

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/05/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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F000000	<p>This visit was for the Investigation of Complaints IN00144134 and IN00145077.</p> <p>Complaint IN00144134 unsubstantiated due to lack of evidence.</p> <p>Complaint IN00145077 substantiated. Federal/state deficiencies related to the allegations are cited at F323 and F333.</p> <p>Unrelated deficiency cited.</p> <p>Survey dates: March 4, 5, 2014</p> <p>Facility number: 000564 Provider number: 155484 AIM number: 100285610</p> <p>Survey team: Connie Landman RN-TC Laura Brashear RN (March 5, 2014)</p> <p>Census bed type: SNF/NF: 116 Total: 116</p> <p>Census payor type: Medicare: 19 Medicaid: 81</p>	F000000		

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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F000226 SS=D	<p>Other: 16 Total: 116</p> <p>Sample: 5</p> <p>These deficiencies cited also reflect state findings in accordance with 410 IAC 16.2.</p> <p>Quality review completed on 03/10/2014 by Brenda Marshall, RN. 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on record review and interview, the facility failed to follow procedure for reporting a significant medication error resulting in a fall with injury for a resident without a fall history.</p> <p>Findings include:</p> <p>The record for Resident E was reviewed on 3/5/14 at 10:00 A.M. Resident E's diagnoses included, but were not limited to, Alzheimer's Disease, senile dementia, malaise and fatigue, and hypertension.</p> <p>A care plan, dated 9/20/12 and last</p>	F000226	In order for this isolated incident not to reoccur, the facility will follow procedure for reporting a significant medication error resulting in a fall with injury for a resident without a fall history. Facilit administrator/designee will review all events to determine if facility is required by law and as stipulated by our facility policy and procedure along with the ISDH reportable guidelines to report incidents within the time as required by the ISDH of occurrence to the Long Term Care Division per CFR 483.13(c) (2) guidelines. All reportable incidents will be reported within 24 hours of event by the administrator/designee.	03/06/2014			

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	<p>revised on 3/5/13, indicated the resident was at low risk for falls related to occasional forgetfulness. The care plan then noted he had a fall with injury on 2/17/14.</p> <p>The Annual Fall Risk Assessment, dated 8/14/13, indicated the resident was not at risk for falls. The Fall Risk Assessment, dated 2/18/14 indicated he was at high risk for falls.</p> <p>Nursing Progress Notes indicated: 2/17/14 "20:15 Resident received incorrect medications...Resident placed on 15 minute checks per facility policy." 2/17/14 "21:05 Left resident's room, resident resting quietly in chair, heard noise as leaving room, re-entered resident room, found resident on floor at the end of his bed. Bleeding from forehead, laceration noted, resident alert, answering questions appropriately, PERRLA [sic] [pupils equal react to light], vital signs within normal limits." 2/17/14 "21:10 Another nurse with resident, this nurse notified MD, new order to send resident to [name of hospital] ER for eval [evaluation] and treat. Family and DNS [Director of Nursing Services] notified."</p>		Reportable events will be reviewed monthly at Facility's Performance Improvement Meeting. Administrator is responsible.		

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	<p>2/18/14 "00:45 Resident returned from [name of hospital] ER via stretcher... Resident has laceration to forehead w/ [with] 7 seven staples intact w/ some bruising noted around laceration, also noted possible bruising under left eye...."</p> <p>During an interview with the DNS on 3/4/14 at 12:10 P.M., she indicated the facility discussed the medication error as a possible precursor to the fall but concluded the resident ambulated independently and had some behavioral issues.</p> <p>During an interview with the Administrator on 3/4/14 at 2:45 P.M., she indicated "we did not report it because we don't know for sure if the med [medication] error caused the fall."</p> <p>A current facility policy, titled "Reportable Incidents Policy", last revised 1/15/13, was provided by the DNS on 4/5/14 at 8:50 A.M. It indicated "Purpose: To ensure that reportable incidents are recorded and monitored to facilitate compliance with state and federal laws.... Procedure:...Reportable Incidents Facilities are required by law to report incidents within 24 hours of</p>				

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F000323 SS=G	<p>occurrence to the Long Term Care Division.... (6) Significant Injuries... B) Medication errors that caused resident harm or require extensive monitoring for 24-48 hours...."</p> <p>This federal tag relates to Complaint IN00145077.</p> <p>3.1-28(a)</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 record review and interview, the facility failed to ensure 1 of 3 residents reviewed for falls in a sample of 5 did not have a fall with a head injury, requiring staples to repair, after receive a medication prescribed for another resident with side effects, including but not limited to, syncope (medical term for fainting or passing out). (Resident E).</p> <p>Findings include: During the initial tour of the facility</p>	F000323	No other residents were affected by this isolated incident. In order for this isolated incident not to reoccur, the facility will follow procedure for medication administration to ensure residents are free of accident hazards as is possible, and each resident receives adequate supervision and assistive devices to prevent accidents. LPN#1 received one-on-one in-servicing on 2-18-14. Medication Administration Observation was conducted with LPN#1 by the Staff Development Coordinator on 2-18-14. Random Medication Administration Observations were conducted with the facility nurses	03/06/2014			

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	<p>on 3/4/14 at 10:40 A.M., Resident E was observed sitting in the central lounge area with an irregular shaped, nickel sized, scabbed area on the top of his forehead.</p> <p>The record for Resident E was reviewed on 3/5/14 at 10:00 A.M. Resident E's diagnoses included, but were not limited to, Alzheimer's Disease, senile dementia, malaise and fatigue, and hypertension.</p> <p>A care plan, dated 9/20/12 and last revised on 3/5/13, indicated the resident was at low risk for falls related to occasional forgetfulness. The care plan then noted he had a fall with injury on 2/17/14.</p> <p>The Annual Fall Risk Assessment, dated 8/14/13, indicated the resident was not at risk for falls. The Fall Risk Assessment, dated 2/18/14 indicated he was at high risk for falls.</p> <p>Nursing Progress Notes indicated: 2/17/14 "20:15 (military time for 8:15 P.M.) Resident received incorrect medications...Resident placed on 15 minute checks per facility policy." 2/17/14 "21:05 Left resident's room, resident resting quietly in chair, heard noise as leaving room,</p>		to assure continued compliance 2-18-14 through 2-27-14. In order for this isolated incident not to reoccur, the Director of Nursing/designee will monitor through observation of medication administration and Nurse competency reviews at least monthly for three months, then quarterly to assure continued compliance. Results will be reviewed monthly at Facility's Performance Improvement Meeting for six months then quarterly until substantial compliance continues to be met. Administrator is responsible for overall compliance.		

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	<p>re-entered resident room, found resident on floor at the end of his bed. Bleeding from forehead, laceration noted, resident alert, answering questions appropriately, PERRLA [sic] [pupils equal react to light], vital signs within normal limits."</p> <p>2/17/14 "21:10 Another nurse with resident, this nurse notified MD, new order to send resident to [name of hospital] ER for eval [evaluation] and treat. Family and DNS [Director of Nursing Services] notified."</p> <p>2/18/14 "00:45 Resident returned from [name of hospital] ER via stretcher...Resident assisted to bed. Resident has laceration to forehead w/ [with] 7 seven staples intact w/ some bruising noted around laceration, also noted possible bruising under left eye...."</p> <p>No other falls were documented in Resident E's record.</p> <p>During an interview with the Administrator on 3/4/14 at 2:45 P.M., she indicated she did not remember Resident E having another fall during the 2 years he had been in the facility.</p> <p>A "Medication Variance Report Worksheet" was provided by the</p>			

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	<p>DNS on 3/4/14 at 12:45 P.M. This form indicated Resident E had received another resident's medications on 2/17/14 at 8:15 P.M. A list of the medications given in error had been provided by the DNS on 3/4/14 at 12:25 P.M. The list included, but was not limited to the drug Flexeril. The 2010 Nursing Spectrum Drug Handbook indicated Flexeril under "Precautions" should be given cautiously in elderly patients. The drug handbook also indicated "Adverse Reactions" included, but were not limited to, dizziness and syncope (fainting or passing out), weakness, and abnormal gait.</p> <p>A "Resident Event Report Worksheet" was provided by the DNS (Director of Nursing Services) on 3/4/14 at 12:45 P.M. This form indicated Resident E had a fall on 2/17/14 at 9:05 P.M. It indicated he fell while transferring from a chair and it was unwitnessed. It also indicated he had hit his head and sustained a laceration to his forehead.</p> <p>During an interview with the Administrator on 3/4/14 at 2:45 P.M., she indicated "we don't know for sure if the med [medication] error</p>						

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F000333 SS=G	<p>caused the fall."</p> <p>This federal tag relates to Complaint IN00145077.</p> <p>3.1-45(a)(1)</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. Based on record review and interview, the facility failed to ensure 1 of 3 residents reviewed for medication errors in a sample of 5 did not receive a medication prescribed for another resident with side effects, including but not limited to, syncope (fainting or passing out) resulting in a fall with a head injury that required staples to repair. (Resident E).</p> <p>Findings include:</p> <p>The record for Resident E was reviewed on 3/5/14 at 10:00 A.M. Resident E's diagnoses included, but were not limited to, Alzheimer's Disease, senile dementia, malaise and fatigue, and hypertension.</p> <p>A care plan, dated 9/20/12 and last revised on 3/5/13, indicated the</p>	F000333	No other residents were affected by this isolated incident. In order for this isolated incident not to reoccur, the facility will follow the procedure for medication administration to ensure residents are free of any significant medication errors. LPN#1 received one-on-one in-servicing on 2-18-14. Medication Administration Observation was conducted with LPN#1 by the Staff Development Coordinator on 2-18-14. Random Medication Administration Observations were conducted with the facility nurses to assure continued compliance 2-18-14 through 2-27-14. In order for this isolated incident not to reoccur, the Director of Nursing/designee will monitor through observation of medication administration and Nurse competency reviews at least monthly for three months, then quarterly to assure continued compliance. Results will be reviewed monthly at Facility's	03/06/2014	

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	<p>resident was at low risk for falls related to occasional forgetfulness. The care plan then noted he had a fall with injury on 2/17/14.</p> <p>The Annual Fall Risk Assessment, dated 8/14/13, indicated the resident was not at risk for falls. The Fall Risk Assessment, dated 2/18/14 indicated he was at high risk for falls.</p> <p>Nursing Progress Notes indicated: 2/17/14 "20:15 (military time 8:15 P.M.) Resident received incorrect medications...Resident placed on 15 minute checks per facility policy." 2/17/14 "21:05 Left resident's room, resident resting quietly in chair, heard noise as leaving room, re-entered resident room, found resident on floor at the end of his bed. Bleeding from forehead, laceration noted, resident alert, answering questions appropriately, PERRLA [sic] [pupils equal react to light], vital signs within normal limits." 2/17/14 "21:10 Another nurse with resident, this nurse notified MD, new order to send resident to [name of hospital] ER for eval [evaluation] and treat. Family and DNS [Director of Nursing Services] notified." 2/18/14 "00:45 Resident returned</p>		Performance Improvement Meeting for six months then quarterly until substantial compliance continues to be met. Administrator is responsible for overall compliance.				

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	<p>from [name of hospital] ER via stretcher...Resident assisted to bed. Resident has laceration to forehead w/ [with] 7 seven staples intact w/ some bruising noted around laceration, also noted possible bruising under left eye...."</p> <p>The February, 2014, Recapitulation of Physician's Orders indicated Resident E was to receive Aricept 10 mg (milligrams) at bedtime, and Lexapro 10 mg at bedtime. Resident E had been receiving the Aricept since 2012, and the Lexapro had been ordered 1/10/14. The Physician's Orders for February, 2014, lacked an order for Tessalon, Lipitor, Colace, Xanax, Ambien, Reglan, Famotidine, or Flexeril.</p> <p>The 2010 Nursing Spectrum Drug Handbook indicated side effects/adverse reactions for Aricept included, but were not limited to, dizziness, fatigue and depression. The side effects/adverse reactions of Lexapro included, but were not limited to, drowsiness, dizziness and fatigue. The record lacked evidence Resident E had exhibited side effects or adverse reactions to these drugs before 2/17/14.</p> <p>Medication error reports were</p>			

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	<p>provided by the DNS on 3/4/14 at 12:05 P.M. She indicated at that time, there was only 1 medication error, there hadn't been any others in a long time. The Medication Variance Report Worksheet indicated the medications given were to the wrong resident.</p> <p>A list of the medications Resident E received in error was provided by the DNS on 3/4/14 at 12:25 P.M. This list indicated Resident E had received Tessalon 100 mg, Lipitor 20 mg, Colace 100 mg, Xanax 100 mg, Ambien 10 mg, Reglan 5 mg, Famotidine 20 mg, and Flexeril 10 mg, which were the bedtime medications prescribed for another resident.</p> <p>The 2010 edition of the Nursing Spectrum Drug Handbook indicated adverse reactions for three of these medications were: Xanax - dizziness, drowsiness, light-headedness, disorientation, and confusion. Ambien -confusion, vertigo, and dizziness. Flexeril - dizziness, drowsiness, syncope (fainting, passing out), confusion, weakness, disorientation, and abnormal gait.</p>			

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	<p>During an interview with LPN #1 on 3/5/14 at 11:30 A.M., she indicated she had set up another resident's medications when Resident E approached the Medication Cart. LPN #1 asked Resident E if he was ready for his medications and he indicated he was. LPN #1 indicated she stopped what she was doing and immediately set up Resident E's medications as he had been refusing his medications at times, and she wanted to catch him when he was ready. She indicated she handed him a glass of water and a medicine cup with pills. She then noticed she had handed him the wrong medicine cup and said "no" and looked at him and he had all the pills in his mouth, was drinking water and was swallowing the pills. LPN #1 indicated she should have given the other resident her medications before she set up Resident E's medications and this wouldn't have happened.</p> <p>This federal tag relates to Complaint IN00145077.</p> <p>3.1-48(c)(2)</p>				