

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/23/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
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F0000	<p>This visit was for the Investigation of Complaint IN00104758.</p> <p>Complaint IN00104758 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Unrelated deficiencies are cited.</p> <p>Survey dates: March 22 and 23, 2012</p> <p>Facility number: 010613 Provider number: 155659 AIM number: 200221040</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 23 SNF/NF: 79 Total: 102</p> <p>Census payor type: Medicare: 48 Medicaid: 37 Other: 17 Total: 102</p> <p>Sample: 8</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review 3/29/12 by Suzanne Williams, RN			

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F0279 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 residents at risk for dehydration had care plans developed to ensure required fluid amounts were offered consistently for 2 of 3 residents reviewed who received nectar thick liquids. in a sample of 8. (Residents E and H)</p> <p>Findings include:</p> <p>1. On 3/22/12 at 4:25 p.m., Resident E was observed in bed. The head of the bed was up, and the resident was receiving a</p>	F0279	It is the policy of this facility to use the results of a resident assessment to develop, review and revise a comprehensive plan of care, that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs. Resident E had care plans revised to reflect interventions for offering required nectar thick liquids to decrease risk of dehydration. Resident H had liquids upgraded to thin liquids on 3/30/12. An audit will be done for all residents on thickened liquids to ensure there is a corresponding care plan	04/06/2012	

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	breathing treatment by mask. His feet were elevated off the bed by a pillow under the legs. In front of the resident on the overbed table was a plastic cup with straw. In the cup was about a quarter inch of liquid. A visitor who identified herself as the resident's wife was at the bedside. During interview at this time, the wife indicated she visits daily from noon until about 6:00 p.m. She indicated the resident came to the facility for therapy after he was in the hospital with pneumonia. She indicated the pneumonia "really took it out of him," and he is "weak." She indicated the resident had been unable to complete his therapy recently, because his blood pressure was too low. She indicated the drop in blood pressure was thought to be related to dehydration. She indicated they "took his pitcher away," as she motioned toward the bedside table. She indicated staff have not brought any fluids in during the afternoons when she is visiting. As she motioned toward the plastic cup on the overbed table, she indicated, "He drank the glass of thickened water" when they did bring it today. She indicated the fluids the resident receives when she is visiting are the three cups on his meal trays during lunch and supper. She indicated at home the resident always consumed plenty of fluids, including water and Gatorade.		addressing interventions to offer fluids to decrease risk of dehydration. All residents on Thickened liquids will be monitored weekly by the IDT at the Nutritional At Risk meeting for plan of care and Intakes. The SDC and/or designee will in-service the IDT and nursing staff to the development of care plans, specifically to implement a care plan for residents on thickened liquids. The DNS and/or designee will audit each unit weekly for 12 weeks to ensure residents with thickened liquids have corresponding care plans (see attachment A). All residents on Thickened liquids will be monitored weekly by the IDT at the Nutritional At Risk meeting for plan of care and Intakes as part of on-going monitoring. The DNS/Designee will review results of the audit at the monthly Performance Improvement (PI) committee-meeting x 3 months then the PI committee will determine if 100% compliance has been achieved and the need for on going monitoring. The DNS will be responsible to ensure compliance with this standard				

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	<p>The clinical record for Resident E was reviewed on 3/22/12 at 4:05 p.m. The record indicated the resident was admitted to the facility on 3/10/12 following hospitalization for treatment of pneumonia. Physician's orders at the time of admission indicated the resident was on a regular diet with regular liquids.</p> <p>A physician's order, signed as requested by the Speech Language Pathologist, was received on 3/14/12 for "Participate in video swallow x-ray [symbol for secondary to] oropharyngeal dysphagia; downgrade to nectar liquid & mechanical soft."</p> <p>The Medical Nutrition Therapy Assessment, dated 3/20/12, indicated the resident's fluid requirement was 1953 cc fluid per day.</p> <p>A care plan, dated as initiated 3/16/12, indicated, "[Name of Resident E] has severe cognitive deficits related to Alzheimer's dementia. New DX [diagnosis] FTT [failure to thrive] on 3/20/12." The care plan also indicated, with date initiated of 3/20/12, "Inadequate po [by mouth] intake...s/s [signs and symptoms] dehydration." Interventions included, but were not limited to, intravenous fluids on 3/20/12 and the</p>			

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	<p>addition of 90 cc of 2-cal HN (liquid food supplement) four times daily. The care plans related to potential for constipation and functional bladder incontinence, both dated as initiated on 3/19/12, indicated interventions including "encourage fluids."</p> <p>The care plan lacked documentation of changes in the care plan related to the downgrade of fluids to nectar thick when the type of fluid was changed on 3/14/12. A specific plan to ensure the resident was offered 1953 cc of the nectar thick fluids was not indicated.</p> <p>During interview on 3/22/12 at 4:55 p.m., LPN #21 indicated Resident E had received a liter of intravenous fluids on 3/20/12 and would be starting more intravenous fluids today, 3/22/12.</p> <p>Documentation was lacking in Nurse's Progress Notes, on the Medication Administration Record, or other Comprehensive Intake-Output Records of fluids offered, or of Resident E's fluid intake from 3/14/12 until 3/20/12.</p> <p>The CNA Report Sheet was provided by LPN #15 on 3/22/12 at 11:30 a.m. The specific assignment for Resident E related to "Thicken Liquids" indicated, "Thin." Documentation was lacking to indicate</p>			

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	<p>the resident was to be offered thickened liquids.</p> <p>During interview on 3/23/12 at 3:20 p.m., the District Director of Clinical Operations (DDCO) indicated she felt the resident's care plan adequately addressed his hydration needs. She indicated nurses would give the resident 90 cc of fluid at each medication pass, he would receive his fluids with each meal, and he was now also receiving the 90 cc of 2-Cal HN four times daily. She indicated the facility's policies did not indicate an Intake and Output record was needed for residents on thickened liquids.</p> <p>2. The clinical record for Resident H was reviewed on 3/23/12 1:40 p.m.</p> <p>The physician's Admission Orders, dated 2/24/12, indicated the resident was on a regular mechanical soft diet with regular liquids.</p> <p>A physician's order, dated 3/1/12, indicated, "1. Downgrade diet to mech [mechanical] soft [symbol for with] NTL [nectar thick liquid]. 2. Add pt. [patient] to restorative dining all meals. 3. Sched [schedule] VFSS [videofluroscopic swallow study] [symbol for secondary to] oropharyngeal dysphagia."</p>			

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	<p>The Medical Nutrition Therapy Assessment, dated 2/29/12, indicated the resident's fluid need per day was 1800 cc.</p> <p>A Nutrition Services Visit Note, dated 3/13/12, indicated, "...Care plan meeting held today and D-I-L [daughter in law] concerned about adequate fluid intake. Beverage preferences updated. Estimated fluid needs 2100 cc [sic]...Patient Comments: Dislikes Ensure Plus. Does not like many NTL choices."</p> <p>The resident's care plan, with date initiated 3/13/12, indicated, "Inadequate...fluid intake r/t [related to]...dislike of NTL aeb [as evidenced by]...poor acceptance of nectar thickened liquids." Interventions included encouraging intake of nectar thick liquids and updating preferences as needed, providing supplements as ordered, monitoring for signs and symptoms of dehydration, and monitoring the weight and food intake. The plan did not include specific interventions for offering the needed fluids daily or monitoring the resident's intake of fluids daily.</p> <p>Review of Resident H's Medication Record for March 2012 on 3/23/12 at 3:20 p.m., indicated the following had been added to the Medication Record effective 3/23/12: "Offer NTL between</p>			

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	meals 240 ml & record amt. [amount] consumed." Times for offering the fluids were listed as 10:00 a.m., 2:00 p.m., and at bedtime. 3.1-35(a)			

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the care plan related to incontinent care was followed for 3 of 3 residents observed during toileting and incontinent care, in a sample of 8 residents. (Residents E, F, and I)</p> <p>Findings include:</p> <p>1. The clinical record for Resident E was reviewed on 3/22/12 at 4:05 p.m.</p> <p>The care plan related to functional bladder incontinence, dated as initiated 3/19/12, indicated, "He will remain free from skin breakdown due to incontinence and brief use through the review date." Interventions included, but were not limited to, "INCONTINENT: ...Wash, rinse, and dry perineum...."</p> <p>During observation of toileting for Resident E on 3/23/12 at 10:30 a.m., the resident was observed seated on the toilet, and a brief was observed in the trash can. CNA #6 was assisting the resident. During interview at this time, CNA #6</p>	F0282	<p>It is the policy of this facility to arrange for services to be provided by qualified persons in accordance with each resident's written plan of care. Residents E, F, I had no adverse outcome. C.N.A. #6, 18 and 24 have had written Performance Improvement and education. All incontinent residents have the potential to be affected. The SDC/Designee has in-serviced all nursing staff on incontinent care and following the plan of care. The SDC/Designee will validate through a skills check off all C.N.A.s for proficient incontinent care. All C.N.A.s will have incontinent care skills checked off X 2 by nursing supervisors and any deficient practice addressed by the SDC/DNS. Incontinent care audits will be completed twice weekly for 12 weeks (see attachment B). Incontinent care skills competency will be completed for all new hires during orientation as part of an on-going system review and annually for current employees. The results of the audit will be reported at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if</p>	04/06/2012			

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	<p>indicated the resident's brief was already wet when she assisted the resident to the toilet. Resident E was not observed to urinate or defecate while on the toilet. When Resident E indicated he was finished on the toilet, CNA #6 applied a clean brief and assisted Resident E to transfer from toilet to wheel chair. No skin care was provided to the resident.</p> <p>2. The clinical record for Resident F was reviewed on 3/23/12 at 1:15 p.m.</p> <p>The care plan, dated as initiated 3/21/12, indicated, "[Name of resident] has bladder and bowel incontinence r/t [related to] dementia with ST/LT [short term/long term] memory impairment. [Name of resident] will be clean, dry, odor free and remain free from skin breakdown due to incontinence and brief use through the review date." Interventions included, but were not limited to, "INCONTINENT...Wash, rinse and dry perineum..."</p> <p>During observation of toileting for Resident F on 3/23/12 at 1:00 p.m., the resident was observed to transfer from wheel chair to toilet with the assistance of CNA #18, who removed the resident's brief. During interview at this time, CNA #18 indicated the brief was wet. When the resident indicated she was finished on</p>		100% compliance has been achieved and if the need for further monitoring is required. The DNS will be responsible to ensure compliance with this standard				

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	<p>the toilet, CNA#18 wiped the resident's perineal area with dry toilet paper, applied a clean brief, and assisted the resident to transfer back to the wheel chair. No skin care was provided to the resident.</p> <p>3. The clinical record for Resident I was reviewed on 3/23/12 at 3:00 p.m.</p> <p>The record indicated a care plan, dated 1/14/12, with "Problem: Incontinence of bowel/bladder - at risk for UTIs [urinary tract infection] and skin breakdown. Goal: To ensure skin clean and dry, odor free daily X [times] 90 days..." Interventions included, but were not limited to, "Incontinent care with each episode."</p> <p>During observation of incontinent care on 3/23/12 at 1:00 p.m., CNAs #24 and #2 transferred Resident I from wheel chair to bed, removed the resident's slacks, and loosened the resident's brief. CNA #24 indicated the brief was wet. CNA #2 went to the resident's restroom and returned with a wet washcloth. The resident was rolled onto her right side, and the inner labia and the anal and surrounding area was cleansed of light brown stool, using the one washcloth. The soiled brief was rolled/folded, and a clean brief was placed under the resident. The resident was rolled to the left side, and the soiled brief was removed from</p>			

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	<p>under the resident, and the clean brief was placed fully under the resident. The resident was rolled onto her back, and the clean brief was fastened. The outer sides of the buttocks, abdomen, vulva, outer labia, and skin creases of the groin were not observed to be cleansed. During interview at this time in regard to the products used to cleanse the resident's skin, CNA #2 indicated she obtained a small amount of the hand soap in the resident's restroom on one end of the wash cloth, and used the other end of the wash cloth for rinsing. CNA #2 looked in the drawer of the resident's bedside table and showed a bottle of no-rinse skin cleanser. CNA #2 indicated she would use the no-rinse skin cleanser if the resident's skin was heavily soiled.</p> <p>During interview on 3/23/12 at 3:20 p.m., the Director of Nursing and District Director for Clinical Operations nodded yes when interviewed as to whether a resident's skin should be cleansed when a wet brief is removed during toileting.</p> <p>On 3/23/12 at 4:15 p.m., the Director of Nursing provided the facility's policy related to "Incontinence/Perineal Care." The policy indicated, "Rationale: Cleanliness of the perineum helps to prevent infection, skin breakdown and odor by removing irritating and odorous</p>			

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	<p>secretions that collect on the inner surface of the labia or under the foreskin of the penis. Perineal care is provided to the resident who needs assistance to maintain perineal cleanliness....Procedure...14. Wet washcloth/disposable washcloth or use a premoistened cloth (e.g., wet wipe), make a mitt and apply soap or no rinse cleansing solution, if not using the a [sic] pre-moistened cloth. 15. Gently wash the pubic area.... 16. Rinse and pat dry, unless using a no rinse cleansing solution. 17. Have resident turn away from you and using new washcloth/disposable washcloth of pre-moistened cloth, wash around anus. Rinse area and dry...."</p> <p>3.1-35(g)(2)</p>				

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(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			
F0312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>Based on observation, interview, and record review, the facility failed to ensure the skin was thoroughly cleansed after wet and soiled briefs were removed for 3 of 3 residents observed during incontinent care in a sample of 8. (Residents E, F, and I)</p> <p>Findings include:</p> <p>1. During observation of toileting for Resident E on 3/23/12 at 10:30 a.m., the resident was observed seated on the toilet, and a brief was observed in the trash can. CNA #6 was assisting the resident. During interview at this time, CNA #6 indicated the resident's brief was already wet when she assisted the resident to the toilet. When interviewed in regard to any problems with Resident E's skin, CNA #6 indicated the skin on Resident E's bottom was red and broken down when he was admitted to the facility but had improved. Resident E was not observed to urinate or defecate while on the toilet. When Resident E indicated he was finished on the toilet, CNA #6 applied a clean brief and assisted Resident E to transfer from</p>	F0312	<p>It is the policy of this facility to provide for a resident who is unable to carry out activities of daily living, the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The SDC or designee will in-service CNAs #6,18 and 24 on providing incontinence care. Residents E, F, and I have had no adverse effect. All incontinent residents have the potential to be affected. The Director of Nursing or designee will assess resident's personal hygiene with special attention to incontinent care. Staff members identified as not providing appropriate incontinent care to residents, identified through this assessment process, will receive individual in-service by the Staff Development Coordinator (or designee) and/or be counseled by the Director of Nursing or designee as indicated. The Staff Development Coordinator or designee will in-service the current nursing staff regarding providing proper incontinent care. The Director of Nursing, Staff Development Coordinator or their designees will observe the nursing staff performing incontinent care. As</p>	04/06/2012			

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	<p>toilet to wheel chair. No skin care was provided to the resident.</p> <p>The clinical record for Resident E was reviewed on 3/22/12 at 4:05 p.m. The record indicated the resident was admitted to the facility on 3/10/12 following hospitalization for treatment of pneumonia.</p> <p>The Medical Nutrition Therapy Assessment, dated 3/20/12, indicated in "Nutrition-Focused Physical Findings" the following "Skin Concerns: Bottom reddened with dark red area to left upper buttocks."</p> <p>The care plan related to functional bladder incontinence, dated as initiated 3/19/12, indicated, "He will remain free from skin breakdown due to incontinence and brief use through the review date." Interventions included, but were not limited to, "INCONTINENT: ...Wash, rinse, and dry perineum...."</p> <p>2. During observation of toileting for Resident F on 3/23/12 at 1:00 p.m., the resident was observed to transfer from wheel chair to toilet with the assistance of CNA #18, who removed the resident's brief. During interview at this time, CNA #18 indicated the brief was wet. When the resident indicated she was finished on</p>		<p>necessary each employee will be re in-serviced and/or counseled to assure compliance with the policies of the facility. The DNS or designee will monitor through direct observation of nursing staff performing incontinent care for proper procedures. All C.N.A.s will have incontinent care skills checked off X 2 by nursing supervisors through direct observation of care and any deficient practice addressed by the SDC/DNS (see attachment B). Incontinent care audits will be completed twice weekly for 12 weeks. Incontinent care skills competency will be completed for all new hires during orientation as part of an on-going system review and annually for currrent employees. The results of the audit will be reported at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if 100% compliance has been achieved and if the need for further monitoring is required. The DNS will be responsible to ensure compliance with this standard</p>				

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	<p>the toilet, CNA#18 wiped the resident's perineal area with dry toilet paper, applied a clean brief, and assisted the resident to transfer back to the wheel chair. No skin care was provided to the resident.</p> <p>The clinical record for Resident F was reviewed on 3/23/12 at 1:15 p.m. The record indicated the resident was readmitted to the facility on 3/12/12.</p> <p>The care plan, dated as initiated 3/21/12, indicated, "[Name of resident] has bladder and bowel incontinence r/t [related to] dementia with ST/LT [short term/long term] memory impairment. [Name of resident] will be clean, dry, odor free and remain free from skin breakdown due to incontinence and brief use through the review date." Interventions included, but were not limited to, "INCONTINENT...Wash, rinse and dry perineum...."</p> <p>3. During observation of incontinent care on 3/23/12 at 1:00 p.m., CNAs #24 and #2 transferred Resident I from wheel chair to bed, removed the resident's slacks, and loosened the resident's brief. CNA #24 indicated the brief was wet. CNA #2 went to the resident's restroom and returned with a wet washcloth. The resident was rolled onto her right side, and the inner labia and the anal and</p>				

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	<p>surrounding area was cleansed of light brown stool, using the one washcloth. The soiled brief was rolled/folded, and a clean brief was placed under the resident. The resident was rolled to the left side, and the soiled brief was removed from under the resident, and the clean brief was placed fully under the resident. The resident was rolled onto her back, and the clean brief was fastened. The outer sides of the buttocks, abdomen, vulva, outer labia, and skin creases of the groin were not observed to be cleansed. During interview at this time in regard to the products used to cleanse the resident's skin, CNA #2 indicated she obtained a small amount of the hand soap in the resident's restroom on one end of the wash cloth, and used the other end of the wash cloth for rinsing. CNA #2 looked in the drawer of the resident's bedside table and showed a bottle of no-rinse skin cleanser. CNA #2 indicated she would use the no-rinse skin cleanser if the resident's skin was heavily soiled.</p> <p>The clinical record for Resident I was reviewed on 3/23/12 at 3:00 p.m. The record included a care plan, dated 1/14/12, with "Problem: Incontinence of bowel/bladder - at risk for UTIs [urinary tract infection] and skin breakdown. Goal: To ensure skin clean and dry, odor free daily X [times] 90 days...." Interventions</p>			

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	<p>included, but were not limited to, "Incontinent care with each episode."</p> <p>During interview on 3/23/12 at 3:20 p.m., the Director of Nursing and District Director for Clinical Operations nodded yes when interviewed as to whether a resident's skin should be cleansed when a wet brief is removed during toileting.</p> <p>On 3/23/12 at 4:15 p.m., the Director of Nursing provided the facility's policy related to "Incontinence/Perineal Care." The policy indicated, "Rationale: Cleanliness of the perineum helps to prevent infection, skin breakdown and odor by removing irritating and odorous secretions that collect on the inner surface of the labia or under the foreskin of the penis. Perineal care is provided to the resident who needs assistance to maintain perineal cleanliness....Procedure...14. Wet washcloth/disposable washcloth or use a premoistened cloth (e.g., wet wipe), make a mitt and apply soap or no rinse cleansing solution, if not using the a [sic] pre-moistened cloth. 15. Gently wash the pubic area.... 16. Rinse and pat dry, unless using a no rinse cleansing solution. 17. Have resident turn away from you and using new washcloth/disposable washcloth of pre-moistened cloth, wash around anus. Rinse area and dry...."</p>			

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	3.1-38(a)(3)(A)			

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F0323 SS=D	<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>Based on observation, record review, and interview, the facility failed to ensure planned supervision and assistive devices were used during transfers for 2 of 3 residents observed during transfer from wheel chair to toilet/bed among 6 residents reviewed related to falls in a sample of 8. (Residents E and F)</p> <p>Findings include:</p> <p>1. From the Nurse's Station on 3/23/12 at 10:30 a.m., Resident E was observed seated in his wheel chair. He was wearing an alarm to alert staff to unsupervised attempt to ambulate. The resident spoke to CNA #6 who was nearby, but the resident's conversation with CNA #6 was not audible. Twice he removed his foot from the wheel chair's foot pedal and stepped toward the floor. The resident's wheel chair was rolled by CNA #6 down the hall and into his room. Upon entrance to the room's restroom, Resident E was observed seated on the toilet with CNA #6 attending him. During interview at this time, CNA #6</p>	F0323	<p>It is the policy of this facility to 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. Residents E and F have had no adverse effect. The SDC/DNS have provided education and counseling to C.N.A.s #6 and # 18 regarding supervision and assistive devices to prevent accidents and injuries. All residents needing supervision and assistive devices with transfers have the potential to be affected. The DNS or designee will assess residents during transfer for proper implementation of supervision and assistive devices. The DNS or her designee, will provide individual in-servicing and/or counseling to staff members identified as not providing necessary care and services to residents identified through this assessment process. The SDC/Designee will in-service all nursing staff on use of the C.N.A. assignment sheet to ensure supervision and use of assistive devices to reduce risk of</p>	04/06/2012	

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	<p>indicated she could not leave the resident, since he had an alarm. When Resident E indicated he was finished, CNA #6 placed a clean brief into the resident's trousers and encouraged the resident to use the grab bar next to the toilet as she pulled the resident's clean brief and trousers into place during the transfer. The resident did not straighten his knees to stand as he transferred into the wheel chair seat. CNA #6 used the resident's trouser waistband to lift and guide him into the seat. A gait belt was not used.</p> <p>The clinical record for Resident E was reviewed on 3/22/12 at 4:05 p.m. The record indicated the resident was admitted to the facility on 3/10/12 following hospitalization for treatment of pneumonia.</p> <p>The Nurse Practitioner's noted, dated 3/20/12, indicated the resident's lower extremities were weak.</p> <p>The care plan, dated as initiated 3/16/12, indicated, "Focus: [name of Resident E] has episodes of rejecting care - he will attempt to transfer and ambulating [sic] independently, placing him at risk for falls. He was able to do these tasks independently at home prior to his hospitalization , and does not appear to understand that this is no longer safe."</p>		<p>accidents and injuries. The DNS/Designee will monitor through direct observation of nursing staff performing transfers, to assure nursing personnel are providing necessary supervision and use of assistive devices as planned on the C.N.A assignment sheets, twice weekly for 12 weeks (see attachment C). Transfers and Gait Belt procedures will be included in orientation for new hires and as part of annual competency skills validation as part of monitoring on-going to prevent accidents and hazards. The results of the audit will be reported at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if 100% compliance has been achieved and if the need for further monitoring is required. The DNS will be responsible to ensure compliance with this standard</p>				

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	<p>Interventions included, but were not limited to, "Encourage [name of Resident E] to attend all therapy sessions to help build his strength....Explain risks of transferring without assistance...."</p> <p>The CNA Report Sheet was provided by LPN #15 on 3/22/12 at 11:30 a.m. The cover page of the Report Sheet included, but was not limited to, "...Always use a gait belt with transfers unless otherwise specified...." The specific assignment for Resident E related to "Assist Device and Transfers" indicated, "GB X 2 - W/C [gait belt times two - wheel chair]."</p> <p>2. During observation on 3/23/12 at 1:00 p.m., Resident F was seated in her wheel chair and was rolled by CNA #18 down the hall and into her room. During interview at this time, CNA #18 indicated she would be toileting Resident F. CNA #18 rolled Resident F into her restroom and closed the door. CNA #18 encouraged the resident repeatedly to hold the grab bar next to the toilet. The resident held one hand and then the other on the grab bar, and with bent knees, transferred to the toilet, while CNA #18 pulled up on the elastic waistband of the resident's sweat pants. The resident was still wearing her sweat pants and brief when she sat on the toilet. CNA #18 encouraged the resident to hold the grab</p>			

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	<p>bar and stand again, and as the resident stood slightly, the CNA pulled the pants and brief down before the resident sat again onto the toilet. When the resident was finished on the toilet, CNA #18 again encouraged the resident to grasp the grab bar. CNA #18 pulled and held the resident's brief and sweat pants to pull them up as the resident transferred with bent knees from toilet to wheel chair. No gait belt was used during the transfers.</p> <p>The clinical record for Resident F was reviewed on 3/23/12 at 1:15 p.m. The record indicated the resident was readmitted to the facility on 3/12/12.</p> <p>The care plan, with date initiated of 3/21/12, indicated, "[Name of Resident F] has an ADL [Activities of Daily Living] Self Care Performance Deficit r/t [related to] dementia inpaired [sic] st/lt [short term/long term] memory impairmnt [sic] and generalized weakness." Interventions included, but were not limited to, "...TRANSFER: [name of Resident F] requires total assistance with transfers."</p> <p>The CNA Report Sheet was provided by LPN #15 on 3/22/12 at 11:30 a.m. The cover page of the Report Sheet included, but was not limited to, "...Always use a gait belt with transfers unless otherwise specified...." The specific assignment for</p>			

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	<p>Resident F related to "Assist Device and Transfers" indicated, "GB X 2 - W/C [gait belt times two - wheel chair]."</p> <p>When interviewed on 3/23/12 at 3:40 p.m., in regard to the assignment for transfer of Residents E and F, and if gait belt and two staff were needed for transfers, the Director of Nursing indicated that is what the assignment sheet says.</p> <p>This federal tag relates to Complaint IN00104758.</p> <p>3.1-45(a)(2)</p>			

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F0327 SS=D	<p>483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION</p> <p>The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.</p> <p>Based on observation, record review, and interview, the facility failed to ensure the resident at risk for dehydration had a care plan developed and implemented to ensure fluids were offered consistently for 1 of 3 residents reviewed who received nectar thick liquids, in a sample of 8. (Resident E)</p> <p>Findings include:</p> <p>On 3/22/12 at 4:25 p.m., Resident E was observed in bed. The head of the bed was up, and the resident was receiving a breathing treatment by mask. His feet were elevated off the bed by a pillow under the legs. In front of the resident on the overbed table was a plastic cup with straw. In the cup was about a quarter inch of liquid. A visitor who identified herself as the resident's wife was at the bedside. During interview at this time, the wife indicated she visits daily from noon until about 6:00 p.m. She indicated the resident came to the facility for therapy after he was in the hospital with pneumonia. She indicated the pneumonia "really took it out of him," and he is "weak." She indicated the resident had</p>	F0327	<p>It is the policy of this facility to provide each resident with sufficient fluid intake to maintain proper hydration and health. Resident E has a care plan developed and implemented to ensure fluids are offered consistently. All residents with thickened liquids have had their care plans reviewed and revised to ensure fluids are offered consistently and recorded. All residents on thickened liquids will be followed weekly by the IDT Nutritional at Risk meeting for plan of care and review Intake records. The SDC/Designee will in-service the IDT and nursing staff on development and implementation of care plans to address consistent offering of fluids to residents on thickened liquids and determined to be at risk for dehydration and documentation of intake. The DNS/Designee will monitor weekly Intake and output record of residents on thickened liquids or determined to be at risk for dehydration for development of the care plan and implementation for 3 months (see attachment A). All residents on thickened liquids will be followed weekly by the IDT Nutritional at Risk meeting for plan of care and</p>	04/06/2012

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	<p>been unable to complete his therapy recently, because his blood pressure was too low. She indicated the drop in blood pressure was thought to be related to dehydration. She indicated they "took his pitcher away," as she motioned toward the bedside table. She indicated staff have not brought any fluids in during the afternoons when she is visiting. As she motioned toward the plastic cup on the overbed table, she indicated, "He drank the glass of thickened water" when they did bring it today. She indicated the fluids the resident receives when she is visiting are the three cups on his meal trays during lunch and supper. She indicated at home the resident always consumed plenty of fluids, including water and Gatorade.</p> <p>During interview on 3/22/12 at 4:55 p.m., LPN #21 indicated Resident E was on Rocephin intravenously for pneumonia. She indicated Resident E had received a liter of intravenous fluids on 3/20/12 and would be starting more intravenous fluids today, 3/22/12. When interviewed about Resident E's thickened liquids, LPN #21 indicated the dietary department brings thickened liquids to the unit, and nursing staff deliver the fluids to the resident every two hours. She indicated staff may or may not leave the fluids at the bedside, depending on the resident, but usually</p>		<p>review Intake records as part of the on-going system monitoring. The results of the audit will be reported at the monthly Performance Improvement (PI) committee-meeting x 3 months. The PI committee will determine if 100% compliance has been achieved and if the need for further monitoring is required. The DNS will be responsible to ensure compliance with this standard</p>				

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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>not, since residents on thickened liquids have swallowing problems.</p> <p>The clinical record for Resident E was reviewed on 3/22/12 at 4:05 p.m. The record indicated the resident was admitted to the facility on 3/10/12 following hospitalization for treatment of pneumonia. Physician's orders at the time of admission indicated the resident was on a regular diet with regular liquids.</p> <p>A physician's order, signed as requested by the Speech Language Pathologist, was received on 3/14/12 for "Participate in video swallow x-ray [symbol for secondary to] oropharyngeal dysphagia; downgrade to nectar liquid & mechanical soft."</p> <p>The Comprehensive Intake-Output Record X 72 (the resident's first three days in the facility; however, recorded for four days) indicated total fluid intakes, when added shift by shift, as follows: 3/11/12, 1900 cc; 3/12/12, 1440 cc; 3/13/12, 1080 cc; and 3/14/12, 1460.</p> <p>Documentation was lacking in Nurse's Progress Notes, on the Medication Administration Record, or other Comprehensive Intake-Output Records of fluids offered, or of Resident E's fluid intake from 3/14/12 until 3/20/12.</p>			

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	<p>The Individual Resident Meal Intake Record for March 2012 included in the instructions that coffee, tea, and water should not be included as intake, and juice was considered 10% of the meal, and milk was 20% of the meal. Documentation was lacking on the record to indicate how much fluid the resident consumed.</p> <p>The Medical Nutrition Therapy Assessment, dated 3/20/12, indicated the resident's fluid requirement was 1953 cc fluid per day.</p> <p>A care plan, dated as initiated 3/16/12, indicated, "[Name of Resident E] has severe cognitive deficits related to Alzheimer's dementia. New DX [diagnosis] FTT [failure to thrive] on 3/20/12." The care plan also indicated, with date initiated of 3/20/12, "Inadequate po [by mouth] intake...s/s [signs and symptoms] dehydration." Interventions included, but were not limited to, intravenous fluids on 3/20/12 and the addition of 90 cc of 2-cal HN (liquid food supplement) four times daily. The care plans related to potential for constipation and functional bladder incontinence, both dated as initiated on 3/19/12, indicated interventions including "encourage fluids."</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172		
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	<p>The care plan lacked documentation of changes in the care plan related to the downgrade of fluids to nectar thick on 3/14/12. A specific plan to ensure the resident was offered 1953 cc of the nectar thick fluids was not indicated.</p> <p>Lab results of a Basic Metabolic Panel, dated 3/21/12, for a blood specimen collected on 3/21/12 at 4:35 a.m., indicated the resident's BUN (blood urea nitrogen) was 27, or high, with a normal range of 1 to 24 mg/dcl, and the BUN/Creatinine Ratio was 30, or high, with a normal range of 6 to 25. The resident had been started on intravenous fluids on 3/20/12 at 6:00 p.m., according to the "Infusion Therapy Medication Record."</p> <p>Resident E's meal tray card was provided by the Food Service Manager on 3/23/12 at 11:05 a.m. During interview at this time, the Food Service Manager indicated dietary sends Resident E three drinks each meal to help with dehydration, since that is such a problem when residents are on thickened liquids. She indicated the resident requests the thickened coffee, so it is provided each meal.</p> <p>The CNA Report Sheet was provided by LPN #15 on 3/22/12 at 11:30 a.m. The</p>				

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	<p>specific assignment for Resident E related to "Thicken Liquids" indicated, "Thin." Documentation was lacking to indicate the resident was to be offered thickened liquids.</p> <p>During interview on 3/23/12 at 10:30 a.m., CNA #6 indicated Resident E doesn't like the thickened milk, but he will drink the thickened orange juice and water. CNA #6 indicated Resident E sometimes asks for the fluids and she would then provide what he requested.</p> <p>During interview on 3/23/12 at 3:20 p.m., the District Director of Clinical Operations (DDCO) indicated she felt the resident's care plan adequately addressed his hydration needs. She indicated nurses would give the resident 90 cc of fluid at each medication pass, he would receive his fluids with each meal, and he was now also receiving the 90 cc of 2-Cal HN four times daily. She indicated the facility's policies did not indicate an Intake and Output record was needed for residents on thickened liquids.</p> <p>3.1-46(b)</p>			