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
	155272		08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	5226 E 82ND ST INDIANAPOLIS, IN 46250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00178700 Complaint IN00178700--Substantiated. Federal/state deficiency is cited at F271, F278, F309 and F514. Survey date: August 3, 4, and 5, 2015 Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census bed type: SNF/NF: 99 Total: 99 Census payor type: Medicare: 14 Medicaid: 67 Other: 18 Total: 99 Sample: 3 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	**Preparation and/or execution of this plandoes not constitute admission or agreement by the provider of the truth of thefacts alleged or conclusions set forth on the statement of deficiencies. Thisplan of correction is prepared and/or executed solely because required.** August 18, 2015 ISDH ATT: Kim Rhoades Director of Long Term Care 2 North Meridian Street Indianapolis, Indiana 46204 RE: Complaint(IN00178700) Survey Kindred Transitional Care and Rehabilitation Castleton 5226 East 82nd Street Indianapolis, Indiana 46250 Dear Kim Rhoades: On August 5, 2015 a survey team from the Indiana State Departmentof Health completed a Complaint Survey at Kindred Transitional Care andRehabilitation Allison Pointe. Pleasefind the submitted Statement of Deficiencies with the facility's Plan ofCorrection for these alleged 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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			Please consider this letter and Plan of Correction to be thefacility's credible allegation of compliance. This letter is our request for a desk review that the facility hasachieved substantial compliance with the applicable requirement as of the dateset forth in the Plan of Correction of August 28, 2015. Please feel free to call me with any further questions at (317)842-6668. Respectfully submitted, Keary Dye Executive Director	
F 0271 SS=D Bldg. 00	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's immediate care. Based on interview and record review, the facility failed to ensure a resident admitted with multiple Stage 4 pressure areas (full skin thickness tissue loss with exposed bone, tendon or muscle) had admission orders for the care and treatment of the pressure areas for 1 of 3 residents reviewed for pressure areas in a sample of 3. This deficient practice has the potential to negatively impact the care and services for this resident which could result in continued decline in the	F 0271	**F 271 Admission Physician Orders** 1.Resident#C has appropriate physician orders for wound care. Orders are reviewed weeklyby the wound care nurse and physician. Identified pressure wounds did notdecline and continue to improve. 2.A full review of admission physicianorders for those residents admitted with pressure areas over the past thirtydays was completed to determine orders were present for immediate care. Physicians were notified and orders wereobtained if	08/28/2015

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	resident's skin and general health status. (Resident #C) Findings include: Resident #C's clinical record was reviewed on 8-4-15 at 10:35 a.m. Her diagnoses included, but were not limited to, Stage 4 pressure areas and osteomyelitis (bone infection). Review of the admission nursing progress notes, dated 7-8-15, indicated Resident #C had seven Stage 4 pressure areas present. Review of the admission recapitulation orders, dated 7-8-15 at 11:54 p.m. indicated an absence of any care or treatment orders for the pressure areas. A telephone order form, dated 7-14-15, six days after admission, indicated the care and treatment for Resident #C's pressure areas. In an interview with the Wound Nurse on 8-4-15 at 12:40 p.m., she indicated there should be admission orders for the care and treatment of Resident #C's pressure areas, but she could not find them. In an interview with the Director of Nursing (DON) on 8-5-15 at 11:15 a.m., she indicated the former Wound Nurse had seen Resident #C on 7-9-15, following the resident's admission late		needed. Any resident had the potential to be affected however nonewere identified. 3.Licensed nursing staff will be educatedon the components of F271. At the timeresidents are admitted, the facility will have physician orders to meet theresident's immediate need. The Unit Managers/designee will reviewadmission orders within twenty-four hours of admission to determine admissionorders are present for immediate resident care, with specific focus on pressurewound orders. The DNS/designee will audit threeadmission records weekly to determine admission orders are present andappropriate. The wound care nurse will review woundorders on new admissions that require wound care for pressure areas onregularly scheduled days of work for appropriate treatment. Identified areas of concern will result inadditional education. New nursing employees will be educated duringorientation, per the Staff Development Coordinator, on the requirement ofobtaining appropriate admission orders for new admissions with specific focuson pressure wounds. 4.The responsible party for this planof correction is the Director of Nursing. The DNS\ designee will audit threeresident admission records weekly for 6 months then randomly	

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	evening on 7-8-15. She indicated the former Wound Nurse had verified care and treatment orders for the pressure areas on 7-9-15, but those orders could not be located. The DON provided documentation of the care and treatment of the pressure areas prior to the resident's admission to the facility. The DON provided documentation of care and treatment orders that had been listed in the facility's electronic medical record for Resident #C's pressure areas that had been indicated to have start dates of 7-10-15, two days after the resident's admission. She indicated she could not explain why admission orders for the care and treatment of the pressure areas were not in place. This Federal tag relates to Complaint IN00178700. 3.1-19(a)		to ensure continuedcompliance. Results of the audits will be taken to thenext Performance Improvement Meeting and monthly thereafter to determine 100%continued compliance.	
F 0278 SS=D Bldg. 00	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed.			

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	Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. 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. Clinical disagreement does not constitute a material and false statement.			
	Based on interview and record review, the facility failed to ensure an admission Minimum Data Set (MDS) assessment accurately reflected the number of pressure areas for a resident with multiple pressure areas for 1 of 3 residents in a sample of 3 reviewed for pressure areas. This deficient practice has the potential to negatively impact the care and services for this resident which could result in continued decline in the resident's skin and general health status. (Resident #D Findings include: Resident #D's clinical record was reviewed on 8-4-15 at 11:20 a.m. His diagnoses included, but were not limited to, pressure areas with wound sepsis	F 0278	F278- 1. Residents #D no longer resides within the facility. 2. An audit ofassessments, (Section M of the Minimum Data Set), completed over the last30days that included those residents with pressure ulcers was completed todetermine accuracy with coding. Any identified areaof concern was immediately corrected. 3. An inservice was provided to the interdisciplinary teamon coding the RAI's correctly with a focus on section M-Skin conditions on8-10-2015 The Director of Nursing/designee will review two residentrecords weekly to determine compliance with RAI coding accuracy related toSection M- Skin Conditions of the MDS. Identification of	08/28/2015

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	(potentially life-threatening infection) and osteomyelitis (bone infection). Review of Resident #D's admission MDS assessment, dated 7-8-15, indicated he had one Stage 4 pressure area (full skin thickness tissue loss with exposed bone, tendon or muscle) and two venous or arterial ulcers upon admission to the facility. Review of the admission nursing assessment, entitled, "Patient Nursing Evaluation, Part 1", "Section F: Skin Inspection," dated 7-1-15 at 9:14 p.m., indicated Resident #D had six pressure areas, with no stage specified, and one blister area. In an interview with the Director of Nursing (DON) on 8-5-15 at 1:05 p.m., she indicated the MDS Nurse was not working and unavailable for an interview. She indicated she would expect the MDS Nurse to have spoken with the Wound Nurse for any clarifications regarding Resident #D's wounds. She indicated the nurse that was the facility's Wound Nurse at the time of the admission MDS assessment was no longer employed by the facility. She indicated she would have expected the MDS Nurse would have utilized the information available in the admission nursing assessment.		any inaccuracies in codingwill be immediately corrected and additional education provided. 4. The responsible party for this plan of correction isthe Executive Director/designee. Review of the RAI audits will be taken to thenext Performance Improvement meeting and for six months thereafter and or untilthe Committee determines 100% compliance has been achieved.	

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	The DON provided documentation for pressure area measurements and assessments for Resident #D, dated 7-7-15, one day prior to the date of the admission MDS assessment. She indicated the facility's electronic medical records (EMR) system will not post entries until the entry is "signed and locked" by the writer. She indicated in the case of Resident #D, the former Wound Nurse's entries for 7-7-15, only the entry regarding the sacral pressure area was "signed and locked" on 7-7-15 and the other six entries for the other pressure areas were dated for 7-7-15, but not "signed and locked" until 7-13-15. Thus, the six entries not "signed and locked" until 7-13-15 for 7-7-15 would not have been posted until 7-13-15. She indicated the only explanation she could provide for the delayed documentation was the Wound Care Team sometimes gets behind in their documentation due to a large volume of pressure areas that requires a lot of time to complete. This Federal tag relates to Complaint IN00178700. 3.1-31(g)			
F 0309 SS=D Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING			

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	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. Based on interview and record review, the facility failed to ensure call lights were responded to in a timely manner for 2 of 3 residents in a sample of 3, reviewed for call light response time, pressure areas, urinary catheters and colostomies. The delayed responses resulted in each of the resident's colostomy bags having significant leakage which created an unpleasant situation in their bed and on their person and has the potential to contribute to possible infection(s) related to pressure areas and the urinary tract. (Resident #B and #D) Findings include: A. Resident #B's clinical record was reviewed on 8-3-15 at His diagnoses included, but were not limited to, pressure areas with wound sepsis (potentially life-threatening infection), osteomyelitis (bone infection), colostomy and urinary catheter. His admission Minimum Data Set assessment, dated 5-30-15, indicated he was cognitively impaired.	F 0309	**F309** 1. Resident's #B and #D no longer reside within the facility **2.** Any residenthas the potential to be affected**.** Interviews are conducted weekly with residents, staff andfamily members. Any concerns voicedregarding call light response will be addressed immediately. Intermittent checkswill continue with residents and family to ensure the issues do notresurface. **3.** Facility staffwas educated on resolving call light issues and customer satisfaction.Interviews are conducted weekly with residents, staff and family members. Any concerns voiced regarding call lightresponse will be addressed immediately. Intermittent checks with residents andfamily will continue during daily facility rounding to ensure the issue doesnot resurface. Audits will be conducted regarding call light usage andresponse times on all three shifts to identify any patterns. **4.** Theresponsible party for this plan	08/28/2015

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	In an interview with a family member of Resident #B on 8-3-15 at 12:20 p.m., she indicated in the last month during a visit with Resident #B, she activated the call light to request the colostomy bag be changed as it was full and leaking. She indicated it took several hours from the time the call light was activated and until the colostomy bag was changed. She indicated the stool leakage from the colostomy bag concerned her due to Resident #B has a suprapubic catheter and several significant pressure areas. B. Resident #D's clinical record was reviewed on 8-4-15 at 11:20 a.m. His diagnoses included, but were not limited to, seven pressure areas with wound sepsis (potentially life-threatening infection), osteomyelitis (bone infection), colostomy and urinary catheter. His admission Minimum Data Set assessment, dated 7-8-15, indicated he was cognitively intact. In an interview with Resident #D on 8-4-15 at 9:20 a.m., he indicated call light response times varied from one minute to one hour. He indicated he had an experience in the last month in which the delayed response time to his call light activation resulted in his colostomy beginning to leak and needing the		of correction is the Executive Director/designee. To ensure continued compliance,Director of Nursing/designee will audit call light usage and response time, onall three shifts to identify patterns of call light use such as mealtimes,bedtime, or shift change. Audits and interviews will continue for six months,if at that time call light issues have substantially declined audits willswitch to random weekly. Review of thedata will be taken to the next monthly Performance Improvement Committee andmonthly thereafter until the committee determines ongoing compliance andrecommends discontinuation.	

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	attention of the staff to it leaking badly and "exploded." He indicated this resulted in stool on him and on the bed. This Federal tag relates to Complaint IN00178700. 3.1-37(a)			
F 0514 SS=D Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on interview and record review, the facility failed to ensure the clinical records of 2 of 3 residents reviewed for pressure areas, in a sample of 3, were timely, complete and accurately reflected their care and services. This deficient practice has the potentially adversely affect the care and servces for each resident. (Resident #C and #D) Findings include:	F 0514	F514 D Clinical Records 1. Resident #C has appropriate orders for wound care.Orders are reviewed weekly by the wound care nurse and physician. Identifiedpressure areas did not decline and continue to improve. Resident #D no longer resides within the facility 2. A full review of physician orders for thoseresident admitted with pressure areas over the past 30 days	08/28/2015

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	A. Resident #C's clinical record was reviewed on 8-4-15 at 10:35 a.m. Her diagnoses included, but were not limited to, Stage 4 pressure areas and osteomyelitis (bone infection). Review of the admission nursing progress notes, dated 7-8-15, indicated Resident #C had seven Stage 4 pressure areas present. Review of the admission recapitulation orders, dated 7-8-15 at 11:54 p.m. indicated an absence of any care or treatment orders for the pressure areas. A telephone order form, dated 7-14-15, six days after admission, indicated the care and treatment for Resident #C's pressure areas. In an interview with the Wound Nurse on 8-4-15 at 12:40 p.m., she indicated there should be admission orders for the care and treatment of Resident #C's pressure areas, but she could not find them. In an interview with the Director of Nursing (DON) on 8-5-15 at 11:15 a.m., she indicated the former Wound Nurse had seen Resident #C on 7-9-15, following the resident's admission late evening on 7-8-15. She indicated the former Wound Nurse had verified care and treatment orders for the pressure areas on 7-9-15, but those orders could		was completed todetermine orders were present for immediate care An audit of assessments (section M of the Minimum DataSet), completed over the last 30 days that included those residents withpressure ulcers was completed to determine accuracy with coding. Any identified area of concern wasimmediately corrected. 3. Licensed nursing staff will be educated on.obtaining Admission Orders at the time residents are admitted; the facilitywill have physician orders to meet the resident's immediate need. The Unit Managers/designeewill review admission orders within twenty-four hours of admission to determineadmission orders are present for immediate resident care, with specific focuson pressure wound orders. The DNS/designee will auditthree admission records weekly to determine admission orders are present andappropriate. The wound care nurse willreview wound orders on new admissions that require wound care for pressureareas on regularly scheduled days of work for appropriate treatment. Identified areas of concern will result inadditional education. New nursing employees will be educated duringorientation, per the Staff Development Coordinator, on the requirement ofobtaining appropriate admission orders for new admissions with specific focuson pressure wound.	

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	not be located. The DON provided documentation of the care and treatment of the pressure areas prior to the resident's admission to the facility. The DON provided documentation of care and treatment orders that had been listed in the facility's electronic medical record for Resident #C's pressure areas that had been indicated to have start dates of 7-10-15, two days after the resident's admission. She indicated she could not explain why admission orders for the care and treatment of the pressure areas were not in place. B. Resident #D's clinical record was reviewed on 8-4-15 at 11:20 a.m. His diagnoses included, but were not limited to, pressure areas with wound sepsis (potentially life-threatening infection) and osteomyelitis (bone infection). Review of Resident #D's admission MDS assessment, dated 7-8-15, indicated he had one Stage 4 pressure area (full skin thickness tissue loss with exposed bone, tendon or muscle) and two venous or arterial ulcers upon admission to the facility. Review of the admission nursing assessment, entitled, "Patient Nursing Evaluation, Part 1", "Section F: Skin Inspection," dated 7-1-15 at 9:14 p.m.,		An in-service was provided tothe interdisciplinary team on coding the RAI's correctly with a focus onsection M-Skin conditions on 8-10-2015 The Director ofNursing/designee will review two resident records weekly to determinecompliance with RAI coding accuracy related to Section M- Skin Conditions ofthe MDS. Identification of anyinaccuracies in coding will be immediately corrected and additional educationprovided. 4.The responsible party for this monitoring will be the Facility ExecutiveDirector\designee. The DNS\ designee will audit three resident admissionrecords weekly for 6 months then randomly, as well as two RAI audits weekly forsix months.. Results of the above auditswill be taken to the next Performance Improvement meeting and for six monthsthereafter and or until the Committee determines 100% compliance has beenachieved.	

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	indicated Resident #D had six pressure areas, with no stage specified, and one blister area. In an interview with the Director of Nursing (DON) on 8-5-15 at 1:05 p.m., she indicated the MDS Nurse was not working and unavailable for an interview. She indicated she would expect the MDS Nurse to have spoken with the Wound Nurse for any clarifications regarding Resident #D's wounds. She indicated the nurse that was the facility's Wound Nurse at the time of the admission MDS assessment was no longer employed by the facility. She indicated she would have expected the MDS Nurse would have utilized the information available in the admission nursing assessment. The DON provided documentation for pressure area measurements and assessments for Resident #D, dated 7-7-15, one day prior to the date of the admission MDS assessment. She indicated the facility's electronic medical records (EMR) system will not post entries until the entry is "signed and locked" by the writer. She indicated in the case of Resident #D, the former Wound Nurse's entries for 7-7-15, only the entry regarding the sacral pressure area was "signed and locked" on 7-7-15 and the other six entries for the other			

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 08/05/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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	pressure areas were dated for 7-7-15, but not "signed and locked" until 7-13-15. Thus, the six entries not "signed and locked" until 7-13-15 for 7-7-15 would not have been posted until 7-13-15. She indicated the only explanation she could provide for the delayed documentation was the Wound Care Team sometimes gets behind in their documentation due to a large volume of pressure areas that requires a lot of time to complete. This Federal tag relates to Complaint IN00178700. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(a)(3) 3.1-50(a)(4)			