

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155188	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/18/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
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F000000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the investigation of Complaint IN00143888 and IN00143199.</p> <p>This visit was in conjunction with the Investigation of Complaint #IN00144573.</p> <p>Complaint number IN00143888 unsubstantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint number IN00143199 unsubstantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: February 11, 12, 13, 14, 17 and 18, 2014</p> <p>Facility number: 000099 Provider number: 155188 AIM number: 100291140</p> <p>Survey team: Karina Gates, Generalist TC Courtney Mujic, RN Beth Walsh, RN Tom Stauss, RN</p> <p>Census bed type: SNF/NF: 146</p>	F000000	<p>March 6, 2014 Indiana State Department of Health2 N. MeridianIndianapolis, IN 46204 RE: Kindred Transitional Care and Rehabilitation-Greenfield Plan of Correction Credible Allegation of Compliance, and Request for DESK REVIEW Dear Kim Rhoades, On February 11th, 2014 surveyors from the Indiana State Department of Health completed an inspection at Kindred Transitional Care and Rehabilitation-Greenfield. As a result of the inspection, the surveyors alleged that the Center was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the HCFA-2567L with the Center's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Center of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies. Please also consider this letter and the Plan of Correction to be the Center's credible allegation of compliance. The center will achieve substantial compliance with the applicable certification requirements on March 20th, 2013. Please notify me</p>	
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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: 146</p> <p>Census payor type: Medicare: 22 Medicaid: 94 Other: 30 Total: 146</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality Review was completed by Tammy Alley RN on February 21, 2014.</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. Based on interview and record review, the facility failed to provide bathing per resident's preferences. This affected 1 of 1 residents</p>	F000242	<p>immediately if you do not find the Plan of Correction to be written credible evidence of the Center's substantial compliance with the applicable requirements as of this date. In that event, I will be happy to provide you with additional evidence of compliance so you may certify that the center is in substantial compliance with the applicable requirements. This letter is also our request for a DESK REVIEW, to verify that the Center achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance. Thank you for your assistance with this matter. Please call me if you have any questions. Sincerely, Monica Jill Pearson, HFAdministrator(317) 462-3311</p> <p>F 242 483.15(b) Self Determination-Right to Make Choices: Resident #174 has had her plan of care updated to reflect her shower choices. The DNS</p>	03/20/2014			

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	<p>reviewed for choices (Resident #174).</p> <p>Findings include:</p> <p>The clinical record for Resident #174 was reviewed 2/17/14 at 1:45 p.m. The diagnoses for Resident #174 included, but were not limited to: arterial fibrillation, hypertension, and hyperkalemia. Resident #174 was admitted 1/24/14.</p> <p>During an interview with Resident #174, on 2/12/14 at 1:35 p.m., she indicated she has had only 1 shower since her admission. She also indicated she was not asked if she would like a bed bath/washcloths to wash up at any other time, since that shower. Resident #174 also indicated she would like to have some type of bathing daily, whether its a basin with soapy water and a washcloth or a shower.</p> <p>On 2/17/14, at 10:30 a.m., Resident #174 indicated she received a shower on 2/14/14, but was not asked since then, if she would like a bed bath or get cleaned up. Resident #174 indicated again, it was her preference to get "cleaned/washed up" in some manner daily. Resident #174 further</p>		<p>has validated Resident #174 is receiving her shower. All residents have the potential to be affected. All residents and/or families have been interviewed and their individual preferences for showering or bathing have been updated with the plan of care. Nursing will be educated on the Resident's Right to make choices with an emphasis on bathing preferences. Nurses have been in serviced to write down which residents on their assignment have showers due during their scheduled shift and to validate with C.N.A. and resident that shower was completed during their shift, and shower sheet was turned in and signed. Unit Managers, DNS or designee are to monitor Nurses and C.N.A.'s daily for compliance. Upon admission or readmission the nurse completing the nursing assessment will interview the resident or family for bathing preferences as part of the initial nursing assessment. The Nursing Managers will follow up with any resident admitted to the facility within 72 hours to validate bathing preferences and coordinate plan of care with the resident's preferences. The IDT will interview residents regarding their bathing preferences during the quarterly and annual care plan meeting. The IDT will complete 40 resident and family interviews quarterly to include resident's choices regarding</p>				

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	<p>indicated no one had ever asked her preference on how often she would like to be bathed.</p> <p>The Admission MDS (minimum data set) assessment, dated 1/31/14, indicated Resident #174 had a BIMS (brief interview of mental status) of 15, which indicated no cognitive impairment.</p> <p>At 3:00 p.m., on 2/17/14, the Director of Nursing (DoN) indicated there was screening that was initiated when a Resident was admitted to the facility. She also indicated the screening does not include how often the Resident would like to be bathed, only the type of bathing and time (a.m./p.m.) preference was asked of the Resident. The DoN provided Resident #174's shower sheets at this time.</p> <p>A Patient Nursing Evaluation, Part 3, dated 1/24/14, indicated, "...Bathing Type/Time Preference-check all that apply...shower." There were no checkmarks in the slots for a.m. or p.m.</p> <p>A review of shower sheets for Resident #174 indicated the following:</p>		<p>bathing preferences. All findings from these interviews will be reviewed in monthly PI and the PI committee will determine when 100% compliance is obtained or if further monitoring will continue. Compliance Date: March 20, 2014</p>				

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	<p>1/28/14-bed bath 2/7/14-shower 2/14/14-shower.</p> <p>A policy, titled Self-Determination and Participation and dated 10/09, was received from the DoN on 2/18/14 at 12:25 p.m. It indicated, "The center creates an environment that is respectful of the right of each resident to exercise his or her autonomy regarding what the resident considers to be important facets of his or her life....Choose schedules consistent with his or her interests, assessments, and plans of care. Choice over schedules includes (but is not limited to) choices over the schedules that are important to the resident, such as...bathing...."</p> <p>A care plan for ADLs (activities of daily living) self care performance deficit related to weakness and debility, dated 2/3/14, indicated to honor resident's choice and preferences whenever possible.</p> <p>3.1-3(u)3</p>				

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F000250 SS=D	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Based on interview and record review, the facility failed to ensure a Pre-Admission Screening and Resident Review (PASRR) was done annually. This affected 1 of 1 residents reviewed for PASRR. (Resident #157)</p> <p>Findings include:</p> <p>The clinical record for Resident #157 was reviewed 2/17/14 at 10:15 a.m. The diagnoses for Resident #157 included, but were not limited to: Down's syndrome, Friedreich's ataxia, and diabetes mellitus.</p> <p>A review of a PASRR, dated 9/27/11, indicated, "The resident requires resident review in one year."</p> <p>No other PASRRs were located in the clinical record.</p> <p>During an interview with Social Services Specialist #2 (SSS#2), on 2/17/14 at 10:30 a.m., she indicated Resident #157 had not had a</p>	F000250	F250 483.15(g)(1) Provision for Medically Related Social Service Resident #157 was scheduled for PASRR Level 2 assessment by IDEC to be completed on March 7, 2014. All residents requiring PASRR Level 2 annual review have the potential to be affected. All other Level 2 annual reviews were audited and found to be current. Social services director educated on compliance for PASRR Level 2 annual reviews. The ED/Designee will review all admissions to identify any resident requiring a PASRR Level 2 and validate monthly for 6 months that any required PASRR Level 2 has been completed. All findings will be reported to the PI committee monthly. The PI committee will determine when 100% compliance is achieved or if further monitoring is required. Compliance Date: March 20, 2014	03/20/2014			

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	<p>PASRR/review since the 9/27/11. She also indicated Resident #157 should have yearly PASRRs/reviews.</p> <p>A progress note, dated 11/14/13, indicated "SS left 2nd message at BDDS (Bureau of Developmental Disabilities Services) for update on yearly review.</p> <p>An email, dated 12/4/13, received from SSS#2, on 2/17/14 at 11:00 a.m., indicated the contact information for the person in charge of PASRRs/reviews was provided to SSS#2.</p> <p>An email received from SSS#2, on 2/17/14 at 11:00 a.m. and dated 12/5/13, indicated several messages were left in regards to a PASRR/review needing to be completed.</p> <p>A review of a document titled, D & E Referral Confirmation, dated 2/12/14 at 9:22 a.m., indicated Resident #157 was scheduled for her PASRR on 3/7/14.</p> <p>At 11:00 a.m., on 2/17/14, SSS #2 indicated her emails only go back to a certain date, so she was unable to provide further documentation that</p>						

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	<p>requests were made for PASRRs to be completed for Resident #157. SSS #2 indicated she was going to call the technology department for the facility to see if they would be able to retrieve other documentation. She also indicated she would try and locate other progress notes in the clinical record that indicated she tried to request PASRRs to be completed for Resident #157 prior to 11/14/13.</p> <p>On 2/17/14, at 2:30 p.m., SSS#2 indicated she was unable to locate any other progress notes documenting her requests for PASRRs/reviews for Resident #157 and she looked all the way back to 2012. She also indicated the technology department was only able to retrieve emails till 10/2/13 and was unable to provide any other documentation of her email requests for a PASRR, except for the emails dated 12/4/13 and 12/5/13.</p> <p>3.1-34(a)</p>				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>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> <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 develop a care plan for a Resident's use of anti-anxiety medication and for an ordered antipsychotic medication (Zyprexa) for 2 of 21 residents reviewed for care plans. (Resident #170 and #9)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #170 was reviewed 2/12/14 at 1:45 p.m. The diagnoses for Resident #170 included, but were not limited</p>	F000279	F 279 483.20(k)(1) Develop Comprehensive Care Plans Residents' #170 and # 9 plans of care updated to include antianxiety and antipsychotic medications and non-medicinal interventions. All residents on psychoactive medications have the potential to be affected. Audits were completed for all residents on psychoactive medications to assure that these medications were included in the plan of care and that the plan of care is individualized has non-medicinal interventions and revised with change in condition. Social service and nursing staff	03/20/2014			

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	<p>to: dementia, depression, insomnia, and bipolar disorder.</p> <p>A review of a Physician's Order, dated 2/7/14, indicated an order for Ativan (anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day, PRN (as needed).</p> <p>The care plans reviewed for Resident #170 included, but were not limited to: Resident has biting/chewing difficulty, dated 12/17/13, Resident uses psychotropic medications Risperdal (anti-psychotic) and Celexa (anti-depressant) related to disease process of bi-polar disorder, dated 2/6/14, and Resident has acute pain related to decreased mobility, history of falls, and recent surgery, dated 12/11/13.</p> <p>A care plan for use of an anti-anxiety medication was not located in the clinical record.</p> <p>During an interview with the Director of Nursing (DoN), on 2/14/14 at 10:30 a.m., she indicated when a new order was written, the care plan related to that order was written within a day or two. The DoN also indicated she was unable to locate a care plan for use of an anti-anxiety</p>		<p>will be educated on Antipsychotic/Psychoactive Medications and development of the plan of care. The DNS/Designee will audit the care plan of any resident with a new order for a psychoactive medication or change in the MD order for a psychoactive medication to verify it is individualized, has non-medicinal interventions and is current with the behavior monitoring sheets. This audit will be completed daily for 30 days, then three times a week for 30 days, then weekly for 60 days and then monthly as an on going practice of this facility. Results of these audits will be shared at monthly PI meetings. All findings will be addressed immediately then monthly in PI meeting. The PI committee will determine when 100% compliance is achieved or if further monitoring is required. Compliance Date: March 20, 2014</p>		

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	<p>medication and there should be a care plan in place for this.</p> <p>2. The clinical record was reviewed for Resident #9 on 2/14/14. Diagnoses included, but were not limited to: other persistent mental disease otherwise due to conditions classified elsewhere; anxiety disorder, depressive disorder, insomnia.</p> <p>The physician orders for Resident #9 indicated orders for : Zyprexa 5mg.</p> <p>A current care plan, dated 7/28/11, for Resident #9 indicated the following: "Pt [patient] psychotropic meds cymbalta, klonopin..." and appropriate interventions for side effect monitoring was also indicated by the care plan. Zyprexa was not a listed medication on the care plan.</p> <p>On 2/18/14 at 11:16 a.m., during an interview, the DON indicated any resident on an antipsychotic medication should have a related care plan entry to guide nursing staff regarding medication side effect and adverse effect monitoring.</p> <p>On 2/18/14 at 12:44 p.m., during an interview, the DON indicated the</p>				

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	<p>facility has no record of behavior monitoring logs for Resident #9 for December of 2013 and January 2014 which, she indicated, should have been kept in the nursing staff's "behavior book" normally kept on the unit where the resident lives. She indicated she doesn't know why they aren't there, but they should have been there.</p> <p>A facility policy titled "Antipsychotic/Psychoactive Medication" was received from facility DON on 2/18/14 at 11:03 a.m. It indicated the social services and/or licensed nursing staff should "...Implement a behavior monitoring log or similar mechanisms to document need for and response to drug therapy..." It also indicated "...Document care plan interventions as developed for patient.."</p> <p>Another facility policy titled "Psychoactive Drug Use" indicated the following: "...Develop a plan of care individualized to patient needs..."</p> <p>On 2/18/14 at 2:03 p.m., during an interview, the DON indicated Resident #9 does not have a current care plan in place for Zyprexa use, but should have one.</p>						

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F000282 SS=D	<p>3.1-35(a) 3.1-35(b)(1) 3.1-35(b)(2)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow physician's orders for acquiring a resident's pulse rate and weigh a resident per facility policy for 2 of 21 resident's reviewed for following the plan of care. (Resident #8 and #241)</p> <p>Findings include:</p> <p>1. The clinical record for Resident #8 was reviewed on 2/18/14 at 11:00 a.m. The diagnoses for Resident #8 included, but were not limited to: hypertension.</p>	F000282	F282 483.20 (k)(3)(ii) Services By Qualified Persons/Per Care Plan Resident #8 had no adverse effect. Resident #8's MD was notified of failure to obtain the pulse before medication administration and the order was received to discontinue the weekly monitoring. Resident #8's family was updated of the failure to obtain the pulse and the new MD order. Resident # 241 is no longer a resident at the facility. Any resident with a medication requiring a pulse be obtained has the potential to be affected. An audit has been completed of all MD orders for a medication requiring a pulse to be obtained	03/20/2014	

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	<p>The February, 2014 Physician's Orders for Resident #8 indicated, "Blood pressure weekly and pulse on Thursday" effective 9/13/13.</p> <p>The January, 2014 and February, 2014 MARs (medication administration records) for Resident #8 indicated a blood pressure weekly, but no pulse rate.</p> <p>An interview was conducted with Unit Manager #3 on 2/18/14 at 11:11 a.m. regarding lack of a pulse rate documented on the MAR. She indicated, "It should be documented next to the blood pressure on the MAR. I see it's not. I don't know why the heart rate is not on there. I don't see it anywhere else in his chart either...I try to review the MARs at least monthly...I possibly just missed it."</p> <p>2. The clinical record for Resident #241 was reviewed on 2/18/14 at 1:45 p.m. She was admitted to the facility on 12/16/13 and discharged on on 1/4/14. The diagnoses for Resident #241 included, but were not limited to: anemia and diabetes.</p> <p>Review of Resident #241's weights indicated she was weighed on</p>		<p>to validate the transcription is on the MAR. Any findings have been reviewed with the residents' MD. Any resident requiring a weekly weight has the potential to be affected. An audit has been completed to validate residents requiring weekly weights are being weighed weekly. Any findings have been reviewed with the residents' MD and family. All licensed nurses have been educated on Documenting in a Patient's Medical record with emphasis on medication administration. All nursing staff has been educated on weight measurement with emphasis on recording weights. The DNS/Designee will audit all MARs five times a week for 30 days to verify complete documentation with medication administration, then three times a week for 30 days, then weekly for 4 months. All findings will be addressed immediately and reported to the PI committee monthly. The monthly PI committee will determine when 100% compliance is achieved or if further monitoring is required. The DNS/Designee will audit residents needing weights five times a week for 30 days, then three times a week for 30 days, then weekly for 4 months and as an on going process of this facility. All findings will be addressed immediately and reported in the monthly PI meeting. The PI committee will</p>				

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	<p>12/17/13 and 12/20/13 only. No weights for Resident #241 were found after the 12/20/13 weight.</p> <p>During a telephone interview with Resident #241 on 2/18/14 at 1:46 p.m., she indicated she lost 8 pounds while residing at the facility.</p> <p>During an interview with the Director of Nursing (DON) on 2/18/14 at 1:10 p.m., she indicated, "We are missing a weight for her for 12/27 (12/27/13). She was discharged on 1/4 (1/4/14), which was her next scheduled weight."</p> <p>The DON provided a copy of the policy entitled Measuring and Documenting Height and Weight on 2/18/14 at 2:00 p.m. It indicated, "Measure weight weekly for the first 4 weeks after admission/readmission...."</p> <p>3.1-35(g)(2)</p>		determine when 100% compliance has been achieved or if further monitoring is required. Compliance Date: March 20, 2014		

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F000312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <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 interview and record review, the facility failed to ensure a resident was assisted with bathing, at least twice weekly, for 1 of 3 residents reviewed for bathing. (Resident #174)</p> <p>Findings include:</p> <p>The clinical record for Resident #174 was reviewed 2/17/14 at 1:45 p.m. The diagnoses for Resident #174 included, but were not limited to: arterial fibrillation, hypertension, and hyperkalemia. Resident #174 was admitted 1/24/14.</p> <p>During an interview with Resident #174, on 2/12/14 at 1:35 p.m., she indicated she has had only 1 shower since her admission. She also indicated she was not asked if she would like a bed bath/washcloths to wash up at any other time, since that shower. Resident #174 also indicated she would like to have some type of bathing daily, whether its a basin with soapy water and a</p>	F000312	F 312 483.25(a)(3) ADL Care Provided for Dependent Residents Resident #174 was immediately offered a shower. Resident did not want to take a shower at that time, stating that she would wait until the next morning. Resident #174 was again offered a shower the next morning and did not want to take a shower at that time. Resident was then given a shower after therapy per her request. Resident was also offered the choice of having a basin and wash cloth available for bathing between shower days. All residents have the potential to be affected. Shower documentation was reviewed and residents and families interviewed to validate showering and bathing are provided. Nursing will be educated on the Resident's Right to make choices with an emphasis on bathing preferences and ADL care. Nurses have been in serviced to write down which residents on their assignment have showers due during their scheduled shift and to validate with C.N.A. and resident that shower was completed during their shift, and shower sheet was	03/20/2014			

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	<p>washcloth or a shower.</p> <p>On 2/17/14, at 10:30 a.m., Resident #174 indicated she received a shower on 2/14/14, but was not asked since then if she would like a bed bath or get cleaned up.</p> <p>The Admission MDS (minimum data set) assessment, dated 1/31/14, indicated Resident #174 had a BIMS (brief interview of mental status) of 15, which indicated no cognitive impairment. The MDS also indicated Resident #174 needed physical help in part of bathing activity with a 1 person physical assist.</p> <p>At 3:00 p.m., on 2/17/14, the Director of Nursing (DoN) indicated Residents were supposed to receive 2 showers/bed baths a week. Shower sheets for Resident #174 were provided at this time.</p> <p>A review of shower sheets for Resident #174 indicated the following: 1/28/14-bed bath 2/7/14-shower 2/14/14-shower.</p> <p>3.1-38(b)(2)</p>		<p>turned in and signed. Unit Managers, DNS or designee are to monitor Nurses and C.N.A.'s daily for compliance. Upon admission or readmission the nurse completing the nursing assessment will interview the resident or family for bathing preferences as part of the initial nursing assessment. The Nursing Managers will follow up with any resident admitted to the facility within 72 hours to validate bathing preferences and coordinate plan of care with the resident's preferences. The IDT will interview residents regarding their bathing preferences during the quarterly and annual care plan meeting. The IDT will complete 40 resident and family interviews quarterly to include resident's choices regarding bathing preferences. All findings from these interviews will be reviewed in monthly PI and the PI committee will determine when 100% compliance is obtained or if further monitoring will continue. Compliance Date: March 20, 2014</p>				

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F000313 SS=D	<p>483.25(b) TREATMENT/DEVICES TO MAINTAIN HEARING/VISION</p> <p>To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident in making appointments, and by arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.</p> <p>Based on observation, interview and record review, the facility failed to follow up with a vision treatment plan for 1 of 1 resident reviewed for vision services. (Resident #114)</p> <p>Findings include:</p> <p>The clinical record for Resident #114 was reviewed on 2/13/13 at 11:00 a.m. The diagnoses for Resident #114 included, but were not limited to: nuclear sclerosis cataract and dry eye syndrome.</p> <p>During a telephone interview with Family Member #5 on 2/12/14 at 1:45 p.m., she indicated Resident</p>	F000313	F 313 483.25 (b) Treatment /Devices To Maintain Hearing/Vision: Resident #114 consult was completed on 2/24/2014 and cataract surgery is scheduled for 3/27/2014. Family and MD were notified. An audit of all current residents' medical records was completed to identify any residents that may have had a follow up appointment that needed to be scheduled. Prime Source staff and all Licensed Nurses will be educated that all referrals for consults will be written on a physician order form and reviewed with the IDT before exiting the facility. The DNS/Designee will review charts of residents seen by ancillary services to validate a physician's order for referrals/consults has	03/20/2014

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	<p>#114 needed glasses and was not sure if they'd been ordered or not.</p> <p>During an interview with and observation of resident #114 on 2/17/14 at 11:34 a.m., he was not wearing any glasses and stated, "I need a hearing aid and glasses."</p> <p>The 12/2/13 Optometry Exam Summary indicated the following:</p> <p>"#1 Presenting Problem/Chief Complaint Evaluated: Blurry Vision Quality: Blur Timing: All the time Severity: Moderate Duration: Always Location: Behind eye(s)</p> <p>Treatment Plan: Diagnosis: Nuclear Sclerosis Cataract Plan: Refer to Ophthalmologist</p> <p>Glasses Plan: No new glasses and Wait until Cataract Sx (surgery)"</p> <p>Attached to the above mentioned Optometry Exam was a referral that indicated the following:</p> <p>"Dear Provider,</p> <p>I am referring (name of Resident</p>		<p>been written and an appointment scheduled weekly for 3 months then monthly for 3 months. Results of these audits will be reported at monthly PI meetings. The PI committee will determine when 100% compliance is achieved or if further monitoring is required. Compliance date: March 20, 2014</p>				

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	<p>#114) to your office following Optometric care on 12/2/2013 for: Cataract - OU (both eyes).</p> <p>Sincerely,</p> <p>(Name of doctor)"</p> <p>An interview was conducted with Unit Manager #3 and the Social Services Director (SSD) on 2/17/14 at 12:40 p.m., regarding whether Resident #114 ever went to the ophthalmologist appointment for which he had a referral. Unit Manager #3 indicated he saw (name of ophthalmologist) on 1/17/14, and this was per Family Member #5, and there were no new orders. She stated, "He didn't come back with anything." The SSD stated, "I didn't know anything about there being no recommendation for cataract surgery."</p> <p>An interview was conducted on 2/17/14 at 1:00 p.m., with the Patient Care Representative (PCR) from the doctors office who made the referral and conducted Resident #114's above mentioned optometry exam . The PCR indicated their office hadn't received any information from an ophthalmologist's office regarding an appointment with Resident #114.</p>				

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	<p>She further indicated, "He (Resident #114) will not ever have good vision until his cataracts are removed...I can't see an ophthalmologist saying no to the surgery."</p> <p>An interview was conducted with Resident #114 and Family Member #5 with the SSD present on 2/17/14 at 1:10 p.m. Family Member #5 indicated Resident #114 never had an appointment with an ophthalmologist, but she would like for him to have one. Resident #114 agreed to this.</p> <p>On 2/17/14 at 1:27 p.m., Unit Manager #3 telephoned the ophthalmologist's office at which Resident #114 had his previously alleged appointment. After hanging up the telephone, she stated, "They said he has not been seen since 2012." Regarding who's responsibility it was to ensure Resident #114 had the ophthalmologist appointment for which he was referred, she indicated, "It was nursing who was responsible for making sure he got an appointment. I don't know what happened. I didn't know before today the referral existed. I don't know where the ball was dropped in the midst of things. It's something I'll</p>				

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F000315 SS=D	<p>have to look into." At this time, Unit Manager #3 called (name of ophthalmologist) and scheduled Resident #114 an appointment for the cataract screening/consult for which he was referred on 12/2/13.</p> <p>3.1-39(a)(1)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation, interview, and record review, the facility failed to ensure proper placement of a Foley catheter drainage bag to prevent the possibility of infection. This affected 1 of 1 residents in random observations. (Resident #156)</p> <p>Findings include:</p> <p>The clinical record for Resident #156 was reviewed on 2/17/2014 at 9:40</p>	F000315	F 315 483.5 (d) No Catheter, Prevent UTI, Restore Bladder Resident #156 bed was adjusted to the lowest position while preventing the catheter bag from touching the floor. Resident #156 remains without signs or symptoms of a CAUTI. All residents with an indwelling catheter have the potential to be affected. All residents have been reviewed to validate the placement of the catheter drainage bag is maintained to prevent CAUTI. All nursing staff	03/20/2014			

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	<p>a.m.</p> <p>The diagnoses for Resident #103 included, but were not limited to: benign prostatic hyperplasia (enlarged prostate) with urinary obstruction and retention.</p> <p>During an observations of Resident #156 indicated; on 2/12/2014 at 11:50 a.m., and at 2:36 p.m., he had his urinary catheter drainage bag hanging off his bed and touching the ground. On 2/13/14 at 10:53 a.m., his urinary catheter drainage bag was touching the ground. On 2/17/2014 at 11:10 a.m., his urinary catheter drainage bag was touching the mat, which next to his bed and directly on top of the floor.</p> <p>During an interview with the Assistant Director of Nursing, on 2/18/2014 at 1:03 p.m., she indicated she was in charge of the infection control program. She indicated a catheter bag, "should never, ever be touching the floor. Even with a low bed there is some leeway for adjustment so that it can stay both below the bladder and not touch the floor."</p> <p>A policy, provided by the Director of Nursing, on 2/18/2014 at 1:20 p.m., indicated, "Indwelling Urinary</p>		<p>will be educated on Indwelling Urinary Catheter Care with emphasis on interventions to reduce or prevent urinary tract infections. The DNS/Designee will validate that catheter drainage bags are positioned to reduce and prevent CAUTI each shift five times a week for 30 days, then three times a week for 30 days, then weekly for 4 months. All findings will be addressed immediately and in the monthly PI meeting. The PI committee will determine when 100% compliance is achieved and if on going monitoring is required. Compliance Date: March 20, 2014</p>		

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F000323 SS=D	<p>Catheter Care Procedure... 16. Position the collecting-bag below the level of the bladder at all times. Do not rest the bag on the floor."</p> <p>3.1-41(a)(2)</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. Based on observation, interview and record review, the facility failed to implement a resident's fall care plan for 1 of 3 residents reviewed for accidents. (Resident #191)</p> <p>Findings include:</p> <p>The clinical record for Resident #191 was reviewed on 2/12/14 at 12:30 p.m. The diagnoses for Resident #191 included, but were not limited to: deconditioning.</p> <p>During an interview with the Unit Manager on 2/12/14 at 12:07 p.m., she indicated Resident #191 fell on 2/5/14.</p> <p>The 2/5/14 Post Fall Evaluation indicated, "Activity At The Time of</p>	F000323	F 323 483.25 (h) Free of Accident Hazards/Supervision/Devices Resident #191 was provided non-skid socks and care plan revised to remove the bed in low position. All residents at risk for falls have the potential to be affected. An audit has been completed of all resident's at risk for an accident reviewing the care plan for individualized interventions. Interventions to prevent accidents have been updated on the C.N.A. assignment sheet and validated for placement. All staff has been educated on the Accidents and Supervision and Fall Management. The IDT will complete safety rounds to validate interventions are implemented related to accident prevention twice daily five times a week for 30 days, then once daily five times a week for 30 days,	03/20/2014	

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	<p>The Fall: Unassisted Transfer, Trying To Go To The Bathroom, Unassisted Ambulation. Conditions That May Contribute To Fall: Unsteady Gait, History of Fall(s), Non-Compliance. Interventions After The Fall: Resident educated to the need of locking w/c (wheel chair) wheels and requesting assistance with any transfer."</p> <p>The 10/1/13 fall care plan for Resident #191 indicated the goal was for her to have a reduced number of falls. Interventions were "Educate/remind resident to request assistance prior to transfer/ambulation. Keep adjustable bed in low position for safe transfers. Provide non-skid footwear."</p> <p>An observation of Resident #191 lying in bed was made on 2/17/14 at 2:28 p.m. The bed was not in low position. She was wearing a sock (not non-skid) on one foot, and the other foot was bare. She indicated she transferred herself into bed with no help, and she normally wore both socks, but didn't know where the other one was. She stated, "They can't find my non-skid socks." Regarding her bed not being in a low position, she indicated, "They</p>		<p>then three times a week for 30 days, then weekly for 2 months. All findings will be addressed immediately then reported to the PI committee in monthly PI. The PI committee will determine when 100% compliance is achieved or if on going compliance is required. Compliance Date: March 20, 2014</p>				

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	<p>haven't put my bed in a low position in a long time."</p> <p>During an interview with LPN #4 and Unit Manager #3 on 2/17/14 at 2:42 p.m., regarding how Resident #191 was transferred into bed, LPN #4 indicated, "She probably put herself in bed." Unit Manager #3 indicated, "She's very noncompliant."</p> <p>On 2/17/14 at 2:45 p.m., an observation of Resident #191 lying in bed was made with LPN #4. Regarding whether her bed was in the correct position, LPN #4 indicated, "It should be lower." LPN #4 proceeded to lower Resident #191's bed approximately 4 inches. He then offered Resident #191 another sock. Resident #191 agreed. LPN #4 looked in Resident #191's closet and drawers for socks and could not find any. He stated, "I don't see any socks. I will go see if we have some." LPN #4 left the room.</p> <p>During another interview with LPN #4 on 2/17/14 at 2:52 p.m., regarding whether Resident #191 should have non-skid socks available for wear, he indicated, "She should have some in her room."</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD	STREET ADDRESS, CITY, STATE, ZIP CODE 200 GREEN MEADOWS DR GREENFIELD, IN 46140
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F000329 SS=D	<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 observation, interview and record review, the facility failed to provide non-medicinal approaches prior to the administration of a PRN (as needed) anti-anxiety medication and to monitor behaviors for 2 of 5 residents reviewed for unnecessary medications. (Resident #170 and #9)</p>	F000329	F329 483.25(1) Drug Regimen is Free of Unnecessary Drugs Resident #170's care plan has been updated to include non-medicinal approaches to anxiety episodes. Resident #170 has an order for to discontinue PRN Ativan and administer Ativan routinely. Resident #170 has a behavior monitoring sheet in place for staff	03/20/2014

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	<p>Findings include:</p> <p>1. The clinical record for Resident #170 was reviewed 2/12/14 at 1:45 p.m. The diagnoses for Resident #170 included, but were not limited to: dementia, depression, insomnia, and bipolar disorder.</p> <p>A review of a Physician's Order, dated 2/7/14, indicated an order for Ativan (anti-anxiety medication) 0.5 mg (milligrams) by mouth twice a day, PRN (as needed).</p> <p>The February MAR (medication administration record) indicated PRN Ativan was given on the following days: 2/7/14, 2/8/14, 2/9/14, 2/10/14 x 2, 2/11/14, and 2/12/14.</p> <p>A review of the clinical record did not indicate any non-medicinal approaches were tried prior to the administration of Ativan on the above dates.</p> <p>During an interview with LPN #1, on 2/13/14 at 9:40 a.m., she indicated</p>		<p>to document behaviors and the effectiveness of intervention implemented. Resident #9's care plan has been updated to include Zyprexa and behavior monitoring sheets were added to Behavior Monitoring book with non-medicinal interventions and monitoring for effectiveness of interventions. All residents on psychoactive medications have the potential to be affected. An audit has been completed to validate any resident with an order for a psychoactive medication has a care plan to include non-medicinal interventions, individualized to the resident's needs, and behavior monitoring sheets are implemented that reflect the symptoms monitored, individualized interventions and the effectiveness of interventions. All staff has been educated on Psychoactive Drug Use with emphasis on care planning, non-medicinal interventions and monitoring with documentation. The DNS/Designee will audit behavior monitoring sheets to validate interventions are implemented and documented accurately and the effectiveness of interventions or need for revision. This audit will be completed five times a week for 30 days, then three times a week for 30 days, then weekly for 30 days, then monthly for 3 months. The DNS/Designee will audit the care plan of any</p>		

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	<p>nursing was suppose to document non-medicinal approaches in the clinical record. She also indicated the facility used to have a form where they could document non-medicinal approaches, but the facility no longer used it.</p> <p>On 2/14/14 at 11:09 a.m., the Director of Nursing (DoN) indicated she was unable to locate non-medicinal approaches prior to administration of the PRN Ativan on the above dates. She also indicated, it was the expectation of staff, to do non-medicinal approaches prior to the administration of PRN anti-anxiety medication.</p> <p>A policy titled Psychoactive Drug Use, dated 8/12 and received by the DoN on 2/14/14 at 11:09 a.m., indicated, "...10. Attempt alternative methods to psychoactive drug use and document effectiveness." 2. The clinical record was reviewed for Resident #9 on 2/14/14. Diagnoses included, but were not limited to: other persistent mental disease otherwise due to conditions classified elsewhere; anxiety disorder, depressive disorder, insomnia.</p>		<p>resident with a new order for a psychoactive medication or change in the MD order for a psychoactive medication to verify it is individualized, has non-medicinal interventions and is current with the behavior monitoring sheets. This audit will be completed five times a week for 30 days, then three times a week for 30 days, then weekly for 30 days and then monthly as an on going practice of this facility. All findings will be addressed immediately then monthly in PI meeting. The PI committee will determine when 100% compliance is achieved or if further monitoring will continue. Compliance Date: March 20, 2014</p>				

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	<p>The physician orders for Resident #9 indicated orders for : Zyprexa 5mg.</p> <p>On 2/14/14 at 2:15 p.m., during an observation, Resident #9 was sitting in his room in a wheelchair. He answered questions appropriately and appeared in no distress. He did not appear sedate or agitated.</p> <p>On 2/17/14 at 10:12 a.m., during an observation, Resident #9 was sitting in his wheelchair in his room watching television. He indicated he enjoys watching television. He did not appear to be agitated or sedate.</p> <p>On 2/17/14 at 1:52 p.m., during an observation, Resident #9 was in his unit's main dining room, seated in his wheelchair, with other residents listening to music. He did not appear sedate, agitated, or in distress.</p> <p>A current care plan, dated 7/28/11, for Resident #9 indicated the following: "Pt [patient] psychotropic meds cymbalta, klonopin..." and appropriate interventions for side effect monitoring was also indicated by the care plan. Zyprexa was not a listed medication on the care plan.</p>						

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	<p>On 2/18/14 at 11:16 a.m., during an interview, the DON indicated any resident on an antipsychotic medication should have a related care plan entry to guide nursing staff regarding medication side effect and adverse effect monitoring.</p> <p>On 2/18/14 at 12:44 p.m., during an interview, the DON indicated the facility has no record of behavior monitoring logs for Resident #9 for December of 2013 and January 2014 which, she indicated, should have been kept in the nursing staff's "behavior book" normally kept on the unit where the resident lives. She indicated she doesn't know why they aren't there, but they should have been there.</p> <p>A facility policy titled "Antipsychotic/Psychoactive Medication" was received from facility DON on 2/18/14 at 11:03 a.m. It indicated the social services and/or licensed nursing staff should "...Implement a behavior monitoring log or similar mechanisms to document need for and response to drug therapy..." It also indicated "...Document care plan interventions as developed for patient...."</p> <p>Another facility policy titled</p>						

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	<p>"Psychoactive Drug Use" indicated the following: "...Develop a plan of care individualized to patient needs...."</p> <p>On 2/18/14 at 2:03 p.m., during an interview, the DON indicated Resident #9 does not have a current care plan in place for Zyprexa use, but should have one.</p> <p>3.1-48(a)(6)</p>				