

|  |  |   |   |                      |   |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140   |                      |   |
| (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 |   |
| F0000  | <p>This visit was for the investigation on Complaint number IN00110639 and Complaint number IN00111866.</p> <p>Complaint number IN00110639 unsubstantiated due to lack of evidence.</p> <p>Complaint number IN00111866 substantiated, Federal/State deficiencies related to the allegations are cited at F-309 and F-425.</p> <p>Survey dates: July 16, &amp; 17, 2012</p> <p>Facility number : 000099<br/>Provider number: 155188<br/>AIM number: 100291140</p> <p>Survey team: Angel Tomlinson RN</p> <p>Census bed type:<br/>SNF/NF: 156<br/>Total: 156</p> <p>Census payor type:<br/>Medicare: 23<br/>Medicaid: 88<br/>Other: 45<br/>Total: 156</p> <p>Sample: 5</p> | F0000   | <p>July 30, 2012</p> <p>Indiana State Department of Health<br/>2 N. Meridian<br/>Indianapolis, IN 46204</p> <p>RE: Kindred Transitional Care and Rehabilitation-Greenfield<br/>Plan of Correction<br/>Credible Allegation of Compliance, and</p> <p><b>Request for Desk Review</b></p> <p>Dear Kim Rhoades,</p> <p>On July 17th, 2012 surveyors from the Indiana State Department of Health completed an inspection at Kindred Transitional Care and Rehabilitation-Greenfield. As a result of the inspection, the surveyors alleged that the Center was not in substantial compliance with certain Medicare and Medicaid certification requirements. Enclosed you will find the HCFA-2567L with the Center's Plan of Correction for the alleged deficiencies. Preparation of the Plan of Correction does not constitute an admission by the Center of the validity of the cited deficiencies or of the facts alleged to support the citation of the deficiencies.</p> <p>Please also consider this letter and the Plan of Correction to be the Center's credible allegation of compliance. The center will achieve substantial compliance with the applicable certification requirements on August 7 th , 2012. Please notify me immediately if you do not find the Plan of Correction to be written credible evidence of the Center's substantial compliance with the applicable requirements as of this date. In that event, I will be happy to provide you with</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:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140  |                      |   |
| (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>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 7/18/12<br/>Cathy Emswiller RN</p> |   | <p>additional evidence of compliance so you may certify that the center is in substantial compliance with the applicable requirements.</p> <p>This letter is also our request for a <b>desk review or re-visit</b>, if one is necessary, to verify that the Center achieved substantial compliance with the applicable requirements as of the dates set forth in the Plan of Correction and credible allegation of compliance.</p> <p>Thank you for your assistance with this matter. Please call me if you have any questions.</p> <p>Sincerely,</p> <p>Monica Jill Pearson, HFA<br/>Administrator<br/>(317) 462-3311</p> |                      |   |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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  |  |   |  |
| F0309<br>SS=D  | <p>483.25<br/>PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br/>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 interview and record review the facility failed to dispense a resident's cholesterol, diabetic, respiratory, sleep aid and pain medication as ordered by the physician and in a timely manner for 1 of 3 residents sampled for medication administration in a total sample of 5 (Resident #A)</p> <p>Finding include:</p> <p>1.) Record review on 7-16-12 at 12:25 p.m. indicated the resident's diagnoses included, but were not limited to, obesity, Coronary Artery Disease (CAD), obesity, Congestive Heart Failure (CHF) and depression.</p> <p>The discharge instructions from the hospital dated, 7-5-12 indicated the discharge diagnosis was infected pancreatic necrosis status post pancreatic debridement on 6-5-12 and partial left colectomy with end colostomy on 6-7-12. The resident had a jejunostomy tube (J-tube) ( a tube that inserted into part of</p> | F0309   | <p>F 309 It is the practice of this facility to 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. <b>What corrective action (s) will be accomplished for those residents found to have been affected by the alleged deficient practice?</b> Resident # A no longer resides at the facility. <b>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</b> Other residents that could potentially be affected by the deficient practice are those residents that are newly admitted to the facility with medication orders. <b>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</b> Licensed nurses will be re-educated relative to provision of care and services, including</p> | 08/07/2012  |  |   |  |

|  |  |   |   |                      |   |
|--|--|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140   |                      |   |
| (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>the small intestine used for nutrition and medication administration).</p> <p>The progress notes for Resident #A dated, 7-5-12 at 3:51 p.m. indicated the resident arrived at the facility at 3:00 p.m. by ambulance.</p> <p>The progress note for Resident #A dated, 7-5-12 at 4:20 p.m. indicated the hospital that the resident was admitted from did not send discharge orders. The hospital was notified and orders received by fax.</p> <p>The progress note for Resident #A dated, 7-5-12 at 7:00 p.m. indicated the resident's blood pressure was 137/72 at 3:50 p.m. and blood sugar was 144 at 3:50 p.m.</p> <p>The "PATIENT NURSING EVALUATION PART 1" dated 7-5-12 at 7:00 p.m. indicated the resident had pain or been hurting in the last 5 days. The resident experienced pain or hurting 25% of the time in the past 5 days. The resident's pain was rated at a 6. The record did not indicate any further pain assessment.</p> <p>The progress note for Resident #A dated, 7-5-12 at 9:20 p.m. indicated attempts were made to notify the physician of admission orders and verify them. A</p> |   | <p>but not limited to, the admission process with regard to medication order verification timeliness to ensure that newly admitted residents receive their medications as scheduled. If for any reason, the medications can not be delivered as ordered, the licensed nurse will contact the Nurse Manager on-call for assistance. The Director of Nursing has discussed the situation with the Pharmacy Director. The Director of Nursing, or designee, will notify the Pharmacy Manager with any future concerns and implement any necessary corrective actions.</p> <p>An audit will be conducted daily by the Unit Managers, or designee, to review the timeliness of the delivery of medications on newly admitted residents and validate that the medications have been received and have been given as ordered. Any concerns will be promptly addressed with responsible individual(s). <b>How will the corrective actions(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?</b> The aforementioned audits will be completed weekly for 4 weeks and then monthly for 2 months. Thereafter, random audits of at least 5 admissions will be completed during the week prior to Monthly Performance Improvement meetings. The</p> |                      |   |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |
|--|---|

| (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>message was left at 7:00 p.m. with no call back received. Notification made at 8:45 p.m. and orders verified. The J- tube feeding started at 20 milliliters an hour.</p> <p>The admission orders for Resident #A dated, 7-5-12 (no time) indicated the resident's physician orders included, but were not limited to, Tylenol liquid 650 mg as needed every four hours for pain, albuterol aerosol two puffs four times a day as needed for wheezing, atorvastatin 40 mg at 8:00 p.m. for hyperlipidemia, ezetimibe (cholesterol medication) 10 mg at 8:00 p.m., flovent HFA (respiratory and aniti inflammatory medication) at 8:00 p.m., hydrocodone/acetaminophen 7.5/500 mg give 15 milliliters every four hours as needed for pain, magnesium gluconate (treats constipation) 1000 mg at 8:00 p.m., and trazadone 25 mg as needed at bedtime for insomnia. The physician order indicated all medication were to be given thru the J-tube.</p> <p>Review of the Medication Administration Record (MAR) for Resident#A dated 7-5-12 and 7-6-12 indicated no medications were given to the resident except hydrocodone/acetaminophen 7.5/500 15 milliliters on 7-6-12 at 2:45 a.m.</p> <p>The progress note for Resident #A dated,</p> |               | <p>Director of Nursing, or designee, will report the results of the audits to the monthly Performance Improvement Committee meeting. The Committee will recommend any necessary corrective actions. Compliance Date: August 7th 2012</p> |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
|--|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>7-6-12 at 2:30 a.m. indicated the CNA called the nurse to the resident's room. The resident's L drain was lying on the bed. Assessed the resident and vital signs stable at this time. Call placed to hospital and indicated to transport the resident back to the hospital. The transportation was notified at 3:00 p.m. of resident's need to be transported back to the hospital. The resident left the facility by ambulance at 4:00 a.m.</p> <p>Interview with RN#1 on 7-16-12 at 2:25 p.m. indicated she was working on 7-5-12 when Resident #A was admitted. RN #1 indicated she was not caring for the resident, but did assist the nurse that was. RN #1 indicated she remembered Resident #A was very complex with health issues. RN #1 indicated she called the hospital that the resident was admitted from and had them fax over the physician orders. RN #1 indicated the resident was admitted to the facility with no physician orders.</p> <p>Interview with LPN #2 on 7-16-12 at 2:46 p.m. indicated she was the nurse caring for Resident #A on 7-5-12 when she was admitted to the facility. LPN #2 indicated she had two residents admit to the facility back to back of each other. LPN #2 indicated she also had another resident pass away during this time. LPN #2</p> |   |   |   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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>indicated things did take longer than usual due to the circumstances. LPN #2 indicated the family thought everything should have been ready before the resident got to the facility. LPN #2 indicated she went through the resident's paperwork two times and could not find the physician admission orders. LPN #2 indicated she had RN #1 look through the resident's paperwork and she could not find them either. RN #1 indicated the resident's family member come to the nursing station a couple times to see when the resident's dressing would be changed. LPN #2 indicated the resident had a dressing on her abdomen from surgery. LPN #2 indicated she explained to the family member that she had to have physician orders before she could do the dressing change. LPN #2 indicated she explained to the family member the facility did not have a pharmacy in the facility. LPN #2 indicated she apologized to the family member and explained it was taking longer than usual due to the hospital not sending the physician orders. LPN #2 indicated the resident asked for pain medication and she passed the information to the night shift nurse in report.</p> <p>Interview with CNA #3 on 7-16-12 at 3:50 p.m. indicated she was caring for Resident #A on third shift on 7-6-12.</p> |   |   |   |  |   |  |

|  |   |   |   |                      |   |
|--|---|---|---|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140                           |                      |   |
| (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>CNA #3 indicated the resident had a lot of anxiety. CNA #3 indicated the resident was pushing her call light a lot. CNA #3 indicated the resident was asking for her medication and she explained the nurse was waiting on pharmacy to deliver them.</p> <p>Interview with RN #4 on 7-17-12 at 9:30 a.m. indicated she was the nurse caring for Resident #A on third shift the day she was admitted to the facility. RN #4 indicated she came to work at 10:00 p.m. on 7-5-12. RN #4 indicated evening shift reported they had called the pharmacy two times attempting to get the resident's medication. RN #4 indicated she had talked to pharmacy two times also. RN #4 indicated pharmacy was verifying some of the physician orders. RN #4 indicated the resident was asking for pain medication every time she went into the resident's room. RN #4 indicated she gave the pain medication as soon as it arrived at the facility around 2:30 p.m. RN #4 indicated she was unsure of the resident's pain level, but knew the resident had not expressed it was at a 10 (extreme pain).</p> <p>Interview with the Director Of Nursing (DON) on 7-17-12 at 9:50 a.m. indicated she had talked with Resident #A and a family member on 7-5-12. The DON indicated the family member was concerned no one was taking care of the</p> |   |   |                      |   |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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. The DON indicated she explained to the family member that no medications could be given without an physician order. The DON indicated she explained the facility does receive information about the resident prior to admission, but not the actual physician orders. The DON indicated she explained after the facility received the orders then the facility physician had to review them. The DON indicated she explained the facility did not have a pharmacy in house. The DON indicated she went to Resident #A's room with the family member and talked with the resident. The DON indicated the resident denied any pain at that time, the DON indicated it was around 5:00 p.m.- 5:30 p.m. The DON indicated the resident was sent back to the hospital around 3:00 a.m. on 5-7-12 because the Jackson Pratt drain (drain used in a wound after surgery) had come out.</p> <p>Interview with family member #1 on 7-17-12 at 11:10 a.m. indicated the concern she had was the resident was admitted to the facility at 3:00 p.m. on 7-5-12 and did not receive her medications.</p> <p>Interview with Family member #2 on 7-17-12 at 11:15 a.m. indicated Resident #A had surgery before being admitted to</p> |   |   |   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
|--|--|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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>the facility on 7-5-12 and felt the resident's medication should have been able to given in the timeframe the resident was at the facility.</p> <p>The pain management policy provided by the DON on 7-17-12 at 1:40 p.m. stated "The center's practice is to assist each resident with pain or that has a potential for pain to maintain or achieve the highest practicable level of well being and functioning through pain management."</p> <p>This federal tag relates to Complaint number IN00111866.</p> <p>3.1-37(a)</p> |   |   |   |  |   |  |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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  |  |   |  |
| F0425<br>SS=D  | <p>483.60(a),(b)<br/>PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p> <p>Based on interview and record review the facility failed to obtain medication from the pharmacy in timely manner for 1 of 3 residents sampled for medication administration in a total sample of 5 (Resident #A)</p> <p>Finding include:</p> <p>1.) Record review on 7-16-12 at 12:25 p.m. indicated the resident's diagnoses included, but were not limited to, obesity, Coronary Artery Disease (CAD), obesity, Congestive Heart Failure (CHF) and depression.</p> | F0425   | <p>F 425 It is the practice of this facility to provide routine and emergency drugs and biologicals to its residents, or obtain then under an agreement described in 483.75 of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services(including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. <b>What corrective action (s) will be accomplished for those</b></p> | 08/07/2012  |  |   |  |

|  |  |   |  |                      |   |
|--|--|---|--|----------------------|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____   |                      | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140  |                      |   |
| (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>The discharge instructions from the hospital dated, 7-5-12 indicated the discharge diagnosis was infected pancreatic necrosis status post pancreatic debridement on 6-5-12 and partial left colectomy with end colostomy on 6-7-12. The resident had a jejunostomy tube (J-tube) ( a tube that inserted into part of the small intestine used for nutrition and medication administration).</p> <p>The progress notes for Resident #A dated, 7-5-12 at 3:51 p.m. indicated the resident arrived at the facility at 3:00 p.m. by ambulance.</p> <p>The progress note for Resident #A dated, 7-5-12 at 4:20 p.m. indicated the hospital that the resident was admitted from did not send discharge orders. The hospital was notified and orders received by fax.</p> <p>The progress note for Resident #A dated, 7-5-12 at 7:00 p.m. indicated the resident's blood pressure was 137/72 at 3:50 p.m. and blood sugar was 144 at 3:50 p.m.</p> <p>The "PATIENT NURSING EVALUATION PART 1" dated 7-5-12 at 7:00 p.m. indicated the resident had pain or been hurting in the last 5 days. The resident experienced pain or hurting 25%</p> |   | <p><b>residents found to have been affected by the alleged deficient practice?</b> Resident # A no longer resides at the facility. <b>How will you identify other resident(s) having the potential to be affected by the same alleged deficient practice and what corrective action will be taken?</b> Other residents that could potentially be affected by the deficient practice are those residents that are newly admitted to the facility with medication orders. <b>What measures will be put into place or what systemic changes you will make to ensure that the alleged deficient practice does not recur?</b> Licensed nurses will be re-educated relative to pharmaceutical services – accurate procedures, including but not limited to, the process for ensuring medications are received in a timely manner in the facility. If for any reason, the medications can not be delivered as ordered, the licensed nurse will contact the Nurse Manager on-call for assistance. The Director of Nursing has discussed the situation with the Pharmacy Director. The Director of Nursing, or designee, will notify the Pharmacy Manager with any future concerns and implement any necessary corrective actions. An audit will be conducted daily by the Unit Managers, or designee, to review the timeliness of the delivery of medications on</p> |                      |   |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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>of the time in the past 5 days. The resident's pain was rated at a 6. The record did not indicate any further pain assessment.</p> <p>The progress note for Resident #A dated, 7-5-12 at 9:20 p.m. indicated attempts were made to notify the physician of admission orders and verify them. A message was left at 7:00 p.m. with no call back received. Notification made at 8:45 p.m. and orders verified. The J- tube feeding started at 20 milliliters an hour.</p> <p>The admission orders for Resident #A dated, 7-5-12 (no time) indicated the resident's physician orders included, but were not limited to, Tylenol liquid 650 mg as needed every four hours for pain, albuterol aerosol two puffs four times a day as needed for wheezing, atorvastatin 40 mg at 8:00 p.m. for hyperlipidemia, ezetimibe (cholesterol medication) 10 mg at 8:00 p.m., flovent HFA (respiratory and aniti inflammatory medication) at 8:00 p.m., hydrocodone/acetaminophen 7.5/500 mg give 15 milliliters every four hours as needed for pain, magnesium gluconate (treats constipation) 1000 mg at 8:00 p.m., and trazadone 25 mg as needed at bedtime for insomnia. The physician order indicated all medication were to be given thru the J-tube.</p> |   | <p>newly admitted residents and validate that the medications have been received and have been given as ordered. Any concerns will be promptly addressed with responsible individual(s). <b>How will the corrective actions(s) be monitored to ensure the alleged deficient practice will not recur, i.e., what quality assurance program will be put in place?</b> The aforementioned audits will be completed weekly for 4 weeks and then monthly for 2 months. Thereafter, random audits of at least 5 admissions will be completed during the week prior to Monthly Performance Improvement meetings. The Director of Nursing, or designee, will report the results of the audits to the monthly Performance Improvement Committee meeting. The Committee will recommend any necessary corrective actions. Compliance Date: August 7th 2012</p> |   |  |   |  |

|  |   |   |   |   |  |   |  |
|--|---|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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>Review of the Medication Administration Record (MAR) for Resident#A dated 7-5-12 and 7-6-12 indicated no medications were given to the resident except hydrocodone/acetaminophen 7.5/500 15 milliliters on 7-6-12 at 2:45 a.m.</p> <p>The progress note for Resident #A dated, 7-6-12 at 2:30 a.m. indicated the CNA called the nurse to the resident's room. The resident's L drain was lying on the bed. Assessed the resident and vital signs stable at this time. Call placed to hospital and indicated to transport the resident back to the hospital. The transportation was notified at 3:00 p.m. of resident's need to be transported back to the hospital. The resident left the facility by ambulance at 4:00 a.m.</p> <p>Interview with RN#1 on 7-16-12 at 2:25 p.m. indicated she was working on 7-5-12 when Resident #A was admitted. RN #1 indicated she was not caring for the resident, but did assist the nurse that was. RN #1 indicated she remembered Resident #A was very complex with health issues. RN #1 indicated she called the hospital that the resident was admitted from and had them fax over the physician orders. RN #1 indicated the resident was admitted to the facility with no physician orders.</p> |   |   |   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>Interview with LPN #2 on 7-16-12 at 2:46 p.m. indicated she was the nurse caring for Resident #A on 7-5-12 when she was admitted to the facility. LPN #2 indicated she had two residents admit to the facility back to back of each other. LPN #2 indicated she also had another resident pass away during this time. LPN #2 indicated things did take longer than usual due to the circumstances. LPN #2 indicated the family thought everything should have been ready before the resident got to the facility. LPN #2 indicated she went through the resident's paperwork two times and could not find the physician admission orders. LPN #2 indicated she had RN #1 look through the resident's paperwork and she could not find them either. RN #1 indicated the resident's family member come to the nursing station a couple times to see when the resident's dressing would be changed. LPN #2 indicated the resident had a dressing on her abdomen from surgery. LPN #2 indicated she explained to the family member that she had to have physician orders before she could do the dressing change. LPN #2 indicated she explained to the family member the facility did not have a pharmacy in the facility. LPN #2 indicated she apologized to the family member and explained it was taking longer than usual due to the</p> |               |   |                      |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____  |                      | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
|--|--|---|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140                           |                      |   |
| (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>hospital not sending the physician orders. LPN #2 indicated the resident asked for pain medication and she passed the information to the night shift nurse in report.</p> <p>Interview with CNA #3 on 7-16-12 at 3:50 p.m. indicated she was caring for Resident #A on third shift on 7-6-12. CNA #3 indicated the resident had a lot of anxiety. CNA #3 indicated the resident was pushing her call light a lot. CNA #3 indicated the resident was asking for her medication and she explained the nurse was waiting on pharmacy to deliver them.</p> <p>Interview with RN #4 on 7-17-12 at 9:30 a.m. indicated she was the nurse caring for Resident #A on third shift the day she was admitted to the facility. RN #4 indicated she came to work at 10:00 p.m. on 7-5-12. RN #4 indicated evening shift reported they had called the pharmacy two times attempting to get the resident's medication. RN #4 indicated she had talked to pharmacy two times also. RN #4 indicated pharmacy was verifying some of the physician orders. RN #4 indicated the resident was asking for pain medication every time she went into the resident's room. RN #4 indicated she gave the pain medication as soon as it arrived at the facility around 2:30 p.m. RN #4 indicated she was unsure of the resident's pain</p> |   |   |                      |   |

|  |  |   |   |   |  |   |  |
|--|--|---|---|---|--|---|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |  | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br>07/17/2012 |  |
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |  |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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>level, but knew the resident had not expressed it was at a 10 (extreme pain).</p> <p>Interview with the Director Of Nursing (DON) on 7-17-12 at 9:50 a.m. indicated LPN #2 had trouble getting medications ordered and verified for Resident #A. The DON indicated the medications the resident was ordered could not be pulled from the Emergency Drug Kit (EDK) because the medication was in liquid form and it was not in the EDK. The DON indicated the EDK had only oral pain medication and Morphine Injectable. The DON indicated the pharmacy the facility used was in Indianapolis. The DON indicated the facility had a back up pharmacy with Pharmacy #1. The DON indicated the pharmacy in Indianapolis calls Pharmacy #1 if it is needed, the facility does not. The DON indicated the pharmacy in Indianapolis had a afternoon run and an midnight run to deliver medications.</p> <p>Interview with pharmacy #1 on 7-17-12 at 3:15 p.m. indicated the pharmacy was open 24 hours a day and 7 days a week.</p> <p>Interview with the Administrator on 7-17-12 at 4:20 p.m. indicated the facility does have an account set up to charge medications if needed with Pharmacy #1 and they bill the facility later.</p> |   |   |   |  |   |  |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                   |   | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 |   | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____                          |  | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |  |
|--|---|---|---|---|--|---|--|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD |   |   |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |  |   |  |
| (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>Interview with the Administrator on 7-17-12 at 4:40 p.m. indicated the pharmacy in Indianapolis had a contract with pharmacy #2.</p> <p>Interview with family member #1 on 7-17-12 at 11:10 a.m. indicated the concern she had was the resident was admitted to the facility at 3:00 p.m. on 7-5-12 and did not receive her medications.</p> <p>Interview with Family member #2 on 7-17-12 at 11:15 a.m. indicated Resident #A had surgery before being admitted to the facility on 7-5-12 and felt the resident's medication should have been able to given in the timeframe the resident was at the facility.</p> <p>The pharmacy services policy provided by the DON on 7-17-12 at 1:40 p.m. indicated the facility provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administrating of drugs and biological's) to meet the needs of each resident. The pharmacy strives to assure that medications are requested, received, and administered in a timely manner as ordered by the authorized prescribe.</p> |   |   |   |  |   |  |

|  |   |  |   |
|--|---|--|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>155188 | X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 00<br>B. WING _____ | X3) DATE SURVEY COMPLETED<br><br>07/17/2012 |
|--|---|--|---|

|  |   |
|--|---|
| NAME OF PROVIDER OR SUPPLIER<br><br>KINDRED TRANSITIONAL CARE AND REHAB-GREENFIELD | STREET ADDRESS, CITY, STATE, ZIP CODE<br>200 GREEN MEADOWS DR<br>GREENFIELD, IN 46140 |
|--|---|

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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 |
|--------------------|--|---------------|---|----------------------|
|                    | This federal tag relates to Complaint number IN00111866.<br><br>3.1-25(a)  |               |   |                      |