

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/13/2011
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN46250
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F0000	<p>This visit was for Investigation of Complaints IN00099985 and IN00100641.</p> <p>Complaint IN00099985- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00100641- Substantiated. Federal/State deficiencies related to the allegations are cited at F279 and F327.</p> <p>Survey dates: December 12 & 13, 2011</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey team: Mary Jane G. Fischer, RN</p> <p>Census bed type: SNF/NF: 117 Total: 117</p> <p>Census payor type: Medicare: 24 Medicaid: 72 Other: 21 Total: 117</p>	F0000	<p>F0000The creation and submission of this Plan of Correctin does not consitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of correction be considered the Credible Allegation of Compliance. Facility respectfully requests desk review.</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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F0279 SS=D	<p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on December 14, 2011 by Bev Faulkner, RN</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). Based on record review and interview, the facility failed to ensure a plan of care was developed to instruct/prompt the nursing staff of interventions in the care of a resident with a diagnosis of diabetes insipidus. This deficient practice affected</p>	F0279	F 279 It is the practice of the facility to develop comprehensive care plans for each resident that includes measurable objectives and timetables to meet a resident's needs as identified in the comprehensive assessment. 1. Corrective Action: Care plan	12/23/2011	

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	<p>1 of 5 sampled residents reviewed for care plan development in the sample of 5. [Resident "C"].</p> <p>Findings include:</p> <p>The record for Resident "C" was reviewed on 12-12-11 at 12:55 p.m. Diagnoses included but were not limited to diabetes insipidus, pituitary disorder, vascular dementia with depression, blindness, and lymphedema. These diagnoses remained current at the time of the record review.</p> <p>The resident had a physician order, dated 08-09-11, which included BMP [basic metabolic profile] weekly "related to hypernatremia [high sodium]."</p> <p>A subsequent physician notation, dated 09-30-11, indicated the resident had "delirium secondary to hypernatremia... ."</p> <p>The resident had a physician order, dated 08-03-11, for the medication desmopressin acetate (DDAVP) [a medication with reduces urinary output while it increases urinary osmolarity] 0.6 mg [milligrams] two times a day.</p> <p>Review of [name of laboratory service] had specific ranges for a sodium level which was 135 to 145 mEq [millequivalent] per liter. A review of</p>		<p>was developed for Resident C addressing diabetic insipidus upon his return to the facility. 2. Identifying Others: Care plans have been reviewed to ensure that appropriate diagnosis have been addressed. 3. Systematic Changes: New admissions are being discussed in the morning clinical meeting and care plans to address special needs/diagnosis are being developed and implemented. Change of condition forms are being utilized which include care plan updates to coincide with new physician orders/condition changes. 4. Monitoring: DNS/ED/designee will randomly audit 4 charts per week X 4 weeks and then X 3 months, then quarterly and as needed to ensure appropriate care plans. 5. Completion Date: 12-23-2011</p>		

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	<p>the resident's sodium levels included the following data. November 1, [2011] "149" November 8, "149" November 15, "159" November 22, "153" November 29, "157" Each laboratory result was "initialed" as reviewed and also indicated the physician's office was notified as well as the Nurse Practitioner "initialed" the result as reviewed. "</p> <p>Review of physician orders on 11-04-11 instructed the nursing staff to administer Lasix [a diuretic medication] 40 mg [milligrams] daily due to venous stasis [ulcers].</p> <p>The nurses notes, dated 12-06-11 at 12:15 p.m., indicated "Resident noted up in w/c [wheelchair] awaiting lunch meal with decreased verbal conversation easily aroused [sic]. Res. [resident] denies pain verbally. Res. appears flushed in face. V/S [vital signs] 127/81, [pulse] 64, [respirations] 16, [temperature] 98.7. NP [Nurse Practitioner] and [Name of physician] made aware."</p> <p>Review of the Nurse Practitioner notation , dated 12-06-11, indicated "decreased LOC [level of consciousness] decreased intake, BMP from 12-05-11 "pending."</p>				

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	<p>[Spouse] and [family member] here and we discussed pts. [patient's] decline, decreased level of consciousness and decreased intake. Family expressed anger with pts. condition. Sodium 157 [result dated 11-29-11]."</p> <p>The Nurse Practitioner instructed the nursing staff on 12-06-11 to "DC Lasix [a diuretic medication], start D5 [5% dextrose] with 0.2 NS [normal saline] at 70 c.c. [cubic centimeters] - give 3 liters. BMP daily times 4 days then weekly indefinitely."</p> <p>Nurses notes, dated 12-06-11 at 4:00 p.m., indicated "Noted res. in bed. Decreased LOC. Lethargic. Skin w/d [warm/dry], Resp. [respirations] shallow, lungs clear and diminished throughout. N/O [new order] rec'd [received] and noted to start right peripheral IV [intravenous] (attempted times two unsuccessful: left arm lymphedema). Noted res. with involuntary mvmnt [movement] (i.e. twitching). No PO [by mouth] intake. color flushed. Fam. [family] at bedside. Family wishes res. to be sent to ER [emergency room]. Nurse agrees upon assessment. Report given to [Name of local area hospital]. MD ok with transfer also noted Na+ [sodium] 167. V/S 97/62, [pulse] 102, [respirations] 18, [temperature] 97.2, and oxygen saturation</p>				

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	<p>level at 96 %."</p> <p>Further review of the Basic Metabolic Profile report as provided by the laboratory service indicated the specimen was "collected" at 9:00 a.m. on 12-06-11, "specimen received" at 11:43 a.m., and the "Final report" provided to the facility at 9:00 p.m. on 12-06-11 indicated the sodium level was documented as 167. The resident's creatinine was 2.1 [normal range .6 - 1.5 mg/dL [deciliter].</p> <p>During an interview on 12-14-11 at 2:45 p.m., licensed nurse employee #4 indicated, "We don't do I & O's [intake and output] on any resident unless there is a doctor order. We monitor the food intake but not fluids."</p> <p>Further interview on 12-14-11 at 3:00 p.m., licensed nurse employee #6 indicated, "The nurse practitioner was here that day [12/6/2011]. We tried and tried to get the IV started. [Name of resident] arm was just so swollen because of the lymphedema. We called the lab. [laboratory services] to come and get the IV started. They were pretty slow and the family decided to go ahead and have [name of resident] taken to the hospital."</p> <p>When questioned if there had been a plan of care developed for the specific needs of</p>				

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	<p>this resident and the specific diagnosis of diabetes insipidus, the nurse indicated, "no not that I'm aware of."</p> <p>During interview on 12-14-11 at 10:10 a.m., a concerned family member indicated that once the resident arrived at the local area hospital emergency room on 12-06-11, the resident's sodium level was 169.</p> <p>Review of the "Lippincott Manual of Nursing Practice Handbook - Third Edition," indicated a resident with a diagnosis of diabetes insipidus indicated "associated with this diagnosis is the resident's body's failure to conserve water due to a lack of the antidiuretic hormone (ADH: vasotensin), which is secreted by the kidneys or because of inability of the kidneys to respond to ADH." "Complications are dehydration and hypernatremia."</p> <p>Further review of the Manual indicated nursing interventions included the need to "monitor intake and output and urine specific gravity to adjust medication dosage if needed and to also monitor for signs of water intoxication while on the medication desmopressin acetate (DDAVP), and to watch for and report signs of water intoxication caused by excess free water and hyponatremia -</p>				

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F0327 SS=D	<p>drowsiness, listlessness, headache, confusion, anuria [low to no urine] and weight gain."</p> <p>Review of the resident's record lacked a specific plan of care to address the needs/interventions related to a resident with a diagnosis of diabetes insipidus.</p> <p>This Federal tag relates to IN00100641.</p> <p>3.1-35(a) 3.1-35(b)(1)</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. Based on record review and interview, the facility failed to ensure a resident's hydration needs were met, in that when a resident had a diagnosis of diabetes insipidus, the facility failed to ensure the hydration needs of the resident were met in an attempt to control the resident's sodium level.</p> <p>This deficient practice affected 1 of 3 residents reviewed for hydration needs in a sample of 5 residents. [Resident "C"].</p> <p>Findings include:</p> <p>1. The record for Resident "C" was reviewed on 12-12-11 at 12:55 p.m.</p>	F0327	<p>F 327It is the practice of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health.1. Corrective Action: The care plan for Resident C has been reviewed and updated.2. Identifying Others: Care plans of other residents have been reviewed and updated to ensure that appropriate diagnosis have been addressed. Nursing assessments are done for all residents upon admission, quarterly and with any significant change to address Risk factors and to screen patients for dehydration. Care plans are developed based upon risks as identified by the comprehensive assessment. 3. Systematic</p>	12/23/2011	

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	<p>Diagnoses included but were not limited to diabetes insipidus, pituitary disorder, vascular dementia with depression, blindness, and lymphedema. These diagnoses remained current at the time of the record review.</p> <p>The record also indicated the resident had a recent re-admission to the facility dated 08-03-11. Discharge diagnoses included hypernatremia, fever and delirium. Upon readmission to the facility, the nursing staff assessed the resident for hydration needs. The total score equaled "9" with a notation that if a resident was assessed and the total score was "10" or greater the resident would be identified at "high risk" for dehydration.</p> <p>The resident had a physician order, dated 08-09-11, which included "BMP [basic metabolic profile] weekly related to hypernatremia [high sodium]."</p> <p>In addition, the resident had a physician order, dated 08-03-11, for the medication desmopressin acetate (DDAVP) [a medication with reduces urinary output while it increases urinary osmolarity] 0.6 mg [milligrams] two times a day.</p> <p>Review of [name of laboratory service] had specific ranges for a sodium level</p>		<p>Changes: Care plans on new admissions are being developed following chart review in the daily clinical meeting. Change of Condition form has been reviewed to ensure appropriate utilization of the care planning portion of the form to address new orders. 4. Monitoring: Care plans will be audited weekly x4, monthly x3 and then quarterly x2 to ensure compliance. The results of the Care Plan audit will be reviewed in Performance Improvement committee monthly x3 or until compliance is achieved. 5. DNS/ED to ensure compliance by 12-23-2011.</p>		

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	<p>which were 135 to 145 mEq [millequivalents] per liter. A review of the resident's weekly sodium levels included the following data:</p> <p>November 1, [2011] "149" November 8, "149" November 15, "159" November 22, "153" November 29, "157"</p> <p>Each laboratory result was "initialed" as reviewed indicated the physician office was notified and the Nurse Practitioner "initialed" the result as reviewed.</p> <p>A physician order, dated 11-04-11, instructed the nursing staff to administer "Lasix [a diuretic medication] 40 mg [milligrams] daily due to venous stasis [ulcers]."</p> <p>The nurses notes, dated 12-06-11 at 12:15 p.m., indicated, "Resident noted up in w/c [wheelchair] awaiting lunch meal with decreased verbal conversation easily aroused [sic]. Res. [resident] denies pain verbally. Res. appears flushed in face. V/S [vital signs] 127/81, [pulse] 64, [respirations] 16, [temperature] 98.7. NP [Nurse Practitioner] and [Name of physician] made aware."</p> <p>Review of the Nurse Practitioner notation,</p>				

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	<p>also dated 12-06-11, indicated "decreased LOC [level of consciousness] decreased intake, BMP from 12-05-11 "pending" [Spouse] and [family member] here and we discussed pts. [patient's] decline, decreased level of consciousness and decreased intake. Family expressed anger with pts. condition. Sodium 157 [the result dated 11-29-11]."</p> <p>The Nurse Practitioner instructed the nursing staff on 12-06-11 to "DC Lasix, start D5 [5% dextrose] with 0.2 NS [normal saline] at 70 c.c. [cubic centimeters] - give 3 liters. BMP daily times 4 days then weekly indefinitely." This entry lacked the time of the day it was written.</p> <p>However, the nurses note dated 12-06-11 at 4:00 p.m., indicated "Noted res. in bed. Decreased LOC. Lethargic. Skin w/d [warm/dry] Resp. [respirations] shallow, lungs clear and diminished throughout. N/O [new order] rec'd [received] and noted to start right peripheral IV [intravenous] (attempted times two unsuccessful: left arm lymphedema). Noted res. with involuntary mvmnt [movement] (i.e. twitching). No PO [by mouth] intake color flushed. Fam. [family] at bedside. Family wishes res. to be sent to ER [emergency room]. Nurse agrees upon assessment. Report given to</p>			

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	<p>[Name of local area hospital]. MD ok with transfer also noted Na+ [sodium] 167. V/S 97/62, [pulse] 102, [respirations] 18, [temperature] 97.2, and oxygen saturation level at 96 %."</p> <p>Further review of the Basic Metabolic Profile report as provided by the laboratory service "collected" at 9:00 a.m. on 12-06-11, indicated "specimen received" at 11:43 a.m., and the "Final report" provided to the facility at 9:00 p.m. on 12-06-11 indicated the sodium level was documented as 167 and the resident's creatinine was 2.1 [normal range .6 - 1.5 mg/dL [deciliter].</p> <p>During an interview on 12-14-11 at 2:45 p.m., licensed nurse employee #4 indicated, "We don't do I & O's [intake and output] on any resident unless there is a doctor order. We monitor the food intake but not fluids."</p> <p>Further interview on 12-14-11 at 3:00 p.m., licensed nurse employee #6 indicated we tried and tried to get the IV started. [Name of resident] arm was just so swollen because of the lymphedema. We called the lab. [laboratory services] to come and get the IV started. They were pretty slow and the family decided to go ahead and have [name of resident] taken to the hospital."</p>				

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	<p>During interview on 12-14-11 at 10:10 a.m., a concerned family member indicated that once the resident arrived at the local area hospital emergency room on 12-06-11, the resident's sodium level was 169.</p> <p>2.) Review of the "Lippincott Manual of Nursing Practice Handbook - Third Edition," indicated a resident with a diagnosis of diabetes insipidus indicated "associated with this diagnosis is the resident's body's failure to conserve water due to a lack of the antidiuretic hormone (ADH: vasotensin), which is secreted by the kidneys or because of inability of the kidneys to respond to ADH." "Complications are dehydration and hypernatremia."</p> <p>Further review of the Manual indicated nursing interventions included the need to "monitor intake and output and urine specific gravity to adjust medication dosage if needed and to also monitor for signs of water intoxication while on the medication desmopressin acetate (DDAVP), and to watch for and report signs of water intoxication cause by excess free water and hyponatremia - drowsiness, listlessness, headache, confusion, anuria [low to no urine] and weight gain."</p>			

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	<p>3.) Review of facility policy on 12-13-11 at 8:15 a.m., titled "Hydration," and dated 10-31-10, indicated the following: "Policy [bold type] Each resident is to be provided sufficient fluid to maintain hydration and health." "Definition - Sufficient Fluid - The amount of fluid needed to prevent dehydration (fluid output far exceeds fluid intake) and maintain health. The amount needed is estimated for each resident's condition fluctuates." "Compliance Guidelines - 1. Resident shall be assessed for risk of dehydration and/or dehydration upon admission, quarterly and with significant change or more frequently if needed. 2. Clinicians consider the following when assessing risk for and presence of dehydration: a.) clinical conditions commonly associated with inadequate fluid intake, b.) presence of factors that increase the risk of dehydration. d.) indirect signs/symptoms of fluid deficit and electrolyte imbalance, e.) laboratory indicators of potential fluid deficit. ... 8. Dehydration and/or potential dehydration are included on the resident care plan if indicated. 9. Educate staff on hydration needs of the elderly, the need for monitoring food and fluid intake and the correct method to estimate fluid</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/13/2011
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	intake." This Federal tag relates to IN00100641. 3.1-46(b)				