

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
---	--

(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	<p>This visit was for the Investigation of Complaints IN00207153 and IN00207368.</p> <p>Complaint IN00207153 - Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00207368 - Substantiated. Federal/State deficiencies related to the allegations are cited at F499.</p> <p>Survey dates: August 22, 23, and 24, 2016</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Census bed type: SNF/NF: 101 Total: 101</p> <p>Census payor type: Medicare: 9 Medicaid: 71 Other: 21 Total: 101</p> <p>Sample: 4</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and / or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and / or executed solely because it is required by the provisions of federal and state law. Attached you will find the completed Plan of Correction and attachments for complaint survey dated August 24, 2016. We respectfully request that our Plan of Correction, be considered for a paper compliance desk review. Should you have any questions, feel free to contact me at (812) 948-0670. Sincerely, John Keaton, Executive Director</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: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
---	--

(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 0499 SS=D Bldg. 00	<p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on August 28, 2016.</p> <p>483.75(g) EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS The facility must employ on a full-time, part-time or consultant basis those professionals necessary to carry out the provisions of these requirements.</p> <p>Professional staff must be licensed, certified, or registered in accordance with applicable State laws.</p> <p>Based on interview and record review, the facility failed to ensure a Licensed Practical Nurse held a current/valid license for employment.</p> <p>Findings include:</p> <p>The SDC (Staff Development Coordinator) provided a binder with copies of the facility staff licenses on 8/22/16 at 3:30 p.m. It included, but was not limited to, the following: "...Online</p>	F 0499	<p>1.The nurse was immediately removed from the floor and schedule pending verification of an active Indiana nurse license. All other licensed nurses were verified ascurrent.</p> <p>2.All residents had the potential to be affected by the deficient practice. All other licensed nurses were verified as current. All facility events were reviewed since June 1, 2016 it was found that no significant events occurred involving this nurse.</p>	08/25/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/24/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
---	--

(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>Validation Results... Validation Result... [LPN [Licensed Practical Nurse] #3's name]...License Type: LPN...Status: Active...Original Date of KY [Kentucky] Licensure: 02-May-16...This license is valid for practice only in KY and does not authorize a privilege to practice in any other state..."</p> <p>During an interview on 8/22/16 at 4:47 p.m., the SDC indicated LPN #3 had applied for an Indiana license last week on Thursday or Friday. The SDC also indicated LPN #3 had 180 days to apply for an Indiana license. The SDC further indicated LPN #3 had been employed as an LPN since May, 2016.</p> <p>During an interview on 8/23/16 at 2:30 p.m., the District Director of Clinical Operations indicated Indiana did not have a grace period and LPN #3 should have obtained an Indiana license by now.</p> <p>On 8/24/16 at 9:55 a.m., the personnel file for LPN #3 was requested but never provided.</p> <p>On 8/23/16 at 1:06 p.m., the SDC provided a current copy of the document titled "Job Description". It included, but was not limited to, the following: "...Job Title...Charge Nurse - LPN...Qualifications...Current valid</p>		<p>3.The ED/designee will provide education to the SDC on state nursing licensure regulations and company policy. The facility will continue to verify license on hire and as per company policy.</p> <p>4.The SDC/designee will continue to verify license on hire and as per company policy. The nurse identified will provide written verification that her license is active in Indiana and is in good standing prior to returning to work. The SDC/ Designee will bring completed new hire Health/ Education/ Licensure files to the DNS/ Designee for review prior to the employee being released to floor orientation as an ongoing process of this facility. Employee Health/Education/ Licensure will be reviewed for completion and accuracy monthly based on date of anniversary by the DNS/ designee prior to PI as an ongoing practice. All findings will be acted upon immediately and results reviewed in the monthly PI meeting for 6 months and ongoing as identified by the facility QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 08/24/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150		
(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>LPN...license in the state employed."</p> <p>On 8/23/16 at 1:11 p.m., the Administrator provided a current copy of the document titled "Verification of Professional Staff Credentials", dated 10/31/10. It included, but was not limited to, the following: "...Rationale...Professional staff are licensed, certified, or registered in accordance with applicable State/Federal laws. This may include, but were not limited to:...d. Licensed Practical Nurse...Procedure...2. Validate the potential license...in accordance with applicable State laws during the pre-employment process..."</p> <p>This Federal tag relates to Complaint IN00207368</p> <p>3.1-14(s)</p>				