

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/19/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
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F000000	<p>This visit was for the Investigation of Complaints IN00165131, IN00162614, IN00161512 and IN00161303.</p> <p>Complaint IN00165131 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F282, and F309.</p> <p>Complaint IN00162614 - Substantiated. Federal/State deficiencies related to the allegations are cited at F309 and F282.</p> <p>Complaint IN00161512- Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F309.</p> <p>Complaint IN00161303 - Substantiated. Federal/State deficiencies related to the allegations are cited at F279, F282, and F309.</p> <p>Survey Dates: February 18, and 19, 2015</p> <p>Facility Number: 010666 Provider Number: 155664 AIM Number: 200229930</p> <p>Survey Team: Kewanna Gordon RN-TC Lora Brettnacher RN Megan Burgess RN</p>	F000000	<p>This plan of correction is to serve as Kindred Transitional Care and Rehabilitation at Eagle Creek's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Kindred Transitional Care and Rehabilitation at Eagle Creek or their management companies that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F000279 SS=D	<p>Census bed type: SNF/NF: 111 Total: 111</p> <p>Census payor type: Medicare: 31 Medicaid: 51 Private: 10 Other: 19 Total: 111</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 02/23/2015 by Brenda Marshall, RN.</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical,</p>						

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	<p>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 record review and interview, the facility failed to develop an individualized plan of care for constipation for 1 of 7 residents reviewed for care plans (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 2/18/15 at 10:40 a.m. An admission assessment, dated 7/24/14, indicated Resident C was admitted to the facility post surgery for rehabilitation, was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of 15, had a history of constipation, took stool softeners/laxatives daily to treat her constipation, and usually had soft, formed bowel movements daily.</p> <p>Untimed admission physician's orders, dated 7/24/14, indicated orders for Senna-Docusate (laxative/stool softener) 1 tablet orally twice daily for constipation and Docusate Sodium (stool softener) 100 milligrams orally daily for constipation.</p>	F000279	<p>I. Resident "C" has been discharged from the facility. II. Current residents identified as having the potential for constipation or constipation have the potential to be affected. An audit has been completed of the care plans and any identified concerns have been addressed. III. Education has been provided to all licensed nurses on comprehensive care plans to include revision with change of condition. IV. The Director of Nursing and/or designee will review: a. The care plans for all residents on admission and with change in condition in the facility's clinical meeting, to validate care plans include potential for constipation and/or constipation as the plan of care. The audit will continue in effect 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for a total of 6 months of monitoring. Any concerns will be addressed. b. The results of these reviews will be discussed at the monthly facility Quality Assurance and Performance Improvement Committee Meeting monthly for 3 months. The PI committee will determine if frequency and</p>	03/02/2015

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	<p>An untimed physician's order, dated 7/25/14, indicated 30 millimeters of Milk of Magnesia (laxative) to be given daily as needed for constipation. The record did not indicate a care plan to address Resident C's diagnoses of chronic constipation.</p> <p>During an interview on 2/19/15 at 12:15 p.m., the Assistant Director of Nursing indicated she expected staff to follow bowel protocols according to residents' individualized needs.</p> <p>During an interview on 2/19/15 at 12:30 p.m., the Director of Nursing indicated Resident C did not have an individualized plan of care to address her chronic constipation.</p> <p>A policy titled "Care Plans" identified as current by the Executive Director, on 2/19/15 at 2:18 p.m., indicated, "...A comprehensive care plan is developed that includes measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment or as identified in relation to the resident's response to the interventions or changes in the resident's condition... The care plan: addresses risk factors that might lead to avoidable declines in functioning or functional levels... Reflects current</p>		<p>duration of reviews needs to continued or revised, the PI committee will determine if compliance is at 100%. V. Completion Date: March 2, 2015</p>				

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F000282 SS=D	<p>professional practice standards; and have treatment objectives with measurable outcomes that are prioritized, if necessary, and used to monitor resident progress...."</p> <p>This Federal tag relates to Complaint(s) IN00165131 and IN00161303.</p> <p>3.1-35(a)</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 record review and interview, the facility failed to administer ordered medication to treat constipation and failed to monitor bowel sounds every shift as ordered for 1 of 7 residents reviewed for following physician's orders (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 2/18/15 at 10:40 a.m. An admission assessment, dated 7/24/14, indicated</p>	F000282	<p>I. Resident "C" has been discharged from the facility. II. All Current residents identified as not having a bowel movement per established pattern, have the potential to be affected. The clinical record for BMs has been reviewed for validation of interventions implemented, documentation noted and appropriate follow up including assessment of resident abdomen and bowel sounds if ordered/indicated. Any identified concerns have been addressed. The BM Tracking log will be</p>	03/02/2015

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	<p>Resident C was admitted to the facility post surgery for rehabilitation, was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of 15, had a history of constipation, took stool softeners/laxatives daily to treat her constipation, and usually had soft, formed bowel movements daily.</p> <p>Untimed admission physician's orders, dated 7/24/14, indicated orders for Senna-Docusate (laxative/stool softener) 1 tablet orally twice daily for constipation and Docusate Sodium (stool softener) 100 milligrams orally daily for constipation.</p> <p>An untimed physician's order, dated 7/25/14, indicated 30 milliliters of Milk of Magnesia (laxative) to be given daily as needed for constipation.</p> <p>The record lacked indication Resident C's bowel movements were monitored during August 2014. The record indicated Resident C did not have a bowel movement on September 15, 16, 17, 18, 19, or 20, 2014. The record did not indicate Milk of Magnesia was administered for treatment of constipation not relieved by administration of routine stool softeners/laxative.</p>		<p>reviewed daily for validation of BMs and administration or implementation of interventions to relieve constipation. Any new physician's orders for bowel assessment and monitoring will be reviewed daily. Any concerns will be addressed. III. Education has been provided to all licensed staff regarding bowel elimination, medication administration and documentation. IV. The Director of Nursing and/or designee will review: a. The bowel management for all residents, in the facility's clinical meeting, five times weekly. Residents identified as not having a bowel movement per established pattern will have clinical record reviewed for having implementation of constipation interventions and documentation noted with appropriate follow up including assessment of resident abdomen and bowel sounds as ordered/indicated. The review will remain ongoing. The audit will continue in effect 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for a total of 6 months of monitoring. Any concerns will be addressed. b. The results of these reviews will be discussed at the monthly facility Quality Assurance and Performance Improvement Committee Meeting monthly for 3 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100% as determined by the PI</p>				

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	<p>A physician's telephone order, dated 9/21/14 at 8:00 a.m., indicated a stat (immediately) KUB (X-ray) of the abdomen due to abdominal pain and no bowel sounds. The order indicated bowel sounds were to be monitored every shift for 48 hours. The record lacked indication Resident C's bowel sounds were assessed during the night shift on 9/21/14.</p> <p>During an interview on 2/19/15 at 12:30 p.m., the Director of Nursing indicated she was unable to find documentation to indicate Milk of Magnesia (laxative) was administered as needed for constipation. She indicated she was unable to find documentation which indicated bowel sound were monitored during the evening shift on 7/21/15 or 7/22/14 prior to Resident C's transfer to the emergency room.</p> <p>A policy titled "Physician Orders" identified as current by the Executive Director, on 2/19/15 at 2:18 p.m., indicated, "...Physician's orders are administered only upon the clear, complete, and signed order of a person lawfully authorized to prescribe...."</p> <p>This Federal tag relates to Complaint(s) IN00165131, IN00162614, IN00161303, and IN00161512.</p>		committee. V. Completion date: March 2, 2015				

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F000309 SS=G	<p>3.1-35(g)(2)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on record review and interview, the facility failed to assess and monitor bowel sounds/elimination patterns and failed to implement interventions in the bowel protocol resulting in hospitalization, fecal impaction, and surgery to remove the large intestine for 1 of 7 residents reviewed for quality of care (Resident C).</p> <p>Findings include:</p> <p>Resident C's record was reviewed on 2/18/15 at 10:40 a.m. An admission assessment, dated 7/24/14, indicated Resident C was admitted to the facility for post surgery rehabilitation, was cognitively intact with a Brief Interview</p>	F000309	<p>I. Resident "C" has been discharged from the facility. II. All Current residents identified as not having a bowel movement per established pattern, have the potential to be affected. The clinical record for BMs has been reviewed for validation of interventions implemented, documentation noted and appropriate follow up including assessment of resident abdomen and bowel sounds if ordered/indicated. Any identified concerns have been addressed. The BM Tracking log will be reviewed daily for validation of BMs and administration or implementation of interventions to relieve constipation. Any new physician's orders for bowel assessment and monitoring will be reviewed daily. Any concerns</p>	03/02/2015

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	<p>Mental Status (BIMS) score of 14 out of 15, had a history of constipation, took stool softeners/laxatives daily to treat her constipation, and usually had soft, formed bowel movements daily.</p> <p>Untimed admission physician's orders, dated 7/24/14, indicated orders for Senna-Docusate (laxative/stool softener) 1 tablet orally twice daily for constipation and Docusate Sodium (stool softener) 100 milligrams orally daily for constipation.</p> <p>An untimed physician's order, dated 7/25/14, indicated 30 milliliters of Milk of Magnesia (laxative) to be given daily as needed for constipation.</p> <p>A policy titled "Bowel Elimination" identified as current by the Director of Nursing, on 2/19/15 at 2:04 p.m., indicated, "...Monitor the patient for bowel movements include form... frequency and size. If patient is cognitively aware, ask the patient when he/she had last bowel movement and document. Note any complaints of constipation or diarrhea... Revise care plan with individualized information to address... constipation and or diarrhea, if applicable... If no bowel movement according to patient's established pattern, follow physician's orders or notify</p>		<p>will be addressed. III. Education has been provided to all licensed staff regarding Bowel Elimination to include Bowel assessment; Plan of care to include medication administration and physician orders and notification of change in condition. IV. The Director of Nursing and/or designee will review: a. The bowel management for all residents, in the facility's clinical meeting, five times weekly. Residents identified as not having a bowel movement per established pattern will have clinical record reviewed for having implementation of constipation interventions and documentation noted with appropriate follow up including assessment of resident abdomen and bowel sounds as ordered/indicated. And physician notification of unrelieved constipation. The review will remain ongoing. The audit will continue in effect 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then weekly for 4 weeks, then monthly for a total of 6 months of monitoring. Any concerns will be addressed. b. The results of these reviews will be discussed at the monthly facility Quality Assurance and Performance Improvement Committee Meeting monthly for 3 months. Frequency and duration of reviews will be increased as needed, if compliance is below 100% as determined by the PI committee. V. Completion date: March 2, 2015</p>	

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	<p>physician...."</p> <p>The record lacked indication Resident C's bowel movements were monitored during August 2014. The record indicated Resident C's was incontinent of 2 medium sized, loose stools on September 14, 2014 during the 6 a.m. - 2 p.m. shift. The record indicated Resident C did not have a bowel movement on September 15, 16, 17, 18, 19, or 20, 2014. .</p> <p>A nurse's note, dated 9/20/14 at 4:36 p.m., indicated, "...Situation: c/o [complaint of] cramping lower abd [abdomen] pain-poor appetite continues pt [patient] reports having this pain at times, but increased yesterday evening. Condition has gotten worse.</p> <p>Background: Pertinent History: R [right] hip fx [fracture], non weight bearing, poor po [oral] intake, hx [history] of constipation...Assessment: Restless in bed...reports she has had lower abd pain since last evening. Abd soft and slightly distended. Poor po intake continues-drinking fluids with encouragement. NWB [non weight bearing] status. Pt reports she has had this pain in the past with constipation, husband confirmed. MD office notified and new order received to given [sic] mom and prune juice x [times]1 if pt can drink it. Also received order for prn</p>			
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	<p>Dulcolax suppository...."</p> <p>A nurse's note, dated 9/20/14 at 5:45 p.m., indicated resident did not have bowel elimination after the Dulcolax suppository.</p> <p>A nurse's note dated 9/20/14 at 8:15 p.m., indicated Resident C had "small amount of liquid emesis-yellow in color." The record lacked indication a physician was notified of Resident C's emesis or additional assessments of her bowel sounds and/or abdominal palpation for distention/firmness/pain throughout the night.</p> <p>A physician's telephone order, dated 9/21/14 at 8:00 a.m., indicated a stat (immediate) KUB (X-ray) of the abdomen due to abdominal pain and no bowel sounds. The order indicated bowel sounds were to be monitored every shift for 48 hours.</p> <p>A nurse's note, dated 9/21/14 at 5:00 p.m., indicated Resident C required much encouragement to drink sips of water, had no appetite, and was very confused and lethargic. The record indicated the Nurse Practitioner was notified and ordered intravenous fluids. The record lacked indication bowel sounds were assessed or abdomen was palpated for</p>			

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	<p>distention, firmness or pain.</p> <p>A nurse's note, dated 9/21/14 at 6:06 p.m., indicated, "...confusion continues-will answer questions appropriately at times. And [sic] Abdomen slightly distended and soft. BS [bowel sounds] remain hypoactive [reduced loudness, tone, and regularity of bowel sounds]-has had smears of liquid stool...."</p> <p>A nurse's note dated 9/21/14 at 8:35 p.m., indicated Resident C complained of abdominal pain, spat out her pain medications when administered, and only took sips of water and Boost with much encouragement. The record lacked indication bowel sounds and/or abdominal assessment was completed.</p> <p>The record lacked indication Resident C's bowel sounds were assessed during the night shift on 9/21/14.</p> <p>A nurse's note dated 9/22/14 at 3:30 a.m., indicated, "In bed. Lethargic. Non responsive to verbal commands. Restless. Raising et [and] lowering right arm. BUE [bilateral upper extremities cool to touch. Continues IV [intravenous] therapy. Hr [heart rate] 135 fluctuating 117. Husband called informed of condition change. Husband</p>						

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	<p>stated he would like for her to be sent to the ER... ambulance here to transport at 4:10 a.m.</p> <p>A hospital record, dated 9/22/14 at 5:59 a.m., titled "Imaging Exam Report" reviewed, on 2/19/15 at 2:30 p.m., indicated a cat scan of the abdomen was obtained due to Resident C's elevated temperature, abnormal white blood count, and abdominal pain. The results indicated, "...There is a large stool burden throughout the colon. Beginning at the level of splenic flexure and extending inferiorly... Large stool burden throughout the colon, greatest in the descending colon and sigmoid. Correlate for fecal impaction...."</p> <p>A hospital document, dated 9/22/14, titled "Case Manager Progress Note" indicated Resident C was admitted to an acute hospital on 9/22/15 with diagnosis of sepsis (life threatening complication of an infection) and colitis (inflammatory reaction in the colon). This note further indicated she was transferred to another acute hospital for an operation for "emergent bowel resection."</p> <p>An operative note, dated 9/22/14, indicated Resident C "...was brought to the emergency (hospital named) with abdominal pain, nausea, vomiting, and</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/19/2015	
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	<p>lethargy...CT [Cat Scan] abdomen and pelvis was obtained and found to have colitis with constipation. Due to her medical condition, the patient was transferred to (hospital named)...." This note indicated a surgical procedure of "total colectomy [removal of the large intestine]" with a wound VAC placement was performed with a post operative diagnoses of "Toxic megacolon [dilatation of the colon] and Left ischemic colitis [inflammation and injury of the large intestine]."</p> <p>A document, dated 9/27/14 at 12:34 p.m., titled "Imaging Exam Report" indicated Resident C required another cat scan of her abdomen due to an increased fever and heart rate post surgery following a total colectomy..."</p> <p>A hospital discharge summary, dated 10/13/14, indicated, "...the patient required multiple returns to the operating room, the last of which was done emergently to address what appeared to be a small bowel perforation...." This note indicated Resident C progressively declined after this surgery and died on 10/4/12014 at 4:25 p.m. This document indicated cause of death "septic and vasodilatory shock, multiorgan failure, severe encephalopathy, and post operative complications."</p>						

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	<p>During an interview on 2/19/15 at 12:15 p.m., the Assistant Director of Nursing indicated she expected staff to follow bowel protocols according to residents' individualized needs.</p> <p>During an interview on 2/19/15 at 12:30 p.m., the Director of Nursing indicated she was unable to find documentation the order, dated 7/25/14, for 30 Millimeters of Milk of Magnesia (laxative) was administered as needed for constipation as ordered. She indicated she was unable to find documentation which indicated bowel sound were monitored during the evening shift on 7/21/15 or 7/22/14 prior to Resident C's transfer to the emergency room. She indicated she was unable to find documentation which indicated Resident C's bowel movements were monitored in August 2014. She further indicated she was unable to find documentation which indicated the facility's bowel elimination protocol was followed for Resident C.</p> <p>This Federal tag relates to Complaint(s) IN00165131, IN00162614 , IN00161303, and IN00161512.</p> <p>3.1-37(a)</p>						