STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/17/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	2100 MIDWAY ST COLUMBUS, IN 47201

(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
F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00207607. This visit was in conjunction with the Recertification and State Licensure Survey and the Investigation of Complaint IN00206249. Complaint IN00207607 - Substantiated. Federal/State deficiencies related to the allegation are cited at F157 and F280. Survey dates: August 8, 9, 10, 11, 15, 16, and 17, 2016 Facility number: 000058 Provider number: 155133 AIM number: 100283340 Census bed type: SNF/NF: 129 Total: 129 Census payor type: Medicare: 14 Medicaid: 90 Other: 25 Total: 129 Sample: 3	F 0000	This Plan of Correction is the center's credible allegationof compliance. Preparation and/orexecution of this plan of correction does not constitute admission or agreementby the provider of the truth of the facts alleged or conclusions set forth inthe statement of deficiencies. The plan of correction is prepared and/orexecuted solely because it is required by the provisions of federal and statelaw.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on August 23, 2016.			
F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or			

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	roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on observation, interview and record review, the facility failed to notify the physician and family of a resident's continuous refusal to wear a heart monitor and failed to follow physician orders for daily weights and orthostatic blood pressures for 1 of 3 residents reviewed for notification of changes and physician orders. (Resident #C) Findings include: 1. The clinical record for Resident #C was reviewed on 8/16/16 at 4:40 p.m. Diagnoses included, but were not limited to, Parkinson's disease and syncope. The Post Fall Investigation, dated 6/9/16 at 8:45 a.m., indicated Resident #C had an intercepted fall and was lowered to the floor. The Post Fall Investigation also indicated Resident #C had a low blood pressure of 68/38: the nurse practitioner was notified and a new order received to sent Resident #C to the emergency department for evaluation.	F 0157	**1.Plan of correction: (actions taken)** **1.Physician and Family notification wascompleted and documented in the medical record.** **2.A chart audit of the past 30 days wascompleted to identify areas of opportunity for notification in refusal of careand services and education of risks related. Any identified opportunity wasimmediately addressed with physician and family notification, education of riskrelated to refusal of care and services, and care plans were updated fornon-compliance with care and services offered with choices and education ofrisk.** **3.Resident #C did not have an order for dailyweights.** **4.Resident #C's orthostatic blood pressureswere completed.** **2.Others at risk: All current residents havepotential to be affected.** **1.A chart audit of the past**	09/16/2016

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	The hospital discharge summary, dated 6/10/16, included, but was not limited to, the following: "...[Resident #C's name]... [Resident #C's cardiologists name]...Discharge Instructions...1. Call my office with any problems or question...2. Event monitoring to be arranged through my office upon discharge...Discharge Diagnoses...1. Syncope...f. Based on his evaluation...His syncope may have been secondary to hypotension...He will also be provided with an event to use for the next 30 days...Hospital Course...He will be provided with a 30-day event monitor because of the potential for arrhythmia's..." The document titled "Additional Extended Care Admitting Orders", dated 6/10/16 at 2:00 p.m., indicated for Resident #C to have an event monitor for 30 days as instructed by Resident #C's cardiologist. The physician order, dated 6/13/16 at 2:32 p.m., included, but was not limited to, the following: "...Order Summary...event monitor x [times] 30 days [sic] on at all times every shift for irregular b/p [blood pressure] until 07/13/2016..." The nurses note, dated 6/10/16 at 7:45		**30 days wascompleted to identify residents refusing care and services.** **2.Audit identified areas of opportunity fornotification in refusal of care and services and education of risks related.Any identified opportunity was immediately addressed with physician and familynotification, education of risk related to refusal of care and services, and careplans were updated for non-compliance with care and services offered withchoices and education of risk.** **3.All resident weights have been reviewedwith the attending Nurse Practioner, resident's responsible party andRegistered Dietician. Residentsassessed to be at nutritional risk will be weighed weekly and followed by theIDT.** **4.All residents' records have been auditedfor blood pressure orders and those orders verified with the documented bloodpressures to ensure compliance.** **3.Education:** **1.SDC/designee will provide education tolicensed nurses related to responsibilities of the licensed nurse whenresidents are refusing or noncompliant with care and services to includedocumentation of**	

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	p.m. and 6/11/16 at 2:48 p.m.,included, but was not limited to, the following: "...Heart monitor placed several times but resident continues to remove hardware. Resident educated several times to not remove patches, but resident continue to be noncompliant [sic] with taking heart monitor off..." The nurses note, dated 6/11/16 at 5:02 p.m., included, but was not limited to, the following: "...resident continue to remove heart monitor and won't leave the hardware alone...has be reapplied 8-10 times...." The nurses note, dated 6/13/16 at 6:38 a.m., included, but was not limited to, the following: "Resident is frequently removing cardiac monitor while awake. Prior to going to bed [sic] resident removed monitor and handed it to this writer and refused to have monitor put back on..." The incident note, dated 6/19/16 at 3:11 a.m., recorded as a late entry, included, but was not limited to, the following: "Follow up r/t [related to] incident on 6/9/2016. [Resident #C's first name] returned to facility with a heart monitor x [times] 30 days as an intervention. [Resident #C's first name] has refused on may occasions to wear heart monitor		**residents' choice, notification of the physician andresponsible party, providing education of risk related to refusal, and updatingthe care plan.** **2.SDC/designee will provide education tolicensed nurses related to following physician orders for weights and vitalsigns.** **4.Ongoing audits/tools:** **1.The DNS/designee will audit records 5 daysper week for 4 weeks, then 4 days per week for 4 weeks, then 3 days per weekfor 4 weeks, then 2 days per week for 4 weeks to identify areas of opportunityfor notification in refusal of care and services and education of risksrelated. Identified areas of opportunity will be corrected immediately.** **2.The dashboard report includingweights/vital signs and physician orders will be reviewed with the IDT morningmeeting as an ongoing process of this facility.** **3.All findings will be acted upon immediatelyand results reviewed in the monthly PI meeting.** **5.The DNS is responsible for this compliance.**	

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	properly without removing it. Will continue to attempt to wear monitor and not changes in condition..." The note text; dated 6/21/16 at 2:00 a.m., 6/26/16 at 11:31 p.m, 7/5/16 at 1:56 a.m., 10:22 a.m. and 10:26 p.m., 7/6/16 at 1:43 p.m., and 7/11/16 at 11:14 p.m., indicated Resident #C refused to properly wear the heart monitor. The note text, dated 7/11/16 at 11:58 a.m., included, but was not limited to, the following: "...can't find the machine..." The clinical record indicated the cardiologist was notified one time, over a 30 day period, of Resident #C's non-compliance with wearing the heart monitor. The clinical record lacked documentation of any notification of Resident #C's POA (Power of Attorney) with regards to his/her refusal/non-compliance with the heart monitor. On 8/17/16 at 10:49 a.m., Resident #C was observed without the heart monitor in place. The heart monitor was observed, unplugged, on top of the facility shredder box. During an interview on 8/17/16 at 10:50 a.m., LPN (Licensed Practical Nurse) #26			

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	indicated Resident #C had just taken the heart monitor off. LPN #26 attempted to turn the heart monitor on and indicated the battery was dead and needed to be charged. LPN #26 further indicated the heart monitor was off more than on since Resident #C removed it often. LPN #26 indicated the cardiologist was to be notified when the resident refused to wear the heart monitor. During an interview on 8/17/16 at 10:55 a.m., LPN #25 indicated the heart monitor was reordered for 30 days, on 8/12/16, due to non compliance. On 8/11/16 at 4:14 p.m., Corporate Nurse #16 provided a current copy of the document titled "Notifications", dated 4/28/13. It included, but was not limited to, the following: "...Policy...Staff informs the patient, consults with their attending physician, and notifies the patient's surrogates when...A significant change occurs...Treatment needs to be altered...Rationale...Patients, families and/or responsible parties have the right to be notified of changes in the patient's physical, mental or psychosocial status, treatment plan...2. If the family has designated a member to receive calls, that individual is notified...." 2. The hospital discharge document titled			

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	"Additional Extended Care Admitting Orders" for Resident #C, dated 6/10/16 at 2:00 p.m., included, but was not limited to, the following: "...5. Weight...Weekly..." The clinical record indicated Resident #C's weight was obtained on 7/7/1 and 8/7/16. The clinical record lacked documentation of a physician order for weekly weights for Resident #C. The physician order, dated 7/5/16 at 1:35 p.m., included, but were not limited to, the following: "...1. BP [blood pressure] [check mark] [check] BID [twice daily] x [times] 5 days...2. Ortho [orthostatic] [checking blood pressure in the lying, sitting and standing position] V/S [vital signs] daily x [times] 5 days..." The weights and vitals summary for Resident #C included, but were not limited to, the following: "...07/06/2016...146/77...(Sitting l/arm [left arm])...07/08/2016...136/66...(Sitting l/arm)..." The clinical record lacked documentation of any other orthostatic blood pressures obtained on 7/6/16 and 7/8/16. On 8/11/16 at 4:37 p.m., the District Director of Clinical Operations provided			

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	a copy of the current document titled "Physician's Orders", dated 8/31/2015. It included, but was not limited to, the following: "...Procedure...1. Obtain physician orders upon admission...3. Obtain treatment orders...All Physicians' Orders...2. Validate the orders received...6. Note the order (e.g., "Noted 3 PM, 05/17/06...)...8. Transcribe the orders...or enter the order into the EMR [Electronic Medical Record]...." This Federal tag relates to Complaint IN00207607 3.1-5(a)(2)(3)			
F 0280 SS=D Bldg. 00	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident,			

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	the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on interview and record review, the facility failed to ensure a resident's POA (Power of Attorney) was included when the plan of care was updated/changed and failed to update a resident's plan of care for continuous non-compliance with a heart monitor and use of W/C (wheelchair) for 1 of 3 residents reviewed for care plans. (Resident #C) Findings include: 1. The clinical record for Resident #C was reviewed on 8/16/16 at 4:40 p.m. Diagnoses included, but were not limited to, Parkinson's disease and syncope. The nurses note, dated 7/17/16 at 5:51 p.m., included, but was not limited to, the following: "...[family member] was unaware of Resident [sic] using wheelchair and was asking questions about it when [he/she] visited today. Unable to give [him/ her] further information other than it was related to [his/her] falls...." The physical therapy note, dated 7/8/16, included, but was not limited to, the following: "...[Resident #C's	F 0280	**1. Plan of correction: (actions taken)** **1.Resident #C's POA has been notified oftherapy interventions and been given the opportunity to participate in his planof care.** **2.Resident #C's care plan has been updated toinclude a care plan for noncompliance.** **1.Others at risk: All current residents havepotential to be affected.** **1.A chart audit of the past 30 days was completed to identify residents refusing care and services.** **2.An audit of the last care plan for each resident was completed to ensure responsible party invitation was completed.** **3.Audit identified areas of opportunity for care planning in refusal of care and services and education of risks related. Any identified opportunity was immediately addressed with invitation of responsible party, education of risk related to refusal of care and services, and care plans were updated for non-compliance with care and services offered with choices and education of**	09/16/2016

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	name]...Start of Care...07/08/2016...Underlying Impairments Other...patient is supposed to be WC bound due to recurrent H/O [history of] falls with walker due to lack of safety awareness and also due to unstable medical condition...Short Term Goal...Transferring patient to us a WC and D/C [discontinue] walker...Goal...caregivers and staff are educated about D/C of [walker] and patient being WC bound due to safety risk leading to falls..." During an interview on 8/17/16 at 12:12 p.m., OT (Occupational Therapist) #22 indicated all therapies were involved with Resident #C since he/she had a walker and poor safety awareness. OT #22 indicated both physical therapy and occupational therapy picked him/her up because of his/her cognition. OT and PT indicated Resident #C should go from a walker to a wheelchair. OT #22 indicated physical therapy transitioned Resident #C from a walker to a WC and Resident #C was able to self propel the WC. OT #22 indicated she thought nursing was in charge of notifying the family based on how orders were written. During an interview on 8/17/16 at 1:00 p.m., the Therapy Program Director indicated for a treatment and evaluation		**risk.** **1.Education:** **1.SDC/designeewill provide education to nursing staff and IDT for care planning and educationrelated to refusal of care and services.** **2.Ongoing audits/tools:** **1.The DNS/designee will audit records 5 days per week for 4 weeks, then 4 days per week for 4 weeks, then 3 days per week for 4 weeks, then 2 days per week for 4 weeks to identify areas of opportunity for care planning with responsible party participation in refusal of care and services and education of risks related. Identified areas of opportunity will be corrected immediately.** **2.SSD/designee will notify responsible party by mail or telephone of scheduled care plans and the right to participate as an ongoing process of this facility.** **1.All findings will be acted upon immediatelyand audit results reviewed in the monthly PI meeting.** **1.The DNS is responsible for this compliance.**	

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	order, the family usually were not notified. The Therapy Program Director also indicated if a resident goes from a walker to a wheelchair then the family should be notified. The Therapy Program Director further indicated Resident #C's family was not notified until after the fact. The clinical record lacked documentation of Resident #C's POA's notification/participation in the change in plan of care related to the WC. 2. The document titled "Additional Extended Care Admitting Orders", dated 6/10/16 at 2:00 p.m., indicated for Resident #C to have an event monitor for 30 days as instructed by Resident #C's cardiologist. The physician order, dated 6/13/16 at 2:32 p.m., included, but was not limited to, the following: "...Order Summary...event monitor x [times] 30 days [sic] on at all times every shift for irregular b/p [blood pressure] until 07/13/2016..." The nurses note, dated 6/10/16 at 7:45 p.m., included, but was not limited to, the following: "...Heart monitor placed several times but resident continues to remove hardware. Resident educated			

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	several times to not remove patches, but resident continue to be noncompliant [sic] with taking heart monitor off..." The nurses note, dated 6/11/16 at 2:48 a.m., included, but was not limited to, the following: "...Heart monitor placed several times but resident continues to remove hardware. Resident educated several times to not remove patches, but resident continue to be noncompliant [sic] with taking heart monitor off..." The nurses note, dated 6/11/16 at 5:02 p.m., included, but was not limited to, the following: "...resident continue to remove heart monitor and won't leave the hardware alone...has be reapplied 8-10 times..." The nurses note, dated 6/13/16 at 6:38 a.m., included, but was not limited to, the following: "Resident is frequently removing cardiac monitor while awake. Prior to going to bed [sic] resident removed monitor and handed it to this writer and refused to have monitor put back on..." The incident note, dated 6/19/16 at 3:11 a.m., recorded as a late entry, included, but was not limited to, the following: "Follow up r/t [related to] incident on 6/9/2016. [Resident #C's first name]			

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	2100 MIDWAY ST COLUMBUS, IN 47201

(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
	returned to facility with a heart monitor x [times] 30 days as an intervention. [Resident #C's first name] has refused on may occasions to wear heart monitor properly without removing it. Will continue to attempt to wear monitor and not changes in condition...." The note text, dated 6/21/16 at 2:00 a.m., indicated Resident #C refused to properly wear heart monitor during the shift. The note text, dated 6/26/16 at 11:31 p.m., indicated Resident #C refused to keep the heart monitor on. The note text, dated 7/5/16 at 1:56 a.m., indicated Resident #C would not leave the appliance (heart Monitor) in place. The note text, dated 7/5/16 at 10:22 a.m., indicated Resident #C would not leave the heart monitor on at all. The note text, dated 7/5/16 at 10:26 p.m., included, but was not limited to, the following: "...Resident won't leave monitor in place." The note text, dated 7/6/16 at 1:43 p.m., indicated Resident #C refused to leave the heart monitor in place. The note text, dated 7/11/16 at 11:58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/17/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201	

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	a.m., included, but was not limited to, the following: "...can't find the machine...." The note text, dated 7/11/16 at 11:14 p.m., indicated Resident #C would not leave the event monitor in place. During an interview on 8/17/16 at 10:55 a.m., LPN #25 indicated the heart monitor was reordered for 30 days, on 8/12/16, due to non-compliance. During an interview on 8/17/16 at 11:49 a.m., the Unit Manager indicated she did not have an answer as to why Resident #C did not have a care plan for non-compliance with the heart monitor. The Unit Manager also indicated non-compliance is usually care planned. The care plan for Resident #C lacked documentation of non-compliance related the heart/event monitor. This Federal tag relates to Complaint IN00207607 3.1-35(c)(1) 3.1-35(d)(2)(B)			