

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 08/28/2013
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F000000	<p>This visit was for the Investigation of Complaints IN00133424 and IN00134761.</p> <p>Complaint IN00133424-Substantiated. A Federal/State deficiency related to the allegations is cited at F 333.</p> <p>Complaint IN00134761-Substantiated. No deficiencies related to the allegations are cited.</p> <p>An unrelated deficiency is cited.</p> <p>Survey dates: August 26, 27, 28 2013</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey team: Chuck Stevenson RN</p> <p>Census bed type: SNF/NF: 110 Total: 110</p> <p>Census payor type: Medicare: 26 Medicaid: 71 Other: 13</p>	F000000	Preparation and or excution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and or excuted soley because required.	

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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	<p>Total: 110</p> <p>Sample: 4</p> <p>These deficiencies also reflect State findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 5, 2013 by Janelyn Kulik, RN.</p>				

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F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to ensure complete and accurate assessments were completed and health care plans were developed and implemented for a resident (Resident D) on scheduled hemodialysis and with a dialysis fistula for 1 resident of 3 reviewed for assessments and care plans in a sample of 4.</p> <p>Findings include:</p> <p>The record of Resident D was reviewed on 8/26/13 at 3:00 p.m.</p> <p>Diagnoses included, but were not limited to, end stage renal disease with hemodialysis, chronic obstructive pulmonary disease, peripheral vascular disease, hypertension, and gastroesophageal reflux disease.</p> <p>An admission Minimum Data Set (M.D.S.) assessment dated 8/16/13 indicated Resident D was mildly cognitively impaired, required staff</p>	F000309	<p>1. Resident D was assessed and had a care plan developed addressing provision of care for dialysis access site with measurable objectives and timetables. 2. A facility audit was conducted to identify those residents receiving dialysis. Identified residents with dialysis cites were re-assessed; care plans reviewed to determine provision of care for dialysis assess cites had measureable objectives and timetables. Residents will be identified through scheduled care plan meetings, the admission process and the ongoing resident assessment instrument (RAI) process. 3. The Interdisciplinary Team was re-educated on care plans with measureable objectives and timetables. Licensed Nursing staff was educated on assessments of dialysis access sites with accurate documentation as well as components of this regulation with emphasis on the process of updating care plans with resident changes and adding new interventions as needed. As care</p>	09/27/2013	

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	<p>assistance with activities of daily living, had no mood or behavior concerns, and moved about the facility by wheel chair.</p> <p>An admission nursing assessment dated 8/02/13 indicated Resident D had an intravenous port (fistula) in her left upper arm as an access site for dialysis.</p> <p>An activity progress note dated 8/05/13 at 10:24 a.m. indicated "...Resident states she will attend activities when in the mood due to attending dialysis..."</p> <p>Nursing progress notes indicated:</p> <p>8/06/13 12:14 p.m. "...Res (resident) currently at dialysis..."</p> <p>8/08/13 10:20 a.m. "...currently out for dialysis..."</p> <p>8/13/13 7:10 a.m. "...pt (patient) was last dialyzed on Saturday and goes out today for HD (hemodialysis)..."</p> <p>8/15/13 6:27 a.m. "...spoke with representative from (name of ambulance company)...states dialysis clinic would like patient to come via stretcher b/c (because) the staff at the dialysis (sic) is having trouble</p>		<p>plans are cycled through they will be evaluated for objectives and timetables by the Interdisciplinary Team, re-writing/revising as needed. 4. The responsible party for this plan of correction if the Executive Director/ Director of Nursing/designee. The DNS/Unit managers will audit two residents records weekly for three months, then randomly quarterly thereafter to determine that those residents receiving dialysis have been assessed and have current updated care plans. The results of reviews will be taken to the next monthly Performance Improvement Meeting for discussion and determination that substantial compliance has been achieved and until such time that the committee recommends that monitoring may be discontinued.</p>	

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	<p>transferring patient into chair..."</p> <p>8/17/13 5:25 p.m. "...res returned from dialysis, no concerns at this time, a/o x 3 (alert and oriented to person, place, time) able to voice needs, pos (positive) bruit/thrill (bruit is the sound and thrill is the vibration blood makes passing through the fistula, used to assess the fistula's patency) noted..."</p> <p>8/20/13 1:56 p.m. "...Res LOA (leave of absence) this shift to dialysis..."</p> <p>8/24/13 7:14 p.m. "...bruit on the LUE (left upper extremity) fistula..."</p> <p>Progress notes contained no other assessments or documentation related to Resident D's fistula, or any other concerns related to her hemodialysis.</p> <p>A "Dialysis Log" for Resident D indicated vital signs had been taken and bruit and thrill checked on return from dialysis on 8/03/13, 8/06/13, 8/08/13, 8/10/13, 8/13/13, 8/15/13, 8/17/13, 8/22/13, and 8/24/13. Vital signs were documented but there is no documentation of checking bruit and thrill on 8/20/13.</p> <p>A social services progress note dated</p>						

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	<p>8/21/13 at 12:10 p.m. of a care plan meeting held on that date for Resident D contained no mention of Resident D's ongoing dialysis or any related issues.</p> <p>Care plans for Resident D included "Activity Intolerance r/t (related to Diagnosis: ESRD with HD (end stage renal disease with hemodialysis)". The record contained no care plans specific to Resident D's status as receiving hemodialysis, or assessing and documenting the condition of her fistula.</p> <p>A facility policy titled "Residents Receiving Dialysis" dated 10/31/09 received from the Director of Nursing (D.O.N.) on 8/27/13 at 8:45 a.m. contained guidelines for documentation to be done following a resident's return from dialysis, to be recorded on the "Dialysis Log" form. During an interview with the D.O.N. on 8/27/13 at 4:00 p.m., she indicated the facility had no policy or procedure related to assessment or documentation of condition of the venous access site (fistula) of a resident receiving dialysis other than when returning from dialysis. She indicated that the condition of the venous access site should be assessed and documented at a</p>				

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	<p>minimum of on a daily basis.</p> <p>A facility policy titled "Comprehensive Plan of Care" dated 8/31/12 received from the D.O.N. on 8/27/13 at 11:15 a.m. indicated:</p> <p>"Rationale: A comprehensive plan of care is developed for each patient within 7 days after completing the comprehensive assessment."</p> <p>A facility policy titled "Residents Receiving Dialysis" dated 10/31/09 received from the D.O.N. on 8/27/13 at 8:45 a.m. indicated:</p> <p>"Policy: The center provides the necessary medical and nursing care and treatment to manage the resident's end-stage renal disease.</p> <p>Compliance Guidelines:...3. Licensed nurses manage dialysis site to maintain patency and adequate blood flow for dialysis...11. Plan of care include directives for managing the resident's needs end-stage (sic) renal disease..."</p> <p>3.1-37(a)</p>				

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F000333 SS=D	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure medications were dispensed and administered in a way which prevented a resident (Resident C) from receiving 13 doses of a medication ordered for another resident (Resident E), for 1 resident of 3 reviewed for medication administration in a sample of 4.</p> <p>Findings include:</p> <p>The record of Resident C was reviewed on 8/27/13 at 9:00 a.m.</p> <p>Diagnoses included, but were not limited to, multiple sclerosis, hypertension, paraplegia, chronic pain, and anemia.</p> <p>A quarterly Minimum Data Set (M.D.S.) assessment dated 7/28/13 indicated Resident C had no cognitive impairment, required total staff assistance for activities of daily living, did not ambulate, and was incontinent of bowel and bladder.</p> <p>A physician's order date 6/20/13 indicated Resident C was to receive</p>	F000333	<p>1. Resident C's attending physician was contacted and informed of the medication administration. No new orders were recieved. Resident C's POA was contacted. Medications were reviewed and the packages containing Copaxone was marked accordingly. Medications of identical nature are placed on seperate shelves. Resident C is receiving his correct medication. The above interventions were accomplished prior to survey. 2. No resident was identified to have been affected by the medication administration. A facility audit was conducted to identify those active residents that are receiving Copaxone. Identified residents were assessed, orders reviewed and revised if needed and care plans updated if applicable. 3. Licensed staff was inserviced on medication administration which included appropriate storage if identical medications. DNS/Designee will visually observe storage of identical medications 3 times weekly. Consultant pharmacy was contacted and provided a quality assurance med pass evaluation with on the spot education as needed. 4. The Director of Nursing, or her designee, will monitor through observation,</p>	09/27/2013			

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	<p>Copaxone (a medication for reducing relapses in multiple sclerosis) 1ml/20 mg (1 milliliter, 20 milligram concentration) daily, injected under the skin.</p> <p>An event report dated 7/25/13, completed by the Nursing Unit Manager, indicated "Resident received the right medication, he received the right dose, received the medication timely; however the medication he received belonged to another resident that was receiving the same med. When counting the vials for this resident it appeared he had not received 13 doses because he had 13 vials left. The medications were kept on the same shelf and have subsequently been seperated (sic)..."</p> <p>During an interview on 8/26/13 at 4:00 p.m., the Director of Nursing indicated Resident C had received 13 doses of medication ordered and intended for resident E.</p> <p>This federal tag relates to complaint IN00133424.</p> <p>3.1-48(c)(2)</p>		<p>Medication Administration and review of Pharmacy Consultant Report, at least monthly for three months, then quarterly, to assure medications are administered according to physician's orders. Any identified issues will be immediately addressed. The DNS and or designee will report any unresolved concerns at the next monthly Performance Improvement Meeting and or until substantial compliance is achieved and the committee recommends discontinuation of the monitoring. The Executive Director is responsible for overall compliance.</p>		

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