DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	152008	A. BUILDING 00 B. WING	03/06/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED HOSPITAL- INDIANAPOLIS SOUTH	607 GREENWOOD SPRINGS DRIVE GREENWOOD, IN 46143

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S 0000 Bldg. 00	This visit was for the investigation of one hospital licensure complaint. Facility Number: 006218 Date: 3/6/17 Complaint Number: IN00190578; Substantiated; A deficiency related to the allegations is cited. QA: 5/1/17 jlh	S 0000		
S 0912 Bldg. 00	410 IAC 15-1.5-6 NURSING SERVICE 410 IAC 15-15-6 (a)(2)(B)(i)(ii) (iii)(iv)(v) (a) The hospital shall have an organized nursing service that provides twenty-four (24) hour nursing service furnished or supervised by a registered nurse. The service shall have the following: (2) A nurse executive who is: (B) responsible for the following: (i) The operation of the services, including, but not limited to, determining the types and numbers of nursing personnel and staff necessary to provide care for all patient care areas of the hospital. (ii) Maintaining a current nursing			

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

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	service organization chart. (iii) Maintaining current job descriptions with reporting responsibilities for all nursing staff positions. (iv) Ensuring that all nursing personnel meet annual in-service requirements as established by hospital and medical staff policy and procedure, and federal and state requirements. (v) Establishing the standards of nursing care and practice in all settings in which nursing care is provided in the hospital.			
	Based on interview and document review, the nursing executive failed to ensure that repositioning of patients occurred every two hours, as per facility practice, for 5 of 5 patients, Patients #1 through #5, and failed to ensure a complaint investigation form was completed after receipt of a telephone complaint related to the care of one patient, Patient #1, as per the facility policy. Findings Include: 1. At 12:45 PM on 3/6/17, interview with the RN (registered nurse) Manager, staff member #52, confirmed that all patients at the facility are to be turned/repositioned every two hours, regardless of scoring on the Braden scale, or whether the patient scores at a risk for skin issues.	S 0912	Deficiency Correction: Verbal education provided to nursing staff and CNA's during patient safety huddle and mandatory staff meetings. Education includes turning and repositioning documentation and timeliness expectation. Scheduled repositioning will be completed at the scheduled time with a plus or minus window of a maximum of 10 minutes. The complaint and grievance process was expanded to include any complaint received after discharge; this includes phone conversations and social media. Deficiency Prevention: The nursing manager will conduct daily audits of repositioning documentation for timeliness. Audits will be performed on a	05/11/2017

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	2. Review of medical records indicated: A. Patient #1 had turns ordered every two hours, on admission by the Wound Nurse, with the following turns found to be not per the order or facility practices by being greater than two hours: i. On 11/5/15 at 0533 hour to 0825 hours (52 minutes late). ii. On 11/5/15 at 1553 hours to 1840 hours (47 minutes late). iii. On 11/6/15 at 0013 hours to 0251 hours (38 minutes late). iv. On 11/6/15 at 1329 hours to 1632 hours (64 minutes late). v. On 11/6/15 at 1749 hours to 2043 hours (54 minutes late). B. Patient #2 had documentation of a turn at 0542 hours on 12/28/15 with the next turn documented at 0711 hours (29 minutes late), a turn at 2255 hours on 12/28/15 and the next turn at 0025 hours on 12/29/15 (30 minutes late). C. Patient #3 had documentation of a turn at 2200 hours on 12/11/15 with the next turn at 0050 hours (50 min late) on 12/12/15, and a turn at 0200 hours on 12/12/15 with the next at 0429 hours (29 minutes late). D. Patient #4 had documentation of a turn/reposition at 1733 hours on 3/2/17 with the next turn at 2009 hours (36 minutes late) and between 0400 hours and 0632 hours (32 minutes late) on		minimum of 20 patients. Re-education and performance improvement will be provided to staff for non-compliance as needed. All complaint and grievances are documented as they are received and reviewed using the complaint process. Completed complaints are reviewed quarterly during Quality Council. Responsible Party: The Chief Clinical Officer will be responsible for ongoing compliance regarding repositioning The Chief Executive Officer will be responsible for ongoing compliance regarding Complaint and Grievance process. Correction Date: Repositioning education to begin on 5/11/2017 during safety huddle and mandatory staff meetings on June 6th, 7th and 8th. Documentation audits will begin 5/15/2017 and will be ongoing. Complaint and Grievance process was expanded in January 2017.	

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	3/3/17. E. Patient #5 had documentation of a turn/reposition at 0747 hours on 2/26/17 with the next documentation at 1028 hours (41 minutes late), from 1145 hours to 1408 hours on 2/26/17 (23 minutes late), and from 2352 hours on 2/17/17 to 0200 hours on 2/28/17 (1 hour and 8 minutes late). 3. Review of the policy Patient Complaint/Grievance Process, policy number H-ML 04-008 PRO, last approved 6/2016, indicated under Procedure, in item 3. "Intake and Initial Handling of a Complaint/Grievance. When reasonably possible, the person who receives a complaint should address and resolve it...If fulfilling the request is either impossible or cannot be addressed be (sic) the receiving person, the staff member should report it promptly to their immediate supervisor...", in section 4. b., it reads: "...ii. Initiate the Complaint and Grievance form...". 4. A review of the complaint/grievance logs for November and December 2015 and January 2016 indicated there was none related to Patient #1. 5. At 1:45 PM on 3/6/17, interview with the Director of Quality, RN staff member #50, confirmed that:			

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	A. This staff member received a phone call from the family of Patient #1, after the patient's discharge, with complaints of pressure ulcers that were observed at the receiving facility when Patient #1 arrived there. B. The caller alleged that Stage IV pressure ulcers were found on Patient #1 by staff at the receiving facility after being discharged from this facility on 12/23/15. C. Once the caller began demanding monetary compensation related to the stay of Patient #1, this staff member referred the caller to corporate staff to handle, as they are not granted the authority to provide monetary awards to patients/families. D. A complaint form was not completed, but should have been, and would have become a grievance issue.			