

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00182598 and IN00183240.</p> <p>Complaint IN00182598 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F315.</p> <p>Complaint IN00183240 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282 and F315.</p> <p>Survey dates: September 28 &amp; 30, 2015 and October 1, 2015</p> <p>Facility Number: 012548 Provider Number: 155790 AIM Number: 201023760</p> <p>Census Bed Type: SNF: 50 SNF/NF: 39 Total: 89</p> <p>Census Payor Type: Medicare: 29 Medicaid: 28 Other: 32 Total: 89</p>	F 0000	<p>This Plan of Correction is 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. The facility respectfully requests a desk review for this plan of correction.</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:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/01/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0282 SS=D Bldg. 00	<p>Sample: 8</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on October 2, 2015.</p> <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 record review and interview the facility failed to ensure physician orders were followed timely for 2 of 5 resident's reviewed for urinary tract infections in a sample of 8. (Residents "D" and "B")</p> <p>Findings include:</p> <p>1. The record for Resident "D" was reviewed on 09-28-15 at 1:30 p.m. Diagnoses included, but were not limited to, history of urinary tract infections, chronic kidney disease, malaise, mood disorder, hypertension and myasthenia gravis. These diagnoses remained current at the time of the record review.</p>	F 0282	<p>1.DNS reviewed U/A collection protocol with medicaldirector. Per his direction an acceptablecollection time frame is within 24hrs and the lab is to be sent on the nextscheduled run unless specified as a STAT order. Neither Resident B nor ResidentD orders were written as STAT orders. Resident B and Resident D do notcurrently reside in the facility.</p> <p>2.All residents that have an ordered U/A and/or antibiotic orders have the potentialto be affected. The Unit Managers reviewed all residents with pending U/A's toensure timely collection was met per the physician protocol. For resident</p>	10/07/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/01/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033		
(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 review of the resident's MDS (Minimum Data Set) assessment, dated 09-23-15 indicated the resident was frequently incontinent of bladder.</p> <p>The current plan of care indicated the resident had "bladder incontinence related to impaired mobility." Interventions to this plan of care included "Monitor/document for s/sx. [signs and symptoms] of UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increase temp. [temperature], urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns."</p> <p>The record contained a physician order dated 09-04-15 for a "UA [urinalysis] C &amp; S [culture and sensitivity] - may In and Out cath. [catherize] if unable to get a clean catch urine."</p> <p>A Progress Note dated 09-06-15 indicated the resident was "alert with confusion. Continues to c/o [complain of] dysuria. In and Out cath. per sterile technique to collect specimen for UA C &amp; S done at 2330 [11:30 p.m.] ...."</p> <p>A Progress Note dated 09-06-15</p>		<p>B, the transcribing nurse received education on electrically transcribing order into the system.</p> <p>3. The SDC will complete in servicing with Licensed Nurses on collection protocol and timeframes. The Unit Managers/designee will track U/A orders and timeframes daily on the lab monitoring tool. All orders transcribed into EMAR are read aloud and reviewed in AM Clinical Meeting Monday thru Friday by Nurse Management and reviewed in the EMAR system for accurate transcription.</p> <p>4. The DNS or designee will review the lab monitoring tool weekly and complete a chart check to ensure that U/A's have been followed up within the acceptable established timeframes. These audits will continue indefinitely. The Medical Records Director will audit 5 orders per week for accurate transcription into the EMAR system. These audits will also continue indefinitely. The results of these audits will be presented to the monthly Performance Improvement Committee and if necessary, changes will be recommended.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>indicated a "partial UA report have been called to [name of physician practice] No new orders at this time."</p> <p>The nursing staff failed to obtain the urine specimen in a timely manner as ordered by the physician which resulted in the resident being transported to the local area hospital and admitted with a UTI.</p> <p>2. The record for Resident "B" was reviewed on 09-28-15 at 11:45 a.m. Diagnoses included, but were not limited to, malaise, osteoporosis, hypertension, irritable bowel syndrome and mood disorder. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS assessment, dated 08-25-15, indicated the resident was occasionally incontinent of bowel and bladder.</p> <p>The resident's current plan of care indicated the resident "has risk for bladder incontinence r/t [related to] active infections with symptoms of UTI, Physical limitations." Interventions to this plan of care included "Monitor/document for s/sx. of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increase temp.,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGewater	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
---	---

(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>urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns."</p> <p>A review of the Physician Progress notes, dated 08-19-15 indicated the resident was "evaluated today for acute/urgent visit related to unit manager/nursing and family all concerned that pt. have [sic] increase confusion. Family requesting UA [urinalysis]... ."</p> <p>The record indicated the urine specimen was collected on 08-21-15 and reported to the facility on 08-23-15. The urine culture indicated the resident's urine was amber in color, cloudy in clarity, contained 2+ in protein with "few" bacteria and mucus present." The culture and sensitivity indicated the organism was "Enterococcus faecalis &gt; [greater than] 100 CFU [colony forming units] / ml [milliliters], and Pseudomonas."</p> <p>The physician was notified on 08-26-15, and ordered Cipro (an antibiotic) 250 mg (milligrams) two times a day for seven days.</p> <p>A review of the Medication Administration Record on 09-30-15 at 10:00 a.m., indicated the resident received the medication on 08-26-15 at 8:00 a.m. and again at 8:00 p.m.</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/01/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 0315 SS=G Bldg. 00	<p>The resident did not receive the physician ordered medication again until 08-29-15, when the licensed nurse discovered an error when the order was entered into the electronic medical record as "Cipro Tablet 250 mg - give one tablet by mouth two times a day every 7 day(s) for UTI for 7 days."</p> <p>The order was corrected and the antibiotic restarted on 08-29-15 and continued through 09-04-15.</p> <p>During an interview on 10-01-15 at 9:30 a.m., the Director of Nurses indicated the Licensed Nurse failed to enter the information correctly in the Electronic Medical record.</p> <p>This Federal tag relates to Complaints IN00182598 and IN00183240</p> <p>3.1-35(g)(2)</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on record review and interview the facility failed to ensure physician orders were completed timely for the treatment of a urinary tract infections for 2 of 2 residents reviewed for Urinary Tract Infections (UTI). (Resident "D" and "B") This deficient practice resulted in Resident "D" being admitted to the hospital for Urinary Tract Infections and metabolic encephalopathy secondary to UTI.</p> <p>Findings include:</p> <p>1. The record for Resident "D" was reviewed on 09-28-15 at 1:30 p.m. Diagnoses included, but were not limited to, history of urinary tract infections, chronic kidney disease, malaise, mood disorder, hypertension and myasthenia gravis. These diagnoses remained current at the time of the record review.</p> <p>A review of the resident's MDS (Minimum Data Set) assessment, dated 09-23-15 indicated the resident was frequently incontinent of bladder.</p> <p>The current plan of care indicated the resident had "bladder incontinence</p>	F 0315	<p>1.DNS reviewed U/A collection protocol with medicaldirector. Per his direction an acceptablecollection time frame is within 24hrs and the lab is to be sent on the nextscheduled run unless specified as a STAT order. Neither Resident B nor ResidentD orders were written as STAT orders. Resident B and Resident D do notcurrently reside in the facility.</p> <p>2.All residents that have an ordered U/A and/or antibiotic orders have the potentialto be affected. The Unit Managers reviewed all residents with pending U/A's toensure timely collection was met per the physician protocol. For resident B,the transcribing nurse received education on electrically transcribing orderinto the system.</p> <p>3. The SDC willcomplete in servicing with Licensed Nurses on collection protocol andtimeframes. The Unit Managers/designee will track U/A orders and timeframes dailyon the lab monitoring tool. All orders transcribed into EMAR are read aloud andreviewed in AM Clinical Meeting Monday thru Friday by Nurse Management andreviewed in the EMAR system for accurate transcription.</p> <p>4. The DNS ordesignee will</p>	10/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/01/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER			STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033		
(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>related to impaired mobility." Interventions to this plan of care included "Monitor/document for s/sx. [signs and symptoms] of UTI [urinary tract infection]: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increase temp. [temperature], urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns."</p> <p>The record contained a physician order dated 09-04-15 for a "UA [urinalysis] C &amp; S [culture and sensitivity] - may In and Out cath. [catherize] if unable to get a clean catch urine."</p> <p>A Progress Note dated 09-06-15 indicated the resident was "alert with confusion. Continues to c/o [complain of] dysuria. In and Out cath. per sterile technique to collect specimen for UA C &amp; S done at 2330 [11:30 p.m.] ...."</p> <p>A Progress Note dated 09-06-15 indicated a "partial UA report have been called to [name of physician practice] No new orders at this time."</p> <p>The Progress Notes, dated 09-07-15 at 7:11 a.m., indicated "Pt. [patient] exhibiting signs of disorientation and significant decline in mental status. Was</p>		<p>review the lab monitoring tool weekly and complete a chart checkto ensure that U/A's have been followed up within the acceptable establishedtimeframes. These audits will continueindefinitely. The Medical RecordsDirector will audit 5 orders per week for accurate transcription into the EMARsystem. These audits will also continueindefinitely. The results of theseaudits will be presented to the monthly Performance Improvement Committee andif necessary, changes will be recommended.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
---	---

(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>attempting to give pt. pain medication. Pt. began chewing the spoon in an animal like manner and growling. Pt. was becoming loud with garbled and non coherent speech. Pt. did have urinalysis which did reveal abnormal findings. Culture no available at that time. Pt. symptoms called to [name of physician practice] and nurse who advised to send pt. to ER [Emergency Room] due to no sensitivity result and not wanting to start pt on an ineffective ATB [antibiotic]."</p> <p>The resident was transported to the local area hospital on 09-07-15 and admitted.</p> <p>A review of the hospital assessment and testing indicated the resident had an E. Coli [Escherichia Coli] urinary tract infection and metabolic encephalopathy secondary to UTI.</p> <p>The nursing staff failed to obtain the urine specimen in a timely manner as ordered by the physician which resulted in the resident being transported to the local area hospital.</p> <p>2. The record for Resident "B" was reviewed on 09-28-15 at 11:45 a.m. Diagnoses included, but were not limited to, malaise, osteoporosis, hypertension, irritable bowel syndrome and mood disorder. These diagnoses remained</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED  10/01/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
---	---

(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>current at the time of the record review.</p> <p>A review of the resident's MDS assessment, dated 08-25-15, indicated the resident was occasionally incontinent of bowel and bladder.</p> <p>The resident's current plan of care indicated the resident "has risk for bladder incontinence r/t [related to] active infections with symptoms of UTI, Physical limitations." Interventions to this plan of care included "Monitor/document for s/sx. of UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increase temp., urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns."</p> <p>A review of the Physician Progress notes, dated 08-19-15 indicated the resident was "evaluated today for acute/urgent visit related to unit manager/nursing and family all concerned that pt. have [sic] increase confusion. Family requesting UA [urinalysis]... ."</p> <p>The record indicated the urine specimen was collected on 08-21-15 and reported to the facility on 08-23-15. The urine culture indicated the resident's urine was amber in color, cloudy in clarity,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  10/01/2015	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER				STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033			
(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>contained 2+ in protein with "few" bacteria and mucus present." The culture and sensitivity indicated the organism was "Enterococcus faecalis &gt; [greater than] 100 CFU [colony forming units] / ml [milliliters], and Pseudomonas."</p> <p>The physician was notified on 08-26-15, and ordered Cipro (an antibiotic) 250 mg (milligrams) two times a day for seven days.</p> <p>A review of the Medication Administration Record on 09-30-15 at 10:00 a.m., indicated the resident received the medication on 08-26-15 at 8:00 a.m. and again at 8:00 p.m.</p> <p>The resident did not receive the physician ordered medication again until 08-29-15, when the licensed nurse discovered an error when the order was entered into the electronic medical record as "Cipro Tablet 250 mg - give one tablet by mouth two times a day every 7 day(s) for UTI for 7 days."</p> <p>The order was corrected and the antibiotic restarted on 08-29-15 and continued through 09-04-15.</p> <p>During an interview on 10-01-15 at 9:30 a.m., the Director of Nurses indicated the Licensed Nurse failed to enter the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155790	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED  10/01/2015
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-BRIDGewater			STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033		
(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>information correctly in the Electronic Medical record.</p> <p>This Federal tag relates to Complaints IN00182598 and IN00183240.</p> <p>3.1-41(a)(1)</p>				