STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	08/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WILDWOOD	7301 E 16TH ST INDIANAPOLIS, IN 46219

(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	This visit was for the Investigation of Complaint IN00179471. Complaint IN00179471 Substantiated. Federal/State findings cited at F157, F282, F504 and F514. Survey dates: August 13 & 14, 2015 Facility Number: 000227 Provider Number: 155334 Aim Number: 100267520 Census Bed Type: SNF/NF: 138 Total: 138 Census Payor Type: Medicare: 24 Medicaid: 91 Other: 23 Total: 138 Sample: 5 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Ms. Kim RhoadesIndiana State Department of Health Long Term Care Division 2 North Meridian Street, Section 4BIndianapolis, Indiana 46204 August 21, 2015 RE: Survey Event ID: 3KYR11 Dear Ms. Rhoades: Attached you will find the completed Plan of Correction and attachments for our Complaint Survey dated August 14, 2015. We request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (317) 353-1290 . Sincerely, Linda VestExecutive Director	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. Based on record review and interview the	F 0157	1.A plan of care meeting has been scheduled for August 31, 2015 at	08/28/2015

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	facility failed to inform a resident's family member of changes related to testing and medications for 1 of 5 sampled residents. (Resident "B"). Findings include: The record for Resident "B" was reviewed on 08-13-15 at 9:00 a.m. Diagnoses included, but were not limited to, legal blindness, obesity, schizophrenia, arthritis, hypertension, coronary artery disease and diabetes mellitus. These diagnoses remained current at the time of the record review. During an interview on 08-13-15 at 1:00 p.m., a concerned family member indicated that she currently is her step father's Health Care Representative and the resident also had another person designated as his Power of Attorney. The concerned family member indicated the resident previously resided with her and she handled making appointments, talking to the Doctor and giving the resident his medications. The family member indicated she is not informed "right a way" when there have been changes and tests being scheduled. "I generally find out about it days later." A review of the clinical record indicated		11:00am with Resident B's family to review all medications, tests and plan of care. The Health Care Representative for Resident B is receiving notification of changes in Resident B's physical, mental or psychosocial status, treatment plan room or roommate change timely. 2.All residents have the potential to be affected. An audit has been completed for all residents to validate family and physician notification with change of physical, mental or psychosocial status, treatment plan or change in condition timely and with documentation for the past 30 days. The resident, family and physician will be notified of any changes. 3.All licensed nursing staff have been educated on Notifications with emphasis on notifying health care representatives, families and physicians timely and appropriate documentation. 4.The DNS/Designee will complete an audit five times a week to validate family/Health Care representative and physician notification with any change in physical, mental or psychosocial status, treatment plan room or roommate change for 30 days, then three times a week for 30 days, then twice a week for 30 days, then weekly for 3 months. All findings will be reported in the monthly PI meeting. The PI committee will determine when 100% compliance is achieved and the PI committee will determine if adjustments to monitoring need to be	

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	the following physician orders, which lacked documentation the family member had been notified: "06-09-15 CBC [complete blood count], CMP [complete metabolic profile], TSH [a thyroid test], HgbA1C [a test related to diabetes] and a Lipid panel. PT [Protime] / INR [International normalization ratio] q [every] week on Monday." Although the physician signature was on this order, the section in which documentation to reflect "Family Notification," was blank. "06-10-15 Check HgbA1C on 06-11-15." The order lacked documentation the family member was notified. "06-11-15 Start DuoNeb [a breathing treatment] unit dose q 6 routine times 10 days. Sat [Oxygen Saturation level] check q shift and prn [as needed]." The order lacked documentation the family member was notified. "07-01-15 Physician authorization required: MBS [modified barium swallow] to assist with diet recs. [recommendations] secondary to h/o [history of] dysphagia." The order lacked documentation the		made to the monitoring plan.	

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	family member was notified. A review of the facility policy on 08-14-15 at 8:30 a.m., titled "Notifications," and dated 04-28-2013, indicated the following: "Rationale: Patients, families and/or responsible parties have the right to be notified of changes in the patient's physical, mental or psychosocial status, treatment plan, room or roommate change and a change if the federal or state patient rights." This Federal tag relates to Complaint IN00179471. 3.1-5(a)			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview the facility failed to ensure residents physician orders were followed for 2 of 5 sampled residents. (Residents "D" and "F"). Findings include:	F 0282	1.Resident D's PT/INR results were received on 8/13/2015 at 1733. Orders for PT/INR were continued for Monday and Thursdays. Coumadin 1.0mg po Q day started on 8/14/2015 per physician's order. Resident D was discharged home on 8/19/2015. Resident F's PT/INR results were received on 8/13/2015 at 1727 and new orders per physician	08/28/2015

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	A listing of resident's who currently received anticoagulation therapy included Resident's "D" and "F," was reviewed on 08-13-15 at 10:00 a.m. The resident's medications were identified by the Pharmacist as currently being "on hold" due to physician orders. 1. The record for Resident "D" was reviewed on 08-13-15 at 10:40 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, diabetes mellitus, and arteriosclerotic heart disease. These diagnoses remained current at the time of the record review. The resident record indicated the resident was on anticoagulation therapy at 2.5 mg (milligrams) of Coumadin daily. The resident had physician orders dated 07-20-15 which instructed the nursing staff for PT (Protime) / INR (International Normalization Ratio) every Monday and Thursday. Further review of the record, contained a laboratory result in which the resident's Protime was 50.2 (normal range 9.5 - 11.8) and the INR was 4.2 (normal range of .9 - 1.1). The Nurse Practitioner instructed the nursing staff to "Hold times 2 days and recheck on Wednesday [08-12-15]."		were received for Coumadin 3.0 mg PO Q day and PT/INR daily while on an antibiotic. 2.All residents with physician's orders to obtain labs have the potential to be affected. An audit of all charts for physician's orders for labs and validation that the lab was received has been completed. Any finding has been communicated to the family, resident and physician. 3.All Licensed nurses have been educated on Physician' Orders. 4.The DNS/Designee will complete an audit daily to validate all physician's orders for labs have been transcribed to a Lab requisition and obtained for 30 days, then five times a week for 30 days, then three times a week for 30 days, then twice a week for 60 days, then weekly for 30 days. All findings will be reported to the PI committee monthly and the PI committee will determine when 100% compliance is achieved and how monitoring will be adjusted.	

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A request was made on 08-13-15 at 11:00 a.m., for the results of the anticoagulation testing.

During an interview on 08-13-15 at 11:45 a.m., Licensed Nurse #6 indicated the laboratory testing was completed and the results were in the Nurse Practitioner folder for review.

The Licensed Nurse then proceeded to obtain the testing results from the folder. The Licensed Nurse indicated the blood testing had not been drawn as ordered and stated, "I don't know why."

During further interview on 08-13-15 at 1:50 p.m., Licensed Nurse #6 indicated the sequence of events, in which the facility failed to ensure the testing was completed as ordered. "The Nurse Practitioner wrote the order on the lab [laboratory] sheet and the nurse didn't enter the order into the computer."

During a review of the phlebotomist binder lacked a requisition for the laboratory testing to be completed as ordered.

2. The record for Resident "F" was reviewed on 08-13-15 at 2:20 p.m. Diagnoses included, but were not limited

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	to, chronic pain, constipation, chronic embolism and thrombosis. These diagnoses remained current at the time of the record review. The resident record indicated the resident was on anticoagulation therapy at 4.0 mg (milligrams) of Coumadin daily. The resident had laboratory results in the clinical record which indicated an elevated PT/INR. The results were: Protime of 43.3 and the INR at 3.7. The laboratory result had a handwritten entry by the Nurse Practitioner which instructed the nursing staff to "hold" the medication for 3 days and "recheck" the resident's blood work on Thursday (08-13-15). A review of the phlebotomist requisition binder, lacked a request for the testing. During an interview on 08-13-15 at 2:30 p.m., Licensed Nurse #6 verified the request had not been completed as ordered. This Federal tag relates to Complaint IN00179471. 3.1-35(g)(2)			
F 0504	483.75(j)(2)(i)			

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SS=D Bldg. 00	LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. Based on record review and interview the facility failed to ensure residents laboratory testing was completed as ordered by the physician for 2 of 5 sampled residents. (Residents "D" and "F"). Findings include: The record for Resident "D" was reviewed on 08-13-15 at 10:40 a.m. Diagnoses included, but were not limited to, atrial fibrillation, hypertension, diabetes mellitus, and arteriosclerotic heart disease. These diagnoses remained current at the time of the record review. The resident record indicated the resident was on anticoagulation therapy at 2.5 mg (milligrams) of Coumadin daily. The resident had physician orders dated 07-20-15 which instructed the nursing staff for PT (Protime) / INR (International Normalization Ratio) every Monday and Thursday. Further review of the record, contained a laboratory result in which the resident's Protime was 50.2 (normal range 9.5 -	F 0504	1.Resident D's PT/INR results were received on 8/13/2015 at 1733. Orders for PT/INR were continued for Monday and Thursdays. Coumadin 1.0mg po Q day started on 8/14/2015 per physician's order. Resident D was discharged home on 8/19/2015. Resident F's PT/INR results were received on 8/13/2015 at 1727 and new orders per physician were received for Coumadin 3.0 mg PO Q day and PT/INR daily while on an antibiotic. 2.All residents with physician's orders to obtain labs have the potential to be affected. An audit of all charts for physician's orders for labs and validation that the lab was received has been completed. Any finding has been communicated to the family, resident and physician. 3.All Licensed nurses have been educated on Physician' Orders. 4.The DNS/Designee will complete an audit daily to validate all physician's orders for labs have been transcribed to a Lab requisition and obtained for 30 days, then five times a week for 30 days, then three times a week for 30 days, then twice a week for 60 days, then weekly for 30 days. All findings will be reported to the PI committee monthly and the PI committee will determine when 100% compliance is achieved and how monitoring will be adjusted.	08/28/2015

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	11.8) and the INR was 4.2 (normal range of .9 - 1.1). The Nurse Practitioner instructed the nursing staff to "Hold times 2 days and recheck on Wednesday [08-12-15]." A request was made on 08-13-15 at 11:00 a.m., for the results of the anticoagulation testing. During an interview on 08-13-15 at 11:45 a.m., Licensed Nurse #6 indicated the laboratory testing was completed and the results were in the Nurse Practitioner folder for review. The Licensed Nurse then proceeded to obtain the testing results from the folder. The Licensed Nurse indicated the blood testing had not been drawn as ordered and stated, "I don't know why." During further interview on 08-13-15 at 1:50 p.m., Licensed Nurse #6 indicated the sequence of events, in which the facility failed to ensure the testing was completed as ordered. "The Nurse Practitioner wrote the order on the lab [laboratory] sheet and the nurse didn't enter the order into the computer." During observation the phlebotomist binder lacked a requisition for the laboratory testing to be completed as			

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	ordered. 2. The record for Resident "F" was reviewed on 08-13-15 at 2:20 p.m. Diagnoses included, but were not limited to, chronic pain, constipation, chronic embolism and thrombosis. These diagnoses remained current at the time of the record review. The resident record indicated the resident was on anticoagulation therapy at 4.0 mg (milligrams) of Coumadin daily. The resident had laboratory results in the clinical record which indicated an elevated PT/INR. The results were Protime of 43.3 and the INR at 3.7. The laboratory result had a handwritten entry by the Nurse Practitioner which instructed the nursing staff to "hold" the medication for 3 days and "recheck" the resident's blood work on Thursday (08-13-15). A review of the phlebotomist requisition binder, lacked a request for the testing. During an interview on 08-13-15 at 2:30 p.m., Licensed Nurse #6 verified the request had not been completed as ordered. This Federal tag relates to Complaint			

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	IN00179471. 3.1-49(f)(1)			
F 0514 SS=E Bldg. 00	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on observation, record review and interview the facility failed to ensure complete and accurate clinical records for 4 of 5 sampled residents. (Resident's "B", "C", "E" and "F"). Findings include: 1. The record for Resident "B" was reviewed on 08-13-15 at 9:00 a.m. The resident was admitted to the facility and at the time of admission, the Inventory Sheet indicated the resident had 1 hat, 2 pair of slacks, 6 shirts, 2 pair of shoes, sunglasses and a radio.	F 0514	1.Residents B, C, E, and F have had their Personal Belongings Inventory sheet updated to include signatures. On August 10, 2015 a letter was mailed to all families/Responsible parties educating them on the process for labeling items and having them placed on the residents' Personal Belongings Inventory Sheet when brought in to the facility or removed items from the facility. 2.All residents have the potential to be affected. All residents have had an audit completed of their Personal Belongings and recorded on the Personal Belongings Inventory	08/28/2015

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	During an interview on 08-13-15 at 1:00 p.m., a concerned family member indicated she brought additional clothing items in to the facility after the resident was admitted and had labeled each article of clothing. The family member indicated she spoke to the Administrator about "missing items." "I'm sure I brought in at least 7 outfits where the top and the bottoms matched. We never got the copy of the original Inventory Sheet." During an observation on 08-13-15 at 1:45 p.m., and with Licensed Nurse #7 in attendance, the resident's closet was observed for clothing. The Licensed Nurse identified "1 pair of jogging pants, 1 polo shirt, 4 white tee shirts and a blue sweater." During further observation 1 tee shirt belonging to Resident "B" was located in his roommates closet. During an interview on 08-13-15 at 2:25 p.m., the Administrator indicated she was aware of the family member's concern and some of the "missing items" had been located. The administrator further indicated she spoke to the family member "several" times related to the issue of missing clothing. During further review, the resident's Inventory sheet had not been updated with the additional clothing which had		Sheet with signatures from staff, resident, and families. Any Missing items have also been documented in the medical record and documentation in the medical record of the missing item, results of the facility search, and notification of the family/responsible party. 3.The Admission coordinator, Executive Director, Licensed Nurses and social services have been educated on the facility policy Patient Personal Belongings with emphasis on the procedure and documentation. 4.The DNS/Designee will have the Personal Inventory sheet completed within 72 hours of a resident's admission to the facility and again in 30 days of admission, then quarterly with plan of care meetings and PRN with any concern or grievance related to missing items. The DNS/Designee will complete an audit weekly of Personal Inventory Sheets for completion and of residents with missing items for documentation and notification to the family/resident in the medical record for 3 months then monthly for 3 months. All findings will be reviewed in monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if monitoring needs to be adjusted or on going.	

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	been located nor any documentation related to the family members concerns or the results. During interview on 08-13-15 at 2:25 p.m., the Administrator verified the Inventory sheet had not been updated. 2. The record for Resident "C" was reviewed on 08-13-15 at 10:a.m. The resident was admitted to the facility on 06-24-15. The resident's clinical record lacked an itemized Personal Inventory Sheet. 3. The record for Resident "E" was reviewed on 08-13-15 at 11:00 a.m. The resident was admitted to the facility on 06-12-15. The resident's clinical record lacked an itemized Personal Inventory Sheet. 4. The record for Resident "F" was reviewed on 08-13-15 at 2:20 p.m. The resident was admitted to the facility on 06-25-15. The resident's clinical record lacked a completed Personal Inventory Sheet in regard to signatures of staff and family members.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155334	A. BUILDING 00 B. WING	08/14/2015

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	5. A review of the directions at the top of the Inventory sheet instructed the facility staff as follows: "Upon admission, identify the resident's personal belongings by indicating quantity of those items listed. Use the space allowed to write in additional items as necessary. The original shall be kept in the resident's chart. The copy is given to the resident or the resident's representative. Update as necessary throughout the resident's stay by using the space provided." 6. A review of the facility policy on 08-14-15 at 8:15 a.m., titled "Patient Personal Belongings," and dated 05-21-2014, indicated the following: "Rationale: The patient has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the right or health and safety of other patients. Patient possessions, regardless of their apparent value to others, are treated with respect, for what they are and for what they may represent to the patient." "Responsible Disciplines: Executive Director, Admission Coordinator's, Licensed Nurses, Social Services."			

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	"Procedure: ... 6. Complete a personal belongings Inventory sheet upon admission. Update as needed with personal belonging added throughout the patients stay and/or removed from the center (e.g., new items are brought in, patient is readmitted and brought new items in)." "Documentation: 1. Document patient's personal belonging on the designated form in the medical record upon admission and throughout patient stay. 2. Document in the patient's medical record, notification of family/responsible party of the center's process on misplaced and/or misappropriated personal items. ... 4. Document in the patient's medical record any missing patient personal items and results of search. ... 6. Document in the patient's medical record notification of family/responsible party of missing personal items and results of search." This Federal tag relates to Complaint IN00179471. 3.1-50(a)(1) 3.1-50(a)(2)			