

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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
F000000	<p>This visit was for a Recertification and State Licensure survey. This visit also included the Investigation of Complaint IN00124805.</p> <p>Complaint IN00124805 - Substantiated - no deficiencies related to the allegations are cited.</p> <p>Survey Dates: January 7, 8, 9, 10 and 13, 2013</p> <p>Facility number: 000166 Provider number: 155265 AIM number: 100267080</p> <p>Survey team: Gloria J. Reisert, MSW/TC Joan Laux, RN Paula Igou, RN Caitlin Lewis, RN Gwen Pumphrey, RN (1/7 and 1/8/14)</p> <p>Census bed type: SNF: 11 SNF/NF: 101 Total: 112</p> <p>Census payor type: Medicare: 20 Medicaid: 67</p>	F000000	<p>Please accept this Plan of Correction as the center's credible allegation of compliance. Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. Please note this facility respectfully requests a paper compliance review for this survey. Sincerely, Tina Martin Executive Director</p>	

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:  155265		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129			
(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
F000241 SS=D	<p>Other: 25 Total: 112</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on January 23, 2014 by Cheryl Fielden RN.</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on record review and interview the facility failed to ensure all of the residents were treated with dignity. This affected 2 out of 5 residents reviewed for dignity. (Residents #50 and #53)</p> <p>Findings included:</p> <p>1. Review of the clinical record of Resident #50 on 01/13/2014 at 3:05 p.m., indicated the resident had the diagnosis of, but not limited to, brain</p>			F000241	<p>This facility respectfully requests Paper Compliance Review for this survey. Resident # 50 was discharged from this facility on 10/15/13. Resident # 53 Was evaluated and felt to have no post traumatic responses to dignity concerns. All residents have the potential to be affected. All residents will be interviewed by 1/31/14 in regards to being treated with dignity/respect and choices. Any concerns shall be reported to the administrator. In-servicing shall be provided to staff, including identified nurse, on both</p>		01/31/2014

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129		
(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>hemorrhage, bi-polar disorder with psychotic features, generalized anxiety, depressive disorder, diabetes mellitus, hypertension and osteoporosis.</p> <p>An Indiana State Department of Health Incident Report Form dated 7/25/2013, indicated the facility reported an incident with Resident #50. The brief description of the incident stated, "Per resident response to ABAQIS Questions (A quality management system that helps long term care facilities prepare for QIS by asking similar questions): Resident states that C.N.A. [CNA #3] yells at her....she pushes you to do things her way. States that [LPN #3] is snippy with her." The immediate action taken section stated the following, "ED immediately spoke with resident for details resident unable to state when these things occurred and was unable to state what specifically C.N.A. was yelling at her. ED spoke with resident for a very long time regarding her concerns and it appears [Resident #50] was upset because C.N.A. did not do her AM care [sic] she set her up to do her own and encouraged her to do her own and encouraged her to do per assignment sheet. This upset</p>		<p>Dignity/Respect and Choices. This in-service education will put emphasis on addressing residents in a respectful manner, timely response to requests for assistance and or care. The Staff Development Coordinator will include this in-service education with the orientation of all new employees. The facility will utilize the Abaqis process to interview all residents about dignity and choices as well as update individual preferences. The Activity Director will poll residents monthly during Resident Council meeting on Dignity and Respect concerns. Any concerns expressed will be reported to the administrator. This will be monitored daily through condition changes, careplan changes and individual sample interviews utilizing the Abaqis process. The Abaqis system which includes Dignity/Respect and choices will continue to be utilized monthly as a ongoing facility performance improvement practice. Results will be discussed monthly in the performance improvement meeting to ensure continued compliance. The DNS/Designee will be responsible to monitor process. Date of Completion 1/31/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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 and she felt C.N.A. should have completed her care. It has been determined through discussion with resident and [LPN #3] that [Resident #50] felt she was snippy while taking her glucose level and level was elevated and resident requested nurse to get a glass of OJ (orange juice) and put 3 packs of sugar in it. [LPN #3] informed resident her sugar was already high and OJ with sugar would increase it more. [LPN #3] informed resident it was time for breakfast and if she chose to get OJ she could get it in DR (dining room) but she recommends she stay within her diet, but if she wanted OJ it was available in DR. Please be advised resident has had increase in delusional episodes regarding a variety of issues over a period of time now. Resident states since we have talked she does not feel staff was abusive, she misunderstood. This report is being sent due to resident's initial responses to ABAQIS questions."</p> <p>The ABAQIS resident interview form dated 7/25/2013 for Resident #50 stated, "Have you ever been treated roughly by staff?" The form indicated the resident replied, "That one CNA on 300 hall. She pushes you, it's her</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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>way, always." "(She said it was [CNA #3] when I asked her name)" was written on the comments section of the ABAQIS resident interview form. The ABAQIS resident interview form stated, "Have staff yelled or been rude to you?" The form indicated the resident replied, "[CNA#3 ] constantly yelled @ (at) her...[LPN #3] is "snippy" with her."</p> <p>During an interview on 01/13/2014 at 3:52 p.m., the Executive Director indicated CNA #3 had already left for the day when the investigation was being conducted. She interviewed Resident #50 after this incident was reported to her. The Executive Director indicated the resident did not feel abused by the staff. She indicated she always takes handwritten statements, but could not locate any statements from this incident.</p> <p>During an interview on 01/13/2014 at 5:07 p.m., the Executive Director indicated she had spoken with both CNA #3 and LPN #3 after the incident about the resident's concerns. The Executive Director indicated she instructed LPN #3 to explain to residents if they cannot have something why they cannot. CNA #3 and LPN #3 were educated</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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 how to approach residents. The Executive Director indicated the resident was often confused.</p> <p>2. Record review on 1-13-14 at 8:53 a.m., Resident #53 was admitted S/P [status post] debridement of left foot decubitis ulcer, anemia, high blood pressure, stroke, dementia, depressive disorder, Parkinson disease, anxiety.</p> <p>The annual minimum data set (MDS) dated 11/14/13 indicated Resident #53 is confused. and requires extensive assistance with bed mobility, dressing, personal hygiene. The MDS indicated the resident was always incontinent of urine. It also indicated that the resident has had no behavioral issues.</p> <p>An observation of a bed bath and peri care on Resident # 53 was completed on 1/8/13 at 8:48 a.m., with CNA #1 and the medical records supervisor. CNA #1 removed the resident's dirty brief then picked up a clean washcloth and began to clean resident without washing hands or changing gloves. CNA # 1 left the resident fully exposed during the procedure without draping. Then after cleaning the resident, CNA #1 grabbed a</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129		
(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>clean towel without changing gloves or washing her hands. After washing the resident's body, the CNA touched the resident's face and stated, " I need to shave you today." The CNA changed washclothes approximately 5 times, but never changed water, gloves or washed hands. The CNA then grabbed cream to put on resident's scrotum with a dirty glove. after using the cream, she removed one glove, but didn't wash her hand. She then replaced the glove. The resident indicted he had to urinate, the medical records supervisor held the urinal for him. They did not clean his penis after urination. He was left un exposed in bed for over 20 minutes</p> <p>The care plan indicated a plan was in place for self care deficit, with approaches as follows: shampoo, complete bed bath 2 times a week. Care plan in place for resident's behavior of refusing to sit up to eat, refusing to turn or get out of bed. No care plan in place for refusal to dress.</p> <p>The monthly behavior sheet does have sheet in place for November 2013 for resist/refuses care. The care plan does not specify what kind of care. There was no documented</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129			
(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			
F000242 SS=D	<p>incidents of this for the month of November. The same behavior sheet is in place for October, no episodes identified.</p> <p>A review of the employee record of CNA #1 on 1/13/14 at 2:12 p.m., indicated that CNA #1 had been oriented on resident's rights and dignity, dated 4/24/13.</p> <p>The CNA core clinical competencies worksheet presented by the DON on 1/13/14 at 8:46 a.m., does indicate that CNA's are instructed on proper handwashing, AM care and peri care.</p> <p>3.1-3(t)</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>Based on interview and record review the facility failed to ensure residents were able to exercise their</p>	F000242	This facility respectfully requests Paper Compliance Review for this survey. Resident # 50 was discharged from this facility on 10/15/13. Resident # 53 Was	01/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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>right to make choice's based on their preferences. This affected 1 of 1 residents reviewed for choice's. (Resident #50)</p> <p>Findings include:</p> <p>Review of the clinical record of Resident #50 on 01/13/2014 at 3:05 p.m., indicated the resident had the diagnosis of, but not limited to, brain hemorrhage, bi-polar disorder with psychotic features, generalized anxiety, depressive disorder, diabetes mellitus, hypertension and osteoporosis.</p> <p>An Indiana State Department of Health Incident Report Form dated 7/25/2013, indicated the facility reported an incident with Resident #50. The brief description of the incident stated, "Per resident response to ABAQIS Questions (A quality management system that helps long term care facilities prepare for QIS by asking similar questions): Resident states that C.N.A. [CNA #3] yells at her....she pushes you to do things her way. States that [LPN #3] is snippy with her." The immediate action taken section stated the following, "ED immediately spoke with resident for details resident unable to state when</p>		<p>evaluated and felt to have no post tramatic responses to dignity concerns.All residents have the potential to be affected. All residents will be interviewed by 1/31/14 in regards to being treated with dignity/respect and choices. Any concerns shall be reported to the administrator.In-servicing shall be provided to staff, including identified nurse, on both Dignity/Respect and Choices. This in-service education will put emphasis on addressing residents in a respectful manner, timely response to requests for assistance and or care. The Staff Development Coordinator will include this in-service education with the orientation of all new employees.The facility will utilize the Abaqis process to interview all residents about dignity and choices as well as update individual preferences. The Activity Director will poll residents monthly during Resident Council meeting on Dignity and Respect concerns. Any concerns expressed will be reported to the administrator. This will be monitored daily through condition changes, careplan changes and individual sample interviews utilizing the Abaqis process. The Abaqis system which includes Dignity/Respect and choices will continue to be utilized monthly as a ongoing facility performance improvement</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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
	these things occurred and was unable to state what specifically C.N.A. was yelling at her. ED spoke with resident for a very long time regarding her concerns and it appears [Resident #50] was upset because C.N.A. did not do her AM care [sic] she set her up to do her own and encouraged her to do her own and encouraged her to do per assignment sheet. This upset resident and she felt C.N.A. should have completed her care. It has been determined through discussion with resident and [LPN #3] that [Resident #50] felt she was snippy while taking her glucose level and level was elevated and resident requested nurse to get a glass of OJ (orange juice) and put 3 packs of sugar in it. [LPN #3] informed resident her sugar was already high and OJ with sugar would increase it more. [LPN #3] informed resident it was time for breakfast and if she chose to get OJ she could get it in DR (dining room) but she recommends she stay within her diet, but if she wanted OJ it was available in DR. Please be advised resident has had increase in delusional episodes regarding a variety of issues over a period of time now. Resident states since we have talked she does not feel staff		practice and discussed monthly in the Performance Improvement meeting to ensure compliance is maintained. The DNS/Designee will be responsible to monitor process.Date of Completion 1/31/14	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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>was abusive, she misunderstood. This report is being sent due to resident's initial responses to ABAQIS questions."</p> <p>A complaints/grievances form dated 7/25 (there was no year indicated) had a handwritten statement signed by the Executive Director. The statement indicated Resident #50 requested the Executive Director to speak with her because the resident was upset. The resident "was again upset" about having orange juice with sugar packets. The resident informed her she could feel the juice going through her veins and it made her stop shaking. The Executive Director attempted to educate the resident about her diabetes. She explained to the resident "it is not protocol for a nurse to give her (orange juice with) sugar in it." The resident appeared very upset and delusion during the conversation. She was very tearful and insisted she had to have orange juice with sugar in it. The Executive Director informed the resident that if she chose to get orange juice and put sugar in it that it was her choice, "however my nurses cannot give this to her."</p> <p>During an interview on 01/13/2014</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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>at 5:07 p.m., the Executive Director indicated she had spoken with LPN #3 after the incident about the resident's concerns. The Executive Director told LPN #3 to explain to residents if they cannot have something why they cannot. LPN #3 was educated on how to approach residents.</p> <p>3.1-3(u)(1)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129		
(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	
F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on observation, record review and interview, the facility failed to ensure a care plan was in place for one of one resident 's refusal of care related to refusing to wear clothes while in bed. (Resident #53)</p> <p>Findings include:</p> <p>A record review on 1/13/14 at 8:53 a.m., indicated resident #53 was admitted with the following diagnosis, which included but were not limited to, S/P [status post]</p>	F000279	This facility respectfully requests Paper Compliance Review for this survey. Resident # 53 care plan has been revised and updated to include individual preferences regarding clothing, care, and refusal of care. All residents have the potential to be affected. All current resident care plans will be reviewed and updated accordingly for individual preferences by 1/31/14. Nurses will be in-serviced by 01/31/14 regarding the development, review and revision of care plan along with Policy and Procedure on resident preferences. New residents will be interviewed upon	01/31/2014	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129			
(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>debridement of left foot decubitis ulcer, anemia, high blood pressure, stroke, dementia, depressive disorder, Parkinson disease, anxiety.</p> <p>The annual minimum data set (MDS) dated 11/14/13 indicated resident #53 was confused and required extensive assistance with bed mobility, dressing, personal hygiene, and the resident was always incontinent of urine. It also indicated that the resident has no behavioral issues.</p> <p>Observation of resident # 53 on 1/13/14 at 8:29 a.m., resident was observed lying in bed with a brief on, covered with thin sheet. Resident was confused and unable to be interviewed.</p> <p>An interview the medical records supervisor on 1/13/14 at 8:49 a.m., she indicated that he usually did not wear clothes while in bed, it's his choice and he does refuse to wear clothes at times. She asked him if he'd put on a shirt and he stated " h*** no."</p> <p>The care plan indicated a plan was in place for self care deficit, with approaches as follows: shampoo, complete bed bath 2 times a week.</p>				<p>admission for preferences and choices and care planned accordingly. All care plans will be reviewed and revised reflecting individual preferences by 1/31/14. Random audits of care plans will be conducted bi-weekly for 3 months and then monthly thereafter and ongoing to ensure personal preferences are addressed on the plan of care. Results will be reviewed monthly during Performance Improvement meeting to ensure continued compliance. Date of completion 1/31/14</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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 was in place for resident's behavior of refusing to sit up to eat, refusing to turn or get out of bed. No care plan was in place for refusal to dress.</p> <p>The monthly behavior sheet was in place for November 2013 for resist/refuses care. The care plan does not specify what kind of care. There was no documented incidents of this for the month of November. The same behavior sheet was in place for October, no episodes identified.</p> <p>An interview with LPN #2 on 1/13/14 at 9:36 a.m., indicated that resident #53 usually wore a gown while in bed. He sometimes requested a tee shirt. She did indicate that at times he refuses to wear anything stating he was "hot".</p> <p>The DON presented the facility's current care plan policy on 1/13/14 at 11:33 a.m. The policy indicated that a comprehensive care plan was developed that was "consistent with the residents' specific conditions, risks, needs, behaviors, preferences, and with the standards of practice including measurable objectives, interventions, services, and timetables to meet the</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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's assessment, or as identified in relation to the resident's response to the interventions or changes in the resident's condition. A care plan needs to be put in place if the resident refuses certain services or treatments that professional staff believe necessary for the resident to attain his or her highest pracicable level of well being. The desires of the resident are documented in the care plan."</p> <p>3.1-35(a)</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129			
(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			
F000441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview and</p>	F000441	This facility respectfully requests Paper Compliance Review for this	02/04/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/13/2014	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD				STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129			
(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 provide adequate infection control during morning care on one of one residents observed in that the CNA failed to wash hands or change gloves during the procedure. (Resident #53)</p> <p>Findings include:</p> <p>A record review on 1/13/14 at 8:53 a.m., indicated resident #53 was admitted with the following diagnosis, which included but were not limited to, S/P [status post] debridement of left foot decubitis ulcer, anemia, high blood pressure, stroke, dementia, depressive disorder, Parkinson disease, anxiety.</p> <p>The annual minimum data set (MDS) dated 11/14/13 indicated resident #53 was confused and required extensive assistance with bed mobility, dressing, personal hygiene, and the resident was always incontinent of urine. It also indicated that the resident has no behavioral issues.</p> <p>An observation of bed bath and peri care on resident # 53 on 1/8/13 at 8:48 a.m., with CNA #1 and medical records supervisor. CNA #1 removed the resident's dirty brief</p>		<p>surveyResident # 53 was assessed on 1/27/14 and found to have no signs or symptoms of any infectious process.All residents who require assistance with care have the potential to be affected. Residents screenings found no resident to be affected.In-service education regarding Policy and Procedures on Infection Control will be provided to Nursing Assistants by 1/31/14. Individual In-service and Competency evaluation was completed on identified staff member on 01/15/14.Competency evaluations regarding bed baths, perineal care and handwashing will be conducted on all Nursing Assistants. Random audits will be conducted daily for 30 days and will include all shifts. 10% of census will be completed weekly: 4% on days, 4% on evenings, and 2% on nights. After Initial 30 days random audits will be conducted bi-weekly for 3 months with results discussed in monthly Performance Improvement meeting. Audits will then be conducted randomly on a quarterly basis as a ongoing facility practice to ensure continued compliance.Date of Completion 02/04/14</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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>then picked up a clean washcloth and began to clean resident without washing hands or changing gloves. After cleaning the resident, CNA #1 grabbed a clean towel without changing gloves or washing her hands. Then, after washing the resident's body, CNA #1 touched the resident's face and stated, " I need to shave you today." CNA #1 changed washclothes approximately 5 times, but never changed water, gloves or washed hands. CNA #1 grabbed cream to put on resident's scrotum with a dirty glove, after using the, cream CNA #1 removed one glove, but didn't wash her hands. She then replaced the glove. The resident indicted he had to urinate, the medical records supervisor held the urinal for him. They did not clean his penis again after urination.</p> <p>In an interview with CNA #1 on 1/8/13 at 9:00 a.m., ahe indicated you should change gloves between residents.</p> <p>A policy on handwashing was received from the DON on 1/13/14 at 8:47 a.m. The policy indicates that handwashing should be performed (but not limited to) before work, after toileting, after touching</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155265	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/13/2014
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129
---	--

(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>blood, body fluids, excretions and contaminated items, whether or not gloves are worn, and between tasks on the same patient when contaminated with body fluids to prevent cross contamination to other body sites, and If moving from a contaminated body site to a clean body site during patient care.</p> <p>The CNA core clinical competencies worksheet presented by the DON on 1/13/14 at 8:46 a.m., does indicate CNA's are instructed on proper handwashing, for a.m. care and peri care.</p> <p>3.1-18(i)</p>			