

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219
--	--

(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 of Complaint IN00100408.</p> <p>Complaint IN00100408 - Substantiated. Federal/state deficiencies related to the allegation are cited at F205.</p> <p>Survey date: December 30, 2011</p> <p>Facility number: 000227 Provider number: 155334 AIM number: 100267520</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 142 Total: 142</p> <p>Census payor type: Medicare: 34 Medicaid: 77 Other: 31 Total: 142</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review 1/03/12 by Suzanne Williams, RN</p>	F0000	<p>F205 The bed hold policy is provided to residents on admission and at time of transfer. For all Residents: The bed hold policy is part of the Admissions package. The admissions Coordinator/designee is responsible to review the Bed Hold policy and transfer Discharge policy with Residents, Families or Legal guardians at the Time of Admission. The licensed staff are responsible to provide the Bed Hold Policy and Transfer/Discharge notice when the resident is transferred or discharged and document in the Nurses notes that the forms were sent with the resident. The Business Office is responsible to follow-up by sending a copy of the Bed Hold Policy and Transfer/discharge notice to the family or legal Guardian and record in the NOTIFICATION OF BEDHOLD POLICY AND TRANSFER/DISCHARGE NOTICE log that the forms have been sent. The admissions coordinator/designee, business office, medical records, and licensed staff have been in-serviced on the Bed Hold policy and Transfer/Discharge Notice. The Medical Records Clerk will be responsible to conduct a weekly audit of all discharges to Ensure that the forms have been sent And the documentation is present. QAA: The Administrator</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: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219		
(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	
F0205 SS=D	<p>Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on interview and record review, the facility failed to provide residents and/or family members/responsible parties bed hold policies at the time of transfers or within the 24 hour time limit, for 3 of 3 residents reviewed for bed hold policy notification in a sample of 3. [Resident #A, #B, and #C]</p> <p>Findings include:</p>	F0205	<p>will be responsible To present the audits to the P.I. Committee monthly for review And actions, as indicated for Three months and will be reviewed in monthly PI rhereafter. Date of alleged compliance to be January 16, 2012.</p> <p>F205 The bed hold policy is provided to residents on admission and at time of transfer. For all Residents: The bed hold policy is part of the Admissions package. The admissions Coordinator/designee is responsible to review the Bed Hold policy and transfer Discharge policy with Residents, Families or Legal guardians at the Time of Admission. The licensed staff are responsible to provide</p>	01/16/2012	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
	<p>1.) Resident #A's clinical record was reviewed on 12/30/11 at 2:25 p.m. and indicated Resident #A was admitted to the facility on 09/26/11 and re-admitted on 12/09/11 and had diagnoses which included, but were not limited to, end stage dementia, pneumonia, end stage renal disease,hemodialysis, failure to thrive, diabetes, neuropathy, osteoarthritis, osteoporosis, anemia, hyperlipidemia, hypertension, gastroesophageal reflux disorder, and constipation.</p> <p>Resident #A's most recent significant change Minimum Data Set [MDS] assessment dated 11/30/11, indicated the resident was moderately impaired with cognitive skills for daily decision making with a score of "8" on her BIMS testing for cognition.</p> <p>Resident #A's clinical record indicated she was transferred to the hospital on 12/26/11 for evaluation secondary to increased white blood count and increased temperature. The clinical record lacked documentation of bed hold paper work being issued prior to or at the time of transfer.</p> <p>2.) Resident #B's clinical record was reviewed on 12/30/11 at 10:45 a.m. and</p>		<p>the Bed Hold Policy and Transfer/Discharge notice when the resident is transferred or discharged and document in the Nurses notes that the forms were sent with the resident. The Business Office is responsible to follow-up by sending a copy of the Bed Hold Policy and Transfer/discharge notice to the family or legal Guardian and record in the NOTIFICATION OF BEDHOLD POLICY AND TRANSFER/DISCHARGE NOTICE log that the forms have been sent. The admissions coordinator/designee, business office, medical records, and licensed staff have been in-serviced on the Bed Hold policy and Transfer/Discharge Notice. The Medical Records Clerk will be responsible to conduct a weekly audit of all discharges to Ensure that the forms have been sent And the documentation is present. QAA: The Administrator will be responsible To present the audits to the P.I. Committee monthly for review And actions, as indicated for Three months and will be reviewed in monthly PI rhereafter. Date of alleged compliance to be January 16, 2012.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 12/30/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219
--	--

(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 Resident #B was admitted to the facility on 08/01/11 and re-admitted on 11/15/11 and had diagnoses which included, but were not limited to, acute respiratory failure, stage III kidney disease, muscular sclerosis, acute cor pulmonale, asthma, obstructive sleep apnea, morbid obesity, diabetes, neuropathy, urinary tract infection, osteoarthritis, osteoporosis, congestive heart failure, anemia, venous insufficiency, radiation induced decubitus ulcers on back, depression, gastroesophageal reflux disorder, and a history of gastritis.</p> <p>Resident #B's most recent quarterly MDS assessment dated 11/24/11, indicated the resident had no problems with cognitive skills for daily decision making with a score of "14" out of 15 on the BIMS testing.</p> <p>Resident #B's clinical record indicated Resident #B was her own responsible party and had signed the admission agreement on 05/02/11, which had documented under Resident Rights the following: "f) Bed Hold Policy. Before the Resident may be transferred to a hospital or for a therapeutic leave, the Center is required to provide the Center's Bed Hold Policy to the Resident and a family member or Responsible Party. The</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219		
(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>Bed Hold Policy includes any state Medicaid bed hold requirements and information on how Medicare only and private pay residents may request and obtain a bed hold. See Attachment C, Bed Hold Policy."</p> <p>Resident #B's clinical record indicated the resident was sent out to the hospital on 11/11/11 for mental status changes, very lethargic, and verbally unresponsive.</p> <p>Hospital records dated 11/11/11 indicated decreased mental status, respiratory failure, and acute renal failure.</p> <p>Resident #B's clinical record lacked documentation of a bed hold policy or an Attachment C.</p> <p>Interview with the Administrator on 12/30/11 at 12:10 p.m. indicated Resident #B and family had concerns about the resident's new room and new staff upon re-admission to another room which was not private as Resident #B had a private room before being hospitalized.</p> <p>Interview with the Administrator on 12/30/11 at 2:05 p.m. indicated social service tried to contact the family, but was unable to do so. The Administrator indicated the assistant administrator at the time and himself had been in contact with</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219		
(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 resident and family as they were upset with the new room. The Administrator indicated they got the resident a telephone cord and made some adjustments to have more room. The Administrator indicated the facility could not find the bed hold sheet for Resident #B.</p> <p>3.) Resident #C's clinical record was reviewed on 12/30/11 at 3:30 p.m. and indicated the resident was admitted to the facility on 07/25/11 and re-admitted on 11/22/11 and had diagnoses which included, but were not limited to, cirrhosis, diabetes, parotid cylindroma of lung and brain, hepatic encephalopathy, seizure disorder, peripheral neuropathy, hypotension, atrial fibrillation, gastroesophageal reflux disorder, lower extremity cellulitis, rib fractures, bilateral pulmonary masses, venous insufficiency, congestive heart failure, obstructive sleep apnea, benign prostate hyperplasia, history of craniotomy 2010, debilitation, muscle weakness, and muscle spasms.</p> <p>Resident #C's most recent MDS assessment dated 12/22/11, indicated the resident was independent with cognitive skills for daily decision making with a score of "14" on the BIMS test.</p> <p>Resident #C's clinical record indicated the resident was sent to the hospital per his</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219		
(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>request for evaluation of chest pain on 12/26/11.</p> <p>Resident #C's clinical record lacked documentation of a bed hold policy being given to him or family or responsible party.</p> <p>Interview with the Administrator on 12/30/11 at 4:30 p.m. indicated it was the responsibility of the unit manager or the nurse sending the resident out to make sure the bed hold policy is provided to the resident/family member/responsible party.</p> <p>Review of the facility's Discharge/Transfer of the Resident policy, dated 04/28/09, indicated, "Transfer to Hospital 16. Notify physician of resident condition and obtain a physician's order to transfer. ... 17. Make arrangement for transportation. 18. Give the resident and/or representative or person(s) responsible for care a copy of the bedhold policy. ... 19. Complete appropriate paper work to send with resident (i.e., transfer form, copy of current medications, copy of current labs, copy of applicable documentation such as nurse's notes, notice of bed-hold policy, most recent history and physical and advanced directives). Place a copy of transfer paper work in resident medical record. 20. Assess and monitor resident's condition</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155334	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 12/30/2011
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 7301 E 16TH ST INDIANAPOLIS, IN46219		
(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>until emergency personnel arrive and take over care. 21. Notify acute care center of impending arrival of resident and condition of resident. 22. Notify resident and/or family member/responsible party of resident condition and transfer to hospital and bed-hold policy...."</p> <p>This federal tag relates to complaint IN00100408.</p> <p>3.1-12(a)(25) 3.1-12(a)(26)</p>				