STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155657		11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00185679, IN00185690 and IN00185975. Complaint IN00185679 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Complaint IN00185690 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Complaint IN00185975 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309. Survey dates: November 2, 4, 5, and 6, 2015 Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census bed type: SNF/NF: 78 Total: 78 Census payor type: Medicare: 26 Medicaid: 37 Other: 15	F 0000	This Plan of Correction is the center's credible allegationof compliance. Preparation and/orexecution of this plan of correction does not constitute admission of agreementby the provider of the truth of the facts alleged or conclusions set forth in thestatement of deficiencies. The plan ofcorrection is prepared and/or executed solely because it is required by theprovisions of federal and state law. Werequest that our plan of correction, monitoring tools and review of systemicchanges we have made be considered for a paper compliance desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Total: 78 Sample: 6 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. QR completed by 34849 on November 13, 2015.			
F 0309 SS=D Bldg. 00	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. Based on interview and record review, the facility failed to provide pain management for 1 of 3 residents reviewed who verbalized pain from a fall (Resident #C) and failed to monitor bowel elimination for 1 of 3 residents reviewed for bowel elimination management. (Resident #B) Findings include:	F 0309	F309 Provide care/services for the highest quality 1.Resident B no longer resides in the facility. 2.All residents that reside in the facility havepotential to be affected. (80 of 80 residents see attachment A). 100% audit ofthe ADL book was completed to validate that no other residents were affectedwith negative outcome. 3 day bowel and	12/02/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON		STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	1. The clinical record for Resident #C was reviewed on 11/4/15 at 11:00 a.m. Diagnosis included, but was not limited to, dementia. The nurses note, dated 10/25/15 at 7:35 a.m., included, but was not limited to, the following: "Alarm was sounding [sic] this nurse went to resident's room, [resident name] was found lying on the floor partially into [sic] the bathroom and mostly in her room on her right side [sic] this was an un-witnessed [sic] fall...S/T [skin tear] to R [right] elbow was found...No other injuries found upon a full head to toe assessment...." The nurses note, dated 10/25/15 at at 1:27 p.m., included, but was not limited to, the following: "Resident alert and able to make needs known. VS's [vital signs] WNL [within normal limits], resp [respirations] even and unlabored w/no [with no] signs of distress. No complaints of pain r/t [related to] recent fall. Will continue to monitor...." The nurses note, dated 10/26/15 at 1:05 a.m., included, but was not limited to, the following: "[name of nursing assistant] CNA [Certified Nursing Assistant] went into residents [sic] room to perform care @ [at] 0110 [1:10 a.m.] [sic] Upon trying		bladder assessment initiated on eachresident to establish appropriate toileting program. Careplan revised toreflect the established toiling program and CNA sheets updated (see attachmentF and C). 3.SDC /Designee will in-service staff onappropriate ADL charting, Bowel movement log, and facility Bowel movement protocol by 12/2/15 4.DNS/Designee will audit ADL books forappropriate documentation 5 days times per week for 30 days than three times weekly for 30 days followedby twice weekly for 30 days, then monthly as an ongoing practice. Allfindings will be acted upon immediately and audit results reviewed in themonthly PI meeting (see attachment G). F309 Provide care/services for the highest quality 1.Resident C is no longer at the facility. 2.All residents that live at the facility have thepotential to be affected. (See attachment A). No other residents wereidentified as having negative outcomes. 100% pain assessment will be completedto establish individualized baseline pain control (see attachment B). 100%careplan revision after pain assessmentcomplete to reflect appropriate intervention in place(see attachment C).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155657		11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	to change resident [sic] she stated resident seemed to be in extreme pain. This nurse and Nurse [name of nurse] went to assess resident. Resident was laying on left side in bed w/ her [with her] R [right] leg drawn up, [sic] when tried [sic] to perform ROM [range of motion] resident grimaced & [and] hollered out, [sic] resident stated it was her hip that was hurting. Asked resident what her pain was on a scale of 1-10 [scale used to determine how severe pain is, with 1 being the least and 10 being the worst] when her leg was moved [sic] she stated it was a "10" [sic] Residents right foot was also swollen w/ pitting [with pitting] edema +1. This nurse called [name of doctor] @ [at] 115 [1:15 a.m.] to request stat X-ray, [sic] told [name of doctor] of residents [sic] situation, [name of doctor] stated to get a Stat [sic] X-ray [sic] of R [right] hip & [and] R [right] femur r/t [related to] recent fall w/ [with] c/o [complaints of] pain. Called [name of radiology company] to order stat Xray [sic] @ [at] 0120 [1:20 a.m.]...Family made aware." The document titled, "Radiology Report", dated 10/26/15 at 3:04 a.m., included, but was not limited to, the following: "...Results: Right femoral neck fracture with superior displacement of the distal fragment...Conclusion: Acute right		100%MAR review on PRN pain medications to reflect the need for any medicationchange to update pain medication regimen (see attachment D). 3.SDC /Designee will in-service staff on paindocumentation and follow up, fall management, documentation of residents healthstatus (see attachment E)by 12/2/15, 4.IDT will audit falls daily (Monday-Friday)during the AM leadership meeting. Pain assessment will be validated and anyissues will be corrected immediately. The IDT will audit, update, and revisecareplans (Monday-Friday) in the IDT leadership meeting to address any newpain issue identified. This process will be ongoingMonday-Friday the results will be reviewed in monthly QA meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	femoral neck fracture as noted...." The nurses note, dated 10/26/15 at 3:13 a.m., included, but was not limited to, the following: "...Acute right femoral neck fracture as noted. Called [name of doctor] to inform him. New order to send to [name of hospital] for eval [evaluation] and treat [sic]...." The nurses note, dated 10/26/15 at 4:42 a.m., included, but was not limited to, the following: "EMT [emergency medical technician] arrived @ [at] 0330 [3:30 a.m.] to transport to [name of hospital]...." The MAR [Medication Administration Record] for October 2015 included the following medication order: "Acetaminophen [medication used for pain] 325mg [milligrams] tablet Give 2 tablets (650mg) by mouth every 4 hours as needed for pain...." The MAR and nurses notes lacked documentation of Resident #C receiving any pain medication from the onset of pain at 1:10 a.m. through Resident #C being transferred out of the facility at 3:30 a.m., after verbalizing a pain rating of 10 on a scale of 1-10. During an interview on 11/4/15 at 2:40			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	p.m., LPN [Licensed Practical Nurse] #3 indicated if a resident had a previous fall with no pain, then complained of pain, he/she would look at what the resident had for pain, administer the pain medication and notify the physician. During an interview on 11/4/15 at 2:45 p.m., RN [Registered Nurse] #4 indicated if a resident had a new onset of pain, he/she would give pain medication and then notify the physician. The document titled, "[name of hospital] ED [emergency department] Notes without Clinical Summary, dated 10/26/15, included, but was not limited to, the following: "...History of Present Illness...Hip Injury-Pain...the onset was 1 days ago...The course/duration of symptoms is constant...The character of symptoms is pain and loss of mobility...The degree at onset was moderate...The degree at present is moderate...Physical examination...Musculoskeletal: Lower extremity: Right, hip, tenderness, range of motion restricted by pain...." The hospital document titled, "History and Physical", dated 10/26/15 at 10:38 a.m., included, but was not limited to, the following: "...REASON FOR ADMISSION: Right femoral neck			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	fracture...She was given IV [intravaneous] Fentanyl [medication for severe pain].... " 2. The clinical record for Resident #B was reviewed on 11/4/15 at 1:22 p.m. Diagnoses included, but were not limited to, depression and chronic pain syndrome. The Minimum Data Set (MDS) assessment, dated 10/15/15, indicated Resident #B was occasionally incontinent of bowel. Resident #B was admitted on 10/1/2015. The nurses note, dated 10/27/15 at 4:08 p.m., late entry for 10/23/15 at 6:00 p.m., included, but was not limited to, the following: "...late entry: res [resident] c/o [complains of] feeling nauseous to c.n.a. [Certified Nursing Assistant] around lunch time, small amount of spit up noted, [sic] this nurse assess [sic] resident to find abd. [abdomen] soft [sic] round [sic] non distended [sic] tender to touch, [sic]bowel sounds positive x's [times] 4 quads, [quadrants] [sic] resident requested something to help her bowels move, [sic] mom [sic] [Milk of Magnesia] given at that time as ordered per resident request along with 120 cc [cubic centimeters] of prune juice per resident request.... " The Health Status Change note, dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	10/23/15 at 10:49 p.m., included, but was not limited to, the following: "...Suspected bowel obstruction...Last BM [bowel movement] noted 7 days ago; Frequent emesis - brown in color; c/o [complains of] stomach cramps; absent bowel sounds...Can we send to ER [emergency department]...." The nurses noted, dated 10/23/15 at 11:00 p.m., inlcuded, but was not limited to, the following: "Resident sent to [name of hospital] ER [emergency department] r/t [related to] suspected bowel obstruction...absent bowel sounds...c/o [complains of] stomach cramps and severe pain; last documented BM bowel movement] 7 days ago; Noted brownish emesis with foul odor...." The Bowel Pattern Record for Resident #B, dated 10/1/2105 - 10/7/2015, indicated Resident #B did not have any bowel movements. The Activities of Daily Living Bowel Function sheet for October 2015 indicated Resident #B had a bowel movement on 10/4/15, 10/8/15, 10/11/15, 10/15/15 and 10/16/15. This document also indicated, between 10/17/15 and 10/23/15, Resident #B did not have any bowel movements.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	On 11/4/15 at 4:05 p.m., the Director of Nursing provided a blank copy of the document titled, "BM [Bowel Movement] Monitoring and indicated it was used as the facility bowel protocol. It included, but was not limited to, the following: "...Residents will be placed on the list if they have not had a sustantial [sic] BM in two or more days. Please take the following action as the residents orders and preferences permit: 1st shift will administer PRUNE JUICE early in the shift...2nd shift will administer MOM [Milk of Magnesia] [medication used to relieve constipation] early in the shift. If no BM as its action can take 3-6 hours...3rd shift will administer a SUPPOSITORY early in the shift if no BM...Other action should be taken by any nurse on any shift as needed...." The October 2015 MAR [Medication Administration Record] for Resident #B included, but was not limited to, the following medication order: "Docusate Sodium 100 mg [milligrams] 1 PO [by mouth] BID [twice a day] PRN [as needed] constipation...MOM 30 cc [cubic centimeters] PO BID PRN constipation...." The MAR lacked documentation of Resident #B receiving Docusate Sodium. It also indicated Resident #B received			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON		STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	one dose of MOM on 10/23/15, 7 days after having no bowel movements. During an interview on 11/6/15 at 9:35 a.m., RN [Registered Nurse] #4 indicated they follow the facility bowel protocol. RN #4 indicated if a resident does not respond to the prune juice, MOM, suppository or enema, the physician is notified. During an interview on 11/6/15 at 9:40 a.m., LPN [Licensed Practical Nurse] #5 indicated if a resident does not have a bowel movement after 2 days, the resident is given prune juice. If no response, on day 2, the resident is given MOM and, if no results, day 3 the resident would be given a suppository. If there was no response, LPN #5 indicated the physician would be notified. During an interview on 11/6/15 at 9:45 a.m., LPN #6 indicated if a resident had not had a bowel movement in 2 days, she would administer prune juice. LPN #6 also indicated, if the prune juice was not effective, she would notify the physician. This Federal tag relates to Complaints IN00185679, IN00185690 and IN00185975. 3.1-37(a)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE