellitus. These diagnoses remained current at the time of the record review.</p> <p>The resident had physician orders, dated 05-21-12, for sliding scale insulin with Accuchecks four times a day at 6:00 a.m., 11:00 a.m., 4:00 p.m. and 8:00 p.m. The orders instructed the nursing staff to call the doctor if the Accucheck was less than 70 or greater than 350.</p> <p>In addition the resident received scheduled insulin at 8:00 a.m., of Humulin 70/30- 35 units subcutaneous before breakfast, and at 5:00 p.m. Humulin 70/30- 20 units subcutaneous</p>			

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	<p>before dinner.</p> <p>Review of the nurses notes, dated 06-05-12 at 8:00 p.m., indicated the resident was A/O [alert and oriented] times three - blood sugar 45. Res. [illegible word] no s/s [signs or symptoms] of decreased BS [blood sugar]. Res. given OJ [orange juice] times 2, BS increased to 65 the drank Ensure and BS increased to 85."</p> <p>Review of the Accucheck/Sliding Scale Record for June 2012 and specifically, dated 06-05-12, indicated the resident's blood sugar after treatment [85] rather than the original reading of 45 with subsequent documentation after the nurse provided intervention.</p> <p>In addition the "Accucheck/Sliding Scale Record" for May 2012 lacked an Accucheck for 8:00 p.m. on 05-24-12.</p> <p>During the Exit Conference on 06-13-12 at 3:00 p.m., the Assistant Director of Nurses verified the nurse should have documented the original reading of 45, notified the physician, and then documented the subsequent readings of the resident's blood sugars until the blood sugar reached 85.</p> <p>3.1-50(a)(1)</p>						

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