

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  03/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
---	---

(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 the Investigation of Complaint IN00125309.</p> <p>Complaint IN00125309 - Substantiated. Federal and State deficiency related to the allegations is cited at F406.</p> <p>Date of Survey: March 12, 2013</p> <p>Facility number: 000172 Provider number: 155272 AIM number: 100267130</p> <p>Survey team: Beth Walsh, RN-TC Gloria Bond, RN</p> <p>Census bed type: SNF/NF: 126 Total: 126</p> <p>Census payor type: Medicare: 32 Medicaid: 79 Other: 15 Total: 126</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
---------	--	---------	--	--

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:  155272	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  03/12/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON	STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250
---	---

(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
	Quality review 3/14/13 by Suzanne Williams, RN			

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  03/12/2013	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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			
F000406 SS=D	<p><b>483.45(a)</b>  <b>PROVIDE/OBTAIN SPECIALIZED REHAB SERVICES</b>                      If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a provider of specialized rehabilitative services.</p> <p>Based on interview and record review, the facility failed to provide referral to a mental health center or obtain a Level II assessment for mental health rehabilitative services, for 3 of 7 residents reviewed for Level II evaluations in the sample of 7. (Resident F, D, E)</p> <p>Findings include:</p> <p>A review of the document, titled, Level II Referrals For (Name of Facility) Provider Number (# of Facility), provided by the Administrator on 3/12/13 at 12:04 p.m., indicated Resident F, Resident D, and Resident E were to be referred to the local community mental health center for an evaluation. The document was signed by the Administrator on 9/20/12, on the line</p>	F000406	<p>Preparation and/or execution of this plan does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and/or executed solely because required.</p> <p><b>F-408 Provide specialized rehab services</b>  <b>(a) What corrective action(s) will be accomplished for those residents found to have been affected by the practice:</b>                      Residents F, D and E were referred to and seen by the mental health center and level II's were completed by 2-16-13.</p> <p>The social service staff was re-educated on the facility standard and guidelines for the referring to mental health and for evaluations and completions of Level II.</p> <p><b>(b) How you will identify other residents having potential to be affected by the same practice and what corrective action will be taken:</b>                      Current Resident charts audited to</p>	04/11/2013			

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  03/12/2013	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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>indicating he had acknowledged receipt of the referral information for these residents with a mental illness (MI) diagnosis.</p> <p>A document, titled, Level II Referrals For (Name of Facility) Provider Number (# of Facility), provided by the Administrator on 3/12/13 at 12:20 p.m., indicated Resident F, Resident D, and Resident E were to be referred to the local community mental health center for an evaluation. There was an asterisk next to Resident F, Resident D, and Resident E's names on the document. The document had a handwritten note that indicated the asterisk means, "These three residents were referred to NF (Nursing Facility) on 9/20/12 to have L-II (Level II) completed. The document was signed by the Administrator on 2/14/13, on the line indicating he had acknowledged receipt of the referral information for MI (mental illness) residents.</p> <p>The Indiana PASRR (Pre-Admission Screening Resident Review) Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment, provided by the Social Services Director (SSD) on 3/12/13 at 12:30 p.m., for Resident F was dated</p>		<p>ensure the Level II's were completed as required per medical diagnosis and referral</p> <p><b>(c) What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur:</b></p> <p>The facility office staff and Social service staff will be re-educated on Level II process. Level I's and 4B's will be placed on the chart as they are received in the facility. Diagnosis list and 4B's for Residents will be given to Social Services as they are received to be evaluated for need of referrals to mental health center. During care plan review IDT will review level I and diagnosis and make referrals as necessary.</p> <p><b>(d) How the corrective action(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place:</b></p> <p>The Director of Social Services will randomly audit 5 residents weekly for the next 4 weeks then monthly thereafter, to determine if residents have required referral to mental health centers. Review of these audits will be reported at the monthly QA/PI meeting for 3 months then monitored quarterly with System reviews.</p> <p><b>(e) Date of compliance:</b> 4-11-13</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  03/12/2013
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON			STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250		
(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>2/15/13.</p> <p>The Indiana PASRR (Pre-Admission Screening Resident Review) Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment, provided by the Social Services Director (SSD) on 3/12/13 at 12:30 p.m., for Resident D was dated 2/16/13.</p> <p>The Indiana PASRR (Pre-Admission Screening Resident Review) Summary of Preliminary Findings and Recommendations of PASRR/MI Level II Mental Health Assessment, provided by the Social Services Director (SSD) on 3/12/13 at 12:30 p.m., for Resident E was dated 2/16/13.</p> <p>During an interview with the Social Services Director (SSD), on 3/12/13 at 12:00 p.m., she indicated she never got the list of referrals for Level II assessments, so Resident F, Resident D, and Resident E did not have Level II assessments completed, as they should have. She also indicated the list was part of a packet that she never saw.</p> <p>The Administrator indicated, on 3/12/13 at 12:28 p.m., the list of</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  03/12/2013	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-CASTLETON				STREET ADDRESS, CITY, STATE, ZIP CODE 5226 E 82ND ST INDIANAPOLIS, IN 46250			
(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>referrals was never given to the SSD, because he was not aware, the referral list was in the packet of papers received from (name of office/company). He also indicated he thought the packet only included papers related to the improvement plan of action from the (name of office/company) visit. The Administrator indicated he did not follow through on the referrals as they (the facility) should have.</p> <p>At 1:04 p.m., on 3/12/13, a representative from the referring agency (the Office/Company that provided referrals for Level II assessments) indicated during the September audit, she gave the facility the name of a service that can come into the facility and perform the Level II assessments/evaluations right away. She also indicated the Administrator signed the list of referrals, from the September audit, which was in the packet she gave him.</p> <p>This federal tag is related to Complaint IN00125309.</p> <p>3.1-23(a)(2)</p>						