

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 07/26/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F0000	<p>This visit was for the Investigation of Complaints IN00111889 and IN00111985.</p> <p>Complaint IN00111889 - Substantiated. Federal/state deficiencies related to the allegations are cited at F224 and F514.</p> <p>Complaint IN00111985 - Unsubstantiated due to lack of evidence.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: July 23, 24, 25, and 26, 2012</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Survey team: Jill Ross, RN, TC Diana Sidell, RN (July 24 and 25, 2012)</p> <p>Census bed type: SNF/NF: 139 Total: 139</p> <p>Census payor type: Medicare: 16 Medicaid: 97 Other: 26</p>	F0000	<p>This plan of correction is the Center's credible allegation of compliance. Preparation and /or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of federal and state law.</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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	<p>Total: 139</p> <p>Sample: 11</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 8/01/12 by Suzanne Williams, RN</p>				

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F0224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRI ATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to ensure a resident's belongings remained safe even after death in that Resident K's engagement ring was missing when her body arrived at the funeral home. This affected 1 of 11 residents reviewed for misappropriation in a sample of 11.</p> <p>Findings include:</p> <p>Clinical record review on 7/25/12 at 2:00 p.m., indicated Resident K had passed away on 7/5/12. The inventory sheet was signed by a nurse in the facility and the niece, who had power of attorney for this resident, as belongings were picked up on 7/11/12, with a note that the resident's engagement ring was missing. The inventory sheet had no documentation that this resident had an engagement ring.</p> <p>In interview on 7/25/12 at 4:10 p.m., with the funeral director, he indicated the resident came to them with a wedding band but no engagement ring. The staff at</p>	F0224	<p>F F 224 Mistreatment/Neglect/Misappropriation The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident K's engagement ring still remains missing and a report was filed with the Columbus Police department on 7/10/2012.</p> <p>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents residing in the facility have the potential to be affected</p>	08/20/2012			

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	<p>the funeral home had not seen an engagement ring.</p> <p>In interview with the Executive Director on 7/26/12 at 9:30 a.m., she stated, "I know this resident had that ring when she was here because she always played with it. She always wore both her engagement ring and wedding band. Yes, the ring is still missing. This was turned over to the police on 7/10/12 but they have not come to interview my staff."</p> <p>An abuse policy, received on 7/23/12 at 10:00 a.m., indicates "...misappropriation of resident property are strictly prohibited...."</p> <p>A policy titled, "Resident Personal Belongings" indicates, "... Resident possessions, regardless of their apparent value to others, are treated with respect, for what they are and for what they may represent to the resident...Definitions Misappropriation of Resident Property - The deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent."</p> <p>This federal tag relates to Complaint IN00111889.</p> <p>3.1-28(a)</p>		<p>by this alleged deficient practice.</p> <p>Personal Inventory records have been completed and updated on the residents residing in the facility.</p> <p>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</p> <p>Facility staff will be re-inserviced on the policies " Preventing Abuse/Neglect and Misappropriation of Resident Funds or Property" and " Resident Personal Belongings" on August 14, 2012.</p> <p>Social Service / Designee will randomly interview 10 residents a week regarding missing property for 8 weeks and a Grievance form will be completed for any missing items and given to the Executive Director to ensure timely and accurate follow-up and to observe for trends.</p> <p>Grievance reports will be tracked by the Executive Director / Designee and any concerns will be discussed monthly in Performance Improvement Committee for further plans of action to be initiated as needed.</p> <p>IV. How will the corrective</p>				

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			<p>actions be monitored to ensure the alleged deficient practice will not recur;</p> <p>The Executive Director / Designee will utilize the audit tool "Review of Process Measures – Preventing Abuse, Neglect and Misappropriation of Residents Funds or Property" weekly times 4 weeks then monthly times 3 and then quarterly. Audit results will be presented to the Performance Improvement Committee for further action if needed until 100% compliance is achieved.</p> <p>Date of Compliance: August 20,2012</p>		

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F0323 SS=G	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on record review and interview, the facility failed to ensure a newly admitted resident received assistance and assistive devices to prevent falls, in that one resident fell and sustained a dislocated hip while ambulating with inadequate assistance. This affected 1 of 5 residents reviewed for falls in a sample of 11. (Resident #E)</p> <p>Findings included:</p> <p>Resident #E's record was reviewed on 7/24/12 at 11:55 a.m. The record indicated Resident #E had diagnoses that included, but were not limited to, arthritis, high blood pressure, colon obstruction, sleep apnea, and left hip replacement with a surgical incision on the left hip.</p> <p>A history and physical from the discharging hospital, dated 5/30/12, indicated: "...Past medical history...She does have a history of significant balance problems for which she is followed by [Physician's name]...Left hip exam...Gait is unsteady and she does nearly lose her</p>	F0323	<p>F 323 Free of Accident Hazards / Supervision / Devices The facility must ensure that the resident environment remains as free of accident hazards as is possible, and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>I. What corrective action will be accomplished for those residents found to have been affected by the alleged deficient practice?</p> <p>Resident E was discharged from the facility on 6/3/2012.</p> <p>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</p> <p>The residents that are high risk for falls have the potential to be affected by this alleged deficient practice.</p> <p>A Fall risk assessment is completed for residents on</p>	08/20/2012			

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	<p>balance and fall during the exam...Imaging...findings are consistent with degenerative arthritis...."</p> <p>Nursing progress notes, dated 6/2/12 at 2:22 p.m., indicated: "...[Resident #E] admitted via private car accompanied by [Family member]...."</p> <p>Nursing progress notes, dated 6/2/12 at 3:05 p.m., indicated: "...Pt had a lt (left) hip replaced - pt stated hip was 'worn out.' Pt also has had a rt (right) should[er] replacement in the past...Pt sees a Neurologist for a disease she has developed which causes slurred speech, flat affect, and severe loss of balance as reported by husband and pt. Lt hip incision is aproximated (sic) and healing with sterri (sic) strips-sterile dressing reapplied."</p> <p>Nursing progress notes, dated 6/2/12 at 9:30 p.m., indicated: "Called to pt's room. CNA sitting on floor with pt. Inquired about circumstances and was told pt was taken to bathroom and told by CNA she would return to assist her back to bed when CNA witnessed pt standing in bathroom doorway attempting to return to bed without assistance. Gait belt in place around pt's waist. CNA was ambulating pt to bed when she stated pt said her leg was going to give out so she</p>		<p>admission, readmission, quarterly, annually, significant change and/or recent fall and resident care plans and resident care sheets are updated to include fall interventions.</p> <p>Facility Staff will be re-educated on policies "Accidents and Supervision to Prevent Accidents" and on safe transfer techniques, identifying high fall risk residents and on implementing interventions to provide safety for our residents on August 14, 2012..</p> <p>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur;</p> <p>The Director of Nursing / Designee has completed an audit of resident Fall Risk Assessments to identify high risk residents and the identified resident care plans and resident care sheets have been reviewed and updated to include preventative interventions.</p> <p>IV. How will the corrective actions be monitored to ensure the alleged deficient practice will not recur;</p> <p>The Director of Nursing / Designee will utilize the audit tool "Review of Process Measures – "Preventing Falls / Accidents" to</p>	

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	<p>eased her to the floor using the gait belt to lower her onto buttocks and rt hip area. v/s taken=T98 Pulse 92 Resp 24 b/p 138/80. Pt awake, alert, oriented. No hematoma, edema, loss of range of motion noted. 3 person lift to a standing position using gait belt. Pt able to bear weight on both legs. Ambulated to chair and sat down. Then proceeded to transfer to bed. Pt c/o discomfort in buttocks-no erythema (redness) noted...."</p> <p>Nurse's notes, dated 6/2/12 at 11:37 p.m., indicated: "Orders received for bed alarm placed on bed. Reeducated pt on use of call light and to wait for assistance before rising...Care Plan reevaluated and new problem added for high risk of falls...."</p> <p>Nurse's notes, dated 6/3/12 at 12:00 midnight, indicated: "[X-ray] technician arrives to perform X-rays...."</p> <p>Nurse's notes, dated 6/3/12 at 4:25 a.m., indicated: "[Physician] (partner of the doctor who performed total left hip replacement on [Resident #E]) called this nurse. He advised this nurse that [Resident #E] be transferred to an emergency room for a "hip reduction" based on the information provided to him by this nurse...."</p> <p>A radiology report dated 6/2/12 indicated</p>		<p>identify any concerns weekly times 4 weeks then monthly times 3 then quarterly.</p> <p>Audit results will be presented to the Performance Improvement Committee until 100% compliance is achieved.</p> <p>Date of Compliance: August 20, 2012</p>	

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	<p>results of "Conclusion: Dislocation of right hip arthroplasty (repair)"</p> <p>Nurse's notes, dated 6/3/12 at 5:35 a.m., indicated the ambulance service arrived to transport the resident to the hospital.</p> <p>A care plan for high risk for falls, dated 6/2/12, indicated: "[Resident #E] is high risk for falls r/t (related to) gait/balance problems, history of falls. Goals: [Resident #E] will comply with safety measures. [Resident #E] will express understanding of personal risk factors. Interventions: [Resident #E] needs to be in the "Falling Stars" program. Educate/remind [Resident #E] to request assistance prior to transfer/ambulation. Encourage [Resident #E] to request assistance in ambulating. Follow toileting regime/schedule. Keep adjustable bed in low position for safe transfers. Lock bed brakes. Monitor for gait changes. Monitor medication for side effects that may increase risk for falls. Notify physician as appropriate. Provide non-skid footwear. PT (Physical Therapy) evaluate and treat as ordered or PRN (as needed). Use bed alarm/pressure pad alarm when in bed. Use chair alarm/pressure pad alarm when in chair/wheel chair."</p> <p>The care plan, as written, failed to</p>				

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	<p>indicate the number of staff needed to safely assist the resident during ambulation and transfers.</p> <p>On 7/26/12 at 9:25 a.m., the Executive Director indicated they could not find a fall risk assessment for Resident #E, that it was documented it was done, but it could not be found.</p> <p>A fall investigation was begun, on 6/2/12 at 9:37 p.m., by the Director of Nurses (DON). This investigation indicated, but was not limited to; "...[RN #1] stated to me that she told [CNA #3] that she was to tell the other c.n.a. on duty that [Resident #E] was a 2 person transfer and to toilet her every 1-2 hours...Both C.N.A.'s deny being told this. [CNA #2] states that they (her and CNA #3) were in [another resident's] room when she heard the resident's call light go off and heard [RN #1] holler for them to go get the new lady's light. [CNA #2] then left and reported that she entered [Resident #E's] room to find her in the restroom and starting to wipe herself standing up. [CNA #2] then states that she told [Resident #E] to please sit down and wait for assistance. The gait belt was on [Resident #E] along with gripper socks. [CNA #2] then stated that the resident then started walking. So [CNA #2] walked with her until midway in the room</p>			

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	<p>when [Resident #E] reported that her left leg was going to give out. [CNA #2] then states that she lowered her to the floor using the gaitbelt and assisted her down with her arms and legs over her but that no part of her body touched her...." On 6/3/12 at 3:47 p.m., the DON spoke with Resident #E's family member, who said the resident had a fractured right femur, and the physician said it happened from the "c.n.a. landing on her." "The resident is alert and oriented. The resident reports that she was up to the restroom and had used her call light to call for assistance back from the toilet. [Resident #E] stated that [CNA #2] entered the room to assist her back to her bed stating 'Come on we can do this.' [Resident #E] told the c.n.a. that she needed to sit down as her leg was about to give out and the c.n.a. wouldn't stop. [Resident #E's] leg gave out and the c.n.a. landed on top of her."</p> <p>During an interview on 7/25/12 at 4:50 p.m., the Executive Director indicated that CNA #2 said she did not "land on top of the resident" and she was terminated for lying during an investigation. The Executive Director said there were no other witnesses besides CNA #2 and the resident.</p> <p>During an interview on 7/25/12 at 4:58 p.m., RN #1 indicated she had two</p>				

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	<p>conflicting stories from the CNAs. She indicated a family member said the resident was a two person assist, and RN #1 told the CNAs she was a two person assist and to do hourly checks. She was told by one CNA the resident was observed in the bathroom door and she tried to assist her back to her bed, and then had to ease her onto the floor. RN #1 said she found out later that both CNAs assisted her to the bathroom then left her alone. She didn't have a gait belt on when she went to assess her. RN #1 indicated Resident #E had been assisted earlier with one CNA and a gait belt and her gait was unsteady.</p> <p>A policy and procedure for "Accidents and Supervision to Prevent Accidents" was provided by the Executive Director on 7/25/12 at 5:56 p.m. The policy included, but was not limited to: "Policy: The center provides an environment that is free from accident hazards over which the center has control and provides supervision and assistive devices to each patient to prevent avoidable accidents. This includes systems and processes designed to: Identify hazards(s) and risks(s); Evaluate and analyze hazard(s) and risk(s); Implement interventions to reduce hazards(s) and risk(s); and Monitor for effectiveness and modify approaches when necessary. Compliance</p>			

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	<p>Guidelines: 1. Center Administration acknowledges the high-risk nature of its population and setting...5. Center provides training to employee for identification of potential hazards, prevention of accidents, safe transfer techniques and safe use of mobility devices...Assistive Devices/Equipment Hazards: 30. Center assess patient to determine the patient's degree of mobility and physical impairment and the proper transfer method...."</p> <p>3.1-45(a)(2)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE 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.</p> <p>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.</p> <p>Based on record review, observation and interview, the facility failed to maintain complete and accurate clinical records on each resident in that the inventory sheets had not been updated on 2 of 11 residents reviewed for complete inventory sheets in a sample of 11. (Residents F and K)</p> <p>Findings include:</p> <p>1. Clinical record review on 7/25/12 at 2:00 p.m., indicated Resident K had passed away on 7/5/12. The inventory sheet was signed by the facility staff and the niece, who had power of attorney for this resident, as belongings were picked up on 7/11/12, with a note that the resident's engagement ring was missing. The inventory sheet had no documentation that this resident had an engagement ring.</p>	F0514	<p>This plan of correction is the Center's credible allegation of compliance.</p> <p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared solely because it is required by the provisions of federal and state law.</p> <p>F 514 Records-Complete / Accurate / Accessible</p> <p>The facility must maintain clinical records on each resident in accordance with acceptable professional standards and practices that are complete; accurately documented; readily</p>	08/20/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/26/2012	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
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	<p>In interview on 7/25/12 at 4:10 p.m., with the funeral director, he indicated the resident came to them with a wedding band but no engagement ring. The staff at the funeral home had not seen an engagement ring.</p> <p>In interview with the Executive Director on 7/26/12 at 9:30 a.m., she stated, "I know this resident had that ring when she was here because she always played with it... Yes, the ring is still missing. This was turned over to the police on 7/10/12, but they have not come to interview my staff."</p> <p>2. Clinical record review on 7/23/12 at 12:33 p.m., indicated on Resident F's inventory sheet that she was admitted on 6/13/08. The inventory sheet dated 6/17/08 only had 3 blouses, 2 pair of pajamas/nightgowns, and 1 ring (gold) listed.</p> <p>During observation on 7/24/12 at 10:55 a.m., there was a purse, a vase with flowers, a basket with 2 stuffed bears, a ceramic angel, a pair of blue tennis shoes and a sweater in Resident F's room. Resident F was sleeping so no further observations were done at this time.</p> <p>In interview on 7/24/12 at 10:57 a.m.,</p>		<p>accessible; and systematically organized.</p> <p>I. What corrective action(s) will be accomplished for those residents found to be affected by this alleged deficient practice?</p> <p>Resident K passed away at the facility on 7/5/2012.</p> <p>Resident F's personal inventory record was updated on 7/24/2012.</p> <p>II. How other residents having the potential to be affected by the alleged deficient practice will be identified and what corrective action(s) will be taken.</p> <p>Residents residing in the facility have the potential to be affected by this alleged deficient practice.</p> <p>Social Service Department and Nursing Department worked together and updated the personal inventory records on residents residing in the facility.</p> <p>III. What measures will be put in place or what systemic changes will be made to ensure that the alleged deficient practice does not recur.</p> <p>The facility staff were re-educated on August 14, 2012 to remind family members to give new items brought into the facility to the licensed nurse so the articles</p>				

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	<p>with LPN #1, she indicated all nursing staff are to update the inventory sheets as new items are brought in. "It is all our (entire staff) responsibility to add items to the inventory list as new items are brought in."</p> <p>On 7/24/12 at 2:00 p.m., the Director of Nursing went into the room with the inventory list and saw there were more items in the room than were on the list. She stated, "I will get you an updated list."</p> <p>A policy titled, "Resident Personal Belongings" was received from the Executive Director on 7/24/12 at 12:56 p.m. It states, "...Procedure: Admission:...6. Complete a personal belongings inventory sheet upon admission. Update as needed with personal belongings added throughout the residents stay and /or removed from the center..."</p> <p>A form which indicated how to fill out an inventory sheet, was received on 7/25/12 at 5:56 p.m., from the Executive Director. This form indicated, "...Purpose of the Form: To document the personal belongings of the resident upon admission, discharge, when clothing and /or personal items are brought into the center or taken home during the resident's</p>		<p>can be added to the resident's personal inventory record.</p> <p>The nursing staff will be re-educated on the policy "Resident Personal Belongings" including timely completion on admission and updating resident personal inventory records as needed on August 16, 2012</p> <p>IV. How the corrective actions will be monitored to ensure the alleged deficient practice will not recur.</p> <p>New admission medical records will be brought to morning clinical meeting Monday thru Friday to review for accuracy and personal inventory completion.</p> <p>Social service / Designee will audit and review the personal inventory records of 5 residents a month to ensure accuracy and completeness. Audit results will be reviewed in Performance Improvement Committee monthly until 100% compliance is obtained.</p> <p>Date of Compliance: August 20, 2012</p>		

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	<p>stay...Instructions for Use: 4. Update as necessary throughout the resident's stay by using the spaces provided. As needed, begin a new inventory sheet to continue documentation of personal items."</p> <p>This federal tag relates to Complaint IN00111889.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				