

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00116204.</p> <p>This visit was in conjunction with an Investigation of Complaint IN00117193.</p> <p>Complaint IN00116204 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Dates of Survey: October 2 - 11, 2012</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Survey team: Beth Walsh, RN-TC Karina Gates, BHS Courtney Mujic, RN</p> <p>Census bed type: SNF/NF: 158 Total: 158</p> <p>Census payor type: Medicare: 49 Medicaid: 93 Other: 16</p>	F0000	Please accept the responses as Kindred Transitional Care and Rehabilitation Center Greenwood's plan of correction for the survey that ended 10/11/2012.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
--------------------	--	---------------	---	----------------------

	<p><b>Total: 158</b></p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 10/17/12 by Suzanne Williams, RN</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to perform Accuchecks (blood sugar monitoring) as indicated by Physician's Orders, for 1 of 3 residents reviewed for blood sugar monitoring/unnecessary medications. (Resident # 286)</p> <p>Findings include:</p> <p>The clinical record for Resident #286 was reviewed on 10/9/12 at 1:30 p.m. The diagnoses for Resident #286 included, but were not limited to: diabetes mellitus, peripheral neuropathy, and cardiomyopathy.</p> <p>A recapitulation of the readmission Physician's Orders, no date or time noted, indicated "...8. Accu (symbol for checkmark) QID (four times daily) @ (symbol for at) AC (before meals) + (symbol for and) HS (at bedtime)."</p> <p>On the Diabetic Monitoring Flow Sheet, bid (twice a day) was written on the top of the form. The dates for September were listed in the column titled, Date. In the column titled,</p>	F0282	F-282This 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 and or executed solely because it is required by the provisions of federal and state law. It is the intention of Kindred Transitional Care and Rehabilitation Center Greenwood to provide or arrange services by qualified persons in accordance with each resident's plan of care. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?Resident #286 medical record reviewed for the current month and found to have accuchecks completed per Md orders. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?Each resident with an MD order for blood glucose monitoring had the potential to be affected. Each resident with blood glucose	11/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
	<p>Time, there was a 7 and 5p next to the dates listed, which would indicate the times that blood sugar monitoring was to be completed.</p> <p>A review of the Diabetic Monitoring Flow Sheet, the Blood Sugar Summary, and the Nurse's Notes indicated the following dates and times were missing Accuchecks:</p> <p>9/1/12 at 9 p.m. (bedtime) 9/2/12 at 12 p.m. (lunch time), 9 p.m. 9/3/12 at 12 p.m., 9 p.m. 9/4/12 at 5 p.m. (dinner time), 9 p.m. 9/6/12 at 12 p.m., 9 p.m. 9/7/12 at 12 p.m., 9 p.m. 9/8/12 at 12 p.m., 9 p.m. 9/13/12 at 12 p.m., 5 p.m., 9 p.m. 9/16/12 at 12 p.m., 9 p.m. 9/18/12 at 9 p.m. 9/22/12 at 5 p.m., 9 p.m.</p> <p>The DoN (Director of Nursing) indicated during an interview, on 10/11/12 at 9:35 a.m., nursing was expected to follow physician's orders as written.</p> <p>On 10/11/12 at 12:25 p.m., the DoN indicated, when queried about the above missing Accuchecks, the Accuchecks were not completed as ordered and were "non-existent," if the Accuchecks were not located on the Blood Sugar Summary, the</p>		<p>monitoring has had a complete audit to ensure the MD order matches what is being completed. Each week the Nurse managers will print a list of all patients with accu checks and compare to the computer charting and accucheck sheets. Each morning during the clinical review the nurse managers or designee will review all orders to ensure changes in accu checks. The nurse manager or designee will ensure the Md orders are followed as perscribed. What measures will be put into place or what systemic changes will be made to ensure that the the deficient practice does not recur? Each resident with an MD order for blood glucose monitoring had the potential to be affected. Each resident with blood glucose monitoring has had a complete audit to ensure the MD order matches what is being completed. Each week the Nurse managers will print a list of all patients with accu checks and compare to the computer charting and accucheck sheets. Each morning during the clinical review the nurse managers or designee will review all orders to ensure changes in accu checks. The nurse manager or designee will ensure the Md orders are followed as perscribed. Education will be provided to licensed staff regarding proper documentation of blood sugars and coordinating sliding sacale coverage, including</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
	<p>Diabetic Monitoring Flow Sheet, or in any other part of the clinical record. When the DoN looked at the Diabetic Monitoring Flow Sheet, she indicated there was not even a spot for Accuchecks to be completed four times a day, as ordered, next to each date listed.</p> <p>3.1-35(g)(2)</p>		<p>employees that are hired into the facility. The weekly audit will continue until substantial compliance is maintained for a period of three months. How the corrective action will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put in place. Each resident with an MD order for blood glucose monitoring had the potential to be affected. Each resident with blood glucose monitoring has had a complete audit to ensure the MD order matches what is being completed. Each week the Nurse managers will print a list of all patients with accu checks and compare to the computer charting and accucheck sheets. Each morning during the clinical review the nurse managers or designee will review all orders to ensure changes in accu checks. The nurse manager or designee will ensure the Md orders are followed as perscribed. The weekly check will continue until substantial compliance is maintained for a period of three months. The performance improvement committee will follow the weekly checks (audits) until a pattern of compliance is established for a period of three months. Meaning each patient is complete and accurate.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
F0323 SS=D	<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. Based on observation, record review, and interview, the facility failed to ensure potentially hazardous products were stored securely to prevent access by 2 of 14 residents who were confused and mobile on the Moving Forward unit. (Resident #296 and Resident #293)</p> <p>Findings included:</p> <p>A tour of the facility was conducted on 10/2/12 at 11:45 a.m. On the Moving Forward unit, located next to room 227, was an unlocked door labeled "Linen." Four containers of antiperspirant and deodorant roll on, and one container of antiseptic perineal wash were found on a shelf inside an open wash basin. Both products were labeled with the following: "Warnings: Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away."</p> <p>During interview on 10/2/12 at 1:00 p.m. with the Director of Nursing, she</p>	F0323	<p>F 323This 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 and or executed solely because it is required by the provisions of federal and state law. It is the intention of Kindred Transitional Care and Rehabilitation Center Greenwood to ensure potentially hazardous products were stored securely to prevent access by residents. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?The chemicals found in the back of the linen closet were immediately removed from the unit. The facility was observed for additional hazards, which none were found. The two residents with dementia residing on that particular hall were both unable to access the door to get to the chemicals. How other residents having the potential to be affected by the same deficient</p>	11/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
	<p>indicated the products were not supposed to be located in the linen room.</p> <p>On 10/2/12 at 1:21 p.m., the Director of Nursing provided a list of 2 ambulatory/self-propelled residents (Resident #293 and Resident #296) who live on the Moving Forward unit and have cognitive impairment. A 'Material safety data sheet' was also provided and indicated, "Section VI-Health hazard data: Emergency and first aid procedures, '[name of brand] roll-on deodorant': Ingestion: drink a glass of milk or water and seek medical attention, '[name of brand] antiseptic perineal wash': Contact physician if ingested."</p> <p>3.1-45(a)(1)</p>		<p>practice will be identified and what corrective action will be taken? Any resident with a diagnosis of dementia had the potential to be affected per report of ISDH. Anti-perspirants, peri wash, soaps and or lotions, and all things that could be considered hazardous will be stored in an area which is not authorized will not be tolerated. Daily rounds will be completed by the Executive Director or designee on an ongoing basis to ensure these products are not in unauthorized areas. This will be completed for a period of one month on a daily basis and then weekly for a period of two months. If compliance is not established the time frame will be extended by the discretion of the Executive Director. What measures will be put into place or what systemic changes will be made to ensure that the the deficient practice does not recur? Any resident with a diagnosis of dementia had the potential to be affected per report of ISDH. Anti-perspirants, peri wash, soaps and or lotions, and all things that could be considered hazardous will stored in an area which is not authorized will not be tolerated. Daily rounds will be completed by the Executive Director or designee on an ongoing basis to ensure these products are not in unauthorized areas. This will be completed for a period of one month on a daily</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
			basis and then weekly for a period of two months. If compliance is not established the time frame will be extended by the discession of the Executive Director. Education will be provided to staff for hazzards and storage. How the corrective action will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put in place. Anti-perspirants, peri wash, soaps and or lotions, and all things that could be considered hazardous will stored in an area which is not authorized will not be tolerated. Daily rounds will be completed by the Executive Director or designee on an ongoing basis to ensure these products are not in unauthorized areas. This will be completed for a period of one month on a daily basis and then weekly for a period of two months. If compliance is not established the time frame will be extended by the discession of the Executive Director. The Performance Improvement Committee will follow the audits for a period of six months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
F0371 SS=D	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to provide a sanitary manner to serve food by touching food with bare hands, while serving food. This affected 1 of 19 residents dining in the Reflections 2 dining room. (Resident #76)</p> <p>Findings include:</p> <p>During a dining observation, on 10/4/12 at 11:57 a.m., CNA #4 placed a plate of food in front of Resident #76. CNA #4 touched Resident #76's bread with her bare hands and moved the bread to a different spot on Resident #76's plate.</p> <p>In an interview with the Administrator, on 10/10/12 at 1:30 p.m., the Administrator indicated staff should not touch a resident's food at any time with bare hands.</p> <p>A list of residents who dine in the Reflections 2 dining room, was</p>	F0371	<p>F-371This 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 and or executed solely because it is required by the provisions of federal and state law. It is the intention of Kindred Transitional Care and Rehabilitation Center Greenwood to procure food from sources approved or considered satisfactory by Federal, State or local authorities; and store, prepare, distribute and serve food under sanitary conditions. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?No corrective for this event on this date. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?Dining room observations will be conducted three time per</p>	11/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142		
(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	
	<p>provided by the DoN (Director of Nursing), on 10/11/12 at 9:36 a.m. There was 19 residents on the list.</p> <p>3.1-21(i)(3)</p>		<p>week to ensure food is not touched with bare hands for our patients by the nurse management staff or designee. Gloves will be provided in the dining room. Charge nurses will be in the dining room for meals. Education will be provided to nursing staff in regard to food handling. What measures will be put into place or what systemic changes will be made to ensure that the the deficient practice does not recur?Dining room observations will be conducted three time per week to ensure food is not touched with bare hands for our patients by the nurse management staff or designee. Gloves will be provided in the dining room. Charge nurses will be in the dining room for meals. Education will be provided to nursing staff in regard to food handling. How the corrective action will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put in place.Dining room observations will be conducted three time per week to ensure food is not touched with bare hands for our patients by the nurse management staff or designee. Gloves will be provided in the dining room. Charge nurses will be in the dining room for meals. Education will be provided to nursing staff in regard to food handlingThe Performance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
			Improvement Committee will monitor the results of the observations (audits) for a period of three months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
F0412 SS=D	<p><b>483.55(b)</b> <b>ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</b> The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>Based on observation, interview, and record review, the facility failed to address an oral/dental condition for 1 of 3 residents reviewed who met the criteria for dental status and services. (Resident #7)</p> <p>Findings include:</p> <p>The clinical record for Resident #7 was reviewed on 10/9/12 at 1:30 p.m.</p> <p>The diagnoses for Resident #7 included, but were not limited to: depression and chronic pain.</p> <p>The 8/8/12 quarterly MDS (minimum data set) assessment indicated Resident #7 had a BIMS (brief interview for mental status) score of 15, the highest possible score indicating resident is cognitively intact.</p>	F0412	F-412This 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 and or executed solely because it is required by the provisions of federal and state law. It is the intention of Kindred Transitional Care and Rehabilitation Center Greenwood to provide or obtain from outside resource, in accordance with of this part, routine, and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist office; and promptly refer residents with lost or damaged dentures to a dentist. What corrective action will be	11/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142		
(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	
	<p>Documentation was lacking in Resident #7's record to indicate the resident was having any oral or dental issues.</p> <p>During an interview with Resident #7 on 10/3/12 at 1:31 p.m., she indicated she had problems with chewing/eating. She indicated she had one whole tooth and two chipped teeth on the bottom. She indicated she had five teeth pulled in July, 2012 and was to schedule an appointment to take care of the three remaining teeth on the bottom. She indicated the facility called the dentist who informed they would call back with an appointment, but the dentist never called back. She indicated she asked the nurses every week since July, 2012 to call the dentist back for an appointment, but she was not sure what was happening. An observation of Resident #7's oral cavity was made at this time. Resident #7 was observed with one discolored tooth as well as two chipped teeth on the bottom front and dentures on top.</p> <p>During an interview with the DON (Director of Nursing) on 10/11/12 at 11:56 a.m., she indicated there was nothing in Resident #7's chart that indicated any oral issues for her and she was unaware of any dental</p>		<p>accomplished for those residents found to have been affected by the deficient practice?The dental appointment was scheduled during the survey. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken?Any residents with dental concerns have the potential to be affected by this practice. A dental assessment will be conducted on each resident. If there is a dental concern, the patient will be placed on the dental list to be seen. If the dental concern is emergent, the patient will be scheduled with an alternate provider with transportation arranged.The facility will continue dental assessments on admission, with quarterly assessments and six month evaluations per the dentist, and as needed. If the patient has a problem in the interim period between visits the staff will arrange for outside services, including transportation. This issue was isolated to one resident and one staff member. This staff member was educated on what to do if no resolution is made with a patient appointment within a one week time frame. Education was provided to all licensed staff to ensure proper care of residents regarding outside services, including those employees that will be hired. This information will be instructed in orientation. The ABAQIS system</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
	<p>conditions for Resident #7.</p> <p>An interview with Resident #7 and an observation of Resident #7's oral cavity was made with the DON on 10/11/12 at 12:00 p.m. Again, Resident #7 was observed with the one tooth and two chipped teeth on bottom. Resident #7 indicated she needed the bottom teeth removed so she could get bottom dentures. She, again, indicated she told the nurses, but hadn't gotten a response or an appointment. The DON left Resident #7's room at 12:05 p.m. Resident #7 continued to explain that she was on a mechanical soft diet because of her bottom teeth and would like to get off the mechanical soft diet and onto a regular diet. She stated, "The one bottom tooth I have hurts. I notice it when I have peaches or strawberries or something cold. I end up not eating it because it hurts. I haven't known anything for the last three months. I'd like to get some answers. I don't know if it's the dentist or if the nurses here aren't calling or what."</p> <p>During an interview with LPN #2 on 10/11/12 at 12:15 p.m., she indicated, "She keeps asking when she's supposed to go to dentist. She says its hard for her to eat with the one tooth. I've called (name of dental</p>		<p>will be completed quarterly to ensure the dental concerns are being addressed. This process is completed by the interdisciplinary team with the DNS as the leader. What measures will be put into place or what systemic changes will be made to ensure that the the deficient practice does not recur?Any residents with dental concerns have the potential to be affected by this practice. A dental assessment will be conducted on each resident. If there is a dental concern, the patient will be placed on the dental list to be seen. If the dental concern is emergent, the patient will be scheduled with an alternate provider with trasportation arranged.The facility will continue with quarterly assessments and six month evaluations per the dentist. If the patient has a problem in the interim period between visits the staff will arrange for outside services, including transportation. This issue was isolated to one resident and one staff member. This staff member was educated on what to do if no resolution is made with a patient appointment within a one week time frame. Education was provided to all licensed staff to ensure proper care of residents regarding outside services. The ABAQIS system will be completed quarterly to ensure the dental concerns are being addressed. This process is</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142		
(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	
	<p>provider) about this and they don't call me back. I've called 4 or 5 times about this, at least. It seems like once a week."</p> <p>During an interview with the DON on 10/11/12 at 12:18 p.m., she stated, "We'll have to find another dentist." She indicated she expected to have been made aware of Resident #7's dental condition sooner.</p> <p>LPN #2 was observed calling another dental provider on 10/11/12 at 12:19 p.m.</p> <p>3.1-24(a)(1)</p>		<p>completed by the interdisciplinary team with the DNS as the leader. How the corrective action will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put in place. Any residents with dental concerns have the potential to be affected by this practice. A dental assessment will be conducted on each resident. If there is a dental concern, the patient will be placed on the dental list to be seen. If the dental concern is emergent, the patient will be scheduled with an alternate provider with transportation arranged. The facility will continue with quarterly assessments and six month evaluations per the dentist. If the patient has a problem in the interim period between visits the staff will arrange for outside services, including transportation. This issue was isolated to one resident and one staff member. This staff member was educated on what to do if no resolution is made with a patient appointment within a one week time frame. Education was provided to all licensed staff to ensure proper care of residents regarding outside services. The ABAQIS system will be completed quarterly to ensure the dental concerns are being addressed. This process is completed by the interdisciplinary team with the DNS as the leader. The performance</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/11/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
			improvement committee will review all results to ensure compliance.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142			
(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			
F0441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, record review, and interview, the facility failed to</p>	F0441	F-441This plan of correction is the center's credible allegation of	11/06/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142		
(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	
	<p>ensure a nurse washed her hands between administering medications to two residents randomly observed during a routine medication pass. (Resident #179 and Resident #12.)</p> <p>Findings included:</p> <p>Observation of LPN #2 on 10/11/2012 at 8:57 am, indicated she did not wash her hands during med pass between Resident #12's and Resident #179's medication administrations. Resident #12 was handed a nasal inhaler which he then used to give himself the medication and then he handed it back to LPN #2. LPN #2 was not wearing gloves and did not wash her hands before proceeding to prepare and administer Resident #179's two insulin injections.</p> <p>A policy provided by the Director of Nursing on 10/11/12 at 9:52 am indicated, "Hand Hygiene/Handwashing: Rationale...Hand hygiene is to be performed: between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments."</p> <p>An interview with the Director of Nursing on 10/11/12 at 1:35 p.m. indicated she would expect nurses to</p>		<p>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 and or executed solely because it is required by the provisions of federal and state law. It is the intention of Kindred Transitional Care and Rehabilitation Center Greenwood to maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and help prevent the development and transmission of disease and infection. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No corrective action for these patients. This licensed nurse was educated on proper handwashing. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? There is a potential for residents to be affected by this deficient practice. Education will be provided to staff for handwashing, including the proper indications. Medpass observations will be completed weekly to ensure compliance is met and maintained. The observations will occur weekly for</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/11/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142		
(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	
	wash their hands between residents when giving medications.  3.1-18(l)		a period of four weeks and then monthly for three months. The results of the observations will be reviewed by the performance improvement committee to ensure substantial compliance or the need for additional education. All employees that are hired will have completed medpass observation to include proper handwashing. What measures will be put into place or what systemic changes will be made to ensure that the the deficient practice does not recur?There is a potential for residents to be affected by this deficient practice. Education will be provided to staff for handwashing, including the proper indications. Medpass observations will be completed weekly to ensure compliance is met and maintained. The observations will occur weekly for a period of four weeks and then monthly for three months. The results of the observations will be reviewed by the performance improvement committee to ensure substantial compliance or the need for additional education. How the corrective action will be monitored to ensure the deficient practice does not recur, i.e., what quality assurance program will be put in place. There is a potential for residents to be affected by this deficient practice. Education will be provided to staff for handwashing, including the		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/11/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
---	--

(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
			proper indications. Medpass observations will be completed weekly to ensure compliance is met and maintained. The observations will occur weekly for a period of four weeks and then monthly for three months. The results of the observations will be reviewed by the performance improvement committee to ensure subntial compliance or the need for additional education.	