

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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. This visit included the Investigation of Complaint #'s IN00192728, IN00192913, and IN00193147.</p> <p>This visit resulted in an Extended Survey-Immediate Jeopardy.</p> <p>Complaint number IN00192728 Substantiated. Federal/State deficiencies related to the allegation are cited at F223, F225, F226, F309, and F323.</p> <p>Complaint number IN00192913 Substantiated. Federal/State deficiencies related to the allegations are cited at F309.</p> <p>Complaint number IN00193147 Substantiated. Federal/State deficiencies related to the allegation are cited at F323.</p> <p>Survey dates: February 18, 19, and 22, 2016</p> <p>Extended Survey dates: February 23, 24, 25, & 26, 2016</p> <p>Facility number: 000564 Provider number: 155484</p>	F 0000		

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: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 0223 SS=J Bldg. 00	<p>AIM number: 100285610</p> <p>Census Bed Type: SNF/NF: 94 Total: 94</p> <p>Census Payor Type: Medicare: 11 Medicaid: 67 Other: 16 Total: 94</p> <p>Sample: 9</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 3/1/16 by 29479.</p> <p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview, and</p>	F 0223	I respectfully request a desk review. F223 No residents	03/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>record review, the facility failed to ensure residents with dementia were not intimidated by staff who attempted to detour exit seeking behaviors by telling residents a "boogy or bad man", "sick people" or a "hairy spider" were on the other side of the door resulting in a resident requesting a knife to "kill the bad man" and another resident reporting people outdoors were trying to hurt her for 3 of 3 residents reviewed for mental abuse (Residents B, C, N).</p> <p>The Immediate Jeopardy was identified on 02/23/2016 and began on 2/18/16 when facility staff attempted to scare Residents B, C, and N to prevent them from eloping and implemented an intervention of placing a linen cart in front of the emergency exit door. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 2/23/16 at 10:57 a.m. The Immediate Jeopardy was removed on 2/24/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>1. During an initial tour of the dementia unit on 2/18/16 at 8:50 a.m., an</p>		<p>were found to have been affected by the deficient practice. There are no other residents that have the potential to be affected by the same deficient practice.</p> <p>In order for this deficient practice not to occur: The employees identified as involved in the allegation were interviewed and suspended immediately. The linen cart was moved immediately on 02/18/2016 upon observation of it. The linen cart was movable therefore it was moved from its location in the hallway to another location to ensure it is not blocking the exit door. The Staff Development Coordinator in-serviced on 02-18-2016 for all staff in regard to placement of carts and other obstacles to ensure there is no blocking of exit doors. The Executive Director / designee have monitored the doors since 02/23/2016 to ensure that the doors have not been blocked. The three (3) residents that were named in the allegations were interviewed by Social services using the Abaqis questions that address abuse and dignity. The families of residents were notified. All inter-viewable residents were interviewed utilizing the same questions. The non-inter-viewable resident's families were interviewed as well.</p> <p>On February 23, 2016 the facility completed in-servicing for all staff on what constitutes physical and verbal abuse, including statements that could</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>emergency exit door that opened to a parking lot had a tall linen cart with a bed/chair alarm clipped to the cover and attached to Velcro strips on the door frame blocking an emergency exit.</p> <p>Licensed Practical Nurse (LPN) #1 stated, "You do not see that! I was supposed to have moved it already!" The LPN indicated the cart was placed in front of the exit door to keep residents with dementia from leaving the unit. She indicated the intervention had been in place for a while, but could not provide a specific date. The dementia unit had a total of 4 exit doors, 2 of which opened to the skilled nursing facility, 1 that opened to an enclosed courtyard and 1 that opened to a parking lot.</p> <p>During an interview on 02/23/2016 at 8:54, the Reflections unit Program Director indicated she told residents with dementia there were "sick people" on the other side of the 2 doors that exited to the nursing facility and indicated she told the residents, " You don't want to get sick. You don't want to go into the nursing home."</p> <p>During an interview on 02/23/2016 at 9:03 a.m., CNA #3 indicated she heard a rumor that someone told residents on the dementia unit there was a "big man" in the courtyard.</p>		<p>be considered a verbal restraint, utilizing specific scenarios as well as abuse reporting guidelines. All staff in-serviced prior to commencing their shift on not placing items in front of any exit doors which might obstruct exit. To prevent any further occurrence and ensure all residents are monitored for abuse, the facility will continue to in-service all staff on abuse and reporting guidelines monthly. In order to ensure all residents are monitored for abuse, facility will conduct Angel Care visits weekly with the residents and/or resident's responsible party. Residents or resident representatives have been educated regarding reporting abuse through the interview process and Abaqis. New admissions will initially receive information through the admission process i.e. Resident's Rights for Federal and State. Facility has "Reporting Suspicions of a Crime" posted in the front lobby for all visitors information and guidelines. Daily rounding will continue by the Facility Managers. Facility is rounding daily of the physical environment to check the exit doors to make sure doors are not obstructed. Executive Director/Director of Nursing/Maintenance Director or manager on duty is responsible for ensuring monitoring/interviews completed. Facility will interview minimum of 10 inter-viewable residents and 10</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 02/23/16 at 9:13 a.m., CNA #2 indicated she heard other staff tell residents who tried leave the dementia unit through the emergency exit door a "hairy spider" was outside. She indicated staff also told residents a "boogy man" was in the courtyard and would "get you" if you go out the door. The CNA indicated Resident B mentioned the incident several times and asked for a knife to "kill the bad man." The CNA indicated she did not report staff's attempts to scare the resident to the Administrator.</p> <p>During an interview on 02/23/2016 at 9:19 a.m., the Activity Director indicated she "would never scare residents" to redirect from attempts to elope, but indicated she told residents with dementia "there might be a bug" to redirect them away from the door.</p> <p>During an interview on 2/25/16 at 3:18 p.m., the Administrator indicated there were no reportable incidents of abuse and indicated she was not aware staff tried to scare residents to keep them from leaving the dementia unit.</p> <p>Resident B's record was reviewed on 02/23/2016 at 11:26 a.m. Diagnoses included, but were not limited to,</p>		<p>non-inter-viewable resident's families monthly to ensure there is no concern related to restraint of movement in addition to continued notification of reporting abuse guidelines. Results of interviews will be reviewed for trends and rounding results will be reviewed daily at the morning stand-up meeting and monthly at facility Performance Improvement meeting. Executive Director and/or Director of Nursing Services are responsible for continued compliance.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>unspecified psychosis not due to a substance or known physiological condition, unspecified dementia without behavioral disturbance, and anxiety disorder due to known physiological condition.</p> <p>A Minimum Data Set (MDS) assessment, dated 1/16/16, indicated Resident B was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and the resident had a behavior of wandering.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident B had exit seeking behaviors 120 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident B had exit seeking behaviors 92 times from February 1-24, 2016.</p> <p>An elopement care plan, initiated 7/13/15, and revised 10/16/15, indicated Resident B had a history of exit seeking behavior. Interventions included, but were not limited to, address wandering behavior by walking with or attempt to redirect from inappropriate area; engage in diversional activity. The care plan indicated Resident B enjoyed keeping busy with familiar homelike tasks such as</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>wiping tables and folding towels and indicated the activities were good distractions between group activities and meals. An additional intervention was to provide structured activities of toileting, walking inside and outside, and reorientation strategies including signs and pictures, offering books or magazines to read and asking her to read it to you. A Wanderguard was initiated 10/16/15</p> <p>A care plan, initiated 7/23/15, indicated Resident B had a history of delusional thought. Interventions included, but were not limited to, administer medications as ordered and, if experiencing delusional thought, offer assistance/reassurance without challenging her belief.</p> <p>2. Resident C's record was reviewed on 2/24/16 at 11:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and psychotic disorder other than schizophrenia.</p> <p>A MDS assessment, dated, 1/6/15, indicated Resident C was cognitively impaired and scored 0 of 15 on the BIMS assessment and indicated the resident had hallucinations and wandered daily.</p> <p>A care plan, initiated 6/10/15 and revised on 2/23/16, indicated Resident C had a</p>			

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 02/26/2016	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802			
(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>behavior of intrusive wandering. The plan indicated the resident usually looked for a bathroom or somewhere to sit and rest or to look out the window and was at risk for elopement. The care plan indicated the resident had decreased safety awareness and wandered near exit doors and did not voice when she wanted to leave the facility. Interventions included, but were not limited to, anticipate and meet needs, caregivers to provide opportunity for positive interaction and attention, stop and talk with resident as passing by, offer a walk outside in the courtyard if weather is appropriate, offer snack, redirect away from doorways, Wanderguard, take to quiet location to sit and provide a program of activities of interest. The care plan indicated the resident liked to go outdoors.</p> <p>A care plan, initialed 1/27/15, and revised 3/20/15, indicated Resident C had impaired cognitive function related to short term and long memory loss, Alzheimer's disease, psychotropic drug use, and pain. The plan indicated the resident got lost in the hall and didn't know where to go. Interventions included, but were not limited to, cue resident to destinations she wants to go to if found in hall looking bewildered, engage in simple, structured activities</p>						

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>that avoid overly demanding tasks. The plan indicated the resident preferred music, current events, and spiritual activity. Additional interventions included, consistent caregivers, close window blinds in the evening to reduce reflections, and communication techniques that facilitate interaction.</p> <p>A care plan, initiated 01/27/15, indicated Resident C had visual hallucinations and paranoia and her family indicated the resident believed reflections in the windows and mirrors were people trying to climb in the window to harm her. The plan indicated she was fearful of men and tended to pull away from caregivers, thinking they might hurt her. Interventions included, but were not limited to, don't challenge her hallucinations or delusions, offer reassurance, change of environment ad distract with snacks. Additional interventions included seating resident with her back to windows and closing blinds at night.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident C had exit seeking behaviors 140 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident C had</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>exit seeking behaviors 82 times from February 1-24, 2016.</p> <p>A "Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review, dated 2/9/2016, indicated, "...[Resident named] has periods of hallucinations and delusions, sees reflections and thinks people are out doors trying to hurt her...."</p> <p>3. Resident N's record was reviewed on 02/22/2016 at 11:11 a.m. Diagnoses include, but were not limited to, Alzheimer's disease and hallucinations.</p> <p>An elopement care plan, initiated 10/8/15 and revised 11/3/15, indicated Resident N had delusional thought that family is on the other side of the door or outside or thinking cars in the parking lot belong to family and they can't get in to see her. Interventions included, but were not limited to, placement on Reflections unit, distract from wandering by offering pleasant diversions, structured activities, food, conversation, and television. The plan indicated the resident preferred religious programs on TV, liked black coffee, had a Wanderguard and indicated she would be offered a room change when a " non-parking lot " room within Reflections Unit was available. Additional interventions included, don't</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>challenge her delusional thought, but instead offer reassurance to her concerns, promote cognitive stimulation with current events, reminiscing, spiritual programs, and word games, and provide a secured environment on the Reflections unit.</p> <p>A MDS assessment, dated 1/18/16, indicated Resident N had a BIMS score of 9 out of 15 an was cognitively impaired.</p> <p>An Interdisciplinary Review of Distressed Behavior, dated 1/28/16, indicated, "[resident named] continues to have much the same mood/behavior. She has occasional delusional thought: that she is married or hallucination: talking to someone not there but was much improved from prior in-patient treatment..."</p> <p>A behavior summary sheet, dated January 2016, indicated Resident N had exit seeking behaviors 9 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident N had exit seeking behaviors 3 times from February 1-24, 2016.</p> <p>A facility abuse policy, dated 7/28/14 and</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 0225 SS=D	<p>identified as current, was received from the DON on 2/23/16 at 2:20 p.m. The policy indicated, "...Verbal, sexual, physical, and mental abuse...are strictly prohibited...staff must report all alleged violations involving mistreatment, neglect, or abuse...immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level and to other officials in accordance with State law...."</p> <p>The Immediate Jeopardy that began on 2/18/16 was removed on 2/24/16 when the facility suspended employees named in the allegations of abuse, and educated residents and responsible parties and in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring for abuse prevention and reporting.</p> <p>This Federal tag relates to complaints IN00192728 and IN00193147.</p> <p>3.1-27(a)(1)</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT</p>			

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 02/26/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802		
(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	
Bldg. 00	<p>ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview, and record review, the facility failed to ensure allegations of</p>	F 0225	I respectfully request a desk review.F225 No residents were found to have been affected by	03/09/2016	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>mental abuse were immediately reported to the Administrator and to other officials in accordance with State law. for 3 of 3 residents reviewed for mental abuse (Residents B, C, N).</p> <p>1. During an interview on 02/23/2016 at 8:54, the Reflections unit Program Director indicated she told residents with dementia there were "sick people" on the other side of the 2 doors that exited to the nursing facility and indicated she told the residents, " You don't want to get sick. You don't want to go into the nursing home."</p> <p>During an interview on 02/23/2016 at 9:03 a.m., CNA #3 indicated she heard a rumor that someone told residents on the dementia unit there was a "big man" in the courtyard.</p> <p>During an interview on 02/23/16 at 9:13 a.m., CNA #2 indicated she heard other staff tell residents who tried leave the dementia unit through the emergency exit door a "hairy spider" was outside. She indicated staff also told residents a"boogy man" was in the courtyard and would "get you" if you go out the door. The CNA indicated Resident B mentioned the incident several times and asked for a knife to "kill the bad man." The CNA indicated she did not report staff's</p>		<p>the deficient practice. There are no other residents that have the potential to be affected by the same deficient practice. In order for this deficient practice not to occur: The employees identified as involved in the allegation were interviewed and suspended immediately. The linen cart was moved immediately on 02/18/2016 upon observation of it. The linen cart was movable therefore it was moved from its location in the hallway to another location to ensure it is not blocking the exit door. The Staff Development Coordinator in-serviced on 02-18-2016 for all staff in regard to placement of carts and other obstacles to ensure there is no blocking of exit doors. The Executive Director / designee have monitored the doors since 02/23/2016 to ensure that the doors have not been blocked. The three (3) residents that were named in the allegations were interviewed by Social services using the Abaqis questions that address abuse and dignity. The families of residents were notified. All inter-viewable residents were interviewed utilizing the same questions. The non-inter-viewable resident's families were interviewed as well.</p> <p>On February 23, 2016 the facility completed in-servicing for all staff on what constitutes physical and verbal abuse, including statements that could be considered a verbal restraint,</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>attempts to scare the resident to the Administrator.</p> <p>During an interview on 02/23/2016 at 9:19 a.m., the Activity Director indicated she "would never scare residents" to redirect from attempts to elope, but indicated she told residents with dementia "there might be a bug" to redirect them away from the door.</p> <p>During an interview on 2/25/16 at 3:18 p.m., the Administrator indicated there were no reportable incidents of abuse and indicated she was not aware staff tried to scare residents to keep them from leaving the dementia unit.</p> <p>Resident B's record was reviewed on 02/23/2016 at 11:26 a.m. Diagnoses included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia without behavioral disturbance, and anxiety disorder due to known physiological condition.</p> <p>A Minimum Data Set (MDS) assessment, dated 1/16/16, indicated Resident B was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and the resident had a behavior of wandering.</p>		<p>utilizing specific scenarios as well as abuse reporting guidelines. All staff in-serviced prior to commencing their shift on not placing items in front of any exit doors which might obstruct exit. To prevent any further occurrence and ensure all residents are monitored for abuse, the facility will continue to in-service all staff on abuse and reporting guidelines monthly. In order to ensure all residents are monitored for abuse, facility will conduct Angel Care visits weekly with the residents and/or resident's responsible party. Residents or resident representatives have been educated regarding reporting abuse through the interview process and Abaqis. New admissions will initially receive information through the admission process i.e. Resident's Rights for Federal and State. Facility has "Reporting Suspicions of a Crime" posted in the front lobby for all visitors information and guidelines. Daily rounding will continue by the Facility Managers. Facility is rounding daily of the physical environment to check the exit doors to make sure doors are not obstructed. Executive Director/Director of Nursing/Maintenance Director or manager on duty is responsible for ensuring monitoring/interviews completed. Facility will interview minimum of 10 inter-viewable residents and 10 non-inter-viewable resident's</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 behavior summary sheet, dated January 2016, indicated Resident B had exit seeking behaviors 120 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident B had exit seeking behaviors 92 times from February 1-24, 2016.</p> <p>An elopement care plan, initiated 7/13/15, and revised 10/16/15, indicated Resident B had a history of exit seeking behavior. Interventions included, but were not limited to, address wandering behavior by walking with or attempt to redirect from inappropriate area; engage in diversional activity. The care plan indicated Resident B enjoyed keeping busy with familiar homelike tasks such as wiping tables and folding towels and indicated the activities were good distractions between group activities and meals. An additional intervention was to provide structured activities of toileting, walking inside and outside, and reorientation strategies including signs and pictures, offering books or magazines to read and asking her to read it to you. A Wanderguard was initiated 10/16/15</p> <p>A care plan, initiated 7/23/15, indicated Resident B had a history of delusional</p>		<p>families monthly to ensure there is no concern related to restraint of movement in addition to continued notification of reporting abuse guidelines. Results of interviews will be reviewed for trends and rounding results will be reviewed daily at the morning stand-up meeting and monthly at facility Performance Improvement meeting. Executive Director and/or Director of Nursing Services are responsible for continued compliance.</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>thought. Interventions included, but were not limited to, administer medications as ordered and, if experiencing delusional thought, offer assistance/reassurance without challenging her belief.</p> <p>2. Resident C's record was reviewed on 2/24/16 at 11:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and psychotic disorder other than schizophrenia.</p> <p>A MDS assessment, dated, 1/6/15, indicated Resident C was cognitively impaired and scored 0 of 15 on the BIMS assessment and indicated the resident had hallucinations and wandered daily.</p> <p>A care plan, initiated 6/10/15 and revised on 2/23/16, indicated Resident C had a behavior of intrusive wandering. The plan indicated the resident usually looked for a bathroom or somewhere to sit and rest or to look out the window and was at risk for elopement. The care plan indicated the resident had decreased safety awareness and wandered near exit doors and did not voice when she wanted to leave the facility. Interventions included, but were not limited to, anticipate and meet needs, caregivers to provide opportunity for positive interaction and attention, stop and talk</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>with resident as passing by, offer a walk outside in the courtyard if weather is appropriate, offer snack, redirect away from doorways, Wanderguard, take to quiet location to sit and provide a program of activities of interest. The care plan indicated the resident liked to go outdoors.</p> <p>A care plan, initialed 1/27/15, and revised 3/20/15, indicated Resident C had impaired cognitive function related to short term and long memory loss, Alzheimer's disease, psychotropic drug use, and pain. The plan indicated the resident got lost in the hall and didn't know where to go. Interventions included, but were not limited to, cue resident to destinations she wants to go to if found in hall looking bewildered, engage in simple, structured activities that avoid overly demanding tasks. The plan indicated the resident preferred music, current events, and spiritual activity. Additional interventions included, consistent caregivers, close window blinds in the evening to reduce reflections, and communication techniques that facilitate interaction.</p> <p>A care plan, initiated 01/27/15, indicated Resident C had visual hallucinations and paranoia and her family indicated the resident believed reflections in the</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>windows and mirrors were people trying to climb in the window to harm her. The plan indicated she was fearful of men and tended to pull away from caregivers, thinking they might hurt her.</p> <p>Interventions included, but were not limited to, don't challenge her hallucinations or delusions, offer reassurance, change of environment ad distract with snacks. Additional interventions included seating resident with her back to windows and closing blinds at night.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident C had exit seeking behaviors 140 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident C had exit seeking behaviors 82 times from February 1-24, 2016.</p> <p>A "Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review, dated 2/9/2016, indicated, "...[Resident named] has periods of hallucinations and delusions, sees reflections and thinks people are out doors trying to hurt her...."</p> <p>3. Resident N's record was reviewed on 02/22/2016 at 11:11 a.m. Diagnoses</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>include, but were not limited to, Alzheimer's disease and hallucinations.</p> <p>An elopement care plan, initiated 10/8/15 and revised 11/3/15, indicated Resident N had delusional thought that family is on the other side of the door or outside or thinking cars in the parking lot belong to family and they can't get in to see her. Interventions included, but were not limited to, placement on Reflections unit, distract from wandering by offering pleasant diversions, structured activities, food, conversation, and television. The plan indicated the resident preferred religious programs on TV, liked black coffee, had a Wanderguard and indicated she would be offered a room change when a " non-parking lot " room within Reflections Unit was available. Additional interventions included, don't challenge her delusional thought, but instead offer reassurance to her concerns, promote cognitive stimulation with current events, reminiscing, spiritual programs, and word games, and provide a secured environment on the Reflections unit.</p> <p>A MDS assessment, dated 1/18/16, indicated Resident N had a BIMS score of 9 out of 15 an was cognitively impaired.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>An Interdisciplinary Review of Distressed Behavior, dated 1/28/16, indicated, "[resident named] continues to have much the same mood/behavior. She has occasional delusional thought: that she is married or hallucination: talking to someone not there but was much improved from prior in-patient treatment..."</p> <p>A behavior summary sheet, dated January 2016, indicated Resident N had exit seeking behaviors 9 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident N had exit seeking behaviors 3 times from February 1-24, 2016.</p> <p>A facility abuse policy, dated 7/28/14 and identified as current, was received from the DON on 2/23/16 at 2:20 p.m. The policy indicated, "...Verbal, sexual, physical, and mental abuse...are strictly prohibited...staff must report all alleged violations involving mistreatment, neglect, or abuse...immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level and to other officials in accordance with State law...."</p> <p>This Federal tag relates to complaints</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 0226 SS=D Bldg. 00	<p>IN00192728 and IN00193147.</p> <p>3.1-28(c)</p> <p>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 interview, and record review, the facility failed to ensure its policies and procedures were implemented for immediately reporting allegations of mental abuse to the Administrator and to other officials in accordance with State law for 3 of 3 residents reviewed for mental abuse (Residents B, C, N).</p> <p>1. During an interview on 02/23/2016 at 8:54, the Reflections unit Program Director indicated she told residents with dementia there were "sick people" on the other side of the 2 doors that exited to the nursing facility and indicated she told the residents, " You don't want to get sick. You don't want to go into the nursing home."</p> <p>During an interview on 02/23/2016 at 9:03 a.m., CNA #3 indicated she heard a rumor that someone told residents on the</p>	F 0226	<p>Facility respectfully request desk review F226 No residents were found to have been affected by the deficient practice. There are no other residents that have the potential to be affected by the same deficient practice. In order for this deficient practice not to occur: The employees identified as involved in the allegation were interviewed and suspended immediately. The linen cart was moved immediately on 02/18/2016 upon observation of it. The linen cart was movable therefore it was moved from its location in the hallway to another location to ensure it is not blocking the exit door. The Staff Development Coordinator in-serviced on 02-18-2016 for all staff in regard to placement of carts and other obstacles to ensure there is no blocking of exit doors. The Executive Director / designee have monitored the doors since 02/23/2016 to ensure</p>	03/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>dementia unit there was a "big man" in the courtyard.</p> <p>During an interview on 02/23/16 at 9:13 a.m., CNA #2 indicated she heard other staff tell residents who tried leave the dementia unit through the emergency exit door a "hairy spider" was outside. She indicated staff also told residents a "boogy man" was in the courtyard and would "get you" if you go out the door. The CNA indicated Resident B mentioned the incident several times and asked for a knife to "kill the bad man." The CNA indicated she did not report staff's attempts to scare the resident to the Administrator.</p> <p>During an interview on 02/23/2016 at 9:19 a.m., the Activity Director indicated she "would never scare residents" to redirect from attempts to elope, but indicated she told residents with dementia "there might be a bug" to redirect them away from the door.</p> <p>During an interview on 2/25/16 at 3:18 p.m., the Administrator indicated there were no reportable incidents of abuse and indicated she was not aware staff tried to scare residents to keep them from leaving the dementia unit.</p> <p>Resident B's record was reviewed on</p>		<p>that the doors have not been blocked. The three (3) residents that were named in the allegations were interviewed by Social services using the Abaqis questions that address abuse and dignity. The families of residents were notified. All inter-viewable residents were interviewed utilizing the same questions. The non-inter-viewable resident's families were interviewed as well.</p> <p>On February 23, 2016 the facility completed in-servicing for all staff on what constitutes physical and verbal abuse, including statements that could be considered a verbal restraint, utilizing specific scenarios as well as abuse reporting guidelines. All staff in-serviced prior to commencing their shift on not placing items in front of any exit doors which might obstruct exit. To prevent any further occurrence and ensure all residents are monitored for abuse, the facility will continue to in-service all staff on abuse and reporting guidelines monthly. In order to ensure all residents are monitored for abuse, facility will conduct Angel Care visits weekly with the residents and/or resident's responsible party. Residents or resident representatives have been educated regarding reporting abuse through the interview process and Abaqis. New admissions will initially receive information through the admission process i.e. Resident's</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>02/23/2016 at 11:26 a.m. Diagnoses included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia without behavioral disturbance, and anxiety disorder due to known physiological condition.</p> <p>A Minimum Data Set (MDS) assessment, dated 1/16/16, indicated Resident B was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and the resident had a behavior of wandering.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident B had exit seeking behaviors 120 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident B had exit seeking behaviors 92 times from February 1-24, 2016.</p> <p>An elopement care plan, initiated 7/13/15, and revised 10/16/15, indicated Resident B had a history of exit seeking behavior. Interventions included, but were not limited to, address wandering behavior by walking with or attempt to redirect from inappropriate area; engage in diversional activity. The care plan</p>		<p>Rights for Federal and State. Facility has "Reporting Suspicions of a Crime" posted in the front lobby for all visitors information and guidelines. Daily rounding will continue by the Facility Managers. Facility is rounding daily of the physical environment to check the exit doors to make sure doors are not obstructed. Executive Director/Director of Nursing/Maintenance Director or manager on duty is responsible for ensuring monitoring/interviews completed. Facility will interview minimum of 10 inter-viewable residents and 10 non-inter-viewable resident's families monthly to ensure there is no concern related to restraint of movement in addition to continued notification of reporting abuse guidelines. Results of interviews will be reviewed for trends and rounding results will be reviewed daily at the morning stand-up meeting and monthly at facility Performance Improvement meeting. Executive Director and/or Director of Nursing Services are responsible for continued compliance.</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>indicated Resident B enjoyed keeping busy with familiar homelike tasks such as wiping tables and folding towels and indicated the activities were good distractions between group activities and meals. An additional intervention was to provide structured activities of toileting, walking inside and outside, and reorientation strategies including signs and pictures, offering books or magazines to read and asking her to read it to you. A Wanderguard was initiated 10/16/15</p> <p>A care plan, initiated 7/23/15, indicated Resident B had a history of delusional thought. Interventions included, but were not limited to, administer medications as ordered and, if experiencing delusional thought, offer assistance/reassurance without challenging her belief.</p> <p>2. Resident C's record was reviewed on 2/24/16 at 11:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and psychotic disorder other than schizophrenia.</p> <p>A MDS assessment, dated, 1/6/15, indicated Resident C was cognitively impaired and scored 0 of 15 on the BIMS assessment and indicated the resident had hallucinations and wandered daily.</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 care plan, initiated 6/10/15 and revised on 2/23/16, indicated Resident C had a behavior of intrusive wandering. The plan indicated the resident usually looked for a bathroom or somewhere to sit and rest or to look out the window and was at risk for elopement. The care plan indicated the resident had decreased safety awareness and wandered near exit doors and did not voice when she wanted to leave the facility. Interventions included, but were not limited to, anticipate and meet needs, caregivers to provide opportunity for positive interaction and attention, stop and talk with resident as passing by, offer a walk outside in the courtyard if weather is appropriate, offer snack, redirect away from doorways, Wanderguard, take to quiet location to sit and provide a program of activities of interest. The care plan indicated the resident liked to go outdoors.</p> <p>A care plan, initialed 1/27/15, and revised 3/20/15, indicated Resident C had impaired cognitive function related to short term and long memory loss, Alzheimer's disease, psychotropic drug use, and pain. The plan indicated the resident got lost in the hall and didn't know where to go. Interventions included, but were not limited to, cue resident to destinations she wants to go to</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>if found in hall looking bewildered, engage in simple, structured activities that avoid overly demanding tasks. The plan indicated the resident preferred music, current events, and spiritual activity. Additional interventions included, consistent caregivers, close window blinds in the evening to reduce reflections, and communication techniques that facilitate interaction.</p> <p>A care plan, initiated 01/27/15, indicated Resident C had visual hallucinations and paranoia and her family indicated the resident believed reflections in the windows and mirrors were people trying to climb in the window to harm her. The plan indicated she was fearful of men and tended to pull away from caregivers, thinking they might hurt her. Interventions included, but were not limited to, don't challenge her hallucinations or delusions, offer reassurance, change of environment ad distract with snacks. Additional interventions included seating resident with her back to windows and closing blinds at night.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident C had exit seeking behaviors 140 times during the month.</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 behavior summary sheet, dated February 2016, indicated Resident C had exit seeking behaviors 82 times from February 1-24, 2016.</p> <p>A "Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review, dated 2/9/2016, indicated, "...[Resident named] has periods of hallucinations and delusions, sees reflections and thinks people are out doors trying to hurt her...."</p> <p>3. Resident N's record was reviewed on 02/22/2016 at 11:11 a.m. Diagnoses include, but were not limited to, Alzheimer's disease and hallucinations.</p> <p>An elopement care plan, initiated 10/8/15 and revised 11/3/15, indicated Resident N had delusional thought that family is on the other side of the door or outside or thinking cars in the parking lot belong to family and they can't get in to see her. Interventions included, but were not limited to, placement on Reflections unit, distract from wandering by offering pleasant diversions, structured activities, food, conversation, and television. The plan indicated the resident preferred religious programs on TV, liked black coffee, had a Wanderguard and indicated she would be offered a room change when a " non-parking lot " room within</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>Reflections Unit was available. Additional interventions included, don't challenge her delusional thought, but instead offer reassurance to her concerns, promote cognitive stimulation with current events, reminiscing, spiritual programs, and word games, and provide a secured environment on the Reflections unit.</p> <p>A MDS assessment, dated 1/18/16, indicated Resident N had a BIMS score of 9 out of 15 and was cognitively impaired.</p> <p>An Interdisciplinary Review of Distressed Behavior, dated 1/28/16, indicated, "[resident named] continues to have much the same mood/behavior. She has occasional delusional thought: that she is married or hallucination: talking to someone not there but was much improved from prior in-patient treatment...."</p> <p>A behavior summary sheet, dated January 2016, indicated Resident N had exit seeking behaviors 9 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident N had exit seeking behaviors 3 times from February 1-24, 2016.</p>			

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 02/26/2016	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802			
(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 0309 SS=J Bldg. 00	<p>A facility abuse policy, dated 7/28/14 and identified as current, was received from the DON on 2/23/16 at 2:20 p.m. The policy indicated, "...Verbal, sexual, physical, and mental abuse...are strictly prohibited...staff must report all alleged violations involving mistreatment, neglect, or abuse...immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level and to other officials in accordance with State law...."</p> <p>This Federal tag relates to complaints IN00192728 and IN00193147.</p> <p>3.1-28(a)</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure physical, mental and psychosocial</p>	F 0309	I respectfully request a desk review.F309 No residents were found to have been affected	03/09/2016			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>well-being of residents with dementia were maintained when staff used physical and verbal restrictions to detour residents from exit seeking behaviors by blocking an emergency exit with a linen cart and telling them a "boogy or bad man", "sick people" or a "hairy spider" were on the other side of the door resulting in a resident requesting a knife to "kill the bad man" and another resident reporting people outdoors were trying to hurt her for 3 of 35 residents reviewed for psychosocial quality of care (Residents B, C, N).</p> <p>B. In addition to the residents in Immediate Jeopardy, the facility failed to ensure a resident's specific condition and treatment regimen were care planned to ensure palliative care continued when hospice services were terminated for 1 of 3 residents reviewed for palliative care (Resident D).</p> <p>The Immediate Jeopardy was identified on 02/23/2016 and began on 2/18/16 when facility staff attempted to scare Residents B, C, and N to prevent them from eloping and implemented an intervention of placing a linen cart in front of the emergency exit door. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 2/23/16 at 10:57 a.m. The</p>		<p>by the deficient practice. There are no other residents that have the potential to be affected by the same deficient practice. In order for this deficient practice not to occur: The employees identified as involved in the allegation were interviewed and suspended immediately. The linen cart was moved immediately on 02/18/2016 upon observation of it. The linen cart was movable therefore it was moved from its location in the hallway to another location to ensure it is not blocking the exit door. The Staff Development Coordinator in-serviced on 02-18-2016 for all staff in regard to placement of carts and other obstacles to ensure there is no blocking of exit doors. The Executive Director / designee have monitored the doors since 02/23/2016 to ensure that the doors have not been blocked. The three (3) residents that were named in the allegations were interviewed by Social services using the Abaqis questions that address abuse and dignity. The families of residents were notified. All inter-viewable residents were interviewed utilizing the same questions. The non-inter-viewable resident's families were interviewed as well. On February 23, 2016 the facility completed in-servicing for all staff on what constitutes physical and verbal abuse, including statements that could be considered a verbal restraint,</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>Immediate Jeopardy was removed on 2/24/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy.</p> <p>Findings include:</p> <p>A1. During an initial tour of the dementia unit on 2/18/16 at 8:50 a.m., an emergency exit door that opened to a parking lot had a tall linen cart with a bed/chair alarm clipped to the cover and attached to Velcro strips on the door frame blocking an emergency exit. Licensed Practical Nurse (LPN) #1 stated, "You do not see that! I was supposed to have moved it already!" The LPN indicated the cart was placed in front of the exit door to keep residents with dementia from leaving the unit. She indicated the intervention had been in place for a while, but could not provide a specific date. The dementia unit had a total of 4 exit doors, 2 of which opened to the skilled nursing facility, 1 that opened to an enclosed courtyard and 1 that opened to a parking lot.</p> <p>During an interview on 02/23/2016 at 8:54, the Reflections unit Program Director indicated she told residents with dementia there were "sick people" on the</p>		<p>utilizing specific scenarios as well as abuse reporting guidelines. All staff in-serviced prior to commencing their shift on not placing items in front of any exit doors which might obstruct exit. To prevent any further occurrence and ensure all residents are monitored for abuse, the facility will continue to in-service all staff on abuse and reporting guidelines monthly. In order to ensure all residents are monitored for abuse, facility will conduct Angel Care visits weekly with the residents and/or resident's responsible party. Residents or resident representatives have been educated regarding reporting abuse through the interview process and Abaqis. New admissions will initially receive information through the admission process i.e. Resident's Rights for Federal and State. Facility has "Reporting Suspicions of a Crime" posted in the front lobby for all visitors information and guidelines. Daily rounding will continue by the Facility Managers. Facility is rounding daily of the physical environment to check the exit doors to make sure doors are not obstructed. Executive Director/Director of Nursing/Maintenance Director or manager on duty is responsible for ensuring monitoring/interviews completed. Facility will interview minimum of 10 inter-viewable residents and 10 non-inter-viewable resident's</p>	

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 02/26/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802		
(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>other side of the 2 doors that exited to the nursing facility and indicated she told the residents, " You don't want to get sick. You don't want to go into the nursing home."</p> <p>During an interview on 02/23/2016 at 9:03 a.m., CNA #3 indicated she heard a rumor that someone told residents on the dementia unit there was a "big man" in the courtyard.</p> <p>During an interview on 02/23/16 at 9:13 a.m., CNA #2 indicated she heard other staff tell residents who tried leave the dementia unit through the emergency exit door a "hairy spider" was outside. She indicated staff also told residents a"boogy man" was in the courtyard and would "get you" if you go out the door. The CNA indicated Resident B mentioned the incident several times and asked for a knife to "kill the bad man." The CNA indicated she did not report staff's attempts to scare the resident to the Administrator.</p> <p>During an interview on 02/23/2016 at 9:19 a.m., the Activity Director indicated she "would never scare residents" to redirect from elopement, but indicated she told residents with dementia "there might be a bug" to redirect the resident away from the door.</p>		<p>families monthly to ensure there is no concern related to restraint of movement in addition to continued notification of reporting abuse guidelines. Results of interviews will be reviewed for trends and rounding results will be reviewed daily at the morning stand-up meeting and monthly at facility Performance Improvement meeting. Executive Director and/or Director of Nursing Services are responsible for continued compliance. F309 (B) No other residents were affected by this practice. In order for residents not to be affected by this practice, any choices as to where families, residents or responsible party choose another pay source, IDT will meet immediately to ensure current physicians orders are reviewed and appropriate and any additional physician orders will be obtained in order to continue to continuum of care. Any changes will be care planned and updated accordingly. Pay source change will be monitored on a daily basis. Executive Director/Business Office Manager and/or designee will be responsible for notification of all pay changes and/or requests. Director of Nursing Services and/or Designee will be responsible for validation of proper physician's orders received and followed. Any pay type changes will be reviewed monthly through the Patient</p>		

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 02/26/2016	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802			
(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 02/23/2016 at 1:36 p.m., the Social Service Director (SSD) indicated Resident B had increased behaviors of intrusive wandering, taking other residents' food, and accelerated movements in January 2016. The SSD provided behavioral tracking.</p> <p>Resident B's record was reviewed on 02/23/2016 at 11:26 a.m. Diagnoses included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia without behavioral disturbance, and anxiety disorder due to known physiological condition.</p> <p>A Minimum Data Set (MDS) assessment, dated 1/16/16, indicated Resident B was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and the resident had a behavior of wandering.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident B had exit seeking behaviors 120 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident B had</p>		Activity Report. Any trends will be monitored and reported to Performance Improvement monthly and on-going				

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>exit seeking behaviors 92 times from February 1-24, 2016.</p> <p>An elopement care plan, initiated 7/13/15, and revised 10/16/15, indicated Resident B had a history of exit seeking behavior. Interventions included, but were not limited to, address wandering behavior by walking with or attempt to redirect from inappropriate area; engage in diversional activity. The care plan indicated Resident B enjoyed keeping busy with familiar homelike tasks such as wiping tables and folding towels and indicated the activities were good distractions between group activities and meals. An additional intervention was to provide structured activities of toileting, walking inside and outside, and reorientation strategies including signs and pictures, offering books or magazines to read and asking her to read it to you. A Wanderguard was initiated 10/16/15</p> <p>A care plan, initiated 7/23/15, indicated Resident B had a history of delusional thought. Interventions included, but were not limited to, administer medications as ordered and, if experiencing delusional thought, offer assistance/reassurance without challenging her belief.</p> <p>A2. Resident C's record was reviewed on 2/24/16 at 11:29 a.m. Diagnoses</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>included, but were not limited to, Alzheimer's disease, dementia, and psychotic disorder other than schizophrenia.</p> <p>A MDS assessment, dated, 1/6/15, indicated Resident C was cognitively impaired and scored 0 of 15 on the BIMS assessment and indicated the resident had hallucinations and wandered daily.</p> <p>A care plan, initiated 6/10/15 and revised on 2/23/16, indicated Resident C had a behavior of intrusive wandering. The plan indicated the resident usually looked for a bathroom or somewhere to sit and rest or to look out the window and was at risk for elopement. The care plan indicated the resident had decreased safety awareness and wandered near exit doors and did not voice when she wanted to leave the facility. Interventions included, but were not limited to, anticipate and meet needs, caregivers to provide opportunity for positive interaction and attention, stop and talk with resident as passing by, offer a walk outside in the courtyard if weather is appropriate, offer snack, redirect away from doorways, Wanderguard, take to quiet location to sit and provide a program of activities of interest. The care plan indicated the resident liked to go outdoors.</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 care plan, initialed 1/27/15, and revised 3/20/15, indicated Resident C had impaired cognitive function related to short term and long memory loss, Alzheimer's disease, psychotropic drug use, and pain. The plan indicated the resident got lost in the hall and didn't know where to go. Interventions included, but were not limited to, cue resident to destinations she wants to go to if found in hall looking bewildered, engage in simple, structured activities that avoid overly demanding tasks. The plan indicated the resident preferred music, current events, and spiritual activity. Additional interventions included, consistent caregivers, close window blinds in the evening to reduce reflections, and communication techniques that facilitate interaction.</p> <p>A care plan, initiated 01/27/15, indicated Resident C had visual hallucinations and paranoia and her family indicated the resident believed reflections in the windows and mirrors were people trying to climb in the window to harm her. The plan indicated she was fearful of men and tended to pull away from caregivers, thinking they might hurt her. Interventions included, but were not limited to, don't challenge her hallucinations or delusions, offer</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>reassurance, change of environment ad distract with snacks. Additional interventions included seating resident with her back to windows and closing blinds at night.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident C had exit seeking behaviors 140 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident C had exit seeking behaviors 82 times from February 1-24, 2016.</p> <p>A "Monthly Behavior Summary/Psychoactive Gradual Dose Reduction (GDR) Review, dated 2/9/2016, indicated, "...[Resident named] has periods of hallucinations and delusions, sees reflections and thinks people are out doors trying to hurt her...."</p> <p>A3. Resident N's record was reviewed on 02/22/2016 at 11:11 a.m. Diagnoses include, but were not limited to, Alzheimer's disease and hallucinations.</p> <p>An elopement care plan, initiated 10/8/15 and revised 11/3/15, indicated Resident N had delusional thought that family is on the other side of the door or outside or thinking cars in the parking lot belong to</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>family and they can't get in to see her. Interventions included, but were not limited to, placement on Reflections unit, distract from wandering by offering pleasant diversions, structured activities, food, conversation, and television. The plan indicated the resident preferred religious programs on TV, liked black coffee, had a Wanderguard and indicated she would be offered a room change when a " non-parking lot " room within Reflections Unit was available. Additional interventions included, don't challenge her delusional thought, but instead offer reassurance to her concerns, promote cognitive stimulation with current events, reminiscing, spiritual programs, and word games, and provide a secured environment on the Reflections unit.</p> <p>A MDS assessment, dated 1/18/16, indicated Resident N had a BIMS score of 9 out of 15 an was cognitively impaired.</p> <p>An Interdisciplinary Review of Distressed Behavior, dated 1/28/16, indicated, "[resident named] continues to have much the same mood/behavior. She has occasional delusional thought: that she is married or hallucination: talking to someone not there but was much improved from prior in-patient</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>treatment...."</p> <p>A behavior summary sheet, dated January 2016, indicated Resident N had exit seeking behaviors 9 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident N had exit seeking behaviors 3 times from February 1-24, 2016.</p> <p>A facility abuse policy, dated 7/28/14 and identified as current, was received from the DON on 2/23/16 at 2:20 p.m. The policy indicated, "...Verbal, sexual, physical, and mental abuse...are strictly prohibited...staff must report all alleged violations involving mistreatment, neglect, or abuse...immediately to a Senior Clinician, or Operational Leader at the facility, or District, or National Level and to other officials in accordance with State law...."</p> <p>A facility accident and supervision policy, dated 04/29/11, and identified as current, was provided by the DON on 2/24/16 at 10:05 a.m. The policy indicated, "...Unsafe Wandering or Elopement: 23. Center addressed both safety issued and evaluates a patient exhibiting non-goal-directed or aimless wandering to identify root causes to the</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>degree possible...24. Center clearly defines the mechanisms and procedures that can help mitigate the risk of a patient from leaving a safe area without supervision. 25. Patients are assessed for the risk of elopement. Patients identified at risk have interventions in their comprehensive care plan to address the potential for elopement..."B. During an interview on 2/22/16 at 9:25 a.m., Business Office Manager (BOM) indicated Resident D was taken off of Hospice care on 11/2/15 and added to Medicare services.</p> <p>During an interview on 2/22/16 at 12:00 p.m., Director of Nursing indicated facility's Registered Dietician assessed his nutritional needs, but there was not a physician's order for palliative care, once hospice was discontinued.</p> <p>During an interview on 2/22/15 at 4:18 p.m., Resident D's daughter indicated she had visited him at the facility on 11/8/15 and Resident D had not attempted to eat or drink and appeared dehydrated.</p> <p>During an interview on 2/23/16 at 11:14 a.m., Social Service Director (SSD) indicated Resident D had no orders for palliative care after hospice was discontinued on 11/2/15.</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 2/23/16 at 11:25 a.m., Resident D's sister in law indicated she had visited him at the facility on 11/8/15 and Resident D's tongue was discolored, hard, and dry. Resident D's sister in law indicated Resident D was not eating or drinking.</p> <p>Resident D's record was reviewed on 2/22/16 at 11:00 a.m. Diagnoses included, but were not limited to, lung cancer with metastasis, altered mental status, major depression, and anxiety disorder.</p> <p>A Minimum Data Set (MDS) assessment, dated 11/10/15, indicated Resident D had severe cognitive impairment.</p> <p>Resident D's clinical record lacked documentation of an order for palliative care once hospice was discontinued on 11/2/15. Resident D's care plans did not indicate the resident was on palliative care or end of life care program.</p> <p>An emergency room record from Union Hospital dated 11/11/15, indicated Resident D was poorly groomed with poor personal hygiene, and had dry, cracked mucus membranes.</p> <p>A hospital Case Management note dated 11/12/15, indicated Resident D had</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 hospital admitting diagnosis of Sepsis secondary to Urinary Tract Infection.</p> <p>A blood test results dated 11/11/15, indicated Resident D had an elevated Sodium level of 153 (135-148 normal range), elevated Blood Urea Nitrogen (BUN) level of 59 (5-25 normal range), elevated Creatinine level of 1.50 (0.50-1.40 normal range), elevated White Blood Count (WBC) level of 16.6 (4.5-10.8 normal range).</p> <p>A Urinalysis lab result dated 11/11/15, indicated Resident D had red color urine and was positive for Bilirubin, Ketones, Blood, Protein, and White Blood Cells in his urine.</p> <p>A End of Life Care policy, dated 1/08/13 and identified as current, was provided by Director of Nursing on 2/23/16 at 2:20 p.m. The policy indicated, "...Palliative Care: Patient and family centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice...."</p> <p>The Immediate Jeopardy that began on</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 02/26/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802		
(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 0323 SS=K Bldg. 00	<p>2/18/16 was removed on 2/24/16 when the facility removed the physical restriction of the linen cart blocking an exit, suspended employees named in the allegations of abuse, educated residents and responsible parties and in-serviced all staff regarding abuse and abuse reporting requirements. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring for abuse prevention and reporting and physical restrictions.</p> <p>This Federal tag relates to complaints IN00192728 and IN00192913.</p> <p>3.1-37(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.</p> <p>A. Based on observation, interview, and record review, the facility failed to ensure interventions implemented to detour Residents B, C, and N from eloping did not pose safety hazards when an</p>	F 0323	Facility Respectfully requests a desk review F323	03/09/2016	

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 02/26/2016
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802		
(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>emergency exit door was obstructed by a tall linen cart for 1 of 2 emergency exits from the Reflections (dementia) unit. This deficient practice had the potential to affect 21 of 21 residents on the dementia unit (Residents B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q, R, S, T, U, and V).</p> <p>B. In addition to the residents in immediate jeopardy, the facility failed to ensure a cognitively impaired resident was supervised when she went to a medical appointment resulting in the physician refusing to examine and treat the resident for 1 of 1 resident reviewed for supervision during medical appointments.</p> <p>The Immediate Jeopardy was identified on 02/23/2016 and began on 2/18/16 when the facility implemented an interventions of blocking an emergency exit door with a linen cart. The Administrator and Director of Nursing (DON) were informed of the Immediate Jeopardy on 2/23/16 at 10:57 a.m. The Immediate Jeopardy was removed on 2/24/16, but noncompliance remained at the lower scope and severity of isolated, no actual harm, with potential for more than minimal harm that is not Immediate Jeopardy.</p>		<p>(A)</p> <p>No residents were found to have been affected by the deficient practice.</p> <p>There are no other residents that have the potential to be affected by the same deficient practice.</p> <p>In order for this deficient practice not to occur:</p> <p>The employees identified as involved in the allegation were interviewed and suspended immediately. The linen cart was moved immediately on 02/18/2016 upon observation of it. The linen cart was movable therefore it was moved from its location in the hallway to another location to ensure it is not blocking the exit door. The Staff Development Coordinator in-serviced on 02-18-2016 for all staff in regard to placement of carts and other obstacles to ensure</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>Findings include:</p> <p>During an initial tour of the dementia unit on 2/18/16 at 8:50 a.m., an emergency exit door that opened to a parking lot had a tall linen cart with a bed/chair alarm clipped to the cover and attached to Velcro strips on the door frame blocking an emergency exit. Licensed Practical Nurse (LPN) #1 stated, "You do not see that! I was supposed to have moved it already!" The LPN indicated the cart was placed in front of the exit door to keep residents with dementia from leaving the unit. She indicated the intervention had been in place for a while, but could not provide a specific date. The dementia unit had a total of 4 exit doors, 2 of which opened to the skilled nursing facility, 1 that opened to an enclosed courtyard and 1 that opened to a parking lot.</p> <p>During an observation on 02/18/16 at 11:10 a.m. with the Administrator and Director of Nursing (DON) present, the emergency exit door in the Reflections unit was closed. A sensor alarm sounded when a beam sensor was crossed. The emergency exit bar was depressed for 15 seconds. An alarm sounded and the emergency door opened. The Administrator indicated the sensor alarm was placed after a resident eloped from</p>		<p>there is no blocking of exit doors. The Executive Director / designee have monitored the doors since 02/23/2016 to ensure that the doors have not been blocked. The three (3) residents that were named in the allegations were interviewed by Social services using the Abaqis questions that address abuse and dignity. The families of residents were notified. All inter-viewable residents on the dementia unit were interviewed utilizing the same questions. The non-inter-viewable resident's families were interviewed at well.</p> <p>On February 23, 2016 the facility completed in-servicing for all staff on what constitutes physical and verbal abuse, including statements that could be considered a verbal restraint, utilizing specific scenarios as well as abuse reporting guidelines. All staff in-serviced prior to commencing their shift on not placing items in front of any exit doors which might obstruct exit.</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>the facility.</p> <p>During an interview on 02/18/2016 at 9:43 a.m., the Assistant Director of Nursing (ADON) indicated the facility began placing the linen cart in front of the emergency exit door in November 2015 and used the clip alarm to alert staff when residents attempted to move the cart and open the exit door.</p> <p>During an interview on 02/18/2016 at 9:44 a.m., the Reflections Program Director indicated the linen cart and clip alarm had been used for "quite a while" as a method to alert staff when a resident attempted to elope.</p> <p>During an interview on 2/18/16 at 11:08 a.m., the Administrator indicated the linen cart should not have obstructed the exit door.</p> <p>Resident B's record was reviewed on 02/23/2016 at 11:26 a.m. Diagnoses included, but were not limited to, unspecified psychosis not due to a substance or known physiological condition, unspecified dementia without behavioral disturbance, and anxiety disorder due to known physiological condition.</p> <p>A Minimum Data Set (MDS)</p>		<p>To prevent any further occurrence, the facility will continue to in-service all staff on abuse and reporting guidelines monthly. Facility is rounding daily of the physical environment to check the exit doors to make sure doors are not obstructed. Executive Director/Director of Nursing/Maintenance Director or manager on duty is responsible for continued compliance.</p> <p>Facility will interview minimum of 1-inter-viewable residents and 10 non-inter-viewable resident's families monthly to ensure there is no concern related to restraint of movement.</p> <p>Results of interviews will be reviewed for trends and rounding results will be reviewed monthly at facility Performance Improvement meeting monthly.</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>assessment, dated 1/16/16, indicated Resident B was cognitively impaired with a Brief Interview for Mental Status (BIMS) score of 11 out of 15 and the resident had a behavior of wandering.</p> <p>An elopement care plan, initiated 7/13/15, and revised 10/16/15, indicated Resident B had a history of exit seeking behavior. Interventions included, but were not limited to, address wandering behavior by walking with or attempt to redirect from inappropriate area, engage in diversional activity. The care plan indicated Resident B enjoyed keeping busy with familiar homelike tasks such as wiping tables and folding towels and indicated the activities were good distractions between group activities and meals. An additional intervention was to provide structured activities of toileting, walking inside and outside, and reorientation strategies including signs and pictures, offering books or magazines to read and asking her to read it to you. A Wanderguard was initiated 10/16/15</p> <p>A behavior summary sheet, dated January 2016, indicated Resident B had exit seeking behaviors 120 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident B had</p>	F323(B)	<p>No residents were found to be affected by this practice.</p> <p>In order for other residents not to be affected by this deficient practice, facility has in-serviced staff in regards to out-of-facility appointments. New transportation forms were initiated which details specifics of how transported, who will be attending resident, i.e. family, friend and/or staff, where appointment is and time of transportation. Transportation form is reviewed resident by resident in the facility's morning management meeting to ensure proper arrangements have been arranged and validated.</p> <p>Director of Nursing and/or Designee will continue to monitor on a daily basis. Results will be reviewed again monthly at facility Performance Improvement meeting.</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>exit seeking behaviors 92 times from February 1-24, 2016.</p> <p>Resident C's record was reviewed on 2/24/16 at 11:29 a.m. Diagnoses included, but were not limited to, Alzheimer's disease, dementia, and psychotic disorder other than schizophrenia.</p> <p>A MDS assessment, dated, 1/6/15, indicated Resident C was cognitively impaired and scored 0 of 15 on the BIMS assessment and indicated the resident had hallucinations and wandered daily.</p> <p>A care plan, initiated 6/10/15 and revised on 2/23/16, indicated Resident C had a behavior of intrusive wandering. The plan indicated the resident usually looked for a bathroom or somewhere to sit and rest or to look out the window and was at risk for elopement. The care plan indicated the resident had decreased safety awareness and wandered near exit doors and did not voice when she wanted to leave the facility. Interventions included, but were not limited to, anticipate and meet needs, caregivers to provide opportunity for positive interaction and attention, stop and talk with resident as passing by, offer a walk outside in the courtyard if weather is appropriate, offer snack, redirect away</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>from doorways, Wanderguard, take to quiet location to sit and provide a program of activities of interest. The care plan indicated the resident liked to go outdoors.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident C had exit seeking behaviors 140 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident C had exit seeking behaviors 82 times from February 1-24, 2016.</p> <p>Resident N's record was reviewed on 02/22/2016 at 11:11 a.m. Diagnoses include, but were not limited to, Alzheimer's disease and hallucinations.</p> <p>A MDS assessment, dated 1/18/16, indicated Resident N had a BIMS score of 9 out of 15 an was cognitively impaired.</p> <p>An elopement care plan, initiated 10/8/15 and revised 11/3/15, indicated Resident N had delusional thought that family is on the other side of the door or outside or thinking cars in the parking lot belong to family and they can't get in to see her. Interventions included, but were not limited to, placement on Reflections unit,</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>distract from wandering by offering pleasant diversions, structured activities, food, conversation, and television. The plan indicated the resident preferred religious programs on TV, liked black coffee, had a Wanderguard and indicated she would be offered a room change when a " non-parking lot " room within Reflections Unit was available.</p> <p>Additional interventions included, don't challenge her delusional thought, but instead offer reassurance to her concerns, promote cognitive stimulation with current events, reminiscing, spiritual programs, and word games, and provide a secured environment on the Reflections unit.</p> <p>A behavior summary sheet, dated January 2016, indicated Resident N had exit seeking behaviors 9 times during the month.</p> <p>A behavior summary sheet, dated February 2016, indicated Resident N had exit seeking behaviors 3 times from February 1-24, 2016.</p> <p>A facility accident and supervision policy, dated 04/29/11, and identified as current, was provided by the DON on 2/24/16 at 10:05 a.m. The policy indicated, "...Unsafe Wandering or Elopement: 23. Center addressed both</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>safety issued and evaluates a patient exhibiting non-goal-directed or aimless wandering to identify root causes to the degree possible...24. Center clearly defines the mechanisms and procedures that can help mitigate the risk of a patient from leaving a safe area without supervision. 25. Patients are assessed for the risk of elopement. Patients identified at risk have interventions in their comprehensive care plan to address the potential for elopement...."</p> <p>An undated preventative maintenance sheet was provided by the Administrator on 2/24/16 at 10:50 a.m., and indicated, "...Means of Egress Free From All Furnishings or Other Objects Placed not to Obstruct Access of Visibility...."</p> <p>B. During an interview on 2/19/16 at 2:45 p.m., Resident G's daughter indicated a physician refused to see her mother when she was sent to a medical appointment unaccompanied by facility staff or another responsible party, because the resident could not communicate her health needs to the physician.</p> <p>During an interview on 2/22/16 at 9:36 a.m., Transcare ambulance employee indicated Resident G was transported by their wheelchair van independently to a doctor's appointment on 2/4/16.</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 2/22/16 at 9:39 a.m., the receptionist at the Neurology doctor's office indicated Resident G's appointment scheduled on 2/4/16 had been canceled by the physician because the resident had been transported to the doctor's office without anyone accompanying her.</p> <p>During an interview on 2/22/16 at 12:00 p.m., Unit Manager # 6 indicated the facility should send a staff member with a resident if family did not accompany the resident. She further indicated Resident G used a wheelchair and was on continuous oxygen therapy.</p> <p>During an interview on 2/22/15 at 2:08 p.m., the Unit Manager # 7 indicated Resident G went out to a doctor's appointment and was returned to the facility because the medical doctor (MD) would not see the resident without someone accompanying her to the appointment.</p> <p>During an interview on 2/23/16 at 3:30 p.m., RN # 4 indicated Resident G was transported to a doctor's appointment on 2/4/16 per wheelchair via a medical transport van. RN # 4 indicated she assumed the daughter was meeting Resident G at the doctor's office. RN # 4 indicated she did not speak with the</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>daughter personally about the doctor's appointment.</p> <p>Resident G's record was reviewed on 2/23/16 at 3:30 p.m. Diagnoses included, but were not limited to, muscle weakness, lack of coordination, chronic obstructive pulmonary disease, and history of subdural hemorrhage.</p> <p>A Minimum Data Set (MDS) assessment, dated 2/9/16, indicated Resident G had severe cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 4 out of 15.</p> <p>Occupational Therapy Plan of Care dated 2/5/16, indicated Resident G had severe cognitive impairment and was orientated to person only. Resident G required moderate/maximum assistance with upper body dressing and was near total dependence for lower body dressing.</p> <p>An Interim Plan of Care, initiated on 2/2/16, indicated Resident G required assistance of two staff for ambulation and transfers. Also, indicated resident used wheelchair for mobility.</p> <p>A wheelchair transportation report dated 2/4/16 was reviewed. The report indicated Resident G left the facility on 2/4/16 at 1:45 p.m. and arrived to doctor's</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>office at 2:13 p.m. Transportation was then dispatched to the doctor's office at 3:18 p.m. Transportation arrived to doctor's office for pick up at 3:43 p.m. and returned to facility at 4:18 p.m.</p> <p>"A Resident Appointments Outside the Center" policy, dated 4/28/09, and identified as current, was provided by the Unit Manager on 2/22/16 at 2:40 p.m. The policy indicated, "...1. Notify family/responsible party of the scheduled appointment in advance so they may accompany resident... 3. In the event the family/responsible party is unable to accompany the resident, determine if the resident is physically and mentally able to go the appointment unattended...."</p> <p>The Immediate Jeopardy that began on 2/18/16 was removed on 2/24/16 when the facility removed the physical restriction of the linen cart blocking an exit and staff were in-serviced regarding placement of linen carts and obstructing emergency exits. The noncompliance remained at the lower scope and severity of isolated, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy because of need for continued monitoring for abuse prevention and reporting and physical restrictions.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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 0325 SS=D Bldg. 00	<p>This Federal tag relates to complaints IN00192728 and IN00193147.</p> <p>3.1-19(c) 3.1-45(a)(1)</p> <p>483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. Based on observation, interview, and record review, the facility failed to monitor the body weight of a resident at risk for significant weight loss for 1 of 4 residents reviewed for nutrition. (Resident #106).</p> <p>Finding includes: On 2/25/16 at 11:59 a.m., during an observation of Resident #106's lunch meal in the assisted dining area, the resident independently ate 5 bites of her chicken and 50% of her roll. Several staff present in the assisted dining area</p>	F 0325	<p>Facility respectfully request desk review. F325</p> <p>No residents were affected by this deficient practice.</p> <p>Facility audited all Residents at Risk for weight loss to ensure no other residents were affected by this deficient practice.</p>	03/09/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 02/26/2016
--	---	---	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>verbally encouraged the resident to eat. The resident was observed to eat only 2 additional bites of her meal with assistance. No substitutions were offered for the resident.</p> <p>On 2/26/16 at 9:10 a.m., the resident was observed in the assisted dining area. Review of the resident's breakfast meal ticket indicated she had refused her breakfast meal.</p> <p>On 2/25/16 at 1:00 p.m., during an interview, Unit Manager #7 indicated the resident "ate like a bird" and she often refused to eat all of her meals.</p> <p>On 2/26/16 at 10:03 a.m., during an interview, the ADON (Assistant Director of Nursing) indicated the resident's weight history indicated a significant weight loss for the 2/14/16 and 2/21/16 recorded weights. The ADON indicated the RD (Registered Dietician) reviewed resident weights and brought the information to the morning clinical meeting for review by the IDT (Interdisciplinary Team).</p> <p>On 2/26/16 at 10:28 a.m., during an interview, the RD indicated she ran a weekly weight report and reviewed the report for any resident who had a significant weight loss. She indicated any</p>		<p>In order to ensure other residents not to be affected by this deficient practice, resident weights will be reviewed weekly by Registered Dietician and Nurse Management and any triggers will be reviewed for nutritional risk by the Registered Dietician/Designee. Initiation of recommendations will be implemented and will be followed through the weekly Nutrition-At-Risk meeting until stable.</p> <p>Staff has been in-serviced in regards to all residents consuming less than 50% of offered meal and for offering substitutions of resident's choice. Substitutions being offered will be documented on resident's tray card.</p> <p>Random audits will be made by Director of Nursing / designee by utilization of resident's Consumption Records. Results of audit will be trended and report to facility's monthly Performance Improvement Meeting.</p> <p>Registered Dietitian is responsible for continued compliance.</p>	

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>resident who had a significant weight loss would be discussed in the morning clinical meeting and the IDT would determine if the resident would be placed on a risk program. The RD indicated she did not run a weekly report for the week of 2/14/16 or 2/21/16. The RD indicated she was not aware of Resident #106's significant weight loss.</p> <p>On 2/26/16 at 10:55 a.m., during an interview, the DON (Director of Nursing) indicated the resident had been on an appetite stimulant, but the resident's son expressed concerns about the resident's weight getting above 120 pounds and this was likely why the appetite stimulant was discontinued. The DON indicated if a resident was determined to be a nutritional risk, the resident would be placed into the assisted dining area for closer monitoring. She indicated she could not recall Resident #106's significant weight loss ever being discussed in the morning clinical meetings.</p> <p>On 2/26/16 at 11:25 a.m., during an interview, the resident's son indicated the family had never mentioned any concerns about the resident's weight exceeding 120 pounds. He indicated he had not been notified about any weight change with his mother recently.</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>On 2/25/16 at 9:58 a.m., review of Resident #106's medical record, indicated the resident's diagnoses included, but were not limited to, nutritional deficiency, unspecified, dysphagia, and Alzheimer's disease.</p> <p>The resident's current diet order was regular, mechanical soft texture with nectar thick liquids. The resident also received fortified cereal with her breakfast.</p> <p>Review of a document titled, Medical Nutrition Therapy Assessment," dated 6/3/14, indicated the resident had dysphagia and weighed 118 pounds at admission.</p> <p>Review of a document titled, "Weights and Vitals Summary," indicated the following:</p> <p>a. A weight record indicated Resident #106 weighed 129.8 pounds on 5/21/15 and weighed 119.7 pounds on 8/16/15, with weight loss in 3 months of 7.8% or 10.1 pounds.</p> <p>b. On 8/27/15, the resident weighed 118.4 pounds and indicated greater than 7.5% weight loss in 3 months (7.9% or</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>10.2 pounds). The record indicated the resident was on an appetite stimulant from 9/6/15-11/6/15 (Marinol).</p> <p>c. On 10/4/15, the resident weighed 117.2 pounds, which was greater than 10% weight loss in 6 months (10.1 % or 13.2 pounds).</p> <p>d. On 10/11/15, the resident's weight was 117 pounds. The record indicated a physician's order, dated 11/6/15 at 4:00 p.m., to discontinue Marinol and start Megace (appetite stimulant) 400 mg (milligrams) po (by mouth) daily time 2 weeks. The record did not indicate the appetite stimulant continued beyond the 2 weeks.</p> <p>e. Weight on 11/22/15 was 119.6 pounds and was 120.6 pounds on 11/29/15.</p> <p>e. On 2/14/16, Resident #106 weighed 109.2 pounds which was greater than 7.5% weight loss in 3 months (8.7% or 10.4 pounds).</p> <p>f. On 2/21/16, the resident's weight remained 109.2 pounds. The record did not indicate additional interventions were implemented to prevent weight loss..</p> <p>The resident's quarterly MDS (minimum data set) assessment dated 12/20/15,</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>indicated the resident had significant cognitive deficit and required extensive assistance with one person physical assist with eating a mechanically altered diet.</p> <p>A nutritional care plan dated 12/29/15, indicated the resident was at risk for nutritional decline related to difficulty swallowing and lack of ability to manage self care. Interventions included, but were not limited to, appetite stimulant per physician's order, monitor and evaluate intake, and provide assistance as needed.</p> <p>Review of documents titled, "Individual Resident Meal Intake Record," dated November 2015 through January 2016, indicated decline in the resident's average meal intake as follows:</p> <p>a. November 2015: breakfast-57%, lunch-55%, and dinner-42%</p> <p>b. December 2015: breakfast-36%, lunch-46%, and dinner-43%</p> <p>c. January 2016: breakfast-27%, lunch-37%, and dinner-40%</p> <p>On 2/26/16 at 11:00 a.m., the ADON provided a copy of a policy titled, "Nutrition Care Process-Identifying Nutritional Problems, Responding to Significant Change," dated 1/30/1998. The policy indicated, "Policy: The Nutrition Care Process is used by registered dietitians to improve the</p>			

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 02/26/2016
--	---	--	---

NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
---	---

(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>consistency and quality of individualized care for patients...Rationale: A patient who demonstrates a potential decline in nutritional status...will have appropriate interventions established and implemented to improve or maintain nutritional status...5. The registered dietician identifies patients needing further monitoring/evaluation...e. Having significant weight loss or gain...6. Through ongoing monitoring, nutritional interventions are evaluated for effectiveness...(i.e., refusal/decline of food)...7. Notify and consult with physician regarding patient's current nutritional status or significant change in nutritional status..."</p> <p>3.1-46(a)(1)</p>			