

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902
--	---

(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
F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>Survey dates: August 5, 6, 7, 8, 9, & 12, 2013.</p> <p>Facility number: 000127 Provider number: 155222 AIM number: 100291430</p> <p>Survey team: Michelle Carter, RN Bobbette Messman, RN Rita Mullen, RN (8/7, 8/8, 8/9, 8/12, 2013) Maria Pantaleo, RN</p> <p>Census bed type: SNF/NF: 82 Total: 82</p> <p>Census Payor type: Medicare: 19 Medicaid: 53 Other: 10 Total: 82</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 August 14, 2013.</p>	F000000	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.</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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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	
F000241 SS=E	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview and record review, the facility failed to ensure dignity was maintained for 3 of 9 residents observed for dignity during meal service for 2 of 2 meal observations in 1 of 3 dining rooms. (Resident # 1, # 14, and # 83)</p> <p>Findings include:</p> <p>1. On 8/6/13 at 5:15 p.m., the South dining room was observed during dinner. Resident #1 was observed being served a meal with other residents at the table. Resident #1 required feeding assistance to eat the meal. At 5:30 p.m., Resident #1 was still waiting for assistance and had not been fed while other residents at the table were eating.</p> <p>On 8/8/13 at 5:08 p.m., the South dining room was observed during dinner. Resident #1 was observed being served a meal with other residents at the table. Resident #1 required</p>	F000241	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.F241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALTY 1. Residents 1, 14, and 83 were assessed and their orders and care plans reviewed. The practice of serving residents requiring assistance with meals has been modified so that they will not be served until a staff member is ready to assist them. In addition, no resident will be served a meal on a tray unless they specifically request that and they have a care plan stating such. 2. A dining room audit was performed to</p>	08/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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>feeding assistance to eat her meal. At 5:25 p.m., Resident # 1 was assisted by Unit Manager # 3, other residents at the table had been eating since 5:10 p.m.</p> <p>A Dining Facilitator Checklist, received from the Director of Dietary Services on 8/8/13 indicated, "if resident requires assistance, meal is not served until assistance is available".</p> <p>2. On 8/8/13 at 5:00 p.m., the South dining room was observed during dinner. Resident #14 and resident #83 were served a meal on a tray. The tray was left on the table. Other residents, at the same table, were served a meal on a tray, but the tray was removed from the table.</p> <p>On 8/9/13 at 11:00 a.m., during an interview with the Director of Nursing (DON), the DON indicated there was not a list for those residents who preferred to be served the meal with the tray remaining on the table.</p> <p>3.1-3(t)</p>		<p>determine if a similar situation was present in any other dining room. It was determined that these practices were only present in the South Dining Room. 3. The systemic change to stop the practice of serving residents who need assistance before the assistance can be provided and the use of trays at the table will be made through education of the facility staff. Dining room monitors will be implemented to reinforce these changes. 4. The DNS or designee will audit as follows: Dining Facilitator Checklists will be utilized to audit the new practice. Audits will be assigned to management team members and will be conducted randomly to include all meals. Audits will be performed daily for 7 days, three times per week for 2 weeks, 2 times per week for 1 week. Weekly for 8 week, monthly for 3 months, then quarterly for 2 quarters. The results of each audit will be reviewed by the IDT at the next Performance Improvement meeting. The IDT may elect to stop monitoring if substantial compliance has been met. Compliance Date: 8/30/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902			
(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			
F000282 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>2. The clinical record of Resident #150 was reviewed on 8/9/13 at 9:30 a.m.</p> <p>Diagnoses included, but were not limited to, diabetes, depression, high blood pressure, obesity, venous insufficiency and pressure ulcers.</p> <p>A nursing assessment, dated 7/31/13, indicated Resident #150 was admitted to the facility with a stage III pressure ulcer on the right upper buttocks, a stage II on the left buttocks and a stage II on the right lower buttocks.</p> <p>A "Wound Care Specialists of Indiana" progress note, dated 8/5/13, indicated the following:</p> <p>Right upper buttocks: "Upgrade mattress - low air loss, upgrade w/c (wheelchair) cushion - Roho and turn every 2 hours."</p> <p>Right lower buttocks: "Upgrade mattress - low air loss, upgrade w/c (wheelchair) cushion - Roho and turn</p>	F000282	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.F282 483.20(k)(3)(ii)SERVICES BY QUALIFIED PERSONS/PER CARE PLAN 1. Resident 150's orders and care plan were reviewed and the resident was assessed. The care plan has been modified to include the turn every two hours and the Roho cushion was placed in the resident's chair while the survey team was still present in the building. Resident 16's orders and care plan were reviewed and the resident was assessed. The Post Dialysis Log is kept in the MAR and will be flagged when the</p>	08/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902			
(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>every 2 hours."</p> <p>Left lower buttocks: "Upgrade mattress - low air loss, upgrade w/c (wheelchair) cushion - Roho and turn every 2 hours."</p> <p>A Care Plan for "Actual alteration (sic) in Skin Integrity" dated 8/1/13, indicated the pressure ulcers were present upon admittance to the facility. Approach's included, but were not limited to, weekly pressure ulcer report, low air loss mattress, turn and reposition as needed, and assess for pain. The Roho wheelchair cushion was not part of the care plan nor was turning the resident every two hours.</p> <p>During an observation with Unit Manager #3, on 8/9/13 at 10:45 a.m., the wheelchair of Resident #150 did not have a Roho cushion.</p> <p>During an interview with Unit Manager #3 on 8/9/13 at 10:50 a.m., she indicated she put the low air loss mattress on the bed right away but was not aware a Roho cushion, for the wheelchair, was ordered on 8/5/13.</p> <p>3.1-35(g)(2)</p>		<p>resident leaves for dialysis to indicate to the next shift that the post dialysis assessments need to be completed. 2. An audit was conducted to determine all residents with an order for any pressure reducing equipment and a turning schedule. These residents were assessed to insure that they had the proper equipment and that the equipment was in good working order. Bedfast residents with a care plan for a turning schedule were observed to insure that they were being turned as directed. An audit was also conducted to determine all residents currently receiving dialysis treatments. The audit also determined if any post dialysis assessments were not completed. It was determined that there were no other missing assessments. 3. Education was provided to the staff on pressure ulcer prevention including turning and positioning along with the proper use of pressure reducing equipment. A systemic change was made to provide pressure reduction seating cushions in all wheelchairs and Broda chairs. The Wound Care Specialist nurse will give each Unit Manager a list of treatment changes and equipment recommendations at the end of each visit to facilitate obtaining orders from the physician and the ordering of equipment in a timely way. All dialysis residents will have the Post Dialysis Log flagged in the</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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	
	Based on record review and interview, the facility failed to follow their interdisciplinary care plan, for completing assessments, for 2 of 20 residents reviewed for care plans. (Resident # 16 & # 150) Findings include:		MAR when the resident leaves for dialysis to indicate that a post dialysis assessment is needed upon their return 4. Audits will be conducted by the DNS/Designee of the Post Dialysis Log of each dialysis resident. These audits will be done weekly of 4 weeks, biweekly for 8 weeks, monthly for 3 months and then quarterly for 2 quarters. The IDT will review all WCS nurse treatment changes and equipment recommendations on the next day Monday-Friday. An audit will be done to assure the orders have been obtained and equipment is in place. The care plan and CNA assignment sheets will be audited to include any changes of equipment and/or treatment at this time. These audits will be conducted weekly for 4 weeks, biweekly for 8 weeks, monthly for 3 months and quarterly for 2 quarters. The results of each audit will be reviewed by the IDT at the next Performance Improvement meeting. The IDT may elect to stop monitoring if substantial compliance has been met. Compliance Date: 8/30/2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902			
(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>1. The record for Resident #16 was reviewed on 8/12/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, end stage renal disease, clostridium difficile colitis (a bacteria found in feces causing diarrhea), and high blood pressure.</p> <p>Nursing notes, dated 7/18/13, indicated Resident #16 began dialysis treatment on 7/18/13.</p> <p>The Interdisciplinary Care plan, dated 7/18/13, indicated Resident #16 required a post dialysis assessment, upon return from dialysis treatment. Resident #16 was scheduled for dialysis services on Tuesdays, Thursdays, and Saturdays.</p> <p>The Communication Dialysis Log indicated Resident #16 was not assessed, after returning back to the facility from dialysis treatment, on 8/8/13 and 8/10/13.</p> <p>During an interview with Unit Manager #3, at 9:05 a.m., on 8/12/13, she indicated the post dialysis assessments were not completed, as expected, on 8/8/13 and 8/10/13.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902			
(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			
F000309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>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 follow their interdisciplinary care plan, for post dialysis assessments, for 1 of 1 resident reviewed for dialysis. (Resident #16)</p> <p>Findings include:</p> <p>The record for Resident #16 was reviewed on 8/12/13 at 9:00 a.m.</p> <p>Diagnoses for Resident #16 included, but were not limited to, end stage renal disease, clostridium difficile colitis (a bacteria found in feces causing in diarrhea), and high blood pressure.</p> <p>Nursing notes, dated 7/18/13, indicated Resident #16 began dialysis treatment on 7/18/13.</p> <p>The Interdisciplinary Care plan, dated 7/18/13, indicated Resident #16 required a post dialysis assessment, upon return from dialysis treatment.</p>	F000309	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 1. Resident 16's orders and care plan were reviewed and the resident was assessed. The Post Dialysis Log is kept in the MAR and will be flagged when the resident leaves for dialysis to indicate to the next shift that the post dialysis assessments need to be completed. 2. An audit was also conducted to determine all residents currently receiving</p>	08/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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>Resident #16 was scheduled for dialysis services on Tuesdays, Thursdays, and Saturdays.</p> <p>The Communication Dialysis Log indicated Resident #16 was not assessed, after returning back to the facility from dialysis treatment, on 8/8/13 and 8/10/13.</p> <p>During an interview with Unit Manager #3, at 9:05 a.m., on 8/12/13, she indicated the post dialysis assessments were not completed, as expected, on 8/8/13 and 8/10/13.</p> <p>3.1-37(a)</p>		<p>dialysis treatments. The audit also determined if any post dialysis assessments were not completed. It was determined that there were no other missing assessments. 3. All dialysis residents will have the Post Dialysis Log flagged in the MAR when the resident leaves for dialysis to indicate that a post dialysis assessment is needed upon their return. 4. Audits will be conducted by the DNS/Designee of the Post Dialysis Log of each dialysis resident. These audits will be done weekly of 4 weeks, biweekly for 8 weeks, monthly for 3 months and then quarterly for 2 quarters. The results of each audit will be reviewed by the IDT at the next Performance Improvement meeting. The IDT may elect to stop monitoring if substantial compliance has been met. Compliance Date: 8/30/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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	
F000314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure pressure ulcer prevention and treatment interventions were implemented as ordered for 1 of 2 residents reviewed with stage III and IV pressure ulcers. (Resident #150)</p> <p>Findings include:</p> <p>The record of Resident #150 was reviewed on 8/9/13 at 9:30 a.m.</p> <p>Diagnoses included, but were not limited to, diabetes, depression, high blood pressure, obesity, venous insufficiency and pressure ulcers.</p> <p>A Care Plan for "Actual alteration (sic) in Skin Integrity" dated 8/1/13, indicated the pressure ulcers were present upon admittance to the facility. Approach's included, but were</p>	F000314	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.F314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCERS 1. Resident 150's orders and care plan were reviewed and the resident was assessed. The care plan has been modified to include the turn every two hours and the Roho cushion was placed in the</p>	08/30/2013	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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>not limited to, weekly pressure ulcer report, low air loss mattress, turn and reposition as needed, and assess for pain. Turing every two hours and a roho cushion for the wheelchair was not included on the care plan.</p> <p>A nursing assessment, dated 7/31/13, indicated Resident #150 was admitted to the facility with a stage III pressure ulcer on right upper buttocks, a stage II on the left buttocks and a stage II on the right lower buttocks.</p> <p>Measurements of the pressure ulcers on admit were as follows:</p> <p>Stage III on right upper buttocks: 1 cm (centimeter) x 3 cm x 2 cm.</p> <p>Stage II on right lower buttocks: 2 cm x 2.8 cm (no depth recorded)</p> <p>Stage II on the left buttocks: 3.3 cm x 3 cm (no depth recorded)</p> <p>A "Wound Care Specialists of Indiana" progress note dated 8/5/13, indicated the following:</p> <p>Right upper buttocks: "Upgrade mattress - low air loss, upgrade w/c (wheelchair) cushion - roho and turn every 2 hours."</p>		<p>resident's chair while the survey team was still present in the building. Resident 16's orders and care plan were reviewed and the resident was assessed. 2. An audit was conducted to determine all residents with an order for any pressure reducing equipment and a turning schedule. These residents were assessed to insure that they had the proper equipment and that the equipment was in good working order. Bedfast residents with a care plan for a turning schedule were observed to insure that they were being turned as directed. 3. Education was provided to the staff on pressure ulcer prevention including turning and positioning along with the proper use of pressure reducing equipment. A systemic change was made to provide pressure reduction seating cushions in all wheelchairs and Broda chairs. The Wound Care Specialist nurse will give each Unit Manager a list of treatment changes and equipment recommendations at the end of each visit to facilitate obtaining orders from the physician and the ordering of equipment in a timely way. 4. Audits will be conducted by the DNS/Designee to assure the orders have been obtained and equipment is in place for recommendations made by the WCS nurse. The care plan and CNA assignment sheets will be audited to include any changes of</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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>Right lower buttocks: "Upgrade mattress - low air loss, upgrade w/c (wheelchair) cushion - roho and turn every 2 hours."</p> <p>Left lower buttocks: "Upgrade mattress - low air loss, upgrade w/c (wheelchair) cushion - roho and turn every 2 hours."</p> <p>During an observation with Unit Manager # 3 on 8/9/13 at 10:45 a.m., the wheelchair of Resident # 150 did not have a Roho cushion.</p> <p>During an interview with Unit Manager # 3 on 8/9/13 at 10:50 a.m., she indicated she put the low air loss mattress on the bed right away but was not aware a roho cushion, for the wheelchair, was ordered on 8/5/13.</p> <p>3.1-40(a)(2)</p>		<p>equipment and/or treatment at this time. These audits will be conducted weekly for 4 weeks, biweekly for 8 weeks, monthly for 3 months and quarterly for 2 quarters. The results of each audit will be reviewed by the IDT at the next Performance Improvement meeting. The IDT may elect to stop monitoring if substantial compliance has been met. Compliance Date: 8/30/2013</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO	STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902
--	---

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902			
(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			
F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on interview and observation, the facility failed to ensure food items, served to residents, were at the recommended serving temperature for palatability, for 4 of 35 residents reviewed for meal palatability and temperature. (Residents # 43, # 9, # 92, & # 94)</p> <p>Findings include:</p> <ol style="list-style-type: none"> 1. During an interview with Resident # 94, on 8/6/13, at 5:20 p.m., he indicated the food did not taste good because items that were supposed to be warm, were served cool, especially instant mashed potatoes and macaroni and cheese. Resident # 94 stated he ate all his meals in his room. 2. During an interview with Resident # 43, on 8/7/13 at 1:20 p.m., she indicated warm food items were not warm enough, therefore the food did not taste good. She stated, "Food was cold, when it should not be cold, and then it needs 	F000364	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.F364 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP 1. Residents 94, 43, 92, and 9 all eat their meals in their rooms. The cold food served to these residents was returned to the kitchen and reheated to the proper temperature before being served to the resident. 2. All residents have the potential to be affected by this deficiency. An investigation found that the "PLATE WARMER" was not functioning properly and it was</p>	08/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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	
	to be warmed, for example, meat, corn and green beans." Resident # 43 indicated she ate all her meals in her room.		repaired immediately. Per regulations, all food temperatures are monitored and recorded before each meal. A Food Temperature Corrective Action Log will be implemented to record any temperatures that are out of range and the corrective action taken. 3. Education will be provided to dietary employees on measuring food temperatures by the Dietary Manager. A Food Temperature Corrective Action Log will be implemented to record any temperatures that are out of range and the corrective action taken. 4. The Food Temperature Corrective Action Log will be audited by the Dietary Manager/designee daily for one month, weekly for 2 months, biweekly for 2 months, then monthly for 7 months. Resident interviews will be conducted using the Resident Food Quality Interview tool. Three residents will be interviewed each time and interviews will be conducted 2 times per week for 4 weeks, weekly for 4 weeks, and then monthly during the Food Committee Meetings for 10 months. The Registered Dietitian will review these audits with each visit. The results of each audit will be reviewed by the IDT at the next Performance Improvement meeting. The IDT may elect to stop monitoring if substantial compliance has been met. Compliance Date: 8/30/2013		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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>3. On 8/6/13 at 10:51 a.m., during an interview with Resident # 92, he indicated that the food was cold on numerous days and was sent back to be re-heated.</p> <p>4. On 8/6/13 at 2:48 p.m., during an interview with Resident # 9, she indicated that the food yesterday was cold at breakfast and was sent back to be re-heated.</p> <p>5. During a kitchen food service observation on 8/8/13 at 5:40 p.m., staff cook #4 tested the temperature of the food on the steam table. The turkey meat slices with gravy was 116 degrees.</p> <p>On 8/8/13 at 5:50 p.m., during an interview with the Director of Dietary Services, she indicated the temperature for the turkey and gravy should have been 140 degrees or higher. She also indicated she would have to reheat the food items.</p> <p>3.1-21(a)(2)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO				STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902			
(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			
F009999	<p>3.1-14 Personnel</p> <p>(t) A physical examination shall be required for each employee of a facility within one (1) month prior to employment. The examination shall include a tuberculin skin test, using the Mantoux method (5 TU PPD),...The tuberculin skin test must be read prior to the employee starting work. The facility must assure the following:</p> <p>(1) At the time of employment, or within one (1) month prior to employment, and at least annually thereafter, employees and nonpaid personnel of facilities shall be screened for tuberculosis...the baseline tuberculin skin testing should employ the two-step method...</p> <p>This state rule was not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to ensure new employees were given the second step TB (tuberculin) skin test. This effected 2 of 5 employees reviewed for pre-employment screenings and TB testing. (RN #1 and CNA #2)</p> <p>Findings include:</p>	F009999	<p>This Plan of Correction is being submitted as documentation of Kindred Transitional Care and Rehabilitation-Kokomo's allegation of compliance. Submission of this document does not constitute an admission or agreement by the provider of the truth of the facts alleged or the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely as a requirement of federal and state law. Kindred Transitional Care and Rehabilitation-Kokomo respectfully requests desk review and paper compliance for this Plan of Correction.F9999 3.1-14 PERSONNEL 1. RN 1 and CNA 2 have both received their first and second step PPD tests. 2. An audit of all employee records was conducted and determined that no other employees had failed to receive their second step PPD tests. 3. A systemic change will be accomplished by requiring all new employees to receive their first step PPD prior the first day of orientation and their second step PPD on the last day of orientation. 4. The DNS/designee will audit new employee records monthly for one year for compliance of this new process. The results of each audit will be reviewed by the IDT at the next Performance Improvement meeting. The IDT may elect to</p>	08/30/2013			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155222	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/12/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-KOKOMO			STREET ADDRESS, CITY, STATE, ZIP CODE 429 W LINCOLN RD KOKOMO, IN 46902		
(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>Employee records were reviewed on 8/6/13 at 10:00 a.m. The following items were not found:</p> <p>The second step TB skin test for RN #1, hired on 6/29/13.</p> <p>The second step TB skin test for CNA #2, hired on 4/22/13.</p> <p>During an interview with the Staff Development Coordinator on 8/12/13 at 8:55 a.m., she indicated the second step TB skin tests were not completed.</p>		<p>stop monitoring if substantial compliance has been met. Compliance Date: 8/30/2013</p>		