STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155664	A. BUILDING _____ B. WING _____	02/19/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to develop an individualized plan of care for constipation for 1 of 7 residents reviewed for care plans (Resident C). Findings include: Resident C's record was reviewed on 2/18/15 at 10:40 a.m. An admission assessment, dated 7/24/14, indicated Resident C was admitted to the facility post surgery for [REDACTED]. Untimed admission physician's orders [REDACTED]. An untimed physician's orders [REDACTED]. The record did not indicate a care plan to address Resident C's [DIAGNOSES REDACTED]. During an interview on 2/19/15 at 12:15 p.m., the Assistant Director of Nursing indicated she expected staff to follow bowel protocols according to residents' individualized needs. During an interview on 2/19/15 at 12:30 p.m., the Director of Nursing indicated Resident C did not have an individualized plan of care to address her chronic constipation. A policy titled Care Plans identified as current by the Executive Director, on 2/19/15 at 2:18 p.m., indicated, .A comprehensive care plan is developed that includes measurable objectives, interventions/services, and timetables to meet the resident's needs as identified in the resident's assessment or as identified in relation to the resident's response to the interventions or changes in the resident's condition. The care plan: addresses risk factors that might lead to avoidable declines in functioning or functional levels. Reflects current professional practice standards; and have treatment objectives with measurable outcomes that are prioritized, if necessary, and used to monitor resident progress. This Federal tag relates to Complaint(s) IN 131 and IN 303. 3.1-35(a)
F 0282 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care by qualified persons according to each resident's written plan of care.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to administer ordered medication to treat constipation and failed to monitor bowel sounds every shift as ordered for 1 of 7 residents reviewed for following physician's orders [REDACTED]. Findings include: Resident C's record was reviewed on 2/18/15 at 10:40 a.m. An admission assessment, dated 7/24/14, indicated Resident C was admitted to the facility post surgery for [REDACTED]. Untimed admission physician's orders [REDACTED]. An untimed physician's orders [REDACTED]. The record lacked indication Resident C's bowel movements were monitored during August 2014. The record indicated Resident C did not have a bowel movement on September 15, 16, 17, 18, 19, or 20, 2014. The record did not indicate Milk of Magnesia was administered for treatment of [REDACTED]. A physician's telephone order, dated 9/21/14 at 8:00 a.m., indicated a stat (immediately) KUB (X-ray) of the abdomen due to abdominal pain and no bowel sounds. The order indicated bowel sounds were to be monitored every shift for 48 hours. The record lacked indication Resident C's bowel sounds were assessed during the night shift on 9/21/14. During an interview on 2/19/15 at 12:30 p.m., the Director of Nursing indicated she was unable to find documentation to indicate Milk of Magnesia (laxative) was administered as needed for constipation. She indicated she was unable to find documentation which indicated bowel sound were monitored during the evening shift on 7/21/15 or 7/22/14 prior to Resident C's transfer to the emergency room . A policy titled Physician Orders identified as current by the Executive Director, on 2/19/15 at 2:18 p.m., indicated, .physician's orders [REDACTED]. This Federal tag relates to Complaint(s) IN 131, IN 614, IN 303, and IN 512. 3.1-35(g)(2)
F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	**Provide necessary care and services to maintain the highest well being of each resident** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to assess and monitor bowel sounds/elimination patterns and failed to implement interventions in the bowel protocol resulting in hospitalization , fecal impaction, and surgery to remove the large intestine for 1 of 7 residents reviewed for quality of care (Resident C). Findings include: Resident C's record was reviewed on [DATE] at 10:40 a.m. An admission assessment, dated [DATE], indicated Resident C was admitted to the facility for post surgery rehabilitation, was cognitively intact with a Brief Interview Mental Status (BIMS) score of 14 out of 15, had a history of [REDACTED]. Untimed admission physician's orders [REDACTED]. An untimed physician's orders [REDACTED]. A policy titled Bowel Elimination identified as current by the Director of Nursing, on [DATE] at 2:04 p.m., indicated, .Monitor the patient for bowel movements include form. frequency and size. If patient is cognitively aware, ask the patient when he/she had last bowel movement and document. Note any complaints of constipation or diarrhea. Revise care plan with individualized information to address. constipation and or diarrhea, if applicable. If no bowel movement according to patient's established pattern, follow physician's orders [REDACTED]. The record lacked indication Resident C's bowel movements were monitored during [DATE]. The record indicated Resident C's was incontinent of 2 medium sized, loose stools on [DATE] during the 6 a.m. - 2 p.m. shift. The record indicated Resident C did not have a bowel movement on [DATE], 17, 18, 19, or 20, 2014. A nurse's note, dated [DATE] at 4:36 p.m., indicated, .Situation: c/o (complaint of) cramping lower abd (abdomen) pain-poor appetite continues pt (patient) reports having this pain at times, but increased yesterday evening. Condition has gotten worse. Background: Pertinent History: R (right) hip fx (fracture), non weight bearing, poor po (oral) intake, hx (history) of constipation.Assessment: Restless in bed.reports she has had lower abd pain since last evening. Abd soft and slightly distended. Poor po intake continues-drinking fluids with encouragement. NWB (non weight bearing) status. Pt reports she has had this pain in the past with constipation, husband confirmed. MD office notified and new order received to given (sic) mom and prune juice x (times)1 if pt can drink it. Also received order for prn [MEDICATION NAME] suppository. A nurse's note, dated [DATE] at 5:45 p.m., indicated resident did not have bowel elimination after the [MEDICATION NAME] suppository. A nurse's note dated [DATE] at 8:15 p.m., indicated Resident C had small amount of liquid emesis-yellow in color. The record lacked indication a physician was notified of Resident C's emesis or additional assessments of her bowel sounds and/or abdominal palpation for distention/firmness/pain throughout the night. A physician's telephone order, dated [DATE] at 8:00 a.m., indicated a stat (immediate) KUB (X-ray) of the abdomen due to abdominal pain and no bowel sounds. The order indicated bowel sounds were to be monitored every shift for 48 hours. A nurse's note, dated [DATE] at 5:00 p.m., indicated Resident C required much encouragement to drink sips of water, had no appetite, and was very confused and lethargic. The record indicated the Nurse Practitioner was notified and ordered intravenous fluids. The record lacked indication bowel sounds were assessed or abdomen was palpated for distention, firmness or pain. A nurse's note, dated [DATE] at 6:06 p.m., indicated, .confusion continues-will answer questions appropriately at times. And (sic) Abdomen slightly distended and soft. BS (bowel sounds) remain hypoactive (reduced loudness, tone, and regularity of bowel sounds)-has had smears of liquid stool. A nurse's note dated [DATE] at 8:35 p.m., indicated Resident C complained of abdominal pain, spat out her pain medications when administered, and only took sips of water and Boost with much encouragement. The record lacked indication bowel sounds and/or abdominal assessment was completed. The record lacked indication Resident C's bowel sounds were assessed during the night shift on [DATE]. A nurse's note dated [DATE] at 3:30 a.m., indicated, In bed. Lethargic. Non responsive to verbal commands. Restless. Raising et (and) lowering right arm. BUE (bilateral upper extremities cool to touch. Continues IV (intravenous) therapy. Hr (heart rate) 135 fluctuating 117.

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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F 0309 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) Husband called informed of condition change. Husband stated he would like for her to be sent to the ER. ambulance here to transport at 4:10 a.m. A hospital record, dated [DATE] at 5:59 a.m., titled Imaging Exam Report reviewed, on [DATE] at 2:30 p.m., indicated a cat scan of the abdomen was obtained due to Resident C's elevated temperature, abnormal white blood count, and abdominal pain. The results indicated, .There is a large stool burden throughout the colon. Beginning at the level of splenic flexure and extending inferiorly. Large stool burden throughout the colon, greatest in the descending colon and sigmoid. Correlate for fecal impaction. A hospital document, dated [DATE], titled Case Manager Progress Note indicated Resident C was admitted to an acute hospital on [DATE] with [DIAGNOSES REDACTED]. This note further indicated she was transferred to another acute hospital for an operation for emergent bowel resection. An operative note, dated [DATE], indicated Resident C .was brought to the emergency (hospital named) with abdominal pain, nausea, vomiting, and lethargy.CT (Cat Scan) abdomen and pelvis was obtained and found to have [MEDICAL CONDITION] with constipation. Due to her medical condition, the patient was transferred to (hospital named). This note indicated a surgical procedure of total colectomy (removal of the large intestine) with a wound VAC placement was performed with a post operative [DIAGNOSES REDACTED]. A document, dated [DATE] at 12:34 p.m., titled Imaging Exam Report indicated Resident C required another cat scan of her abdomen due to an increased fever and heart rate post surgery following a total colectomy. A hospital discharge summary, dated [DATE], indicated, .the patient required multiple returns to the operating room, the last of which was done emergently to address what appeared to be a small bowel perforation. This note indicated Resident C progressively declined after this surgery and died on [DATE] at 4:25 p.m. This document indicated cause of death septic and [MEDICATION NAME] shock, multiorgan failure, severe [MEDICAL CONDITION], and post operative complications. During an interview on [DATE] at 12:15 p.m., the Assistant Director of Nursing indicated she expected staff to follow bowel protocols according to residents' individualized needs. During an interview on [DATE] at 12:30 p.m., the Director of Nursing indicated she was unable to find documentation the order, dated [DATE], for 30 Millimeters of Milk of Magnesia (laxative) was administered as needed for constipation as ordered. She indicated she was unable to find documentation which indicated bowel sound were monitored during the evening shift on [DATE] or [DATE] prior to Resident C's transfer to the emergency room . She indicated she was unable to find documentation which indicated Resident C's bowel movements were monitored in [DATE]. She further indicated she was unable to find documentation which indicated the facility's bowel elimination protocol was followed for Resident C. This Federal tag relates to Complaint(s) IN 131, IN 614 , IN 303, and IN 512. 3XXX,[DATE](a)