

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 05/30/2014
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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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F000000	<p>This visit was for the Investigation of Complaints IN00149584 and IN00147240.</p> <p>Complaint IN00149584 - Substantiated. Federal/ state deficiencies related to the allegation are cited at F309.</p> <p>Complaint IN00147240 - Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: May 28, 29 and 30, 2014.</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Survey team: Shelly Miller- Vice, RN</p> <p>Census bed type: SNF/NF: 140 Total: 140</p> <p>Census payor type: Medicare: 16 Medicaid: 101 Other: 23 Total: 140</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.

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F000309 SS=D	<p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed on June 6, 2014 by Brenda Meredith, R.N.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 record reviews, and interviews, the facility failed to ensure a resident was not moved after a fall with injury. This resulted in causing the resident to complain of pain. This affected 1 of 1 residents sampled (Resident C).</p> <p>Findings included:</p> <p>On 5/28/14 at 12:55 p.m., a record review was conducted of Resident C's Clinical Medical Record (CMR). Resident C was admitted from an acute hospital to the nursing facility on 3/26/14 at 13:38 (1:38 p.m.). A fall was documented on 3/26/14</p>	F000309	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of 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.</p> <p>F309</p> <p>I. Resident has been discharged from facility.</p> <p>II. Residents residing in the facility who have a high fall risk score on assessment have the potential to be affected by this</p>	06/20/2014

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	<p>at 23:00 (11:00 p.m.) and a transfer to a local acute hospital for evaluation and treatment.</p> <p>The Admission Assessment, dated 3/26/14 at 13:30 (1:30 p.m.), indicated the resident was confused but able to answer questions.</p> <p>The Admission Orders Record, dated: 3/26/14 through 3/31/2014, indicated the resident was able to "Ambulate c[with] assist...."</p> <p>The Progress Notes indicated the following: "3/26/14. 13:38 Type: Health Status Note. Note Text. Arrived to facility via [Hospital initials] ambulance....</p> <p>3/26/14. 23:00. Type: Incident Note: At approximately 2140 the residents bed alarm was set off. Upon entering the room the resident was up out of bed. He was assisted back into bed....Resident alert and oriented to person and time. When asked where he was he stated 'home'. At 2145 the bed alarm was set off again. Upon arrival of the CNA [Certified Nurse Aide] the resident was found laying on the left side of the bed on the floor facing north. He had a skin rear to his L [left] elbow and complaints of L hip pain. L foot noted to be turned out.</p>		<p>alleged deficient practice. An audit was completed during the week of 6/16/14 thru 6/19/14 residents who have had a fall since 5/1/14 have had their interventions audited by Interdisciplinary team and validated that they are in place and effective, any errors noted were reported to DNS/ED and were immediately fixed.</p> <p>III. Facility staff were re-educated on fall response, assessment, and management policy. Interdisciplinary team will review falls Monday through Friday in morning clinical meeting and will ensure that residents fall events are managed in a prompt and efficient manor. Interventions for safety are initiated on resident care plans. Interdisciplinary team will complete "fall rounds" following morning clinical meeting for all incidents to determine a root cause, assess interventions are in place and are effective.</p> <p>IV. DNS/Designee will complete review of process measures falls/accidents CQR weekly times four, then monthly times three, then quarterly until compliance is achieved. Results will be reviewed in PI Committee and action plans implemented as necessary.</p>				

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	<p>Neuro checks done. Grips equal bilaterally. Upper extremities moderate. Lower R [right] leg moderate. Unable to lift L leg off bed. Vitals taken... Resident assisted via Hoyer to the bed. Resident observed for other injuries. None found. NP [Nurse Practitioner] notified. Order placed for X-ray. X-ray proved Acute left femoral neck fracture. NP notified of findings. Order to be sent to [local acute hospital name] ER [Emergency Room]...</p> <p>3/27/14. 09:42. Type: Health Status Note. IDT [inter-disciplinary team] met to review incident on 3/26/14. Resident bed alarm sounding and staff entered room to find resident on floor on left side. Resident with c/o [complaints of] pain to L hip...."</p> <p>On 5/29/14 at 12:15 p.m., an interview was conducted with the DNS (Director of Nursing Services). The DNS indicated when a resident sustains a fall with pain, the resident would be assessed without being moved until emergency personnel arrive.</p> <p>On 5/29/14 at 1:25 p.m., an interview was conducted with the Administrator. The Administrator indicated a resident that sustained a fall with pain should not be moved from the floor.</p>			

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	<p>On 5/29/14 at 2:00 p.m., a record review was conducted of Resident C's CMR alongside of the DNS. The Progress Note dated 3/26/14 at 23:00 was indicated to have been completed by a Registered Nurse and represented moving a resident in pain from the floor to the bed after falling from which a fracture was sustained. It was indicated this was not the expected procedure of the nursing staff of the facility. "... when a Resident falls, an assessment is done, if the resident has pain after a fall, the resident should remain on the floor until emergency personnel arrive...."</p> <p>On 5/30/14 at 8:15 a.m., a record review was conducted of the policy and procedure titled, "Fall Response and Management. PRO[sic]: 61035-01.... Procedure: ...6. If the fall is un-witnessed by staff, take the following actions: a. Confirm the patients identity using at least two patient identifiers according to facility's protocol, b. Ask the patient or a witness what happened, c. Ask wether the patient experienced pain or a change in level of consciousness. 7.... observe for such signs and symptoms as... pain...."</p> <p>On 5/30/14 at 8:30 a.m., an interview was conducted with the Administrator. The Administrator indicated it was the practice of the facility to assess for pain</p>						

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	<p>after a fall and to not move a resident whom complained of pain after a fall.</p> <p>This Federal tag relates to Complaint IN00149584.</p> <p>3.1-37(a)</p>				