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
	155188		07/01/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	200 GREEN MEADOWS DR GREENFIELD, IN 46140

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00199009, Complaint IN00201100, Complaint IN00202345 and Complaint IN00202628. Complaint IN00199009 -- Substantiated. Federal/state deficiencies related to the complaint are cited at F279 and F425. Complaint IN00201100 -- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00202345 -- Substantiated. No deficiencies related to the allegations are cited. Complaint IN00202628 -- Substantiated. No deficiencies related to the allegations are cited. Unrelated deficiency is cited. Survey dates: June 27, 28, 29, 30 and July 1, 2016 Facility number: 000099 Provider number: 155188 AIM number: 100291140 Census bed type:	F 0000	Preparation and submission of this Plan of Correction does not constitute the admission oragreement by the Provider to the truth of the "findings" alleged orconclusions set forth in the Statement of Deficiencies (CMS 2567). The Plan ofCorrection is prepared, executed and submitted solely because it is required bythe provisions of federal and state law. **The Provider formally requests adesk review for all deficiencies.**	

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.

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	SNF/NF: 146 Total: 146 Census payor type: Medicare: 30 Medicaid: 88 Other: 28 Total: 146 Sample: 9 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 30576 on July 5, 2016			
F 0279 SS=D Bldg. 00	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. 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. The care plan must describe the services			

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	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). Based on interview and record review, the facility failed to ensure a care plan was developed regarding the cautious use of antipsychotic medications for a newly admitted resident who had a significant reaction prior to admission of hypothermia following the use of an antipsychotic medication for 1 of 4 residents reviewed for medications. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 6-27-16 at 2:00 p.m. His diagnoses included, but were not limited to, unspecified dementia with behavioral disturbances, Parkinson's disease, cerebral infarct, depression and history of alcohol abuse. His admission Minimum Data Set (MDS) assessment, dated 3-29-16, indicated he was significantly cognitively impaired. Review of his discharge instructions from an area geriatric psychiatric facility, dated 3-22-16, indicated his allergies were	F 0279	1.The Facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed certified skilled nursing facility. Resident #A discharged from the Facility on 4/21/16. 2.All other Residents who have been identified with allergies listed as severe have been identified and reviewed by the IDT. Each Resident's Care Plan has been edited and updated to reflect their specific allergy reaction. In-Servicing has been provided to Licensed Nurses to ensure accurate documentation of any severe allergy listed in the Care Plan. 3.To ensure that this practice doesn't recur, all future admissions to the Facility, the Residents allergies will be reviewed by the Licensed Nurse providing direct care and listed in the electronic medical chart noting the severity of reaction. UM or designee will verify each severe allergy and update the Care Plan. 4.The corrective action will be monitored by the DNS or	07/08/2016

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	"ALL Psychotropic medications." This notation was marked through to indicated it was invalid, and replaced with an allergy to Risperdal, an antipsychotic medication. The discharge summary from this facility, dated 3-22-16, indicated on 2-25-16, the resident had a "significant change in consciousness...was extremely cold and almost unresponsive...extremely hypothermic," requiring care in an area emergency room to re-warm him. "At the time of discharge, we had decided then that he would be termed ALLERGIC TO ANY ANTIPSYCHOTICS in the future as this was extremely dangerous in regards to his severe hypothermia-induced as believed by the psychotropic Prolixin." Review of the discharging nurse practitioner's history and physical note, dated 3-23-16, indicated the resident had previously "experienced a dangerous, near fatal reaction to Risperdal [an antipsychotic medication], involving a neuroleptic hypothermic state (core body temp was 92 degrees F)...This unfortunately limits the use of psychotropics to help manage behavioral incidents." Review of the nursing progress notes indicated on the day of admission,		designee by completing weekly audits of the Care Plans to ensure that those Residents with allergies listed as severe are properly documented for 4 weeks then as needed there after. The data will be brought to PI each month by DNS and reviewed for the next 4 months then as needed thereafter. 5.The systemic changes will be completed by or on 7/8/16.	

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	3-22-16, "Writer called [name of facility] to request an explanation of allergies listed, per [name of attending facility at other facility and name of staff person], risperdone [generic medication name of Risperdal] was the medication that resident had an adverse reaction to." In interview with the Director of Nursing Services (DNS) on 6-27-16 at 3:32 p.m., she indicated she had worked with Resident #A on the evening of 4-20-16. She indicated on that evening, at the request of a family member, she had added the allergies of "Haldol" and "antipsychotic" to the resident's clinical record. Previously, the clinical record had Prolixin and Risperdal as the only allergies listed. In interview with the Corporate Nurse on 7-1-16 at 2:40 p.m., she indicated their facility does not typically care plan medication allergies. On 7-1-16 at 2:40 p.m., the DNS provided a copy of a policy entitled, "Care Plans." This policy indicated, "A comprehensive care plan is developed consistent with the patients' specific conditions, risks, needs, behaviors, preferences and with standards of practice including measurable objectives, interventions/services, and timetables to			

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	meet the patient's needs as identified in the patient's assessment or as identified in relation to the patient's response to the interventions or changes in the patient's condition...The care plan: Addresses the patients' needs, strengths and preferences identified in the comprehensive assessment; Addresses risk factors that might lead to avoidable declines in functioning or functional levels..." This Federal tag relates to Complaint IN00199009. 3.1-35 (a) 3.1-35 (b)(1)			
F 0425 SS=D Bldg. 00	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.			

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	The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on interview and record review, the facility failed to ensure the administration of a psychotropic medication for 1 of 4 residents reviewed for medications. (Resident #A) Findings include: Resident #A's clinical record was reviewed on 6-27-16 at 2:00 p.m. His diagnoses included, but were not limited to, unspecified dementia with behavioral disturbances, Parkinson's disease, cerebral infarct, depression and history of alcohol abuse. His admission Minimum Data Set (MDS) assessment, dated 3-29-16, indicated he was significantly cognitively impaired. Review of the nursing progress notes, dated 4-20-16 at 7:45 p.m., indicated, "Patient became physically and verbalize [sic] abusive towards staff. Nurse on phone with [name of attending physician] and new orders given. Order for Haldol [an antipsychotic medication] 5mg [sic/milligrams] IM [intramuscular injection] q6h [every 6 hours] prn [as needed for] agitation and combativeness..." Continued review of the nursing progress notes, as well as the	F 0425	1.The Facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed certified skilled nursing facility. Resident #A discharged from the Facility on 4/21/16. 2.Upon review of other Residents clinical records, documentation on Medication Administration was lacking in some cases. Nursing Staff was requested to correct the identified documentation errors. 3.To ensure that this practice doesn't recur, In-Servicing has been provided to instruct Licensed Nursing providing direct care to utilize the dashboard component of the electronic medical chart at shift change to verify Medication Administration and documentation have occurred. 4.The corrective action will be monitored daily by the UM and the DNS or designee will conduct a weekly audit of the dashboard component of the electronic medical chart. The data will be collected and brought to PI each month for the first 4 months by DNS and then as needed thereafter. 5.The systemic changes will be completed by or on 7/8/16.	07/08/2016

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	medication administration record [MAR] failed to indicate this resident was administered to the medication. In interview with the Director of Nursing Services (DNS) on 6-29-16 at 12:25 p.m., she indicated an EDK (emergency drug kit) requisition slip was located for one dose of Haldol 5 mg per milliliter for Resident #A by RN #2 on 4-20-16. The DNS indicated she was unable to locate any documentation of the actual administration of the medication to Resident #A. On 7-1-16 at 2:40 p.m., the DNS provided a copy of a policy entitled, "6.0 General Dose Preparation and Medication Administration," with an effective date of 12-1-07, and the most recent revision date of 1-1-13. This policy indicated, "Document necessary medication administration/treatment information (e.g., when medications are opened, when medications are given, injection site of a medication, if medications are refused, PRN medications, application sight [sic]) on appropriate forms." This Federal tag relates to Complaint IN00199009. 3.1-25(b)(3)			

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F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			

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	Based on observation, interview and record review, the facility failed to ensure a facility-owned glucometer was cleaned after use with the facility-approved cleaning agent for 1 of 3 observations of glucometer use and cleaning during one of two observations with one of four licensed nurses for five residents. (Resident #G) Findings include: On 6-28-16 at 7:45 p.m., LPN #1 was observed to have utilized a glucometer to obtain a bedtime blood sugar result for Resident #G during a medication pass observation. After completing the administration of the resident's medication and obtaining the blood sugar, LPN #1 was observed to obtain an alcohol wipe to wipe down the glucometer. LPN #1 was queried as to what the facility's policies are for cleaning of the glucometer between uses. LPN #1 indicated staff are to use bleach wipes, "but they are not always available, like now." She demonstrated there were no containers of bleach wipes available on her medication cart. On 6-29-16 at 11:58 a.m., the Director of Nursing Services (DNS) provided a copy of a portion of a procedure entitled, "Blood Glucose Monitoring Using a	F 0441	1.The Facility is committed to providing quality care for all of its residents, as well as substantial compliance with all regulatory requirements for a licensed certified skilled nursing facility. No Resident was identified to have been affected by the deficient practice. 2.In-Servicing has occurred for all Licensed Nurses regarding the proper cleaning method of glucometers to ensure that no other Residents will be affected by this deficient practice. 3.To ensure that this practice doesn't recur, in addition to In-Servicing of all current staff on the proper cleaning method of glucometers, any new Staff that is hired will be provided education during the orientation period on the proper cleaning method of glucometers. 4.The SDC or designee will conduct random bi-weekly audits on all shifts for 4 weeksand then weekly there after. The data will be brought to PI by SDC and reviewed for the next 4 months then as needed thereafter. 5.The systemic changes will be completed by or on 7/8/16.	07/08/2016

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	[namebrand] Glucometer." This procedure indicated, "...Cleans the glucometer using a 10% bleach solution moistened wipe between each patient. Allows a 1-minute contact time and wipe any residual bleach solution off the meter...Verbalizes frequency of cleaning meter...Verbalizes appropriate solution for cleaning a meter is 10% bleach." In interview at the time of provision of this procedure, the DNS indicated this policy takes precedence over the manufacturer's guidelines for use of alcohol for cleaning of the glucometer. On 6-29-16 at 12:50 p.m., the DNS provided a portion of a copy of the manufacturer's cleaning instructions for the "[Namebrand] Glucose Hospital Meter." These instructions indicated, "The meters should never be immersed in any cleaning agent. Always apply the cleaning agent to a soft cloth to wipe the meter surface. Once complete, immediately dry thoroughly. When cleaning the meter, please follow the guidelines listed below: Dilute Bleach. A 10% solution of household bleach (Sodium Hypochlorite) may be used. 70% Isopropyl (rubbing) Alcohol may be used..." 3.1-18(a)			

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