STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	X3) DATE SURVEY COMPLETED
	155657		08/28/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-HARRISON	150 BEECHMONT DR CORYDON, IN 47112

(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	This visit was for a Recertification and State Licensure Survey. Survey dates: August 24, 25, 26, 27, and 28, 2015. Facility number: 010597 Provider number: 155657 AIM number: 200204440 Census bed type: SNF/NF: 71 Total: 71 Census payor type: Medicare: 20 Medicaid: 37 Other: 14 Total: 71 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Date of compliance ThursdaySeptember 24, 2015 This Plan of Correction is thecenter's credible allegation of compliance. Preparation and/or execution ofthis plan of correction does not constitute admission or agreement by theprovider of the truth of the facts alleged or conclusions set forth in thestatement of deficiencies. The plan of correction is prepared and/or executedsolely because it is required by the provisions of federal and state law.Attached you will find the completed Plan of Correction and attachments forannual survey dated August 28, 2015. We respectfully request that our plan ofcorrection, be considered for a paper compliance desk review. Should you haveany questions, please feel free to contact me at (812) 738-0550. Sincerely, AaronClarke, Executive Director	
F 0282 SS=D Bldg. 00	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			

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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	written plan of care. Based on interview and record review, the facility failed to ensure a physician's order was followed, as written, related to the obtainment of daily weights for 2 of 33 residents reviewed for physician's orders. (Residents #80 and #178) Findings include: 1. The clinical record for Resident #178 was reviewed on 8/26/15 at 10:32 a.m. Diagnoses included, but were not limited to, coronary artery bypass graft (CABG), coronary artery disease (CAD), diabetes, and hypertension. The admission orders for Resident #178, dated 8/22/15, included but were not limited to the following: "Daily weights - report to physician for excessive swelling in ankles or feet, rapid weight gain (3 to 5 pounds) in 1 - 2 days, fast or irregular heart rhythm, or shortness of breath at rest". The transcribed order was for daily weights x (times) 3 days. A "Health Status Note", dated 8/23/15 at 10:25 a.m., indicated the following, "Sats [level of oxygen measured in the blood] between 70 - 88% on 2L [liters] PNC [per nasal cannula] Resident given Duo-neb [breathing treatment] with no change in o2 [oxygen] sats, resident	F 0282	F282 1. Residents #80 and #178 are nolonger residents of this facility. 2. All residents with physicianorders for daily weights have potential to be affected. Audit of physicianorders for daily weights with corresponding weights was completed. Any residentwithout daily weights ordered and not consistently completed were weighed. Anyvariance in weight of +/-2% after reweight required IDT review to determinecausal factors, review with the attending physician, implementation ofindividualized interventions, and family notification. 3. Staff Development Coordinatoror designee will in-service nursing staff on Implementing and FollowingPhysician Orders and Weight Documentation Process by Thursday September 24,2015. 4. The Director of Nursing ordesignee will audit daily weights 5 times a week for 30 days, then 3 times aweek for 30 days, then twice weekly for 30 days, then weekly as an ongoingprocess of this facility all findings will be addressed immediately for correction.Audit results will be reviewed in monthly PI meeting x3 months then the PIcommittee will determine if 100% compliance has been achieved and the need forongoing monitoring.	09/24/2015

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-HARRISON		STREET ADDRESS, CITY, STATE, ZIP CODE 150 BEECHMONT DR CORYDON, IN 47112	

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	placed on o2 mask nd [sic] stats [sic] came up to 89%. Call placed to [name of physician]. N/O [new orders] received and noted to transfer resident back to [name of hospital]. A "Health Status Note" dated 8/23/15 at 15:28 (3:28 p.m.), indicated the ER notified facility that the resident had a diagnosis of "exacerbation of CHF [congestive heart failure] and Pneumonia". Resident #178 was treated with IV (intravenous) Zithromax (antibiotic) and Bumex (medication to reduce swelling) and would return to the facility after 1700 (5:00 p.m.). Resident #178's weight record indicated he was only weighed on 8/22/15, the day he was admitted to the facility, and on 8/26/15, the day he was sent out to the hospital. The Treatment Administration Record (TAR) did not contain any weights for the resident. During an interview on 8/28/15 at 10:15 a.m. with Registered Nurse (RN) #5, she indicated, "We normally follow the transfer sheet which has the orders on it from the hospital that we verify with the physician. The discharge summary orders trumps all and are the orders we follow. If no discharge summary or transfer sheet, then we follow the reconciliation			

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	orders and verify with physician". 2. The clinical record for Resident #80 was reviewed on 8/26/15 at 9:59 a.m. The resident was admitted to the facility on 6/5/15. Diagnoses included, but were not limited to, congestive heart failure (CHF) and edema. Physician orders for Resident #80, dated 6/5/15 included, but were not limited to: "daily weights due to CHF, notify MD (physician) of increase of 2+ pounds per day or 5 pounds per week". Review of the resident's weight records and the daily heart monitoring program records indicated daily weights were not obtained on the following days: - June 6, 7, 8, 9, 10, 12, 15, 16, 17, 18, 19, 20, 21, 22, 23, 26, 27, 28, 29, and 30, 2015. - July 1, 2, 3, 4, 5, 6, 10, 11, 12, 17, 18, 19, 21, 23, 24, 25, 27, 28, 29, 30 and 31, 2015. - August 1, 2, 3, 4, 5, and 6, 2015. During an interview with the Medical Records Nurse on 8/26/15 at 12:20 p.m., she indicated the resident was on the daily heart monitoring program (which			

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	includes daily weights) through July but had been removed from the program in August. She was unable to say why the resident was removed from the program. On 8/28/15 at 9:00 a.m., the Medical Records Nurse provided additional documentation with the resident's weights and indicated they were all she had. She also indicated that weights were either recorded on the weight record in the computer or on the daily paper record, which was then recorded into the computer. 3.1-35(g)(2)			
F 0309 SS=D Bldg. 00	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 record review and interview, the facility failed to ensure the highest level of physical well being related to the	F 0309	F309 1. An assessment of residents#124s fistula site was	09/24/2015

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	proper monitoring of a dialysis access site for 1 of 1 resident (Resident #124) reviewed for dialysis care. Findings include: Resident #124's clinical record was reviewed on 8/26/15 at 12:16 p.m. Diagnoses included, but were not limited to, chronic kidney disease stage five, diabetes and end stage renal disease with dialysis. Review of the current care plans, revised on 5/01/14, provided by the Medical Records Nurse on 8/27/15 at 2:00 p.m., indicated the following, "Resident needs dialysis (hemo) r/t (related to) ESRD (End Stage Renal Disease), At risk for Electrolyte imbalance, At risk for fluctuating weights, low albumin; Risk associated with hemodialysis include bleeding at access site, access site patency, homeostasis, and infection. Approaches included, but were not limited to, monitor and assess site (left upper arm) post dialysis for signs and symptoms of infection and bleeding." During an interview with Licensed Practical Nurse (LPN) #5 on 8/27/15 at 10:30 a.m., the LPN indicated the resident's dialysis shunt would be monitored as often as the physician		completed on 8/28/15, with no adverse signs or symptomsdocumented 2. All residents with hemodialysisaccess sites have potential to be affected. An audit was completed and it wasdetermined no other residents residing in the facility had potential to beaffected. 3. Staff Development Coordinatoror designee will in-service licensed nurses on Proper Assessment, Care,Treatment, and Documentation of residents receiving Hemodialysis by ThursdaySeptember 24, 2015. 4. The Director of Nursing ordesignee will audit the dialysis logs 5 times a week for 30 days, then 3 timesa week for 30 days, then twice weekly for 30 days, then weekly as an ongoingprocess of this facility all findings will be addressed immediately forcorrection. Audit results will be reviewed in monthly PI meeting x3 months thenthe PI committee will determine if 100% compliance has been achieved and theneed for ongoing monitoring.	

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	designated. The August, 2015 Monthly Physician Orders indicated the resident had an order initiated on 1/20/14 to "monitor lower upper [sic] extremity fistula thrill and bruit (how well the blood flows through the dialysis shunt) every shift". The treatment administration record (TAR) lacked documentation that indicated the fistula site was monitored on the day shift for the following days: July, 2015: 7/21, 7/24, 7/26, 7/27, 7/28, 7/30 and 7/31 June, 2015: 6/20 and 6/21 During an interview with the Corporate Nurse Consultant on 8/28/15 at 10:30 a.m., she indicated the thrill and bruit monitoring [of the fistula site] would be documented on the TAR. On 8/27/15 at 1:11 p.m., the Corporate Nurse Consultant provided a copy of the facility's current policy titled, "Residents Receiving Dialysis". This policy included, but was not limited to, "Policy: The center provides the necessary medical and nursing care and treatment to manage the resident's end-stage renal disease. Compliance guidelines... 3. Licensed nurses manage dialysis access site to maintain patency and adequate			

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	blood flow for dialysis...". On 8/27/15 at 1:11 p.m., the Corporate Nurse Consultant provided a copy of the facility's current policy titled, " Hemodialysis Site Care". This policy included, but was not limited to, "Post Hemodialysis Care... ...2. Upon return, assess access site for patency and unusual redness or swelling... ...4. Assess the site upon return from dialysis for a. Bleeding from the site, b. Redness, c. Swelling, d. Pain, e. Non-functioning graft... ...9. Document Post Hemodialysis Care in the patient's medical record". 3.1-37(a)			
F 0441 SS=D Bldg. 00	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease			

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	and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.			
	Based on observation, interview and record review, the facility failed to ensure proper infection control measures were followed by staff for 2 of 2 direct care observations (Residents #54 and #127) in that handwashing was not done at the proper times and proper technique was not followed during the performance of	F 0441	F441 1. Resident #54 and #127 wereassessed on 9/10/2015 and found to have no signs or symptoms of a newlyacquired infectious process. Certified Nursing Assistants performing incontinencecare completed 1:1 education on handwashing,	09/24/2015

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	catheter care and incontinence care. Findings include: 1. On 08/26/15 at 10:03 a.m., CNA (Certified Nursing Assistant) #1 and CNA # 2 were observed providing incontinence care for Resident # 54. CNA # 1 and # 2 performed handwashing, donned gloves, obtained supplies, and prepped the resident for care. CNA # 1 obtained a washcloth, placed it into the pan of water and applied the no-rinse soap to the wet washcloth. The CNA folded the washcloth after cleaning the right crease. She then used the folded area of the washcloth to clean the front/labia area and the left crease, using a front to back motion. Another wet washcloth was obtained and used to rinse the right crease, the labia, and the left crease. The CNA obtained a dry towel and dried the genitalia, using one area of the towel with a front to back motion. During an interview on 08/26/15 at 10:20 a.m., CNA # 2 indicated when providing incontinence care she would rotate washcloths and not rewipe, clean with a fresh washcloth, dry and apply a clean brief. 2. On 08/26/15 at 11:37 a.m., CNA # 3		incontinence care, and cathetercare followed by competency check-off observed by SDC/Designee. RN performing cathetertubing and bag change completed 1:1 education on handwashing and procedure forcatheter bag and tubing change followed by competency check-off observed bySDC/Designee. 2. All incontinent residents andresidents with urinary catheters have potential to be affected. Facilityinfection control surveillance and infection screenings have found no residentsto be presenting with signs or symptoms of newly acquired infectious processesrelated to these causal factors. 3. Staff Development Coordinatoror designee will in-service nursing staff on handwashing, indwelling cathetercare, and incontinence care by Thursday September 24, 2015. Nursing staff willcomplete competency check-offs on handwashing, incontinence care, and indwellingcatheter care by Thursday September 24, 2015. Licensed Nurses will completecompetency check-offs on catheter tubing and bag change by Thursday September24, 2015. 4. The Director of Nursing ordesignee will observe handwashing, incontinence care, and catheter care 5 timesa week	

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	and CNA # 4 were observed performing indwelling urinary catheter care for Resident # 127. CNA # 3 and # 4 performed handwashing, donned gloves, obtained supplies, and prepped the resident for care. Soap was applied to a wet washcloth by CNA # 3. She folded the washcloth with each swipe, while cleaning the tip of the penis. She then cleaned the creases, using a back to front motion with the same washcloth. The resident resident was rolled to the left side. The resident had stool on his buttocks. Two washcloths were used to clean the buttocks using a back and forth motion, as the resident continued to have a small bowel movement. The resident was then dried with a towel, from the scrotum to the anal area, folding and patting dry. The CNAs then placed a clean brief under the resident. Barrier cream was applied to the buttocks and the resident was rolled onto his back. CNA # 4 applied fresh gloves. The front creases of the groin were dried with the same towel and barrier cream was applied to the penis, creases and the scrotum. The brief was then fastened. Resident # 127's catheter was observed leaking onto the bed linen. CNA # 4 removed her gloves and applied clean gloves. CNA # 3 removed her gloves and washed her hands for 23 seconds and notified RN (Registered Nurse) # 1 that the catheter		for 30 days, then 3 times a week for 30 days, then twice weekly for 30days all findings will be addressed immediately for correction. Competencyobservation results will be reviewed in monthly PI meeting x3 months then the PIcommittee will determine if 100% compliance has been achieved and the need forongoing monitoring.	

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	bag was leaking. CNA # 4 emptied the urine from the catheter into a container and emptied it into the toilet. She removed her gloves and washed her hands for 32 seconds and applied fresh gloves. RN # 1 entered the room to change the catheter tubing and bag. She applied gloves, without washing her hands, removed the existing catheter tubing and bag, and then replaced the catheter tubing and bag while wearing the same gloves. During an interview on 08/26/15 at 12:02 p.m., CNA # 4 indicated when performing indwelling urinary catheter care to apply no-rinse soap to the washcloth and start washing from the top of the penis, then wash the sides, then the testicles, and pat dry with a towel. She would then clean the resident's back side, dry the resident and replace the brief. On 08/27/15 at 12:10 p.m., the Director of Nursing (DON) provided a copy of the current "Hand Hygiene/Handwashing" procedure. This document included, but was not limited to the following, "Hand Hygiene is performed when hands are visibly soiled, such as after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn; Between tasks and procedures on the same patient when			

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	contaminated with body fluids to prevent cross-contamination of different body sites; If moving from a contaminated-body site to a clean-body site during patient care. Also after removal of medical/surgical or utility gloves; Intermittently after gloves are removed, between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments; and After touching bare parts of the body other than clean hands and clean, exposed portions of arms." On 08/27/15 at 12:10 p.m., the DON provided a copy of the current policy and procedure titled, "Indwelling Urinary Catheter Care." The policy and procedure indicated, but was not limited to, the following, "...3. Perform hand hygiene, and put on gloves. 4. Empty the collecting bag regularly using a separate, clean collecting container for each patient/resident; avoid splashing, and prevent contact of the drainage spigot with the nonsterile collecting container. 5. Measure output, if indicated... ...7. Remove gloves and perform hand hygiene. 8. Put on gloves. 9. Wash perineum beginning at the junction of the catheter tubing and meatus working outward to the surrounding perineal structures with soap and water or a no			

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	rinse cleansing solution and cleaning from front to back. Use a circular motion when cleaning.... If the resident has had an involuntary bowel movement, clean this area first to eliminate contamination. Change gloves to prevent contamination of catheter tubing and meatal juncture. 10. Cleanse area well and remove all debris from catheter at insertion site. 11. Rinse well with warm water, unless a no rinse cleansing solution and pat dry gently with a clean towel...." 3.1-18(l)			