

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F0000	<p>This visit was for the Investigation of Complaint IN00102457.</p> <p>Complaint IN00102457-Substantiated. Federal/state deficiencies related to the allegations are cited at F282, F309 and F425.</p> <p>Survey dates: January 25, 26, 2012</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Ann Arney, RN</p> <p>Census bed type: SNF/NF: 132 Total: 132</p> <p>Census payor type: Medicare: 12 Medicaid: 89 Other: 31 Total: 132</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		
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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 completed on January 30, 2012 by Bev Faulkner, RN			
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F0282 SS=D	<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, interview and record review, the facility failed to follow treatment orders for a resident who developed a boil. This deficiency affected 1 of 3 resident's whose skin conditions were reviewed in a sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>On 1/25/12 at 10:00 a.m., during the orientation tour, LPN #15 indicated Resident #C had a history of reoccurring boils.</p> <p>On 1/25/12 at 10:10 a.m., Resident #C was observed up and about in his motorized wheelchair and he indicated he currently had a boil in his right groin.</p> <p>The clinical record of Resident #C was reviewed on 1/25/12 at 3:30 p.m., and indicated the resident was admitted to the facility on 3/28/07, with diagnoses which included but were not limited to, cerebral palsy.</p> <p>The MDS (Minimum Data Set) assessment, dated 11/9/11, indicated the resident had no cognitive impairments. The assessment indicated the resident was</p>	F0282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>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.</i></p> <p>F282</p> <p>1. LPN #16 removed the expired tubes of Clindamycin from the treatment cart during the survey. The Clindamycin order for Resident #C has been clarified.</p> <p>2. Treatment carts have been inspected to ensure no expired medications are present. Treatment Administration Records (TARs) have been audited to identify any other orders that require clarification with clarifications obtained, as necessary.</p> <p>3. Nursing staff has been educated relative to provision of</p>	02/21/2012			

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	<p>totally dependent on 2 persons for transfer.</p> <p>Resident #C's weekly skin sheets indicated the following: On 1/11/12, "ongoing tx (treatment) to "boil" areas R (right) groin.." On 1/19/12, boil L (left) groin ongoing..." On 1/25/12, boils bil (bilateral) groin areas ongoing..."</p> <p>The January 2012 treatment record indicated Resident #C had the following treatment order, initiated on 3/28/11, "Clindamycin Gel BID (twice daily) to boils PRN (as needed) when they develop until healed."</p> <p>Although the skin sheets and nursing notes indicated the resident had ongoing boils since 1/10/12, the Clindamycin Gel was only documented on the treatment administration records as being applied one time, on 1/10/12.</p> <p>Nursing notes indicated the Clindamycin gel was applied one time on 1/11/12 at 3:25 a.m.</p> <p>On 1/26/12 at 9:30 a.m., Resident #C, who was identified by the facility as interviewable, indicated he currently had a boil in his right groin that he thought started last week. He indicated staff had applied Clindamycin gel last night and</p>		<p>services in accordance with each resident's written plan of care, including but not limited to following treatment orders for skin conditions, and ensuring that expired medications are removed from the treatment carts.</p> <p>A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, and then monthly, compliance with clarification of treatment orders, as necessary, and with removal of expired medications from the treatment carts.</p> <p>4. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>5. Completion Date: 02.21.12</p>				

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	<p>this morning but he was unsure how often it was to be applied. He indicated the staff get the gel from the treatment cart and applied it "sporadically."</p> <p>On 1/26/12 at 10:00 a.m., the treatment cart was checked with LPN #16. Resident #C had two open tubes of Clindamycin Gel in the cart. LPN #16 indicated one of the tubes was filled on 1/19/11 and expired (12/2011) and the second tube was filled on 4/11/11 and expired on 2/12/12.</p> <p>On 1/26/12 at 11:00 a.m., accompanied by the ADON (Assistant Director of Nursing), the boil on Resident #B's right groin was observed. The ADON measured a red firm indurated area on the right groin. The area measured 5.5 cm by 5 cm and had a raised center that measured 1 cm by 1 cm. The resident indicated the area was "sore."</p> <p>On 1/26/12 at 11:10 a.m., the ADON indicated the PRN Clindamycin order was confusing and needed to be clarified.</p> <p>This Federal tag relates to Complaint IN00102457.</p> <p>3.1-35(g)(2)</p>			
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F0309 SS=D	<p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interviews and record review, the facility failed to complete a thorough skin assessment, including examination of the perineum and buttocks, after a change in condition and prior to transfer to the hospital for 1 of 3 residents whose skin assessments were reviewed in a sample of 3. (Resident #B)</p> <p>Findings include:</p> <p>On 1/25/11 at 10:00 a.m., during the orientation tour of the secured unit, LPN #10 indicated Resident #B was currently in the hospital for treatment of an area on her buttocks.</p> <p>The clinical record of Resident #B was reviewed on 1/25/12 at 11:00 a.m., and indicated the resident was admitted to the facility on 4/13/10 with diagnoses which included but were not limited to, dementia and insulin dependent diabetes mellitus.</p> <p>The MDS (Minimum Data Set) assessment, data 12/22/11, indicated Resident B required supervision of one for transfer, ambulation, dressing and</p>	F0309	<p>F309</p> <ol style="list-style-type: none"> Resident #B was at the hospital during the time of survey and remains at an LTACH at present. Therefore, no further corrective action could be taken for Resident #B. All residents have the potential to be affected by the practice, therefore, this plan of correction applies to all residents currently residing in the center. Licensed nursing staff have received education relative to ensuring that residents receive necessary care and services, including but not limited to completion of thorough skin assessments after a change in condition and prior to transfer to the hospital. <p>Supervisors on duty during a shift when residents undergo a condition change and/or require transfer to the hospital shall be responsible for ensuring all skin issues are identified and accurately documented.</p> <p>A performance improvement tool</p>	02/21/2012			

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	<p>toileting. The MDS indicated the resident had severe cognitive impairments.</p> <p>Nursing notes on 12/30/11 at 10:00 a.m., indicated Resident #B became unresponsive for two minutes during the breakfast meal at 8:10 a.m. The note indicated the resident aroused with an emesis and had an increase in confusion, dizziness, and was sweating/hot. The physician was notified and laboratory tests were ordered.</p> <p>The SBAR (situation, background, assessment, and recommendation) report, dated 12/30/11, indicated the resident was assessed. The report had a section for skin condition and indicated there was no change in the resident's skin.</p> <p>A laboratory report for a complete blood count, dated 12/30/11, indicated the resident's white blood count was high at 11.9 (Normal range 4.5-11)</p> <p>Nursing notes, dated 12/31/11 at 6:40 a.m., indicated the resident had an elevated temperature of 101.3 at 4:30 a.m., Tylenol was given and the resident's temperature was 98.6 at 6:00 .a.m.</p> <p>On 12/31/11 at 2:00 p.m., nursing notes indicated the resident was shaking with tremors. The physician was notified and a urinalysis was ordered.</p>		<p>has been developed that DNS, ADNS, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, and then monthly, compliance with skin assessment completion and documentation.</p> <p>4. DNS, or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>5. Completion Date: 02.21.12</p>		

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	<p>On 12/31/11 at 8:30 p.m., nursing notes indicated the resident's temperature was 102.1, the physician was notified and ordered the resident to be sent to the hospital for an evaluation.</p> <p>The SBAR (situation, background, assessment, and recommendation) report, dated 12/31/11, indicated the resident was assessed. The report indicated there was no change in the resident's skin.</p> <p>On 12/31/11 at 10:00 p.m., nursing notes indicated the resident was transported to the hospital with an elevated temperature and weakness.</p> <p>The emergency room report, dated 12/31/11, indicated the resident had a large area of peri-rectal inflammation and cellulitis of the buttocks.</p> <p>The CT scan of the pelvis, dated 1/1/12 at 1:28 a.m., noted "infectious/ inflammatory changes involving the subcutaneous soft tissue of right perineum/medial gluteal region without evidence of air or peripheral enhancing fluid collections..."</p> <p>The hospital admission history and physical summary, dated 1/1/12, indicated "1. The patient with right perianal or perineal induration/inflammation/early</p>						

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	<p>abscess. The patient will be commenced on IV (Intravenous) Unasyn (an antibiotic medicine)..."</p> <p>On 1/6/11, a surgery report indicated an incision, drainage and debridement was performed on Resident #B's right buttocks and perineal abscess. The report indicated "...all necrotic skin was debrided...and the abscess was followed in all directions until viable skin and viable fatty tissue were encountered...The wound was then packed.."</p> <p>LPN #11 was interviewed on 1/25/12 at 11:10 a.m. The LPN indicated she assessed Residents #B on 12/30/11, after the resident became unresponsive, but did not checked the resident's perineum or buttocks.</p> <p>CNA #14 was interviewed on 1/25/12 at 2:00 p.m., and she indicated the nurse asked her to sit with the resident while they were waiting for the resident to be transported to the hospital. The CNA indicated the resident was restless and was pulling her legs up towards her face.</p> <p>CNA #13 was interviewed on 1/25/12 at 2:30 p.m. She indicated Resident #B was normally continent but on 12/31/11 (the day of her transfer to the hospital), she</p>				

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	<p>had taken the resident to the bathroom, and her pants were wet. The CNA indicated she had washed the resident but did not see her perineal area because she was looking at the resident and assisting her to stand while she was washing her. The CNA indicated the resident did not complain of pain while she was being washed.</p> <p>LPN #12 was interviewed on 1/25/12 at 4:00 p.m. LPN #12 indicated, on 12/31/11, while Resident #B was in the bathroom, she slid a hat (a device used to collect urine) underneath Resident #B from behind but did not observe anything unusual about the resident's buttocks or perineum. The LPN indicated she assessed Resident #B on 12/31/11, prior to the resident's transfer to the hospital, and the resident had no complaints of discomfort. She indicated she did not check the resident's perineum or buttocks.</p> <p>Resident #B's physician was interviewed on 1/26/12 at 10:14 a.m. The physician indicated Resident #B's abscess progressed internally and worsened after the resident was admitted to the hospital. The physician indicated she did not work on 12/30/11 and 12/31/11, when Resident #B had a change of condition. She</p>						

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	<p>indicated she talked to the on call physician about Resident #B and the on call physician indicated he asked the nurses in the facility to check the resident but nothing unusual about the resident's skin was reported to him.</p> <p>On 1/26/12 at 3:45 p.m., the DON (Director of Nursing) was interviewed she indicated it was the policy of the facility to comprehensively assess residents using the SBAR form, when they had a change of condition.</p> <p>This Federal tag relates to Complaint IN00102457.</p> <p>3.1-37(a)</p>				

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F0425 SS=D	<p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. Based on observation, interview and record review, the facility failed to ensure expired medications were removed from the treatment cart. This deficiency affected 1 of 3 residents whose treatments were reviewed in a sample of 3. (Resident #C)</p> <p>Findings include:</p> <p>On 1/25/12 at 10:00 a.m., during the orientation tour, LPN #15 indicated Resident #C had a history of reoccurring boils.</p> <p>On 1/25/12 at 10:10 a.m., Resident #C was observed up and about in his motorized wheelchair and he indicated he</p>	F0425	<p>F425 1. LPN #16 removed the expired tubes of Clindamycin from the treatment cart during the survey. 2. Treatment carts have been inspected to ensure no expired medications are present. 3. Nursing staff has been educated relative to provision of pharmaceutical services to meet the needs of each resident, including but not limited to ensuring that expired medications are removed from the treatment carts. A performance improvement tool has been developed that Unit Managers, or designee, will utilize to monitor daily, on scheduled days of work, for 30 days, and then monthly, compliance with removal of expired medications from the treatment carts. 4. DNS, or</p>	02/21/2012			

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	<p>currently had a boil in his right groin.</p> <p>The clinical record of Resident #C was reviewed on 1/25/12 at 3:30 p.m., and indicated the resident was admitted to the facility on 3/28/07, with diagnoses which included but were not limited to, cerebral palsy.</p> <p>Resident #C's weekly skin sheets indicated the following: On 1/11/12, "ongoing tx (treatment) to "boil" areas R (right) groin.." On 1/19/12, boil L (left) groin ongoing..." On 1/25/12, boils bil (bilateral) groin areas ongoing..."</p> <p>The January 2012 treatment record indicated Resident #C had the following treatment order, initiated on 3/28/11, "Clindamycin Gel BID (twice daily) to boils PRN (as needed) when they develop until healed."</p> <p>Although the skin sheets and nursing notes indicated the resident had ongoing boils since 1/10/12, the Clindamycin Gel was only documented on the treatment administration record as being applied one time on 1/10/12. Nursing notes indicated the Clindamycin gel was applied one time on 1/11/12 at 3:25 a.m.</p> <p>On 1/26/12 at 10:00 a.m., the treatment cart was checked with LPN #16.</p>		<p>designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter. 5. Completion Date: 02.21.12</p>				

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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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
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	<p>Resident #C had two open tubes of Clindamycin Gel in the cart. LPN #16 indicated one of the tubes was filled on 1/19/11 and expired 12/2011 and the second tube was filled on 4/11/11 and expired on 2/12/12. She indicated she would remove the expired Clindamycin Gel from the treatment cart.</p> <p>This Federal tag relates to Complaint IN00102457.</p> <p>3.1-25(o)</p>			
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