

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 04/01/2013
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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 IN00125830, IN00126256, IN00126530, and IN00126665.</p> <p>Complaints IN00125830 and IN00126530 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00126256 - Substantiated. Federal/state deficiency related to the allegations is cited at F246.</p> <p>Complaint IN00126665 - Substantiated. Federal/state deficiency related to the allegations is cited at F157.</p> <p>Survey dates: March 26, 27, 28, April 1, 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: 118 Total: 118</p>	F000000		

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>Census payor type: Medicare: 25 Medicaid: 77 Other: 16 Total: 118</p> <p>Sample: 13</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 4/02/13 by Suzanne Williams, RN</p>			

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F000157 SS=D	<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 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 a resident's physician was consulted when a medication was not continued following a hospital stay, resulting in</p>	F000157	Preparation and/or execution 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.	04/19/2013			

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	<p>the resident (Resident F) not receiving a medication for 15 months. This deficient practice affected 1 resident of 3 reviewed for medications in a sample of 13.</p> <p>Findings include:</p> <p>1. The record of Resident F was reviewed on 3/28/13 at 2:30 p.m.</p> <p>Diagnoses included, but were not limited to, a history of breast cancer with mastectomy and chemotherapy, history of a gun shot wound to the head, chronic obstructive pulmonary disease, and diabetes mellitus.</p> <p>A Minimum Data Set (M.D.S) annual assessment dated 1/16/13 indicated Resident F was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>A hospital discharge medication list dated 5/24/11, the day before Resident F's admission to the facility, included an order for tamoxifen citrate (an anti-cancer drug) 20 milligrams a day.</p> <p>Facility admission orders dated 5/25/11 included an order for</p>		<p>This plan of correction is prepared and/or executed solely because required.</p> <p>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Resident #F's MD was notified upon notification from family and medication was restarted. There were no adverse affects. (b)How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: A facility audit was conducted to identify current residents that had been discharged in past 30 days and readmitted back to the facility had any medications that were taken prior to discharge to the hospital was either removed or discontinued while in the hospital and discuss those changes with the MD. Any identified issues will result in immediate MD notification and disciplinary action/counseling to the responsible caregiver. (C) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: Licensed nursing staff was educated regarding MD/Family notification with change of condition including reconciliation of medications prior to and post transfers from the facility and communication with the MD for specific medication changes. Medical records will place a copy</p>		

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	<p>tamoxifen citrate 20 milligrams a day.</p> <p>Resident F was transferred to an acute care hospital for evaluation and treatment on 12/06/11. The medication list provided to the hospital by the facility included the order for tamoxifen citrate.</p> <p>Resident F returned to the facility on 12/16/11. Discharge orders from the hospital did not contain an order for tamoxifen citrate.</p> <p>Resident F's readmission orders to the facility did not include tamoxifen citrate.</p> <p>Resident F's Nursing Unit Manager was interviewed on 3/28/13 at 3:30 p.m. She indicated that a family member had advised her that during an out of facility physician's appointment, it was discovered tamoxifen citrate was not currently being administered. Following a review of Resident F's history, she contacted the resident's physician and obtained an order to restart the medication on 3/21/13.</p> <p>Resident F's record contained no documentation of contact with the physician to determine whether the tamoxifen citrate should have been</p>		<p>of the previous medication list in the new file upon return from the hospital to be able to accurately complete reconciliation. (d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place: DNS/Designee will review admission medications to compare with previous medication list to identify any discrepancies 5 days weekly and discuss during morning clinical meeting, any identified issues will result in review of Residents clinical record to ensure documentation of MD/Family notification this will be an ongoing plan of correction. The ED will report results of audits at the next PI meeting and monthly for 3 months then will have quarterly monitoring by the DNS/Designee to maintain compliance. (e) Date of compliance: 4-19-13</p>				

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	<p>continued following his hospital stay.</p> <p>During an interview on 4/01/13 at 2:30 p.m. with the Administrator, Director of Nursing (D.O.N.) and Nursing Unit Manager, the D.O.N. indicated the facility should have followed up with the resident's physician to determine if the tamoxifen citrate, a medication Resident F had been on since his treatment for cancer had begun in 2007, should have been re-started following his hospitalization in December 2011. She indicated she did not know why this did not occur.</p> <p>This federal tag relates to Complaint IN00126665.</p> <p>3.1-5(a)(3)</p>				

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F000246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. Based on observation, interview and record review, the facility failed to ensure call lights were accessible for 8 residents who were dependent on staff for assistance with mobility and activities of daily living or had identified safety risks(Residents G, H, I, J, K, L, M, and N) of 8 residents reviewed for call lights in a sample of 13.</p> <p>Findings include:</p> <p>1. The record of Resident G was reviewed on 4/01/13 at 8:30 a.m.</p> <p>Diagnoses included, but were not limited to, cerebrovascular disease, chronic respiratory failure, coronary artery disease, gastrostomy feeding tube, and tracheostomy.</p> <p>An admission Minimum Data Set (M.D.S) assessment dated 2/28/13 indicated Resident G was cognitively impaired, did not ambulate, required staff assistance for all activities of</p>	F000246	<p>Preparation and/or execution 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 executed solely because required.</p> <p>F-246 Accommodation of Needs (a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice: Residents F, G, H, I, J, K, L, M, and N had no adverse effects. The nursing staff was re-educated on the facility standard and guidelines for call lights. .</p> <p>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken: Current Resident rooms were audited to ensure call lights were in place and functioning properly.</p> <p>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur: .</p> <p>The facility staff will be re-educated on accommodation of needs including the availability of call lights and proper</p>	04/19/2013			

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	<p>daily living, and was incontinent of bowel and bladder.</p> <p>A Nursing Assessment dated 2/19/13 indicated Resident G was unable to get out of bed without assistance, had moderate to severe disorientation, and did not speak.</p> <p>During an observation on 3/27/13 at 10:10 a.m., the call light for Resident G was noted to be not accessible to the resident. A private duty nurse and a facility maintenance worker in the room at the time looked for the call light and found it under the bed.</p> <p>2. The record of Resident H was reviewed on 4/01/13 at 9:00 a.m.</p> <p>Diagnoses included, but were not limited to, cerebrovascular disease, congestive heart failure, coronary artery disease, gastrostomy feeding tube, diabetes mellitus, and tracheostomy.</p> <p>An admission Minimum Data Set (M.D.S) assessment dated 1/05/13 indicated Resident H was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, had a urinary catheter, and was incontinent of bowel.</p>		<p>placement for Residents Clips ordered for call lights so they can be positioned appropriately for availability to the Residents.</p> <p>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</p> <p>The Unit Managers/Designees will randomly audit 5 residents rooms daily for the next 4 weeks then weekly x 4 weeks and randomly thereafter, to determine if residents have access and availability to the call lights. Review of these audits will be reported at the monthly QA/PI meeting for 3 months then monitored quarterly with System reviews.</p> <p>(e) Date of compliance: 4-19-13</p>		

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	<p>A Nursing Assessment dated 1/14/13 indicated Resident H was non verbal, had limited sensory perception, was completely immobile, and was at high risk for pressure sores.</p> <p>Resident H had a breath pressure activated call light. During an observation on 3/27/13 at 11:40 a.m., the tube to the call light was not positioned so the resident could access it. LPN #1, who was in the room at the time, indicated "Oh, I'm not sure what happened" and moved the call light tube so it was accessible.</p> <p>3. The record of Resident I was reviewed on 4/01/13 at 9:30 a.m.</p> <p>Diagnoses included, but were not limited to, cerebrovascular disease with hemiplegia, chronic systolic heart failure, altered mental status, and dysphagia.</p> <p>A quarterly Minimum Data Set (M.D.S) assessment dated 1/17/13 indicated Resident G was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>A Nursing Assessment dated 1/11/13 indicated Resident I was at high risk</p>				

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	<p>for pressure sores, required staff assistance to move in bed, and had poor safety awareness.</p> <p>A care plan for Resident I dated 11/27/12 indicated "At risk for falls...Be sure the call light is within reach...."</p> <p>During an observation on 3/27/13 at 1:30 p.m., Resident I's call light was observed to be hanging off the bed and not accessible to the resident.</p> <p>4. The record of Resident J was reviewed on 4/01/13 at 8:30 a.m.</p> <p>Diagnoses included, but were not limited to, congestive heart failure, convulsions, coronary artery disease, dementia, hypertension, atrial fibrillation, and a gastrostomy feeding tube.</p> <p>An significant change Minimum Data Set (M.D.S) assessment dated 2/27/13 indicated Resident J was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>A Nursing Assessment dated 3/14/13 indicated Resident J was at risk for pressure sores, had a history of falls,</p>						

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	<p>and was frequently incontinent.</p> <p>A care plan for Resident J dated 3/14/13 indicated "...is at high risk for falls...Be sure call light is within reach."</p> <p>5. The record of Resident K was reviewed on 4/01/13 at 10:30 a.m.</p> <p>Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes mellitus, hypertension, heart disease, and dementia.</p> <p>An admission Minimum Data Set (M.D.S) assessment dated 3/19/13 indicated Resident K was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>A Nursing Assessment dated 3/12/13 indicated Resident G was unable non-verbal, at high risk for pressure sores, was unable to get out of bed without assistance, and was disoriented to time and place.</p> <p>A care plan for Resident K dated 3/22/13 indicated "At high risk for falls...Be sure call light is within reach."</p>						

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	<p>6. The record of Resident L was reviewed on 4/01/13 at 11:00 a.m.</p> <p>Diagnoses included, but were not limited to, intestinal obstruction, gastrostomy feeding tube, cerebrovascular disease, dementia with delirium, and atrial fibrillation.</p> <p>An annual Minimum Data Set (M.D.S) assessment dated 2/10/13 indicated Resident L was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>A Nursing Assessment dated 2/07/13 indicated Resident L was unable to get out of bed without assistance, and was at risk for pressure sores.</p> <p>A care plan for Resident L dated 2/07/13 indicated "Is at risk for falls...Be sure call light is within reach."</p> <p>7. The record of Resident M was reviewed on 4/01/13 at 11:30 a.m.</p> <p>Diagnoses included, but were not limited to, organic brain disease, dementia with behavioral disturbance, psychosis, and a personal history of</p>						

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	<p>falls.</p> <p>An annual Minimum Data Set (M.D.S) assessment dated 1/02/13 indicated Resident M was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was incontinent of bowel and bladder.</p> <p>A Nursing Assessment dated 3/27/13 indicated Resident M was non verbal, at high risk for pressure sores, was totally immobile in bed, and had altered safety awareness.</p> <p>A care plan for Resident M dated 1/16/13 indicated "High risk for falls...Be sure call light is within reach."</p> <p>8. The record of Resident N was reviewed on 4/01/13 at 1:00 p.m.</p> <p>Diagnoses included, but were not limited to, a history of traumatic brain injury, diabetes mellitus, paraplegia, hypertension, and vascular dementia.</p> <p>A significant change Minimum Data Set (M.D.S) assessment dated 2/10/13 indicated Resident N was cognitively impaired, did not ambulate, required staff assistance for all activities of daily living, and was</p>						

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	<p>incontinent of bowel, and had an indwelling urinary catheter.</p> <p>A Nursing Assessment dated 3/11/13 indicated Resident N had limited sensory perception, was at high risk for pressure sores, had a history of falls, and was at high risk for falls.</p> <p>A care plan for Resident N dated 2/28/13 indicated "At risk for falls...Be sure call light is within reach."</p> <p>During an interview on 3/28/13 at 11:30 a.m. the D.O.N. indicated it was facility policy for all residents to have a call light accessible.</p> <p>9. A facility policy received from the D.O.N. on 3/28/13 at 8: 30 a.m., titled "Call Light, Use Of," dated 9/25/03, indicated:</p> <p>"The call light is a communication tool for the resident to request assistance...Position call light within reach of the resident..."</p> <p>This federal tag relates to Complaint IN00126256.</p> <p>3.1-3(v)(1)</p>						