

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/18/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
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F 0000 Bldg. 00	<p>This visit was for a Post Survey Revisit (PSR) to the Investigation of Complaint IN00199009 completed on 7/1/16.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00199009-not corrected.</p> <p>Survey dates: July 11, 12, 13, 14,15, and 18, 2016.</p> <p>Facility number: 000099 Provider number: 155188 AIM number: 100291140</p> <p>Census bed type: SNF/NF: 136 Total: 136</p> <p>Medicare: 17 Medicaid: 90 Other: 29 Total: 136</p> <p>Sample: 6</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>Preparation and submission of this Plan of Correction does not constitute the admission or agreement by the Provider to the truth of the "findings" alleged or conclusions set forth in the Statement of Deficiencies (CMS-2567). The Plan of Correction is prepared, executed and submitted solely because it is required by the provisions of federal and state law.</p> <p>The Provider formally requests a desk review</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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F 0279 SS=D Bldg. 00	<p>Quality review completed by 30576 on July 21, 2016</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <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 observation, interview and record review, the facility failed to develop a plan of care for activities of daily living (ADL's) to coordinate resident care, develop a plan of care for hydration for a resident with a history of dehydration, and develop a plan of care for a resident who had received Lasix medication, for 3 of 20 residents</p>	F 0279	I. The Facility failed to develop a care plan for Resident #55 for ADLs, Resident #122 for hydration, and Resident #167 for medication of Lasix. The Facility added the care plan for resident #167 for Lasix on 7/14/16. The Facility added a care plan for resident #55 for ADLs on 7/27/16. Resident #122 was discharged from the Facility for a planned	08/09/2016

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	<p>reviewed for care plans. (Resident #55, #122, and #167)</p> <p>Findings include:</p> <p>Resident #55's record was reviewed on 7/13/16 at 1:35 p.m. His diagnosis documented on his July 2016 physician's recapitulation orders included but were not limited to, diabetes type II, diabetic neuropathy, enlarged prostate with lower urinary tract symptoms, hypertension, and depressive episodes.</p> <p>Resident #55's quarterly Minimum Data Set (MDS) assessment dated 5/19/16, indicated he was understood and had the ability to understand others. He was cognitively intact for his daily decision making skills. He required supervision of 1 person for bed mobility, transfer, toileting, personal hygiene, and eating. He required limited assistance of 1 person to dress. He required limited assistance of 1 person to walk in his room and utilized a walker and wheelchair.</p> <p>A "Health Status Note" for Resident #55 dated 6/1/16 at 10:38 a.m., indicated he was at risk for falls, diminished safety awareness, and poor vision related to glaucoma.</p>				<p>psychiatric care stay. His care plan will be added upon his return for "at risk of dehydration". II. All residents have the potential to be affected by the Facilities deficient practices. III. Education has been provided to all licensed staff on the Facilities care plan policy. All current resident charts will be audited to ensure each resident's care plan actively reflects any current diagnosis, allergy that is severe, ADLs, code status, pain, and at risk conditions by the IDT. The IDT will audit each new admit after the 5 day initial assessment period and update care plans as needed, as well as any significant change in condition or any order change. IV The IDT will take the results of the audit to Performance Improvement Committee monthly for 6 months and re-educate as needed.</p>		

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	<p>On 7/12/16 at 10:29 a.m., Resident #55 indicated he could brush his own teeth and dentures. He indicated his denture brush disappeared and he had quit wearing his dentures because he could not see well enough to put the adhesive on them. He indicated there were some staff who would help him with it.</p> <p>An interview with Unit Manager #13 on 7/13/16 at 2:23 p.m., indicated Resident #55 received his showers on Monday and Thursday evening and received oral care twice a day. Resident's showers and oral care were documented by staff in the Kiosk. No plan of care had been developed for Resident #55's bathing or oral care except where the staff documented in the Kiosk.</p> <p>On 7/13/16 at 2:30 p.m., during and interview with Resident #55, he was observed to have some lower teeth that were yellowish in color. He had some dentures in a denture cup on his bedside table. Resident #55 indicated he used to have a denture brush but didn't know what happened to it. He had practically quit wearing his dentures because he used his walker to go to the bathroom sink and he had to hold onto something and it made it difficult for him to clean his dentures and put adhesive on them. He could take his wheelchair to the bathroom</p>			

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	<p>sink but an arm on the toilet made it difficult to get close to the sink. He hadn't been asking for staff assistance because he felt staff didn't want to help him. He had been told he could practically do everything himself. His wife was visiting him at the time of the interview and she found his denture brush in a bag attached to his walker. He had miscellaneous grooming items in the bag and in a plastic tub in his closet. His wife indicated he had very poor vision and he had not recognized her that day when she entered his bedroom and had recognized her voice when she spoke with him.</p> <p>An interview with CNA #9 on 7/13/16 at 3:49 p.m., indicated Resident #55 brushed his own teeth in the bathroom after staff set up his supplies and put toothpaste on his toothbrush. It depended on how Resident #55 felt that day if he used his walker or wheelchair to go to the bathroom. She didn't think he had dentures but she couldn't actually remember but "he may have a partial." She had never observed Resident #55 have any trouble brushing his own teeth. If he was in his wheelchair in the bathroom he would propel his wheelchair close to the sink and then stand up at the sink and brush his teeth. Sometimes he didn't like asking for help because he felt like he was bothersome to staff.</p>			

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	<p>On 7/14/16 at 9:38 a.m., Resident #55 indicated he had not brushed his teeth that morning. His denture cup was on his bedside table.</p> <p>On 7/14/16 at 9:56 a.m., CNA #10 indicated Resident #55 had asked her to help him change his pants that morning and she had been surprised because he usually didn't ask for help getting dressed. Resident #55 had not requested any further help after she had assisted him with his pants. She was informed in report he was mostly independent. He walked with a walker and was not an extensive assist.</p> <p>On 7/14/16 at 9:58 a.m., Resident #55 agreed for CNA #10 to assist him with his oral care while he was in the bathroom with his walker. CNA #10 gathered Resident #55's oral care supplies and he requested his wheelchair. CNA #10 took Resident #55 his wheelchair and removed his walker from the bathroom. CNA #10 positioned Resident #55's wheelchair as close to the bathroom sink as possible and he remained seated. She placed toothpaste on his toothbrushes and he brushed his teeth and dentures. She applied adhesive to his dentures and he placed them in his mouth.</p>			

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	<p>On 7/14/16 at 4:25 p.m., CNA #11 indicated Resident #55 would take his own supplies into his bathroom and stand from his wheelchair and brush his teeth. Resident #55 did not require any assistance and CNA #11 would stand behind Resident #55 while he brushed his teeth. CNA #11 did not believe Resident #55 wore any dentures or partials.</p> <p>On 7/18/16 at 4:13 p.m., Case Manager #12 indicated a plan of care had not been developed for Resident #55 specific to ADL's. Resident #55 required supervision to limited assistance. His need for set up with meals was documented on his diet plan of care. He had 1 assistance with his suprapubic catheter and he was encouraged to prop his feet up as needed. He was encouraged to call for assistance if needed. "We incorporated those type of things in with his other care plans." She was going to schedule a new MDS assessment. Staff would be able to speak with Resident #55 about how he felt and what he needed, so if he felt he needed more assistance his care plans could be updated.</p> <p>On 7/18/16 at 5:52 p.m., Resident #55's wife indicated Resident #55 needed assistance with his personal hygiene, cleaning his teeth, and placing his</p>			

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	<p>dentures in his mouth. He could do a lot for himself but his eyesight was poor and he needed assistance with his personal care.</p> <p>2. Resident #122's record was reviewed on 7/15/16 at 11:35 a.m. His diagnoses documented on his July 2016 physician's recapitulation orders included but were not limited to, Parkinson's disease, dementia with behavioral disturbances, altered mental status, hypertension, anemia, coronary artery disease, congestive heart failure, chronic obstructive pulmonary disease, acute and chronic respiratory failure, type II diabetes, and kidney failure.</p> <p>Resident #122's quarterly MDS assessment dated 5/31/16, indicated he was understood and had the ability to understand others. He was cognitively intact in his daily decision making skills. He was not dehydrated and received a diuretic medication.</p> <p>A physician's order for Resident #122 dated 6/25/16 at 5:00 p.m., indicated he would receive 1 liter intravenously of sodium chloride 0.9% solution 1 time only at 96 milliliters (ml) an hour (hr) times 1 after initial bag, then at 200 ml/hr.</p>			

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	<p>A physician's order for Resident #122 dated 6/26/16 at 12:05 p.m., indicated he would receive a Basic Metabolic Panel (BMP) laboratory test 1 time a day for increased lab values.</p> <p>A physician's order for Resident #122 dated 6/26/16 at 12:16 p.m., indicated he would receive sodium chloride 0.9% solution at 100 ml/hr every 12 hours intravenously for lab values continuously.</p> <p>A physician's order for Resident #122 dated 6/30/16 and no time, indicated he would receive a BMP laboratory test in the a.m., for a diagnosis of dehydration.</p> <p>A "Progress Note" for Resident #122 dated 6/30/16 at 8:15 p.m., indicated his intravenous fluids had been discontinued and a BMP laboratory test would be obtained the next morning.</p> <p>A "Dehydration Screening" for Resident #122 dated 7/2/16, indicated he had no signs or symptoms of dehydration.</p> <p>An interview with Resident #122 on 7/12/16 at 10:04 a.m., indicated he hadn't received the fluids he wanted</p>			

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	<p>between meals because he was only offered water.</p> <p>An interview with Resident #122 on 7/14/16 at 9:43 a.m., indicated staff only offered him water between meals. He had asked for Coke to drink when he first started residing at the facility but was informed if he wanted Coke to drink he would have to buy it. He was offered orange juice and kool-aid at meal time and he liked those. He felt like he did not receive enough fluids to drink because he only drank approximately half of his water.</p> <p>An interview with CNA #10 on 7/14/16 at 9:53 a.m., indicated fresh water was passed every shift. If a resident requested something to drink besides water, staff could get them something from the pantry or kitchen.</p> <p>On 7/15/16 a 9:50 a.m., Resident #122 was observed seated on the side of his bed drinking water from a Styrofoam cup independently.</p> <p>An interview with Unit Manager #13 on 7/18/16 at 3:09 p.m., indicated no hydration plan of care had been developed for Resident #122. Resident #122's intravenous fluids</p>			

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	<p>had started on 6/24/16 and had been discontinued on 6/30/16. His dehydration had happened so quickly was why she believed a plan of care for hydration had not been developed.</p> <p>3. Resident #167's record was reviewed on 7/13/16 at 1:17 p.m. Physician's recapitulation orders, dated July 2016, indicated Resident #167 had diagnoses that included, but were not limited to, Alzheimer's disease, hypothyroidism, atherosclerotic heart disease, osteoarthritis, high blood pressure, and gastro-esophageal reflux disease.</p> <p>A physician's telephone order, dated 4/13/16, indicated an order for Lasix (diuretic) 20 milligrams by mouth every day times 2 days for edema, and K-Dur (potassium supplement) 10 milliequivalents by mouth every day times 2 days.</p> <p>The Medication Administration Records (MARs) indicated the Lasix had been given every day from April 14, 2016 through July 14, 2016.</p> <p>A Quarterly Minimum Data Set assessment, dated 6/1/16, indicated Resident #167 had severe impairment in cognitive skills for daily decision</p>			

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	<p>making, required stand by assist with walking, and received a diuretic 7 times in the last 7 days.</p> <p>On 7/18/16 at 1:55 p.m., the DHS indicated the prior care plan for her Lasix was as follows: "[Resident #167] has HTN/CAD (high blood pressure/coronary artery disease): at risk for edema. Goal: [Resident #167] will remain free from s/sx (signs or symptoms) of hypertension through the review date. Interventions: Avoid taking the blood pressure reading after physical activity or emotion[al] distress. Compression stocking as ordered to reduce lower extremity edema. Encourage to elevate feet as tolerated. Monitor for and document any edema. Notify MD. Monitor/document abnormalities for urinary output. Report significant changes to the MD. Monitor/document/report to MD PRN (as needed) any s/sx of malignant hypertension: Headache, visual problems, confusion, disorientation, lethargy, nausea and vomiting, irritability, seizure activity, difficulty breathing (Dyspnea). Monitor/record medication side effects. Report to MD as necessary."</p> <p>The care plan, as written did not address the use of Lasix, as a diuretic nor address the possible side effects of dehydration,</p>			

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	<p>potassium depletion, nor labs to monitor the potassium levels.</p> <p>A Physician's Telephone Order, dated 7/14/16, indicated: "BMP (Basic Metabolic Profile) today dx (diagnosis) HTN (high blood pressure), BP (blood pressure) sitting and standing today, record in PCC (Point Click Care-electronic records). Weigh Patient."</p> <p>Progress notes, dated 7/14/16, at 6:18 p.m., indicated: "Received lab results with Potassium level of 3.3. (Normal limits are 3.5-5.0) Notified [Name of Nurse Practitioner] who ordered 10 meq (milliequivalents) of potassium PO (by mouth) daily as supplement. Resident has order for Lasix daily due to bilateral edema of lower extremities."</p> <p>A Policy and Procedure for "Care Plans" was provided by the Nurse Consultant on 7/18/16 at 5:33 p.m. The policy included but was not limited to, "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 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</p>			

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	<p>in the patient's condition. Rationale: Plan of care is developed on the patient's individual needs as identified by assessments. The care plan includes a treatment plan, patient's preferences, patient goals that are measurable and contain a schedule to evaluate the patient's progress or lack of progress toward his/her goals...."</p> <p>This deficiency was cited on 7/1/16. The facility failed to implement a systemic plan of correction to prevent recurrence.</p> <p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p>			