

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155657	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/14/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112
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F000000	<p>This visit was for the Investigation of Complaints #IN00142069 and #IN00135560.</p> <p>Complaint #IN00142069-Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint #IN00135560-Substantiated. Federal deficiency related to allegation are cited at F441.</p> <p>Survey dates: February 12 & 13, 2014.</p> <p>Facility number: 010597 Provider number: 155657 AIM: 200204440</p> <p>Survey team: Joan Laux, RN/TC Caitlin Lewis, RN</p> <p>Census bed type: SNF/NF: 88 Total: 88</p> <p>Census payor type: Medicare: 20 Medicaid: 45 Other: 23</p>	F000000	<p>Preparation and/or execution of this plan of correction does not constitute admission or 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. Attached you will find the completed Plan of Correction and attachments for the complaint survey dated February 14, 2014. We respectfully request that our plan of correction, be considered for paper compliance desk review. Should you have any questions, please feel free to contact me at (812) 738-0550. Sincerely, Christopher Lung Executive Director.</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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	<p>Total: 88</p> <p>Sample: 6</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on Febraury 14, 2014 by CHeryl Fielden RN.</p>			
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F000441 SS=D	<p>483.65 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.</p> <p>Based on observation, interview and</p>	F000441	1. Indwelling catheter care for resident # C was immediately	03/07/2014			

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	<p>record review the facility failed to perform sanitary catheter care. This deficient practice affected 1 of 3 residents investigated for infection control (Resident # C).</p> <p>Findings Include:</p> <p>Review of the clinical record of Resident #C on 2/12/2014 at 7:00 a.m., indicated the resident had the diagnosis of, but not limited to, transient cerebral ischemia, congestive heart failure, atrial fibrillation, hypertension, peripheral vascular disease, chronic airway obstruction, depressive disorder, chronic kidney disease, spinal stenosis and Clostridium difficile (a bacteria that causes antibiotic associated diarrhea).</p> <p>During an observation on 2/13/2014 at 9:15 a.m., CNA #1 washed her hands, for 20 seconds, and followed contact precautions by donning gloves and a gown. The CNA then began performing perineal care for resident #C. She began wiping his anal area front to back with a wet wipe. She placed the wipe in a garbage bag and then had the resident roll onto his back. The CNA then began to perform catheter care by wiping the urethral area and</p>		<p>completed and documented by licensed nurse. Certified Nursing Assistant performing care completed 1:1 education on catheter care followed by competency check-off observed by SDC. Attachment F441A & F441B 2. All residents with urinary catheters have potential to be affected. All nursing staff will complete competency check-off Attachment F441A on indwelling catheter care by March 7th, 2014. 3. Staff Development Coordinator or designee will in-service all nursing staff on indwelling catheter care. Attachment F441B4. The Director of Nursing or designee will observe catheter care Attachment F441A 5 times a week for 30 days, then 3 times a week for 30 days, then twice weekly for 30 days all findings will be addressed immediately for correction. Competency observation results will be reviewed in monthly PI meeting x3 months then the PI committee will determine if 100% compliance has been achieved and the need for ongoing monitoring.</p>		

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	<p>around the catheter. There was no glove change or handwashing noted inbetween performing care to the anal area and the catheter area. She then threw away the used wipe, removed her gloves and gown and hand washed for 20 seconds.</p> <p>During an interview, with the ADON, on 2/13/2014 at 1:25 p.m., she indicated the facility does not have a specific policy on providing perineal care for a resident with Clostridium difficile. She indicated during perineal care, (standard practice is to) "start with the urinary tract first, always wiping front to back." (Because they)"do not want to get E coli (Escherichia coli; a type of bacteria commonly found in the lower intestine) in the urinary tract." During record review on 2/13/2014 at 2:30 p.m., an "Infection Control Log" dated 02/01/2014 - 02/28/2014, indicated Resident # C had Clostridium difficile with the onset date of 1/20/2014. There was a culture done on 1/21/2014. This was an "ongoing" issue. The resident was being treated with "Flagyl" and was on isolation precautions. A</p>				

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	<p>Policy and Procedure titled, "Clostridium Difficile Infection (CDI)- Associated Diarrhea" dated 09/19/2012, indicated "Wash hands using soap and water...after incontinence care."</p> <p>This Federal tag relates to complaint IN00135560. 3.1-18(l)</p>			