

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
---	---

(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: February 15, 16, 17, 18, 19 and 22, 2016</p> <p>Facility number: 010613 Provider number: 155659 AIM number: 15106131</p> <p>Census bed type: SNF: 16 SNF/NF: 64 Total: 80</p> <p>Census payor type: Medicare: 30 Medicaid: 41 Other: 9 Total: 80</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 30576 on February 22, 2016.</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 of 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 0441	483.65			

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: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172		
(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	
SS=D Bldg. 00	<p>INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. Based on observation, interview, and record review , the facility failed to</p>	F 0441	It is the policy of this facility to establish and maintain an infection Control Program designed to	03/17/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
---	---

(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>ensure infection control practices and standards were maintained related to the use of personal protective equipment and handwashing during care to 2 of 7 residents with clostridium difficile (Resident # 219 and 26).</p> <p>Findings include:</p> <p>During the observation of the 200 Hall dinner meal tray service on 02/15/16 between 5:10 p.m., and 5:26 p.m., CNA (Certified Nursing Assistant) # 1, was observed to remove her personal protective equipment (PPE) and exit Resident # 219's room without performing handwashing. Resident # 219 was in contact isolation for clostridium difficile (C-diff). CNA # 1 applied hand sanitizer and walked to the room of Resident # 238 and was stopped before entering the room.</p> <p>On 02/17/16 at 9:00 a.m., during the room observation for Resident # 26, LPN(Licensed Practical Nurse) # 1, entered the resident's room to answer the call light without applying PPE for the resident in contact isolation for C-diff. The LPN turned off the call light and exited the resident's room without washing her hands. The LPN then walked to the medication cart to prepare medications.</p>		<p>provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Related to Resident #219, the involved CNA(#1) received one on one education regarding the use of personal protective equipment, hand washing, and isolation with competency check-off by SDC. Related to Resident #26, the involved LPN (#1) received one on one education regarding the use of personal protective equipment, hand washing, and isolation with competency check-off by SDC. All residents have the potential to be affected. Facility infection control surveillance and infection screenings have found no additional residents to be presenting with signs or symptoms of newly acquired infectious processes related to these causal factors. Education regarding the use of personal protective equipment, hand washing, and isolation with competency check-off by SDC will be completed on facility staff no later than March 17, 2016. The Director of Nursing or designee will monitor staff compliance (Attachment A) with hand washing, the use of personal protective equipment, and adherence to the isolation policy and procedures for a minimum of 30 total individual observations a week for 4 weeks, then 30 total</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
---	---

(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>During an interview on 02/15/16 at 5:30 p.m., the Staff Development Coordinator indicated CNA# 1 was educated on handwashing after removing the PPE for a resident with C-diff in January, 2016. She also indicated the CNA was new and just didn't remember.</p> <p>During an interview on 02/16/19 at 2:18 p.m., LPN # 1, indicated, upon entering the room of a resident with c-diff., she would knock on the door and apply a gown and gloves. She indicated after care she would remove the gown and gloves, and wash her hands.</p> <p>During an interview on 02/19/16 at 2:09 p.m., CNA# 2 and CNA #3 indicated the procedure when entering a room for a resident with c-diff., was to gown up, apply gloves, introduce themselves, finish care, ungown, and wash their hands. They indicated they would wash their hands again in the utility room.</p> <p>On 02/22/16 at 8:59 a.m., during an interview with the Staff Development Coordinator, she indicated the facility provided education quarterly on the use of PPE for contact isolation, unless there was an issue, then they would re-educate. She indicated the facility did handwashing in-service check offs</p>		<p>individual observations every two weeks for 4 weeks, then 30 total individual observations every month as an ongoing practice. All findings will be addressed immediately for corrections as warranted.</p> <p>Competency observation results will be reviewed in monthly PI meeting. The Director of Nursing is responsible to ensure compliance with this standard.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
---	---

(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>periodically and educate the staff to hand wash upon removing the PPE before leaving the room and again after leaving the room. She indicated she monitors the resident care by staff and in-service them as needed.</p> <p>On 02/18/16 at 2:00 p.m., the Staff Development Coordinator provided a list of the 7 residents in the facility currently c-diff infections. This included 2 residents on the 100 Hall, 2 residents on the 200 Hall, 1 resident on the 300 Hall, and 2 residents on the 400 Hall.</p> <p>The Staff Development Coordinator provided a copy of the facility policy for TRANSMISSION-BASED PRECAUTIONS on 02/18/16 at 2:00 p.m., which indicated, but was not limited to:</p> <p>"2. Appropriate personal protective equipment is used per Standard Precautions and/or Transmission-Based Precautions.</p> <p>* For a patient that has an active C-diff infection should be placed on Enteric Contact Precautions. Staff should gown and glove before entering the room to prevent contact with contaminated environment from the spores of C-diff.</p> <p>3. Hand Hygiene - is the most important method of control to prevent transmission.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/22/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
---	---

(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>a. Staff are educated on:</p> <p>1) Appropriate hand washing technique</p> <p>2) When to perform hand hygiene *Refer to policy and procedure for hand hygiene</p> <p>4. Gloves</p> <p>a. Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient (e.g., medical equipment, bed rails).</p> <p>b. Don gloves *Refer to policy and procedure for personal protective procedures.</p> <p>5. Gowns</p> <p>a. Wear a gown whenever anticipating that clothing will have direct contact with the patient or potentially contaminated environmental surfaces or equipment in close proximity to the patient.</p> <p>b. Don gown if exposure is anticipated. Remove gown and observe hand hygiene before leaving the patient care environment. * Refer to policy and procedure for personal protective procedures</p> <p>c. Wear a gown for direct patient contact if the patient has uncontained secretions or excretions.</p> <p>d. Remove gown and perform hand hygiene before leaving the patient's environment.</p> <p>3.1-18(l)</p>			

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

PRINTED: 03/09/2016

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/22/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172		
(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	