

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2015
--	---	---	---

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 a Recertification and State Licensure Survey.</p> <p>Survey dates: June 25, 26, 29, and 30, 2015</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Census bed type: SNF/NF: 86 Total: 86</p> <p>Census payor type: Medicare: 5 Medicaid: 66 Other: 15 Total: 86</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</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 of 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. We request that our plan of correction, monitoring tools and review of systemic changes we have made be considered for a paper compliance desk review.</p>	
F 0371 SS=E Bldg. 00	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or</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 06/30/2015	
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>local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>Based on observation, interview and record review, the facility failed to ensure appropriate sanitary practices were maintained in the dietary department in that proper hand washing was not performed by staff during meal preparation during 2 of 2 kitchen observations. This potentially affected 82 of 86 residents who received meals from the facility kitchen.</p> <p>Findings Include:</p> <p>1. On 06/29/15 at 10:02 a.m., Cook # 1 was observed to wash her hands for 9 seconds before she retrieved a pan of squash from the stove to place into the puree machine by scoop. Upon completion, she covered the puree with double plastic, with her bare hands and placed the pan into the steamer until lunch service. Cook # 1 was then observed to wash her hands for 8 seconds.</p> <p>On 06/29/15 at 10:09 a.m., Cook #1 indicated when washing her hands she would turn on the water, soap up to the arms, and sing the Happy Birthday song twice. She indicated she would then rinse and dry with paper towels. She</p>	F 0371	<p>It is the policy of this facility to procure food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. I. All residents who receive meals from the facility kitchen have the potential to be affected. (82 of 86; Attachment A). No residents were identified as having negative outcome. II. All residents who receive meals from the facility kitchen have the potential to be affected. (82 of 86). The 82 residents were assessed for any GI distress with no negative findings. The two deficient staff members were immediately educated and hand washing competencies completed. (Attachment B) III. SDC or designee will in-service all staff on proper hand washing technique. SDC or designee will ensure all staff complete hand washing competency. (Attachment C & D). IV. The Nutrition Manager/Designee will audit dietary staff to ensure proper Hand Washing Procedures are being followed 5 times per week for 30 days, 3 times per week for 30 days, then weekly ongoing. (Attachment E) The results will be reviewed and analyzed during the monthly performance improvement</p>	07/21/2015			

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 06/30/2015	
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>would turn the water off with the paper towel.</p> <p>On 06/29/15 at 10:11 a.m., the Nutritional Manager indicated she expects the kitchen staff to wash their hands for 20 seconds.</p> <p>2. On 06/30/15 at 9:31 a.m. Cook # 1 was observed to wash her hands for 30 seconds before sandwich preparation. Cook # 2 then walked up to the sink and Cook # 1 indicated to her to watch the clock while handwashing. Cook # 2 was then observed to wash her hands for 10 seconds before covering a pan of pork chops with double plastic. She did not come in contact with the food.</p> <p>On 06/29/15 at 10:11 a.m., the Nutritional Manager provided the current policy for Hand Hygiene/Handwashing. This policy included, but was not limited to, the following:</p> <p>"1. Wet hands, wrists and exposed portions of the arms under clean running water, and apply soap from dispenser. 2. Rub hands together with vigorous friction for 20 seconds (The amount of time is takes to sing 'Happy Birthday' through twice) or as designated by state regulations, covering all surfaces of the hands, exposed arms, fingertips and</p>		<p>meeting for three months; after three months of 100% compliance is achieved the PI committee will determine the frequency of further monitoring. A subsequent plan of action will be developed and implemented if indicated. The Nutritional Service Manageris responsible to ensure compliance with this standard.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 06/30/2015
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>between fingers. 3. Rinse hands with warm water. 4. Prevent recontamination by holding hands below elbow level to prevent water from running up the arms and back down. 5. Dry hands with individual disposable paper towel. 6. Turn faucets off with paper towel. 7. Discard paper towel in appropriate receptacle."</p> <p>3.1-21(i)(2) 3.1-21(i)(3)</p>				