

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00174151.</p> <p>Complaint IN00174151 Substantiated. Federal/State deficiencies related to the allegation are cited at F278, F279, F280 and F356</p> <p>Survey dates: June 2 & 3, 2015</p> <p>Facility Number: 000123 Provider Number: 155218 AIM Number: 100266720</p> <p>Census bed type: SNF/NF: 116 Total: 116</p> <p>Census payor type: Medicare: 27 Medicaid: 63 Other: 26 Total: 116</p> <p>Sample: 10</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a Desk Review of this Plan of Correction.</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 0278 SS=D Bldg. 00	<p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set assessment was accurate related to pressure ulcer assessment for 1 of 6 residents reviewed for pressure ulcers in a sample of 10. (Resident #1010)</p>	F 0278	F 278 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by	07/01/2015

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F 0279 SS=D Bldg. 00	<p>Finding includes:</p> <p>The clinical record for Resident #1010 was reviewed on 6/3/2015 at 9:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, cerebral palsy and hemiplegia.</p> <p>The discharge Minimum Data Set assessment dated 3/11/2015, indicated the resident did not have one or more unhealed pressure ulcers at Stage 1 or higher.</p> <p>The Weekly Pressure Ulcer Report dated 3/5/2015 indicated the resident had a Stage 2 pressure ulcer on the coccyx and a deep tissue injury on the right heel.</p> <p>During an interview on 6/3/2015 at 2:45 p.m., MDS Coordinator #3, indicated the 3/15/2015 Weekly Pressure Ulcer Report should have been used to code the discharge assessment and the discharge assessment was not coded accurately.</p> <p>3.1-31(i)</p>				<p>state and federal law. We respectfully request a Desk Review of this Plan of Correction. A modification to correct the discharge minimum data set was completed for resident #1010. Like residents have been identified as those requiring minimum data set assessments. The DNS/designee will audit all types of minimum data set assessments in their entirety for accuracy. Any needed corrections will be addressed. MDS coordinator will refer to data within the ARD to complete all MDS types. MDS manuals are available for use to verify definitions for each MDS question. The DNS/Designee will randomly audit 3 minimum data sets for accuracy weekly x 4 then monthly x 2. Findings will be forwarded to the monthly QI/PI committee for review. Audit criteria taken to QAPI must show 100% accuracy for a minimum of 3 consecutive months, then a random audit of 3 minimum data set records will be reviewed and reported quarterly.</p> <p>Completion July 1, 2015</p>		
	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS						

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	<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 individualized care plans for 3 of 6 residents reviewed for pressure ulcers in a sample of 10. (Residents #1006, 1009 and 1010).</p> <p>Findings include:</p> <p>1. The clinical record for Resident #1009 was reviewed on 6/2/2015 at 1:15 p.m. Diagnoses included, but were not limited to, diabetes mellitus and end-stage renal disease.</p> <p>The care plan problem of potential for pressure ulcer development related to</p>	F 0279	F 279 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a Desk Review of this Plan of Correction. The care plan for resident #1009 and #1006 were reviewed and updated. All care needs are reflective in the care plan. Like residents have been identified as those requiring care plans. Care plans have been reviewed and updated with any changes as needed to reflect	07/01/2015

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	<p>disease process and immobility was initiated 1/22/2015 relative to the Admission Minimum Data Assessment dated 1/21/2015. Problem had a target date (next care plan review date) of 7/18/2015. The goal was for staff to have interventions in place to prevent altered skin integrity. The interventions were to follow facility policies/protocols for the prevention/treatment of skin breakdown; monitor nutritional status, serve diet as ordered and monitor intake and record; and monitor/document/report to medical doctor as needed changes in skin status.</p> <p>The care plan failed to have a problem that was specific as to disease process, co-morbidities or other risk factors and the problem did not address resident's needs and strengths. The goal was not measurable, nor related to resident. The care plan interventions were not individualized, or complete. The interventions did not address support surfaces and redistribution to prevent skin breakdown, repositioning, resident choices or moisture factor of resident's incontinency of bowel and bladder.</p> <p>A care plan problem of actual impairment to skin integrity related to pressure ulcer of spine was initiated 4/14/2015. The goal was for the pressure ulcer to exhibit signs of healing evidenced by decrease in</p>		<p>specific strengths, needs and co-morbidities. Changes in patients care needswill be evaluated by the clinical team during clinical meetings. Care plans will be reviewed and updated asidentified during clinical meetings. The MDS team/designee willrandomly audit three (3) records for accuracy weekly x 4 weeks then monthly x2. Findings will be reviewed by QI/PIcommittee during monthly meetings for further discussion of continuation or resolution. Completion date July 1,2015</p>		

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	<p>size, improved appearance, and free of signs and symptoms of infection. The interventions were to encourage good nutrition and hydration in order to promote healthier skin; identify/document potential causative factors and eliminate/resolve where possible; keep skin clean and dry with use of lotion on dry skin; and monitor/document location, size and treatment of skin injury; report abnormalities, failure to heal, signs and symptoms of infection, maceration etc. to medical doctor.</p> <p>The care plan failed to have a problem that addressed causative factor (s) related to the development of the pressure ulcer on the spine. The interventions did not address support surfaces and redistribution to prevent skin breakdown, repositioning, or resident choices. The approaches did not address specific interventions related to possible causative factors.</p> <p>During an interview on 6/3/2015 at 1:00 p.m., Minimum Data Set Coordinator #3, indicated the facility was not to use the intervention of follow facility policies/protocols for the prevention/treatment of skin breakdown and the care plan should have reflected more specific interventions.</p>			

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	<p>2. The clinical record for Resident #1010 was reviewed on 6/3/2015 at 9:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, cerebral palsy and hemiplegia.</p> <p>During an observation on 6/3/2015 at 9:30 a.m., the resident demonstrated she could reposition herself in bed. The resident was observed laying on mattress with no pillows being used under her legs or feet. The resident had socks on her feet, but no pressure relieving boots were observed on the resident's feet.</p> <p>During an observation on 6/3/2015 at 3:40 p.m., the resident was observed laying on the bed mattress with no pillows being used under her legs or feet. The resident had socks on her feet, but no pressure relieving boots were observed on the resident.</p> <p>The care plan problem of potential for pressure ulcer development related to occasional incontinence and requires extensive assistance with activities of daily living was initiated 7/26/2013. Care plan was revised on 7/9/2014, continued for the annual Minimum Data Assessment dated 4/21/2015, and had a target date (next care plan review date) of 7/12/2015. The goal was to have intact</p>			

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	<p>skin and be free of redness, blisters or discoloration. The interventions were to monitor nutritional status, serve diet as ordered and monitor intake and record; obtain and monitor lab/diagnostic work as ordered, report results to medical doctor and follow up as indicated; provide perineal care with each incontinent episode; and turn and reposition per facility policy.</p> <p>The annual Minimum Data Set assessment dated 4/21/2015 indicated the resident was continent of bowel and the resident was able to reposition herself in bed.</p> <p>The care plan failed to have a problem that addressed co-morbidity of diabetes mellitus and the resident's needs and strengths. The interventions did not address support surfaces and redistribution to prevent skin breakdown and resident choices.</p> <p>The care plan problem of pressure ulcer to the right heel related to immobility was initiated 2/23/2015. The goal was for the resident to not develop any new areas of skin breakdown. The interventions included, but were not limited to, administer medications as ordered, monitor/document for side effects and effectiveness; administer treatment as</p>			

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	<p>ordered; assess/record/monitor wound healing; follow facility policies/protocols for the prevention of skin breakdown; and float heels while in bed. The intervention of relief of pressure on heels with pillows under heels/boots when in bed was initiated 4/27/2015.</p> <p>During an interview on 6/3/2015 at 9:30 a.m., the resident indicated she could reposition herself in bed.</p> <p>3. The clinical record for Resident #1006 was reviewed on 6/3/2015 at 1:00 p.m. Diagnoses included, but were not limited, to quadriplegia and multiple sclerosis.</p> <p>The care plan problem of impairment to skin integrity to coccyx related to incontinence was initiated 5/14/2015 for annual Minimum Data Set dated 4/14/2015. The goal was that the coccyx wound would be healed by review date. The interventions included cleanse area with normal saline, pat dry, apply calmoseptine (skin protectant) every shift to coccyx until healed; turn and reposition while in bed every 2 hours; and encourage resident not to scratch skin related to long fingernails that she refused to have cut.</p> <p>The care plan failed to have a problem</p>			

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F 0280 SS=D Bldg. 00	<p>that addressed co-morbidities of quadriplegia or multiple sclerosis and causative factors. The goal was not measurable. The interventions did not address resident choice of wanting staff to wake her during night to turn and reposition her.</p> <p>3.1-35(a)(b)(d)</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent</p>			

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	<p>practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on interview and record review, the facility failed to revise care plans for 3 of 6 residents reviewed for pressure ulcers in a sample of 10. (Residents #1002, 1005, and 1006).</p> <p>1. The clinical record for Resident #1002 was reviewed on 6/2/2015 at 3:15 p.m. Diagnoses included, but were not limited to, diabetes mellitus, cerebral vascular accident and chronic ulcers.</p> <p>A care plan problem of alteration in skin integrity of the right outer ankle, deep tissue injury, was initiated 4/15/2015. The goal was for the wound to decrease in size weekly until resolved. The interventions were to administer medications per physician order, see medication record; complete daily monitoring pressure ulcer report; avoid pressure from draining tubes, Foley catheter; follow physician orders for skin care and treatment; monitor pain/comfort level every shift as needed and medicate per physician order; turn and reposition every two hours; speciality mattress; monitor for signs and symptoms of infection; and wound doctor to follow wounds for treatment and adjustments as</p>	F 0280	<p>F 280 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a Desk Review of this Plan of Correction. The care plan for resident #1002, 1005 and # 1006 have been updated and are current. All specifics to wound care plans are current. Resident #1002's care plan reflects the changes in staging of right ankle wound. Resident #1005's care plan has been updated to reflect time to be out of bed. Resident #1006's care plan has been updated to reflect the resolution of right lateral foot wound. Resident care plans that address wounds have the potential to be affected as not being current. All wound care plans will be evaluated for accuracy. Any needed corrections will be completed immediately. All wound care changes will be updated in their care plan a minimum of weekly. These will be reviewed for accuracy by the IDT committee</p>	07/01/2015

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	<p>needed.</p> <p>A wound doctor progress note was dated 4/29/2015 indicated, the wound on the right outer ankle was unstageable due to necrosis.</p> <p>The current care plan problem was not revised to address current staging with goals and interventions associated with current staging. The care plan problem did not address causative factor (s) related to the development of the pressure ulcer on the ankle and co-morbidities of cerebral vascular accident and diabetes mellitus. The problem did not address the resident's needs and strengths. The goal was not measurable and the interventions did not include specific approaches for healing of ankle.</p> <p>During an interview on 6/3/2015 at 3:10 p.m., Minimum Data Set Coordinator #3, indicated the care plan had not been updated to reflect the change in staging of the pressure ulcer.</p> <p>2. The clinical record for Resident #1005 was reviewed on 6/3/2015 at 11:00 a.m. Diagnoses included, but were not limited to, diabetes mellitus, anemia, and bladder cancer.</p> <p>The care plan problem of pressure ulcer</p>		<p>during their weekly meeting. The MDS team/designee will randomly audit wound care plans for accuracy 3 days per week for 4 weeks, then weekly for 1 month. All audits will be reviewed by QI/PI committee during monthly meeting for further discussion of continuation or resolution. Completion date July 1, 2015</p>				

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	<p>related to mobility was initiated 5/14/2015 for the Admission Minimum Data Set dated 5/20/2015. The goals were for the pressure ulcer to show signs of healing and remain free from infection; exhibit signs of healing evidenced by decreased in wound size, improved appearance; and be free of signs and symptoms of infection. The approaches were to monitor nutritional status, monitor/document/report to physician changes in skin status, appearance, color, wound healing, signs and symptoms of infection and wound size.</p> <p>The care plan failed to have a problem that addressed co-morbidities of cancer or diabetes mellitus and causative factors. The problem did not address the resident's needs and strengths. The interventions did not address support surfaces and redistribution to prevent skin breakdown, resident choices, nor specific interventions related to possible causative factors. The interventions did not include the physician order dated 5/20/2015 which indicated resident was to be up for only one hour at a time.</p> <p>During an interview on 6/3/2015 at 3:15 p.m., Minimum Data Set Coordinator #3, indicated the care plan had not been updated to reflect the intervention of the</p>			

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F 0356 SS=C Bldg. 00	<p>limited time the resident was to be up in the chair.</p> <p>3. The clinical record for Resident #1006 was reviewed on 6/3/2015 at 1:00 p.m. Diagnoses included, but were not limited to, quadriplegia and multiple sclerosis.</p> <p>The care plan problem of new deep tissue injury to the right lateral foot was initiated 1/14/2015.</p> <p>During an interview on 6/3/2015 at 3:00 p.m., Minimum Data Set Coordinator #3, indicated the pressure ulcer was resolved on 1/21/2015. The Minimum Data Set Coordinator #3 indicated the care plan problem had not been updated to reflect the resolution of the pressure ulcer.</p> <p>3.1-35(d)(2)(B)</p> <p>483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/03/2015
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	<p>- Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.</p> <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.</p> <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>Based on observation, record review, and interview, the facility failed to ensure that the daily staffing pattern posted included the hours worked for licensed and unlicensed direct care staff.</p> <p>Finding includes:</p> <p>On 6/2/2015 at 8:28 a.m. the daily staffing sheet was observed posted in the lobby area of the Main Entrance. There were no hours worked noted for 6-2 Shift, 2-10 Shift or 10-6 Shift, for RN's, LPN's, QMA's or CNA's for 6/1/2015.</p>	F 0356	<p>F 356 This Plan of Correction constitutes my written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. We respectfully request a Desk Review of this Plan of Correction.</p> <p>The daily staffing sheet was corrected immediately.</p> <p>Hours were added to the posted staffing sheet.</p> <p>The staffing sheet was</p>	06/26/2015

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	<p>Review of the daily staffing sheets, on 6/2/2015 at 12:15 p.m. indicated that there were no licensed and unlicensed staffing hours worked, reported for 6-2 Shift, 2-10 Shift, 10-6 Shift, for RN's, LPN's, QMA, or CNA's for 3 records reviewed dated, June 1, 2015, June 2, 2015, and December 1, 2014</p> <p>Interview with Administrator on 6/3/2015 at 4:25 p.m., indicated that the hours worked were not included on the staffing sheets.</p>		<p>further lowered to wheelchair level immediately.</p> <p>The administrator/designee will audit the form minimally three times a week for accuracy.</p> <p>Any needed corrections will be done so immediately.</p> <p>Completion June 26, 2015</p>		