

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 01/22/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaints IN00160957, IN00162071, & IN00159971.</p> <p>Complaint IN00160957- Substantiated. Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Complaint IN00159971-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00162071-Unsubstantiated due to lack of evidence.</p> <p>Survey dates: January 13, 14, 15, 16, 20, 21, & 22, 2015.</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey team: Beth Walsh, RN-TC Karina Gates, Generalist Tom Stauss, RN Angie Stallsworth, RN</p> <p>Census bed type: SNF/NF: 106</p>	F000000	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.	

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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F000242 SS=D	<p>Total: 106</p> <p>Census payor type: Medicare: 22 Medicaid: 69 Other: 15 Total: 106</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on January 30, 2015 by Cheryl Fielden, RN.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review, the facility failed to ensure a resident's preference for a shower or bed bath was honored for 1 of 3 residents reviewed for choices. (Resident # 217)</p> <p>Findings include:</p>	F000242	<p>1.The unit manager met with the resident #217 to determine preferences regarding bathing choice i.e. frequency, time, and type. resident recieved a bed bath per his request.</p> <p>Adjustments were made to the plan of care to accommodate preferences for bathing. C.N.A</p>	02/21/2015			

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	<p>An interview was conducted with Resident #217 on 1/14/15 at 11:15 a.m. Resident #217 indicated, " I have not had a shower or bath since I've been here. They've only washed me up."</p> <p>The clinical record for Resident #217 was reviewed on 1/16/15 at 9:00 a.m. The current diagnosis included but were not limited to, seizure, ventricular tachycardia, diabetes mellitus, atrial flutter, and cerebrovascular accident.</p> <p>The Admission Minimum Data Sheet (MDS) assessment on 1/14/15 indicated the Brief Interview for Mental Status (BIMS) score was 13 out of 15 (cognitively intact).</p> <p>Resident #217's January, 2015 Flow Sheet Record was reviewed on 1/16/15 at 9:13 a.m. This record indicated Resident #217 received a partial bath on 1/9/15, 1/11/15, 1/12/15, 1/13/15, 1/14/15, and 1/15/15, and received no bed baths or showers since his 1/7/15 admission.</p> <p>The CNA assignment sheet was reviewed on 1/16/15 at 9:20 a.m., and indicated Resident #217's shower days were on Thursday and Saturdays.</p> <p>An interview was conducted with Unit</p>		<p>assignment sheets were adjusted to reflect resident choice.2.During monthly resident and family interviews it will be identified what the residents preferred schedule for showering/bathing is. Identification of needed adjustments will be made plan of care will be adjusted to reflect accomodations of preferences. C.N.A assignment sheets were updated to reflect preferences. A facility wide audit was completed to reflect residents bathing and shower preferences.3.Nursing staff were inserviced by Staff Development Coordinator on the components of F242; Resident right to Make Choices. A minimum of 10 resident and family interviews will be conducted monthly to determine that the facility ensures resident's preferences for a shower or bed bath. Any identified issues will be addressed timely. During regular facility rounds by the Executive Director and Director of Nursing and or designee will question residents regarding preferences/choices being honored.The Social Services Director and or designee will meet with resident council two times monthly for six months, then monthly thereafter to ascertain that resident preferences are being met. Any identified issues will be addressed timely. Interviews and resident council minutes will be reviewed monthly during</p>	

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	<p>Manager #6 on 1/16/15 at 9:35 a.m. She indicated a partial bath meant the staff would clean privates, buttocks, underarms, and the face.</p> <p>During an interview on 1/16/15 at 3:15 p.m., Resident #217 indicated he was unaware of his scheduled shower days on Thursdays and Saturdays and had not received nor were offered a shower on 1/15/15 (Thursday).</p> <p>An interview on 1/16/15 at 3:29 p.m., LPN #15 indicated the staff's shower sheets were signed by the nurse on the hall and turned in every shift to the unit manager. LPN #15 could not indicate if Resident #217 was offered or refused a shower on 1/15/15.</p> <p>Resident #217's Flow Sheet Record was provided by Unit Manager #6 on 1/16/15 at 3:52 p.m. The record indicated Resident #217 received showers on 1/11/15 and 1/15/15.</p> <p>During an interview on 1/21/15 at 12:25 p.m. Resident #217 indicated he had not been given a shower or bed bath since admission, and was only getting the "hot spots" cleaned. Resident #217 clarified the "hot spots" were private areas, and had to request the staff to clean his underarms.</p>		Performance Improvement Meetings and until such time the committee members determine that the facility has remained in substantial compliance				

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F000246 SS=D	<p>The policy, "Activities of Daily Living," dated 1/4/14, was provided on 1/21/15 at 10:41 a.m. It indicated, "...Compliance Guidelines...3. Patients preferences are respected and reasonable accommodations are made for: a. Bathing choice: 1) Frequency of bathing 2) Time of Day 3) Type of bating (e.g., shower, tub, bath, etc).."</p> <p>3.1-3(3)(v)(l)</p> <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.</p> <p>Based on observation, interview, and record review, the facility failed to provide a resident with a proper armrest on his wheel chair to ensure proper positioning for 1 of 35 residents observed for proper positioning. (Resident #217)</p> <p>Findings include:</p> <p>The clinical record for Resident #217 was reviewed on 1/14/15 at 2:00 p.m. The diagnoses for Resident #217 included, but were not limited to, left-sided stroke with residual weakness. He was admitted</p>	F000246	<p>1. Resident #217 was assessed for proper wheelchair positioning and an order was obtained for the armrest. Care Plan was updated to reflect these changes.2.The facility rehab department completed a positioning audit on current facility residents in wheelchairs to determine proper wheelchair positioning. Any identified areas of concern based upon the positioning audit were addressed to ensure reasonable accommodations were met. New admissions will be screened by therapy for appropriate adaptive equipment which will include</p>	02/21/2015

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	<p>to the facility on 1/7/15.</p> <p>An observation of Resident #217 was made on 1/14/15 at 11:21 a.m. He was observed in his wheel chair, with his left arm bent, on his lap. He indicated, "I need the right [correct] wheel chair, with the right [correct] arm rest." He picked up his left arm with his right arm, and attempted to rest it on his left wheel chair armrest. It would not stay on the armrest. He indicated he could not rest his left arm on his left wheel chair armrest, because the armrest was too small.</p> <p>Social Services Director (SSD) #17 was informed of Resident #217's concerns with his wheel chair on 1/14/14, at 1:00 p.m. An interview was conducted with the SSD #17 on 1/14/15, at 3:00 p.m. She indicated, "Me and therapy went down there (to Resident #217's room). We're ordering him a sling for his left arm. He said he should have a platform for his arm, and therapy said 'you're absolutely right', so we ordered him a platform as well."</p> <p>The 1/14/15 at 3:03 p.m., social services note indicated, "Therapy director with (name of Resident #217) also discussed the need for a sling for (name of Resident #217's) affected arm (left), as well as a platform for his wheelchair to support his</p>		<p>wheelchair positioning within 72 hours of admission.3. A minimum of 10 residents observations will occur monthly which will include wheelchair positioning and adaptive equipment utilization to determine if preferences have been met. Identified issues will result in therapy screen and evaluations as necessary. Care plans will be reviewed and updated to reflect any changes and accommodations of preferences. Nursing and therapy staff were inserviced per the SDC on accommadation of need and meeting reasonable resident preferences.Facility staff were additionally inserviced on stop and watch, an early warning tool, to help identify any changes observed during resident care. 4.The responsible party for this plan of correction will be the Executive Director and the Director of Nursing and or designee. Observational audits will occur during routine facility rounds for appropriate wheelchair positioning and correct use of adaptive equipment. Any resident identified to have questionable wheelchair positioning, or need additional adaptive equipment will be referred to therapy for evaluation and treatment as necessary. Ten resident will be interviewed monthly to determine continued accommadation of needs, and continue for 12 months and or until the Performance Improvement</p>	

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F000279 SS=D	<p>affected arm. Therapy director will order both."</p> <p>An interview was conducted with the Therapy Director on 1/15/15 at 2:07 p.m. She indicated, "When OT (occupational therapy) did his eval (evaluation) the day after admission, we didn't notice anything with his arm. A sling is not recommended. We're trialling a half lap tray. We put that on today....I did not assess whether he needed a platform when he came, but based on what I saw yesterday, I think he needs something there."</p> <p>The 1/8/15 Physical Therapy Plan of Care indicated, "Underlying Impairments Other: LUE (left upper extremity) flaccid."</p> <p>3.1-3(v)(1)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS 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>		Committee determines after monthly review of interviews and observations that substantial compliance has been achieved and sustained.		

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	<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 interview and record review, the facility failed to ensure a care plan for diabetes mellitus was developed for 1 of 25 residents reviewed for care plans. (Resident #188)</p> <p>Findings include:</p> <p>The clinical record for Resident #188 was reviewed on 1/21/15 at 10:15 a.m. The diagnoses for Resident #188 included, but were not limited to, diabetes mellitus, congestive heart failure and anemia.</p> <p>The Admission MDS (minimum data set) assessment, dated 10/23/14, indicated a diagnosis of diabetes mellitus for Resident #188.</p> <p>A Diabetes Mellitus Care Plan was not located in the clinical record.</p> <p>During an interview with the Director of Nursing (DON), on 1/21/15 at 12:13 p.m., the DON indicated she was unable</p>	F000279	<p>1.A care plan was developed for resident#188 addressing diabetes.2. A facility audit was conducted to identify those residents with diabetes mellitus. Identified residents were assessed and care plans reviewed to determine provision of care for diabetes had measurable timetables and objectives. residents will be identified through scheduled care plan meetings, the admission process and the ongoing resident assement instrument (RAI) process.3.The interdisciplinary team was re-educated on care plannign. As care plans are cycled through t hey will be evaluated for objectives and timetables byt the interdisciplinary team, re-writing/revising as necessary.4.The responsible party for this plan of correction is the DNS/MDS Coordinator and or designee. The DNS/MDS Coordinator will review residents clinical record upon admission, annually, quarterly and with significant change to determine that those residents with</p>	02/21/2015

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F000280 SS=D	<p>to locate a diabetes mellitus care plan for Resident #188 and she further indicated Resident #188 should have care plan for the diagnosis.</p> <p>3.1-35(a)</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 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 a urinary catheter care plan for 1 of 3 residents reviewed for urinary catheters. (Resident #24)</p>	F000280	<p>diagnosis for diabetes have a current updated care plan that addresses measurable objectives for care. The results of the reviews will be taken to the next monthly Performance Improvement Meeting and monthly thereafter for 12 months and or until the Performance Improvement Committee determines that substantial compliance has been met and sustained.</p> <p>1. Resident's #24 care plans were reviewed and revised to include catheter care.2. A facility audit was conducted to identify those current residents with foley catheters, to determine that care</p>	02/21/2015

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F000312 SS=D	<p>Findings include:</p> <p>The clinical record for Resident #24 was reviewed on 1/20/15 at 9:50 a.m. The diagnoses for Resident #24 included, but were not limited to, diplegic infantile cerebral palsy, unspecified intellectual disabilities, convulsive epilepsy, dysphagia, and cerebellar ataxia disease.</p> <p>A Physician's Order, dated 8/5/14, indicated to provide catheter care every shift to Resident #24.</p> <p>A Catheter Care Plan, dated 10/18/14 and remained current at time of review, did not indicate an intervention of catheter care to be provided each shift to Resident #24.</p> <p>During an interview with the Director of Nursing (DON), on 1/20/15 at 2:10 p.m., she indicated catheter care should be listed as an intervention on Resident #24's Catheter Care Plan and the DON also indicated she was unable to locate that intervention on the catheter care plan at that time.</p> <p>3.1-35(d)(2)(B)</p> <p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p>		<p>plans reflected urinary catheter care. Any identified issues of concern were immediately corrected. No negative outcomes were identified. Residents will be identified upon admission and during scheduled care plan meeting as well as routine clinical meetings.3.Licensed nursing staff was educated on careplanning urinary catheter care per SDC. DNS/designee will audit/review new admission residents with catheters as well as those current residents that have catheters to determine accurate care planning for catheter care.4.The responsible party for this plan of correction is the DNS/designee. The DNS/designee will do weekly random reviews of those residents with catheters to determine accurate care plan revisions for six months then decrease to monthly reviews for six months. Identified issues will be immediately addressed. Reports of findings will be taken to the next monthly Performance Improvement meeting for review and continue monthly thereafter until PI committee determines that substantial compliance has been met and sustained.</p>		

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	<p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to regularly brush a resident's teeth and address a resident's dandruff problem for 2 of 3 residents reviewed of 8 who met the criteria for ADL's (activities of daily living). (Residents #11 and #68)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #11 was reviewed on 1/14/15 at 10:30 a.m. The diagnoses for Resident #11 included, but were not limited to, severe osteoarthritis, rheumatoid arthritis, and chronic pain.</p> <p>An interview was conducted with Resident #11 on 1/14/15 at 10:40 a.m. She indicated staff did not help her, as necessary to clean her teeth. She indicated, "They haven't brushed my teeth in a month or more." Resident #11 was observed at this time with a substantial amount of whitish yellow debris in between her teeth and along the top and bottom gum lines.</p> <p>The 9/2/14 Quarterly MDS (minimum</p>	F000312	<p>1. resident #11 had her teeth brushed. Resident #68 had his hair washed. Liscensed nursing staff and C.N.A's were in-serviced on the provision of ADL care.2. A facility audit was conducted to identify those residents that require assistance with brushing their teeth and washing their hair. Random weekly audits of 10 residents will be conducted throughout the facility to determine that those residents identified are recieving oral hygiene and shampoos. Documentation will be reviewed weekly per the unit managers with DNS oversight.3.Nursing staff was in-serviced on the provision of ADL care to include oral hygiene, and grooming. DNS/Unit Managers/designee will randomly interview 5 residents weekly that require assistance with oral care, shampooing and ADL care using the Abaqis process. Any issues will be immediatly addressed with physician notification and orders recieved as necessary. The facility ADL flow sheet was revised to include oral care and shampooing.4. DNS/designee is the responsible party for this plan of correction.10 Resident interviews will be conducted weekly for the provision of oral</p>	02/21/2015

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	<p>data set) assessment indicated Resident #11 had a BIMS (brief interview for mental status) score of 15, indicating she was cognitively intact. It indicated she required extensive assistance of 1 person for personal hygiene.</p> <p>The 10/12/14 ADL care plan for Resident #11 indicated, "Assist with hair and nail care daily and oral care upon rising and at bedtime as needed."</p> <p>An interview was conducted with Resident #11 on 1/16/15 at 11:39 a.m. She indicated staff did not brush her teeth that day. At this time, she was observed with a substantial amount of whitish yellow debris in between her teeth and along the top and bottom gum lines.</p> <p>An interview was conducted with CNA #12 on 1/16/15 at 11:48 p.m. He indicated he was assigned to Resident #11 that day. He indicated, "I did assist her with getting ready today. I have to wash her bottom, face, wash up. It takes two to get her in the chair....I used a swab and some mouthwash, no toothbrush. I don't know if she has teeth. If she does, she should get them brushed with a toothbrush...."</p> <p>An interview was conducted with UM (Unit Manager) #6 on 1/16/15 at 12:02</p>		<p>care, shampooing and ADL care. DNS/designee will report unresolved issues with compliance at the next Performance Improvement Committeemeeting and monthly thereafter until continued substantial compliance is achieved and sustained.</p>	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
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	<p>p.m. She indicated oral care was part of morning ADL care. She indicated, "I check those daily. We do a spot audit once a week. I think (name of CNA #12) has a valid point about not using a brush, and just a swab, since she's so fragile. I'm not aware of any recommendation not to brush her teeth. I don't think what he (CNA #12) did was inappropriate. She's (Resident #11) alert and oriented. She could have asked him to brush her teeth. I'm not saying we can't use a toothbrush." UM #6 indicated Resident #11 would have had to have asked that morning for her teeth to be brushed with a toothbrush, in order for it to have been done.</p> <p>The 7/1/14 Dental Exam for Resident #11 indicated, "...staff assistance is needed with brushing."</p> <p>An interview was conducted with Resident #11 on 1/16/15 at 1:06 p.m. She indicated, "They did not swab my mouth out this morning or yesterday. I'd like for them to brush my teeth if they would."</p> <p>The ADL Flow Sheet for Resident #11 did not include oral care. It indicated a 'P' for bathing daily on the 3-11 shift.</p> <p>An interview was conducted with the DON (Director of Nursing) on 1/16/15, at</p>						

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	<p>2:38 p.m. She indicated, "When a CNA documents a 'P' on the (ADL) flow sheet record for bathing, that indicates the resident received a partial bath with care, which includes oral care, grooming, and hygiene....I asked her (Resident #11) why she never told us, and she couldn't say why. I am satisfied with her care plan that states she has a plan for completing grooming and hygiene, including oral care."</p> <p>2. The clinical Record for Resident #68 was reviewed on 1/15/15, at 9:30 a.m. The diagnoses for Resident #68 include, but were not limited to, dandruff.</p> <p>An interview was conducted with Resident #68 on 1/15/15 at 9:59 a.m. He indicated, "When they give me a shower, they just put some shampoo on a rag, and run it over my head, and don't massage my hair. I have all this build up, when I run my nails across." Resident #68 ran his nails through his hair. White, crusty, flakes were observed in his fingernails. He stated, "I'm going to have to go to the beauty parlor, and get it done. It's the only way I'm going to get it cleaned. They laughed at me, when I said I wanted to go. I'm waiting for a price now."</p> <p>An interview was conducted with Resident #68 on 1/21/15 at 2:50 p.m. He</p>						

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	<p>indicated, "I'm going to the beauty shop on Friday to get my hair washed....I expect for them to do an \$11 job. Hopefully my daughter can come up with the money every week. When I take a chair shower, they just put some shampoo on a rag. When I have a bed bath, they don't touch it. That would be lovely, if they could wash my hair with a bed bath.</p> <p>An interview was conducted with CNA #7 on 1/21/15, at 3:38 p.m. She indicated she gave him a shower the previous day and washed his hair. She indicated, "But I can't get all that white stuff out. He needs a special shampoo or something. I told the nurses about it. I know I told (name of LPN #13) a couple of weeks ago."</p> <p>An interview was conducted with Unit Manager (UM) #6 on 1/21/15 at 3:45 p.m. She indicated, "I don't know anything about the beauty shop. I'll found out what we've done to address his hair problem."</p> <p>An interview was conducted with UM #6 on 1/21/15 at 3:55 p.m. She indicated, "None of the nurses know about his hair problem....They said (name of Resident #68) has never expressed an issue regarding his scalp. (Name of Physician</p>						

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
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F000323 SS=D	<p>#8) is here right now, and wrote an order for a special shampoo. I heard (name of CNA #7) say she told (name of LPN #13) a couple of weeks ago about it, and I will follow up with her tomorrow."</p> <p>The 1/21/15 M.D. progress note indicated, "Dry scalp/Fungal Dermat (dermatitis)/Dandruff"</p> <p>The 1/21/15 Physician's Order for Resident #68 indicated, "Ketoconazole (antifungal) 2% shampoo...Dandruff Scalp QOD (every other day) x 10 days & continue prn (as needed) QOD."</p> <p>3.1-38(a)(3)(B) 3.1-38(a)(3)(C)</p> <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 observation, interview, and record review, the facility failed to ensure a resident was properly positioned in a wheelchair, which resulted in a fall, for 2 of 4 residents reviewed for accidents. (Resident #C)</p> <p>Findings include:</p>	F000323	<p>1. Resident #C was from closed record review, therefore no longer resides within the facility.2. A facility audit was conducted using the most current QIQM indicators to identify those residents that may be at risk for falls. Those identified residents will be referred to therapy for evaluation/screen using the Falls Management Interdisciplinary</p>	02/21/2015			

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	<p>The clinical record for Resident #C was reviewed on 1/20/15 at 2:30 p.m. The diagnoses for Resident #C included, but were not limited to, lower limb amputation, multiple sclerosis, and hemiplegia.</p> <p>A Fall Data Information document, dated 9/5/14 at 1:50 p.m., indicated Resident #C had a fall on 9/5/14 at 9:00 a.m. The document indicated a description of the fall as, "...while staff was pushing resident from dining room [sic] patient slid from w/c [wheelchair] to floor..." The document also indicated, "...If injury choose all that apply...first aid [was checked]...if injury resulted in a skin tear, abrasion, or bruise: a non-pressure skin sheet is required [was checked]..."</p> <p>During an interview with the Director of Nursing (DON), on 1/21/15 at 4:06 p.m., the DON indicated the facility determined the root cause of Resident #C's fall, on 9/5/14, as the Resident was not positioned correctly in the wheelchair before the employee started to wheel the resident out of the dining room. The DON further indicated the resident slid out of his wheelchair and somehow hit his head to cause an abrasion on his forehead.</p>		<p>referral/Screen Form. Residents will additionally be identified through the admission, annual, quarterly and significant change assessment process. Identified residents' fall care plans were reviewed with safety interventions revised if necessary.3. Residents will be monitored through the 24-hour report process,(I-PASS) Stop and Watch program and reviewed at departmental stand-up meetings daily during working hours. Nursing staff are educated upon hire and yearly through competency requirements. Staff is additionally educated on safety interventions, supervision, and assistive devices. Any identified areas of concern will be addressed timely. C.N.A assignment sheets are updated as needed to identify those residents identified to be at risk for falls.4. Executive Director/Director of Nursing/designee will monitor those residents identified to be at risk for falls through the weekly fall risk meetings. Additional monitoring is accomplished through routine facility rounds to ensure proper wheelchair positioning. Any questions regarding positioning will be brought to the immediate attention of administration/therapy for appropriate followup and referral. Audits will be conducted monthly using the QIQM to identify residents at risk. Lab audits will additionally be</p>	

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	<p>A Quarterly MDS (minimum data set) assessment, dated 7/6/14, indicated Resident #C needed extensive assistance with 1 person physical assistance for locomotion off of the unit.</p> <p>At 11:20 a.m., on 1/22/15, the DON indicated CNA #18 wheeled Resident #C out of the dining room.</p> <p>Positioning skills checklists, titled Turning and Positioning a Resident, were received from the DON on 1/22/15 at 11:47 a.m. The Turning and Positioning A Resident checklists, dated 4/5/14 and 9/12/14, indicated CNA #18 was able to properly perform the skill of positioning a Resident in a wheelchair by the checkmark in the section, "...23. In a Wheelchair....d. Instruct the resident to push on the footrests with their feet while using your body weight and momentum to gently assist the resident into the new position..."</p> <p>During an interview with the DON, on 1/22/15 at 11:53 a.m., the DON indicated the Turning and Positioning A Resident checklist indicated CNA #18 was able to properly perform the skill of positioning a resident in wheelchair, which included ensuring the Resident's back was against the seat of the wheelchair.</p>		<p>completed 3 times weekly to ensure orders have been processed, obtained timely and are available on the clinical record. Results of those audits will be taken to the next Performance Improvement meeting and monthly thereafter for no less than six months. Continued monitoring will be at the direction of the PI Committee once it has been determined that substantial compliance has been achieved and sustained.</p>				

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F000329 SS=D	<p>This Federal tag relates to Complaint IN00160957.</p> <p>3.1-45(a)(2)</p> <p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on interview and record, the facility to ensure a resident was free from unnecessary medication by not discontinuing insulin as ordered. This had the potential to affect 1 of 6 residents reviewed for unnecessary medication.</p>	F000329	1. Lantus Insulin was discontinued for resident#188 on 1-21-2015. resident #188 was assessed and found to hav had no negative outcomes. Pyhsician notified, careplan reviewed and revised. Resident #24 had Dilantin level, CBC, Phenobarbital	02/21/2015	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250		
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	<p>(Resident #188) The facility also failed to obtain ordered labs for monitoring of medication for 1 of 6 residents reviewed for unnecessary medication. (Resident #24)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #188 was reviewed on 1/21/15 at 10:15 a.m. The diagnoses for Resident #188 included, but were not limited to, diabetes mellitus, congestive heart failure and anemia.</p> <p>A Physician's Order, dated 12/30/14, indicated an order to, "DC [discontinue] Lantus (insulin)" due to low blood sugar levels.</p> <p>The January MAR (Medication Administration Record) indicated Resident #188 received 8 units of Lantus at bedtime 1/1/15-1/20/15.</p> <p>During an interview with Unit Manager #3, on 1/21/15 at 10:56 a.m., she indicated according to the MAR, Resident #188 received Lantus on 1/1/15-1/20/15. Unit Manager #3 indicated the Lantus should've been discontinued on 1/1/15 as ordered. Unit Manager #3 further indicated she will look into why Resident #188 continued to</p>		<p>and Depakote levels drawn. Physician notified. Nursing staff were educated on processing lab orders and ensuring results are available within the clinical record. No negative outcomes identified to resident #24.2. Residents will be identified through the 24-hour report process and discussed daily during scheduled clinical stand-up meetings. Orders have been verified on active residents receiving insulin. Careplans reviewed and revised as necessary. Lab audit conducted to determine any resident who receives lab orders were completed and results are available. Any identified areas of concern were addressed timely with physician notification.3.Charge nurses will review all new admission orders and verify accuracy with two licensed nurse signatures. Unit managers or designee will additionally review all new orders within 24 hours to determine accurate transcription has occurred. Licensed nursing staff have been educated by SDC on the process of taking off orders and correct transcription into the medication and treatment administration record. Any changes in physician orders will be reported to the oncoming nursing shift using the I-PASS to ensure awareness of medication changes. Liscensed staff educated on the use of the</p>		

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>receive Lantus when the medication was ordered to be discontinued.</p> <p>No further information was recieved regarding why Resident #188 continued to receive Lantus after the medication was ordered to be discontinued, by final exit on 1/22/15.</p> <p>2. The clinical record for Resident #24 was reviewed on 1/20/15 at 9:50 a.m. The diagnoses for Resident #24 included, but were not limited to, diplegic infantile cerebral palsy, unspecified intellectual disabilities, convulsive epilepsy, dysphagia, and cerebellar ataxia disease</p> <p>A Nurse Practioner (NP) Visit note, dated 11/15/14, indicated to check Resident #24's dilantin level (lab to ensure medication was at therapeutic levels) on 11/17/14.</p> <p>A Physician's Order, dated 11/15/14, indicated to check Resident #24's dilantin level on 11/17/14. The order also indicated to draw a CBC (lab for complete blood count) lab on 11/17/14.</p> <p>A NP Visit note, dated 11/18/14, indicated the dilantin lab was pending from 11/17/14.</p> <p>A NP Visit note, dated 12/18/14,</p>		<p>laboratory tracking log, procedures which include verifying orders, inputting and obtaining results.4. The responsible party for this plan of correction will be the Director of Nursing and or designee. Audits will be completed three times weekly on three residents identified to recieve insulin to determine that orders have been taken off and transcribed correctly. Audits will continue three times weekly for six months then weekly thereafter. Results of auditing will be taken to the next Performance Improvement Committee meeting and monthly thereafter or until the committee determines that substantial compliance has been achieved and sustained.</p>	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
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	<p>indicated to check the dilantin, phenobarbital, and depakote levels (labs to ensure medication was at therapeutic levels).</p> <p>A Physician's Order, dated 12/18/14, indicated to draw a dilantin, phenobarbital and depakote level labs.</p> <p>A dilantin level lab and CBC lab from 11/17/14 was not located in the clinical record. A phenobarbital and depakote level lab from the 12/18/14 Physician's Order was not located in the clinical record.</p> <p>During an interview with the Director of Nursing (DON), on 1/20/15 at 11:09 a.m., she indicated the facility called the lab company and the lab company was unable to locate the dilantin level lab and CBC lab from 11/17/14 or phenobarbital and depakote level lab from the 12/18/14 Physician's Order for Resident #24. The DON further indicated the lab company/facility was still looking into the missing labs. The DON also indicated the facility had a lab monitoring/record system in place to ensure labs were drawn as ordered and the DON indicated she will provide the lab monitoring record.</p> <p>The above labs and lab monitoring record</p>			

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F000460 SS=D	<p>for Resident #24 was not provided by final exit on 1/22/15.</p> <p>3.1-48(a)(6) 3.1-48(a)(3)</p> <p>483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident.</p> <p>In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident with a roommate was provided a privacy curtain in his room for 1 of 35 residents observed for privacy curtains. (Resident #217)</p> <p>Findings include:</p> <p>The clinical record for Resident #217 was reviewed on 1/14/15 at 11:00 a.m. The diagnoses for Resident #217 included, but were not limited to, left-sided stroke with residual weakness.</p> <p>The 1/8/15 Physical Therapy Plan of Care for Resident #217 indicated, "Patient required assist with ADLs (activities of</p>	F000460	<p>1. Privacy curtains were hung in room #217.2. Current residents have the potential to be affected; however no other resident was identified to have been affected.</p> <p>3. Contracted housekeeping services were educated on the requirement of F460 related to privacy curtains. Audits will be conducted weekly for six months then random monthly observational audits thereafter.</p> <p>4. Monitoring of this plan of correction will be the responsibility of the Executive Director/Director of Nursing. During routine facility rounds weekly identification of any missing privacy curtains will be immediately corrected. Results of audits will be taken to the next Performance Improvement</p>	02/21/2015

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE & REHAB-ALLISON POINTE				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
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F000504 SS=A	<p>daily living) and mobility. Patient was non-ambulatory.</p> <p>An interview was conducted with Resident #217 on 1/14/15 at 11:45 a.m., in his room. He indicated, "I don't even have a privacy curtain. I've told them, and I still don't have one. No privacy curtain was observed on the curtain track in his room.</p> <p>An interview was conducted with the Housekeeping Account Manager on 1/15/15, at 2:20 p.m. He indicated, "I knew earlier this week he didn't have one....A resident should have one the day they get here. He's been here since 1/7/15."</p> <p>3.1-19(k)(7)</p> <p>483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician.</p> <p>Based on interview and record review, the facility failed to ensure there was a Physician's Order for a lab draw that performed on a resident. This had the potential to affect 1 of 6 residents reviewed for unnecessary medications. (Resident #188)</p>	F000504	<p>Committee meeting and monthly thereafter until PI committee determines continued and sustained compliance.</p> <p>1. Resident #188 physician was informed regarding CBC drawn.2. Current residents who receive lab orders have been audited to assure the labs were drawn, orders written, and results are available.3. Licensed staff educated on the lab tracking log. Unit managers will monitor</p>	02/21/2015			

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 01/22/2015
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	<p>Findings include:</p> <p>The clinical record for Resident #188 was reviewed on 1/21/15 at 10:15 a.m. The diagnoses for Resident #188 included, but were not limited to, diabetes mellitus, congestive heart failure and anemia.</p> <p>A Lab Report, dated 12/15/14, indicated the results of a lab drawn for a CBC (complete blood count) for Resident #188.</p> <p>A Physician's Order for the CBC lab drawn on 12/15/14 was not located in the clinical record.</p> <p>During an interview with the Director of Nursing (DON), on 1/21/15 at 10:45, the DON indicated she was unable to locate a Physician's Order for the CBC lab drawn on 12/15/14, but she will continue to look to for an order, as there might be a standing order for the CBC lab to be drawn.</p> <p>ON 1/22/15 at 2:20 p.m., the DON indicated she had no further information on the Physician's Order for the CBC lab drawn on 12/15/14.</p> <p>3.1-49(f)(1)</p>		<p>accuracy of lab log daily during working hours. Education provided per the SDC to licensed nursing staff on lab procedures, verifying orders, inputting orders and obtaining results. 4. The responsible party for this plan of correction is the DNS/designee. Random audits will be completed three times weekly to determine that appropriate physician orders accompany labs for six months then monthly for six months thereafter. Results of audits will be taken to the next Performance Improvement Committee meeting and monthly thereafter until substantial compliance has been achieved and sustained.</p>	