

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/09/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F000000	<p>This visit was for the Investigation of Complaint IN00150453.</p> <p>Complaint IN00150453- Substantiated. Federal/State deficiencies related to the allegations are cited at F241, F323, and F371.</p> <p>Survey dates: June 7 & 9, 2014</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey team: Janet Adams, RN-TC Janelyn Kulik, RN (June 7, 2014)</p> <p>Census bed type: SNF/NF: 113 Total: 113</p> <p>Census payor type: Medicare: 27 Medicaid: 67 Other: 19 Total: 113</p> <p>Sample: 12</p>	F000000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance.</p> <p>Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency.</p> <p>Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by</p>	
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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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F000241 SS=D	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on June 12, 2014, by Janelyn Kulik, RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, record review, and interview, the facility failed to provide care for residents in a manner which respected their dignity related to residents not served their meals trays while other residents in the Dining room were eating or being assisted with their meals for 5 of 10 residents observed during the Dinner meal in 1 of 3 Dining rooms. (The West Unit Dining Room).</p> <p>Findings include:</p> <p>The Dinner meal service was observed in the West Unit Dining Room on 6/7/14 at 5:40 p.m. There were four tables in the Dining Room. Eight residents were observed in the Dining Room. There were (3) residents at the first table, (2)</p>	F000241	<p>the facility.</p> <p>F -241 Resident Dignity</p> <p>The facility respectfully requests a desk review for paper compliance with this citation.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was: All residents with diet orders were served a tray during the observed meal.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p>	07/09/2014	

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	<p>residents at the second table, (1) resident at the third table, and (2) residents at the fourth table. The meal trays had not yet been delivered to the unit at this time.</p> <p>A Dietary staff member delivered a cart of meal trays to the Dining Room at 5:50 p.m. At 5:54 p.m., LPN #1 began serving trays. Meal trays were served to three residents in the Dining Room at this time. Trays were served to one of three residents at the first table, one of two residents at the second table, and one of two residents at the fourth table. LPN #1 finished passing the three trays, closed the food cart door, and began to assist the above three residents at 5:56 p.m. The other (5) residents at the tables had not received their meal trays. Other staff members began passing meal trays to the other residents in the Dining Room at 6:08 p.m.</p> <p>When interviewed on 6/9/14 at 10:00 a.m., the facility Administrator indicated a Nurse was to be in the Dining Room during the meal service. The Administrator indicated resident's should be served together.</p> <p>When interviewed on 6/9/14 at 10:25 a.m. , the Dietary Manager indicated the meal carts were to be sent out to the West unit at 5:50 p.m. The Dietary Manager</p>		<p>ADNS has documented seating arrangements for the West Dining Room. Dietary Service Manager has arranged the tray card order to match resident seating arrangements in the West Dining Room. DNS/designee will perform observation of meal service in the West dining room to ensure all residents sitting at the same table are served at the same time.</p> <p>The measures put into place and systemic change made to ensure the deficient practice does not recur is: ADNS/designee will update seating arrangements in the West Dining Room weekly to reflect census changes. DSM/designee will arrange the order of the trays in the cart to reflect seating arrangements so all residents seated at the same table will be served at the same time. Dietary staff will be inserviced on filling the west dining room cart in the order of seating. Nursing staff will be inserviced that residents seated at the same table will receive their meals at the same time. DNS/designee will perform a random audit of west dining room meal service to include all meals 5x/wk to ensure that residents at the same table receive their meals at the same time.</p> <p>To ensure the deficient practice does not recur, the monitoring</p>				

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F000323 SS=D	<p>indicated residents should be served their trays at that time.</p> <p>This Federal tag relates to Complaint IN00150453.</p> <p>3.1-3(t)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, record review, and interview, the facility failed to ensure adequate supervision was provided related to a resident exiting a secured exit area for 1 of 4 residents reviewed for supervision while being outside of the facility building. (Resident #E)</p> <p>On 6/7/14 at 4:40 p.m., Resident #E was observed going through the double doors leading to the Therapy Department. There was a coded key pad on the wall to open the first set of doors. The second set of door led to the outside. These</p>	F000323	<p>system established is: DNS will compile the audit results and present to the facility Performance Improvement Committee monthly X 6 months.</p> <p>F -323 Supervision to Prevent Accidents</p> <p>The facility respectfully requests a desk review for paper compliance with this citation.</p> <p>It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done:</p> <p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p>	07/09/2014	

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	<p>doors were not locked. The resident was then observed sitting in a wheel chair just outside of the covered over-hang outside of the second set of doors. The resident had a cup of coffee and asked for a cigarette lighter. The resident remained outside until 4:47 p.m. At that time he propelled himself under the over-hang and got out of his wheel chair and pushed the handicap push button which opened the second set of doors. The resident pushed his wheel chair back inside and indicated he knew the code to get back in the next set of doors and proceeded to punch the buttons on the key pad. The door opened and the resident entered. Two staff members had walked by and observed Resident #E outside of the back entrance during the above times. The staff members did not intervene or instruct the resident to return inside.</p> <p>The record for Resident #E was reviewed on 6/7/14 at 7:10 p.m. The resident's diagnoses included, but were not limited to, bipolar disorder, chronic ischemic heart disease, high blood pressure, anxiety state, and obesity.</p> <p>Review of the 4/29/14 Minimum Data Set Quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive</p>		<p>Resident E was educated on the risks of going outside on the facility grounds unsupervised prior to the ISDH survey. He continues to desire to go outside unsupervised on the facility grounds despite the risks; his care plan was updated to reflect this choice.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Residents who desire to go outside on the facility grounds unsupervised have been educated on the risks, if he/she is cognitively able to make that decision. Their care plans were updated to reflect their choice.</p> <p>The measures put into place and systemic change made to ensure the deficient practice does not recur is: The door alarm code was changed for every exit that has an alarm keypad in the facility. All departments were educated on the importance of not sharing the door alarm code with anyone other than staff or the emergency service personnel. Social Service Director/designee will monitor for residents using to the keypad to exit the building 2x/wk at random times and random doors.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p>		

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	<p>patterns were intact. The assessment indicated the resident had no behaviors. The assessment also indicate the resident required only supervision for locomotion on and off the unit. The assessment indicated the resident's balance was steady at all times and he utilized a wheelchair for mobility.</p> <p>The 5/2014 Nursing Progress Notes were reviewed. An entry made on 5/19/14 at 7:32 p.m. indicated the resident had been outside unsupervised, pushing his wheelchair and tripped and fell on his left knee. The resident came back into the building and did not immediately tell the Nurse of the incident. The resident pulled up his pant leg and showed the Nurse his knee. The Physician was notified and orders were received to cleanse the area with normal saline and cover with a bandage. The resident's family was also notified. The Nurse spoke with the resident about going outside unsupervised and "he stated he will be fine."</p> <p>When interviewed on 6/9/14 at 1:50 p.m., the facility Administrator stated Resident #E was alert and orientated and able to propel himself in his wheel chair. The Administrator indicated the resident usually would go outside through the front door and the Receptionist would see</p>		Social Service Director will compile the data from the audits and present to the facility Performance Improvement Committee monthly X 6 months.				

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F000371 SS=D	<p>him. The facility Administrator indicated she was not aware the resident knew the security code to the back exit. The Administrator indicated the resident should not have given the code and she would now have to change the code.</p> <p>This Federal tag relates to Complaint IN00150453.</p> <p>3.1-45(a)(2)</p> <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 local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, review, and interview, the facility failed to ensure meal trays served to residents in their rooms were at the proper temperatures for 2 of 2 room trays tested for meal temperatures at the time they were served to the residents on 1 of 3 Units . (Residents #N and #P) (West unit)</p> <p>Findings include:</p> <p>The Dinner meal service was observed on the West Unit on 6/7/14 at 5:45 p.m. The Dietary food cart was delivered form the</p>	F000371	<p>F -371 Food Sanitation</p> <p>The facility respectfully requests a desk review for paper compliance with this citation. It is the practice of this facility to ensure the highest quality of care is afforded our residents. Consistent with this practice, the following has been done: The corrective action taken for the residents found to have been affected by the deficient practice was: Trays that were observed to have been below acceptable</p>	07/09/2014			

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	<p>kitchen to the unit Dining Room at 5:50 p.m. The cart was not heated. Nursing staff began passing the trays to residents seated in the Dining Room at 5:54 p.m. Meal trays for Residents #N and #P were on this meal cart. Residents #N and #P were not in the Dining Room at these times.</p> <p>CNA #1 removed Resident #P's meal tray from the above cart at 6:35 p.m. and walked down the hall to the resident's room. Food temperatures were taken at this time. The resident's food was pureed and served on a divided plate. Temperatures were taken on the three food items on the plate. The items appeared to be meat, beans, and a bun. The temperatures of the food items on the divided plate were 85.6 degrees Fahrenheit, 90.2 degrees Fahrenheit, and 87.8 degrees Fahrenheit. A replacement tray was ordered for Resident #P.</p> <p>Resident #N was brought into the Dining Room at 6:40 p.m. The resident's tray was placed on the table. The resident was served a hot dog on a bun and beans. The temperature of the hot dog was 86.4 degrees Fahrenheit and the temperature of the beans was 91.8 degrees Fahrenheit. A replacement tray was ordered for Resident #N.</p>		<p>range were replaced with one newly prepared in the kitchen during the survey. The corrective action taken for those residents having the potential to be affected by the same deficient practice is: Residents who receive room trays have the potential to be affected. An audit was completed related to processes surrounding hall tray service with corrections made as needed. It was noted during the audit that the plate warmer was not operating as expected. Quotes have been received related to service and replacement of the equipment. The measures put into place and systemic change made to ensure the deficient practice does not recur is: Plate warming system has been repaired. Dietary Service Manager/designee will obtain food temperatures on the last hall tray at time of service for random meals 5x/wk to ensure food is served at the proper temperatures. Dietary department will be inserviced on obtaining food temperatures prior to food leaving the kitchen and what to do if the food is not at the proper temperature. Nursing staff will be inserviced on timely tray pass for hall trays. To ensure the deficient practice does not recur, the monitoring system established is: DSM will compile the data from the audits and present to the Performance Improvement Committee monthly X 6 months.</p>				

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	<p>The record for Resident #P was reviewed on 6/9/14 at 8:30 a.m. The resident's diagnoses included, but were not limited to, cerebrovascular disease, high blood pressure, stroke, and aphasia (inability to speak).</p> <p>The 5/28/14 Minimum Data Set (MDS) Quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (4). A score of (4) indicated the resident's cognitive patterns were severely impaired. The assessment also indicated the resident required extensive assistance from staff for eating.</p> <p>The 6/2014 Nursing Progress Notes were reviewed. An entry made on 6/2/14 at 10:29 a.m. indicated the resident was fed by staff.</p> <p>The record of Resident #N was reviewed on 6/9/14 at 8:40 a.m. The resident's diagnoses included, but were not limited to, dementia with behavioral disturbances, Multiple Sclerosis, and insomnia.</p> <p>The 3/25/14 Minimum Data Set (MDS) Quarterly assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (11). A score of (11) indicated the resident's cognitive</p>			

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	<p>patterns were moderately impaired. The assessment also indicated the resident required extensive assistance from staff for eating.</p> <p>When interviewed on 6/9/14 at 10:25 a.m., the Dietary Manager indicated the meal service for the West unit was scheduled for 5:50 p.m. The Dietary Manager indicated the Cook checks the temperatures of the foods at the time they are put out for the tray line, and also at the end of the tray line. The Dietary Manager indicated the temperature of the foods served should be between 140-155 degrees Fahrenheit when served to the residents. The Dietary Manager indicated the above residents should have been served their meal at the appropriate temperatures as above. The Dietary Manager indicated the food carts were not heated and the trays should have been served from the cart when it was sent to the unit.</p> <p>When interviewed on 6/9/14 at 10:00 a.m., the facility Administrator indicated the meal trays should have been served to resident at the proper temperatures.</p> <p>This Federal tag relates to Complaint IN00150453.</p> <p>3.1-21(i)(3)</p>			

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