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 05/07/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	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
F000000	This visit was for the Investigation of Complaint IN00128413. Complaint IN00128413 Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F309. Survey dates: May 6 & 7, 2013 Facility number: 000564 Provider number: 155484 Aim number: 100285610 Survey team: Joyce Hofmann, RN Census bed type: SNF/NF: 134 Total: 134 Census payor type: Medicare: 33 Medicaid: 81 Other: 20 Total: 134 Sample: 8 These deficiencies also reflect state findings in accordance with 410 IAC 16.2. Quality Review completed 05/13/2013	F000000	Facility respectfully requests a desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	by Brenda Nunan, RN.			

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F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.			
	Based on interview and record review, the facility failed to ensure physician's orders were followed as care planned for 1 of 3 residents reviewed for constipation in a sample of 8 (Resident B). Findings include: Resident B's closed clinical record was reviewed on 05/06/13 at 10:10 a.m. and indicated the resident had diagnoses which included, but were not limited to, Alzheimer's Disease with behavior disturbance, psychosis, hallucinations, delusions, hypertension, hypothyroidism, anxiety, and constipation. Resident B's Bowel Movement [BM] record, dated October 2012, indicated the resident had no bowel movement for 4 days from October 26 to October 30, 2012. November 2012's BM record indicated Resident B had no bowel movements for 6 days from November 16 to November 22, 2012.	F000282	Resident A & B no longer reside at the facility.In order for this practice not affect any resident, the DNS/Designee will audit the residents care plan and communicate resident care plan via MAR and Bowel Elimination records to the nursing staff. DNS/Designee will audit resident's medical records for any residents having the potential to be affected for symptons of constipation. Audit was completed 5-21-13. The attending physicians for any residents found to have positive symptons will be notified and treatments will be administered as ordered.The SDC will re-inservice nursing staff on how to properly follow Physician orders and Plan of Care. SDC will in-inservice nursing staff on completion of documentation of bowel elimination. Inservicing was completed 5-24-13.The DNS/Designee will conduct a random audit 3 times per week to insure physician's orders and Plan of Care for all residents are being followed. DNS/Designee will audit bowel elimination regime protocol 3 times weekly. Resident's bowel elimination record will be reviewed daily by	05/27/2013

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	December 2012 BM record indicated Resident B had no bowel movements for 5 days from December 15 to December 20, 2012, and no bowel movements for 7 days from December 23 to December 30, 2012. January 2013 BM record indicated Resident B had no bowel movements for 8 days from January 1 to January 9, 2013 and for 7 days from January 19 to January 26, 2013. February 2013 BM record indicated Resident B had no bowel movements for 3 days from February 1 to February 4, 2013 and for 7 days from February 7 to February 14, 2013. The BM records from February 26 to March 4, 2013 indicated Resident B had no bowel movements for 6 days. The Medication Administration Records [MARs] from November 16, 2012 to March 2013 indicated Miralax 17 grams in water or juice at bedtime was ordered for diagnosis of constipation. The November 2012 through March 2013 MAR's also indicated prn [as needed] medications of Surfak (Docusate) [laxative] 240 milligrams by mouth twice a day as needed (after 3rd day with no BM)		DNS/Designee. Results will be reported to monthly PI Committee meeting until facility is in compliance for 3 consecutive months. Then quarterly there after.DNS is responsible for ensuring continued complaince.	

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	and Milk of Magnesia [M.O.M.] [laxative] 30 milliliters by mouth as needed for constipation. The records indicated the M.O.M. had been given only on November 8, 2012, and not during the 6 days in November when the resident went without a bowel movement. The prn medications for constipation were not given at all in December 2012. M.O.M. was given 1 time on February 13, 2013. A new order was given on 02/14/13 for Dulcolax suppositories daily prn and the resident received the suppository on 02/16/13. Resident B also received a suppository on 03/04/13, the day of her discharge to home. Resident B did not receive the Surfak medication as ordered by the physician in October 2012 when the resident went 4 days without a bowel movement and November 2012 when the resident went 6 days without a bowel movement. Resident B did not receive the Surfak medication as ordered by the physician in December 2012 when the resident went 5 and 7 days without a bowel movement. Resident B did not receive the Surfak medication as ordered by the physician in February 2013 when the			

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	resident went 3 and 7 days without a bowel movement. The resident did not receive the Surfak from February 26 to March 4, 2013 when the resident went 6 days without a bowel movement. Resident B's care plan for mood with initial date of 02/07/13, indicated, "...Nursing observes mood worsens when not having regular BM...." Interventions included, but were not limited to, "...Contact physician for laxative, follow bowel regimen...." The facility's bowel protocol/regimen which was documented on the monthly BM records indicated, "...Resident at risk or with hx [history] of fecal impactions, chronic constipation should receive prunes, prune juice or extra fiber with meals as diet allows admin [administer] laxative or stool softener as ordered...as tolerated toilet resident routinely ... Milk of Magnesia or Dulcolax as ordered perform GI [Gastro-intestinal] assessment - Monitor bowel sounds, abd [abdominal] distention, decreased appetite, c/o [complaint of] gas pain, n/v [nausea/vomiting] & document prn signs & symptoms initiate episodic event (record nutrition intake & GI assessment) continue non-medication			

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	interventions...Continue GI assessment & non-medication interventions & fax/call MD...CALL MD IF 2 OR MORE EPISODES IN CALENDAR MONTH - REQUEST MD ORDER FOR ROUTINE BOWEL REGIMEN...." Interview on 05/06/13 at 4:10 p.m., with the Director of Nursing [DON], indicated the facility had a bowel protocol/regimen of Milk of Magnesia and prune juice after 3 days with no bowel movement . The DON had no documentation to indicate the facility bowel protocol/regimen was followed for Resident B. This federal tag is related to Complaint IN00128413. 3.1-35(g)(2)			

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F000309 SS=D	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.			
	Based on interview and record review, the facility failed to monitor and implement the facility's protocol for constipation for 2 of 3 residents reviewed for constipation in a sample of 8 (Resident A and Resident B). Findings include: 1). Resident B's closed clinical record was reviewed on 05/06/13 at 10:10 a.m. and indicated the resident had diagnoses which included, but were not limited to, Alzheimer's Disease with behavior disturbance, psychosis, hallucinations, delusions, hypertension, hypothyroidism, anxiety, and constipation. Resident B's Bowel Movement [BM] record, dated October 2012, indicated the resident had no bowel movement for 4 days from October 26 to October 30, 2012. November 2012's BM record indicated Resident B had no bowel	F000309	Resident A & B no longer reside at the facility.In order for this practice not affect any resident, the DNS/Designee will audit the residents care plan and communicate resident care plan via MAR and Bowel Elimination records to the nursing staff. DNS/Designee will audit resident's medical records for any residents having the potential to be affected for symptons of constipation. Audit was completed 5-21-13. The attending physicians for any residents found to have positive symptons will be notified and treatments will be administered as ordered.The SDC will re-inservice nursing staff on how to properly follow Physician orders and Plan of Care. SDC will in-inservice nursing staff on completion of documentation of bowel elimination. Inservicing was completed 5-24-13.The DNS/Designee will conduct a random audit 3 times per week to insure physician's orders and Plan of Care for all residents are being followed. DNS/Designee will audit bowel elimination regime	05/27/2013

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	movements for 6 days from November 16 to November 22, 2012. December 2012 BM record indicated Resident B had no bowel movements for 5 days from December 15 to December 20, 2012, and no bowel movements for 7 days from December 23 to December 30, 2012. January 2013 BM record indicated Resident B had no bowel movements for 8 days from January 1 to January 9, 2013 and for 7 days from January 19 to January 26, 2013. February 2013 BM record indicated Resident B had no bowel movements for 3 days from February 1 to February 4, 2013 and for 7 days from February 7 to February 14, 2013. The BM records from February 26 to March 4, 2013 indicated Resident B had no bowel movements for 6 days. The Medication Administration Records [MARs] from November 16, 2012 to March 2013 indicated Miralax 17 grams in water or juice at bedtime was ordered for diagnosis of constipation. The November 2012 through March 2013 MAR's also indicated prn [as needed] medications of Surfak (Docusate) [laxative] 240		protocol 3 times weekly. Resident's bowel elimination record will be reviewed daily by DNS/Designee. Results will be reported to monthly PI Committee meeting until facility is in compliance for 3 consecutive months. Then quarterly there after.DNS is responsible for ensuring continued complaince.	

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	milligrams by mouth twice a day as needed (after 3rd day with no BM) and Milk of Magnesia [M.O.M.] [laxative] 30 milliliters by mouth as needed for constipation. The records indicated the M.O.M. had been given only on November 8, 2012, and not during the 6 days in November when the resident went without a bowel movement. The prn medications for constipation were not given at all in December 2012. M.O.M. was given 1 time on February 13, 2013. A new order was given on 02/14/13 for Dulcolax suppositories daily prn and the resident received the suppository on 02/16/13. Resident B also received a suppository on 03/04/13, the day of her discharge to home. Resident B did not receive the Surfak medication as ordered by the physician in October 2012 when the resident went 4 days without a bowel movement and November 2012 when the resident went 6 days without a bowel movement. Resident B did not receive the Surfak medication as ordered by the physician in December 2012 when the resident went 5 and 7 days without a bowel movement. Resident B did not receive the Surfak			

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	medication as ordered by the physician in February 2013 when the resident went 3 and 7 days without a bowel movement. The resident did not receive the Surfak from February 26 to March 4, 2013 when the resident went 6 days without a bowel movement. Resident B's care plan for mood with initial date of 02/07/13, indicated, "...Nursing observes mood worsens when not having regular BM...." Interventions included, but were not limited to, "...Contact physician for laxative, follow bowel regimen...." The facility's bowel protocol/regimen which was documented on the monthly BM records indicated, "...Resident at risk or with hx [history] of fecal impactions, chronic constipation should receive prunes, prune juice or extra fiber with meals as diet allows admin [administer] laxative or stool softener as ordered...as tolerated toilet resident routinely ... Milk of Magnesia or Dulcolax as ordered perform GI [Gastro-intestinal] assessment - Monitor bowel sounds, abd [abdominal] distention, decreased appetite, c/o [complaint of] gas pain, n/v [nausea/vomiting] & document prn signs & symptoms initiate episodic			

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	event (record nutrition intake & GI assessment) continue non-medication interventions...Continue GI assessment & non-medication interventions & fax/call MD...CALL MD IF 2 OR MORE EPISODES IN CALENDAR MONTH - REQUEST MD ORDER FOR ROUTINE BOWEL REGIMEN...." 2). Resident A's closed clinical record was reviewed on 05/06/13 at 1:35 p.m. and indicated the resident had diagnoses which included, but were not limited to, dementia, diabetes, hypertension, hypothyroidism, anxiety and depression. Resident A's Bowel Movement [BM] record, dated February 2013, lacked documentation of a bowel movement from February 21, 2013 through March 1, 2013. Review of Resident A's Medication Administration Records [MARs, dated February 2013 and March 2013 lacked documentation of any medication for laxatives or stool softeners. The facility's bowel protocol/regimen which was documented on the monthly BM record indicated, "...Resident at risk or with hx [history]			

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	of fecal impactions, chronic constipation should receive prunes, prune juice or extra fiber with meals as diet allows admin [administer] laxative or stool softener as ordered...Encourage fluids as diet allows with med pass offer prune juice or other forms or fiber increase mobility as tolerated toilet resident routinely...Milk of Magnesia or Dulcolax as ordered perform GI [Gastro-intestinal] assessment - Monitor bowel sounds, abd [abdominal] distention, decreased appetite, c/o [complaint of] gas pain, n/v [nausea/vomiting] & document prn signs & symptoms initiate episodic event (record nutrition intake & GI assessment) continue non-medication interventions...Continue GI assessment & non-medication interventions & fax/call MD...CALL MD IF 2 OR MORE EPISODES IN CALENDAR MONTH - REQUEST MD ORDER FOR ROUTINE BOWEL REGIMEN...." The record lacked documentation the facility's bowel protocol was implemented when Resident A went 8 days without a bowel movement. Interview on 05/06/13 at 4:10 p.m., with the Director of Nursing [DON], indicated the facility had a bowel protocol/regimen of Milk of Magnesia			

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	and prune juice after 3 days with no bowel movement. The DON had no documentation to indicate the facility's bowel protocol/regimen was followed for Resident A and B. This federal tag is related to Complaint IN00128413. 3.1-37(a)			