

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  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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	<p>This visit was for the Investigation of Complaints IN00203045, IN00204146, IN00204914, IN00207586, and IN00208923.</p> <p>Complaint IN00203045- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00204146- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00204914- Substantiated. Deficiencies related to the allegations are cited at F157 and F279.</p> <p>Complaint IN00207586- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00208923- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: August 24, 25, 26, 29, 30, and 31, 2016</p> <p>Facility number: 000172</p>	F 0000		

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.

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  08/31/2016
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250		
(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>Provider number: 155272 AIM number: 100267130</p> <p>Census bed type: SNF: 15 NF: 65 SNF/NF: 13 Total: 93</p> <p>Census payor type: Medicare: 15 Medicaid: 65 Other: 13 Total: 93</p> <p>Sample: 21</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on September 2, 2016</p>				
F 0157 SS=D Bldg. 00	<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</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>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 was notified when a resident refused treatment and medication which had potential for negative outcomes, including dialysis treatment, blood sugar testing, and insulin administration. Resident D; 1 resident in 4 reviewed for physician notification.</p> <p>Findings include:</p>	F 0157	<p>F157-</p> <p>1. MD was notified of ResidentD refusals of dialysis, blood sugar checks and insulin administration.</p> <p>2.A lab audit was completed for all residents to ensure MDwas notified of refusals of dialysis, blood sugar checks and insulinadministration. Facility systemicchanges are a refusal audit tool will be utilized by Social Services.</p>	09/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>The record of Resident D was reviewed on 8/25/16 at 1:30 P.M. Diagnoses, obtained from the current electronic diagnoses list, included, but were not limited to, end stage renal disease with dialysis, diabetes mellitus, peripheral vascular disease, and hypertension.</p> <p>Care plans for resident B, dated 8/26/16 and indicated by the Administrator to be current and complete, included, but were not limited to:</p> <p>"(Resident D) has potential/actual impairment to skin integrity r/t (related to) fragile skin...</p> <p>Actual Alteration in Skin Integrity...Contact physician for treatment changes as necessary.</p> <p>...has diabetes mellitus r/t kidney disease...needs hemodialysis r/t End Stage Renal Failure...</p> <p>Progress Notes for Resident D indicated:</p> <p>6/30/16 9:28 A.M.: "Res (resident) is a smoker and is on dialysis, 3 days a week (M, W, F) (Monday, Wednesday, Friday) Res occasionally refuses therapy and dialysis."</p>		<p>3. The licensed nursing staff and certified nursing assistants were in-serviced on refusals of significant meds or treatments and notification of MD. Social Services. Social Services will ensure compliance and report audit tool to DNS 3x weekly.</p> <p>4. The Director of Nursing Services/ designee will review the audit tools for compliance. The review of these audits will be presented to the Performance Improvement Committee monthly for 6 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/31/2016
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250		
(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 0279 SS=D Bldg. 00	<p>7/18/16 10:23 A.M.: "Called dialysis center...spoken (sic) with nurse resident refused dialysis. Resident stated, I do not wanna (sic) go to dialysis. I'm not going..."</p> <p>7/29/16 11:26 P.M.: "Res came back from dialysis...when asked to check his blood sugar, he refuses to let checking (sic) and refuses insulin..."</p> <p>8/18/16 4:22 P.M.: "Res occasionally refuses therapy and dialysis..."</p> <p>Resident D's care record contained no documentation of physician notification of the above noted refusals of dialysis, blood sugar testing, and insulin administration.</p> <p>This Federal tag relates to complaint IN00204914.</p> <p>3.1-5(a)(1) 3.1-5(a)(4)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure care plans were developed and implemented for a resident who refused dialysis treatment, refused blood sugar testing and insulin administration, was non-compliant with fluid restrictions, and who was non-compliant with therapeutic dietary interventions. Resident D; 1 resident in 4 reviewed for care plans.</p> <p>Findings include:</p> <p>The record of Resident D was reviewed on 8/25/16 at 1:30 P.M. Diagnoses, obtained from the current electronic diagnoses list, included, but were not limited to, end stage renal disease with dialysis, diabetes mellitus, peripheral</p>	F 0279	<p>F279-</p> <ol style="list-style-type: none"> <li>Resident D has an updated care plan and eMAR entry for behavior monitoring to includerefusals of dialysis, blood sugar checks, and insulin administration;non-compliant with fluid restrictions.</li> <li>An audit tool wasinitiated to ensure care plans include resident refusals and non-compliance andbehavior monitoring is in place for refusals and noncompliance.</li> <li>The licensed nursing staff and interdisciplinary team wasin-serviced on educating residents on risks of refusals and initiating andrevising care plans related to refusals and non-compliance. Facility systemicchanges are a refusal audit tool will be utilized by Social</li> </ol>	09/30/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>vascular disease, and hypertension.</p> <p>Care plans for resident B, dated 8/26/16 and indicated by the Administrator to be current and complete, included, but were not limited to:</p> <p>"(Resident D) has potential/actual impairment to skin integrity r/t (related to) fragile skin.</p> <p>...has diabetes mellitus r/t kidney disease...needs hemodialysis r/t End Stage Renal Failure...</p> <p>...is underweight due to inadequate oral intake and has increased needs due to End Stage renal disease with hemodialysis...</p> <p>...Actual Alteration in Skin Integrity...r/t Diabetic Ulcer..."</p> <p>Progress Notes for Resident D indicated:</p> <p>6/30/16 9:28 A.M.: "Res (resident) is a smoker and is on dialysis, 3 days a week (M, W, F) (Monday, Wednesday, Friday) Res occasionally refuses therapy and dialysis."</p> <p>7/14/16 3:45 P.M.: "Weekly Pressure Ulcer...Report Complete...encouraged resident to lay down between meals,</p>		<p>Services. Social Services will ensure care planning of refusals and non-compliance and ensure behavior monitoring for refusals and non-compliance 3x weekly.</p> <p>4. The Director of Nursing Services/ designee will review the audit tool for compliance. The review of these audits will be presented to the Performance Improvement Committee monthly for 6 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>prefers to sit up so he won't miss and (sic; "any") smoke breaks..."</p> <p>7/18/16 10:23 A.M.: "Called dialysis center...spoken (sic) with nurse resident refused dialysis. Resident stated, I do not wanna (sic) go to dialysis. I'm not going..."</p> <p>7/29/16 11:26 P.M.: "Res came back from dialysis...when asked to check his blood sugar, he refuses to let checking (sic) and refuses insulin..."</p> <p>8/18/16 12:10 A.M.: "Spoke with resident about his weight and diet. Resident states he doesn't drink his nutritional drink..."</p> <p>8/18/16 4:22 P.M.: "Res occasionally refuses therapy and dialysis..."</p> <p>8/22/16 2:51 P.M.: "(Resident D) is refusing to drink supplements to help promote weight gain and protein repletion...He refuses nutritional treat and other supplements..."</p> <p>8/24/16 9:39 A.M.: "Res is to be on 1500mL/day (milliliters per day) fluid restrictions per dialysis every shift Record fluid intake per shift. Not to exceed 1500mL per day. Res drank several cups of coffee during therapy</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/31/2016	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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 0323 SS=E Bldg. 00	<p>even after education of fluid restriction."</p> <p>The Registered Dietitian was interviewed on 8/15/16 at 9:15 A.M. She indicated Resident D's dietary assessments were current and interventions were in place to address his nutritional needs.</p> <p>Resident D's care record contained no care plans for the behavior of refusing dialysis, blood sugar testing and insulin administration, positioning to prevent pressure sores, or following dietary interventions and fluid restrictions.</p> <p>This Federal tag relates to complaint IN00204914.</p> <p>3.1-35(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 observation, record review, and interview, the facility failed to provide an environment that was free of potential risks for harm, by not ensuring residents had call lights that were accessible to residents (4 residents of 19 observed for</p>	F 0323	<p>F323</p> <p>1.Call lights were placed in reach for Resident M, N, O, and G. Residents G, H,I, J, K, L, M, N, O, P, Q, R, S, T, and U have mattress gaps smaller than4¾.</p>	09/30/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>call light placement; Residents G, M, N, and O) and failed to ensure mattresses fit bed frames without having a gap that exceeded 4 3/4 inches, presenting a possibility of entrapment (29 beds of 93 observed) and potentially effecting residents who were assessed as being at high risk for entrapment based on cognitive impairment and need for staff assistance with bed mobility and transfers. (12 of 29 residents in affected beds; Residents G, H, I, J, K, L, P, Q, R, S, T, and U.)</p> <p>Findings include:</p> <p>The facility was toured on 8/26/16 beginning at 11:20 A.M., with the Administrator and the Director of Maintenance. All beds and mattresses were measured by the Director of Maintenance to check the gap, or space, between the mattress and the head or footboard. 29 occupied bed and mattress combinations were determined to have a gap in excess of 4 3/4 inches, as follows:</p> <p>104 A, 8"; 107 B, 8"; 110A, 6"; 110B, 8"; 111A, 11"; 112B, 6"; 118B, 5"; 117A, 6"; 119B, 6"; 120 A, 5"; 123B, 8"; 125B, 8"; 126A, 11 1/2"; 130B, 8"; 132A, 8"; 133A, 8"; 135B, 6"; 136A, 6"; 138B, 8"; 204P, 6"; 205P, 8"; 207P, 6"; 210A, 8"; 212B, 8"; 214A, 6"; 225P, 8"; 227A, 10";</p>		<p>2. Audit tools were initiated. The Angel Check sheets and bed boards will be used to ensure call lights are in reach and all mattress gaps are smaller than 4 3/4.</p> <p>3. Licensed nurses, certified nursing aides, and interdisciplinary team has been in-service on placing call lights within reach of all residents. Maintenance department has been in service on mattress gaps. Facility systemic changes are CareAngels will use Angel Check sheets 2x weekly to ensure call lights are within reach. Maintenance will use facility bedboard weekly x 4, then monthly to ensure all beds have gaps smaller than 4 3/4.</p> <p>4. The Executive Director / designee will review Angel Check sheets and Maintenance board audit for compliance. The review of these audits will be presented to the Performance Improvement Committee monthly for 6 months.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>234B, 6"; 235B, 8".</p> <p>The record of all residents in beds noted to have a gap in excess of 4 3/4 inches were reviewed for being at high risk for entrapment, based on assessments of cognitive status, and need for staff assistance with bed mobility and transfers. Residents with a BIMS (Basic Interview for Mental Status) score of 7 or below, indicating severe cognitive impairment, or residents assessed by staff as being severely cognitively impaired; residents requiring total assistance for bed mobility or transfers; and residents who had a combination of BIMS scores between 7 and 12 and who required extensive assistance for bed mobility or transfers were considered to be at high risk for entrapment. 12 residents in affected beds were found to meet the criteria:</p> <p>1a. The record of Resident G was reviewed on 8/30/16 at 11:30 A.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, vascular dementia with behavioral disturbance, bipolar disorder, and acute kidney failure with dialysis. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/29/16 indicated Resident G had a BIMS score of 10, and required extensive staff</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/31/2016	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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>assistance for both bed mobility and transfers. Resident G was in bed 118B which had a gap of 5" (inches).</p> <p>b. The record of Resident H was reviewed on 8/30/16 at 12:00 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, multiple sclerosis, hypertension, muscle spasms, and paraplegia. An annual Minimum Data Set (M.D.S.) assessment dated 6/07/16 indicated Resident H had a BIMS score of 15, and required extensive, 2 person physical staff assistance for both bed mobility and transfers. Resident H was in bed 119B which had a gap of 6".</p> <p>c. The record of Resident I was reviewed on 8/30/16 at 12:30 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, vascular dementia with behavioral disturbance, cerebrovascular disease, dysphagia, and malnutrition. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/29/16 indicated Resident I was unable to complete a BIMS interview and had a staff assessment of severely impaired cognitive status. Resident I required extensive staff assistance for both bed mobility and transfers. Resident I was in bed 104A which had a gap of 8".</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>d. The record of Resident J was reviewed on 8/30/16 at 1:00 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, dementia, bipolar disorder, difficulty walking, weakness, and anxiety. A significant change Minimum Data Set (M.D.S.) assessment dated 6/29/16 indicated Resident J had a BIMS score of 10, and required extensive staff assistance for both bed mobility and transfers. Resident J was in bed 110A which had a gap of 6".</p> <p>e. The record of Resident K was reviewed on 8/30/16 at 1:30 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, cerebrovascular disease, dysphagia, and convulsions. A quarterly Minimum Data Set (M.D.S.) assessment dated 7/11/16 indicated Resident K was unable to complete the BIMS interview, was assessed by staff as being severely cognitively impaired, had impaired vision, and required extensive staff assistance for both bed mobility and transfers. Resident K was in bed 111A which had a gap of 8".</p> <p>f. The record of Resident L was reviewed on 8/30/16 at 2:00 P.M. Diagnoses, obtained from the current</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>electronic diagnoses record, included, but were not limited to, a history of alcohol abuse and dependence, coronary artery disease, diabetes mellitus, anxiety, and depression. A Medicare 60 day Minimum Data Set (M.D.S.) assessment dated 7/06/16 indicated Resident L had a BIMS score of 10, and required extensive staff assistance for both bed mobility and transfers. Resident L was in bed 112A which had a gap of 6".</p> <p>g. The record of Resident P was reviewed on 8/30/16 at 2:30 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, cerebrovascular accident, adult failure to thrive, weakness, and hereditary and idiopathic neuropathy. A Medicare 5 Day Minimum Data Set (M.D.S.) assessment dated 8/16/16 indicated Resident P had a BIMS score of 10, and required extensive staff assistance for both bed mobility and transfers. Resident P was in bed 204P which had a gap of 6".</p> <p>h. The record of Resident Q was reviewed on 8/30/16 at 3:00 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, dementia, bipolar disorder, difficulty walking, weakness, and anxiety. A significant change</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/31/2016	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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>Minimum Data Set (M.D.S.) assessment dated 6/29/16 indicated Resident Q had a BIMS score of 10, and required extensive staff assistance for both bed mobility and transfers. Resident Q was in bed 205P which had a gap of 8".</p> <p>i. The record of Resident R was reviewed on 8/31/16 at 9:30 A.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, sepsis, end stage renal disease with dialysis, altered mental status, and conversion disorder with seizures or convulsions. A Medicare 30 Day Minimum Data Set (M.D.S.) assessment dated 8/10/16 indicated Resident R had a BIMS score of 6, and required extensive staff assistance for both bed mobility and transfers. Resident R was in bed 210A which had a gap of 8".</p> <p>j. The record of Resident S was reviewed on 8/31/16 at 10:00 A.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, history of intracranial injury, persistent vegetative state, and multiple contractures. A Quarterly Minimum Data Set (M.D.S.) assessment dated 7/23/16 indicated Resident S could not complete the BIMS interview, was assessed as being severely cognitively</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>impaired by staff, and required total staff assistance for both bed mobility and transfers. Resident S was in bed 130B which had a gap of 8".</p> <p>k. The record of Resident T was reviewed on 8/30/16 at 10:30 A.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, Alzheimer's Disease, history of falling, atrial fibrillation, and generalized muscle weakness. A quarterly Minimum Data Set (M.D.S.) assessment dated 8/11/16 indicated Resident T could not complete the BIMS interview, was assessed by staff as being severely cognitively impaired and required extensive staff assistance for both bed mobility and transfers. Resident T was in bed 133A which had a gap of 8".</p> <p>l. The record of Resident U was reviewed on 8/30/16 at 11:00 A.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, dementia, gastrostomy tube, fracture of the 6th cervical vertebra, and gastro esophageal reflux disease. An admission (M.D.S.) assessment dated 8/24/16 indicated Resident U could not complete the BIMS interview, was assessed as being severely cognitively impaired by staff, and</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>required total staff assistance for both bed mobility and transfers. Resident U was in bed 234B which had a gap of 6".</p> <p>The Director of Maintenance indicated on 8/26/16 at 12:30 P.M. that he had identified issues that led to the excess gap between mattresses and bed frames. He noted that standard beds were made to accommodate an 80" mattress. He noted that "a number" of beds had "scoop" or anti-roll mattresses, which measured 75", leaving a 5" gap. He also noted "several" beds had been extended to accommodate 84" mattresses for taller residents. When the longer mattresses were removed, the beds were not returned to standard position for an 80" mattress, causing an additional gap.</p> <p>During the tour on 8/26/16 beginning at 11:20 A.M., with the Administrator and the Director of Maintenance, residents who were in their beds, or were in their rooms and adjacent to their beds, were observed for call light accessibility. Where appropriate, residents were interviewed concerning the placement and accessibility of call lights. Concerns were noted for the following residents:</p> <p>2a. The record of Resident G was reviewed on 8/30/16 at 11:30 A.M. Diagnoses, obtained from the current</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/31/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
--	---

(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>electronic diagnoses record, included, but were not limited to, vascular dementia with behavioral disturbance, bipolar disorder, and acute kidney failure with dialysis. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/29/16 indicated Resident G had a BIMS score of 10, and required extensive staff assistance for both bed mobility and transfers. At the time of observation Resident G was in bed with his eyes closed. His call light was secured above the moveable arm holding his television set and was not accessible by him.</p> <p>b. The record of Resident M was reviewed on 8/31/16 at 11:30 A.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, encephalopathy, altered mental status, urinary tract infection, and adult failure to thrive. A quarterly Minimum Data Set (M.D.S.) assessment dated 5/29/16 indicated Resident M had a BIMS score of 4, and required extensive staff assistance for both bed mobility and transfers. he did not ambulate. At the time of observation Resident M was in his wheelchair on the left side of his bed. The call light was attached to the side rail on the right side of the bed and was not accessible by him.</p> <p>c. The record of Resident N was</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  08/31/2016	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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>reviewed on 8/31/16 at 12:00 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, chronic congestive heart failure, a history of myocardial infarction, schizoaffective disorder, and insomnia. A significant change Minimum Data Set (M.D.S.) assessment dated 5/28/16 indicated Resident N had a BIMS score of 15, and required limited staff assistance for both bed mobility and transfers. At the time of observation Resident N was in his wheelchair on the left side of his bed. His call light was secured on the side rail on the right side of his bed. Resident N indicated that to reach his call light he would have to lean out of his wheelchair and reach across bed, which he indicated he was unable to do.</p> <p>d. The record of Resident O was reviewed on 8/31/16 at 12:30 P.M. Diagnoses, obtained from the current electronic diagnoses record, included, but were not limited to, Parkinson's Disease, hypertension, diabetes mellitus, seizures, cerebrovascular disease, atrial fibrillation, and chronic kidney disease. An admission Minimum Data Set (M.D.S.) assessment dated 8/21/16 indicated Resident O had a BIMS score of 10, and required limited staff assistance for both bed mobility and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  08/31/2016
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250		
(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>transfers. At the time of observation Resident G was sitting on the bed. The call light was secured above the moveable arm holding the television set. Resident O indicated they were not able to reach the call light.</p> <p>During an interview with the Administrator on 8/26/16 at 5:15 P.M., she indicated all beds with unacceptable gaps had been identified, mattresses were being exchanged, extended beds had been returned to standard position, and bolsters were being placed in any beds with a gap. She indicted all residents should have an easily accessible call light.</p> <p>3.1-45(a)(1)</p>				