

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
--------------------	--	---------------	---	----------------------

F0000	<p>This visit was for the Investigation of Complaint IN00102775.</p> <p>Complaint IN00102775- Substantiated. Federal/State deficiencies related to the allegations are cited at F 241, F 279, F 280, F 282, and F 309.</p> <p>Survey dates: January 24, 25 and 26, 2012</p> <p>Facility number: 000124 Provider number: 155219 AIM number: 100266730</p> <p>Survey team: Sandra Haws, RN- TC Susan Bruck, RN</p> <p>Census bed type: SNF/NF: 107 Total: 107</p> <p>Census payor type: Medicare: 17 Medicaid: 63 Other: 27 Total: 107</p> <p>Sample: 7</p> <p>These deficiencies also reflect State findings cited in accordance with 410 IAC</p>	F0000	<p>The facility requests that this plan of correction be considered its credible allegations of compliance. Submission of this response and Plan of Correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited and is also not to be construed as an admission of interest against the facility, the Administrator, or any employee, agents, or other individuals who draft or may be discussed in the response and Plan of Correction. In addition, preparation and submission of the Plan of Correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or the corrections of a conclusions set forth in this allegation by the survey agency. Accordingly, the facility has prepared and submitted this Plan of Correction prior to the resolution of appeal of this matter solely because of the requirements under State and Federal law that mandates submission of the Plan of Corrections a condition to participate in the Title 18 and Title 19 programs. The submission of Plan of Correction within this timeframe should in no way be of non-compliance or admission by the facility. The facility respectfully requests a desk review to determine if substantial</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:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 01/26/2012
---	--	--	--

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
--------------------------	--	---------------------	--	----------------------------

	16.2.  Quality review completed on January 31, 2012 by Bev Faulkner, RN		compliance has been achieved.	
--	--	--	-------------------------------	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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			
F0241 SS=E	<p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation , interviews and record review, the facility failed to ensure resident's call lights were answered in a timely manner leaving residents wait for up to an hour for assistance with toileting and care needs for 6 of 7 residents reviewed for call lights in a sample of 7. Resident's # B, # D, # E, # F, # G and # H</p> <p>Findings include :</p> <p>1. During a tour of the 200 unit on 1/24/12 at 9:30 a.m., an observation was made of Resident #B in her bed. The resident indicated the staff just placed her on the bedpan. The staff were observed to answer the resident's call light within 7 minutes. Resident #B indicated staff usually leave her on the bedpan for nearly an hour. She indicated staff will come in and turn the light off, tell you they will be right back and they never come back. The resident indicated the staff were better today at answering the call light. The resident indicated she had pressure ulcers on her bottom that developed in the hospital and it was painful to sit on a bedpan for a long time or a soiled bed pad.</p>	F0241	<p>1. Resident B has been discharged. For Resident D, bladder and pain reassessments have been performed and the dressing was replaced during observation by the Surveyor. For Resident E, bladder and pain reassessments have been performed. For Resident E, a bladder reassessment has been performed. Resident F &amp; H's needs had been met by the time of interview. Resident G has been discharged. Resident H has had a bladder reassessment. 2. Residents requiring assistance have the potential to be affected. Interviewable residents will be interviewed relative to call light issues and provided with appropriate follow-up. 3. Staff will be educated on policy related to call light response. Nursing staff will be educated on bed pan use policy and procedure. Random call light audits will be performed by department heads on all shifts weekly to ensure compliance. Call light response will be discussed in Resident Council 2x/month X 2 months. 4. Angels will interview residents and/or responsible parties weekly to ensure satisfaction with call light response. DNS will track and trend responses with data presented to the Performance</p>	02/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>During an observation of Resident # B's pressure ulcers on 1/24/12 at 10:05 a.m., accompanied by LPN # 2 and CNA # 3, the resident was turned on her right surgical hip with the assistance of both staff members. The resident's bed pad was observed to smell and be soaked with yellow urine. Resident #B's buttocks was observed to have a bandage dressing, dated 1/24/12. LPN # 2 loosened the dressing to expose two open pressure areas to the resident's bottom.</p> <p>Resident # B's record was reviewed on 1/24/12 at 10:30 a.m.. The resident's record indicated diagnoses of, but not limited to; diabetes, hip dislocation, urinary tract infection, depression and J (Jejunostomy) tube.</p> <p>Resident #B's admission MDS (Minimum Data Set) assessment, dated 1/19/12, indicated she had no cognition impairment, was alert and oriented, she needed the assistance of two staff for transfers, extensive assistance for dressing and bathing. The resident required total assistance with nutrition via tube feeding and had occasional incontinence of bowel and bladder.</p> <p>The resident's admission assessment, dated 1/11/12, indicated the resident was admitted with the pressure areas to her</p>		Improvement Committee monthly X 3 months then quarterly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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>bottom.</p> <p>2. During an interview with alert and oriented Resident # D on 1/24/12 at 12 p.m., she indicated she waits 30 to 45 minutes for staff to answer her call light. She stated "they will put me on the bedpan and not come back." The resident indicated her bottom would be sore from being left on the bedpan so long.</p> <p>The resident was observed to have a below the knee amputation. The stump of her left leg was observed to be propped on a pillow. The tip of the stump was observed to have an open area slightly larger than a half dollar in size. The wound was open to air, reddened and dry. The resident indicated her wound was supposed to be dressed with a bandage. She indicated the dressing was pulled off when the CNA "ripped her blankets off" around 7:30 or 8:00 in the morning. She indicated she asked the nurse to put it back on in the morning and they never came back to do it.</p> <p>An observation was made of Resident # D putting her call light on at 12:05 p.m., on 1/24/12 to request her dressing to be put on her leg. The resident's call light was answered within a couple of minutes and was told by a therapist she would tell the nurse about the dressing needing to be put</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(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>on. The therapist came back in and told Resident # D the nurse said she would be in, in 15 minutes to apply her dressing. LPN # 5 did not return until 45 minutes later to apply the dressing to Resident # D's open wound.</p> <p>During an interview at that time with LPN # 5 regarding the 45 minute wait for the resident's dressing to be done and the resident's wound being undressed since morning, LPN # 5 had no reply.</p> <p>Resident # D's record was reviewed on 1/25/12 at 8:40 a.m. The resident's record indicated diagnoses of, but not limited to; bilateral below the knee amputation, multiple rib fractures, pelvic fracture, pulmonary contusion, L5 (lumbar spine) fracture and a bladder rupture. The resident's record indicated she received multiple trauma after being hit by a car while she was in the street with her motorized wheelchair.</p> <p>Resident #D's admission MDS, dated 12/27/11 indicated the resident was alert and oriented, needed total assistance with bed mobility, and her hygiene and bathing needs, and was continent of bowel, and bladder. The resident was observed to have metal rods protruding from her pelvic area. She indicated it was painful to use the bedpan let alone be left on it for</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>45 minutes.</p> <p>3. During an interview with alert and oriented Resident #E on 1/24/12 at 9:20 a.m., regarding staff answering her call light, she stated "They come in and answer the call light right away, they will turn it off and leave. It will be an hour before they come back." Resident #E indicated when she's on the bedpan they will turn the light off and she will have to wait "forever" for them to come back, at least 40 minutes. Resident # E indicated it is painful to be on a bedpan for that long. Resident #E further indicated sometimes a nurse will come in and turn the light off and tell you she'll get the CNA and they never come back. Resident #E indicated sometimes "I just need a minor thing handed to me that's out of my reach but they won't take the time to do it, they just turn the light off and leave."</p> <p>Resident # E's record was reviewed on 1/26/12 at 10:00 a.m. The resident's record indicated diagnoses of, but not limited to; Multiple sclerosis, reflux, cystitis and paraplegia.</p> <p>The resident's initial MDS assessment, dated 11/8/11 indicated she was alert and oriented, needed total assistance with transfers and extensive assistance with dressing and hygiene needs. The MDS</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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 the resident was occasionally incontinent of bowel.</p> <p>4. During an interview with alert and oriented Resident # F regarding her call light being answered timely on 1/24/12 at 9:40 a.m., she stated "I wait 2 hours for them to answer the call light. I am a Hoyer lift and they will answer the light and tell me they'll be right back and they don't come back." Resident # F indicated she spoke to the DON (Director of Nursing) about the call light problem and indicated the DON talked to her about staffing numbers and how they have enough staff. Resident # E indicated after the talk with the DON, the staff still come in and turn it off and leave.</p> <p>Resident # F's record was reviewed on 1/26/12 at 12:00 p.m. The resident's record indicated diagnoses of, but not limited to; Left ankle fracture, neuropathy, diabetes and non-Hodgkin lymphoma.</p> <p>The resident's admission MDS assessment, dated 1/17/12, was reviewed on 1/26/12 at 12:10 p.m. The MDS indicated the resident's cognition was alert and oriented, needed extensive assistance with 2 staff for transfers. She needed extensive assistance with dressing and hygiene needs. The MDS indicated she</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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>was occasionally incontinent of bowel and bladder.</p> <p>5. During initial tour on 1/24/12 at 9:05 a.m., accompanied by the Unit Manager # 4, she indicated that Resident # H was normally continent unless his toileting needs were not met fast enough. She further indicated that he was not on a toileting program to assist with maintaining continence.</p> <p>During an interview on January 24, 2012 at 11:45 a.m., with Resident # H and his family, they both indicated the resident's call light was not answered timely. The resident indicated that it takes 15 minutes to an hour, but more like 30 minutes to an hour before staff respond to his call light. He further added it's never any sooner than that. The resident's family member indicated it takes one staff member to assist the resident to use the toilet and was unaware of the resident being incontinent. Resident # H indicated he has occasional accidents when it takes too long for staff to come in.</p> <p>Resident # H's record was reviewed on 1/24/2012 at 1:00 p.m. The resident's record indicated the following diagnoses, but not limited to: Bladder neck obstruction, spinal stenosis, malaise and fatigue. Resident's quarterly MDS</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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>(Minimum Data Set) assessment, dated 12/09/2011, indicated the resident's cognition is moderately impaired. The MDS also indicated the resident requires extensive assistance of one staff member for transfers, limited assist of one staff member for dressing, requires set up and supervision for meals, and was frequently incontinent of bladder and bowel. The record review further indicated the resident was not currently on a toileting program and indicated the resident does not ambulate; however, he utilizes an electric scooter throughout the facility.</p> <p>6. Interview with Resident # G on 1/25/12 at 2:30 p.m., Resident # G indicated that staff are slow to answer his call light; at least a half hour. He indicated it takes more than 30 minutes for the staff to respond and he doesn't think it should take that long. The resident indicated that it was worse in the mornings before breakfast and in the evenings after supper. He further indicated that he has had to get out of bed to go find someone.</p> <p>Resident # G's record was reviewed on 1/25/12 at 2:45 p.m. The resident's record indicated the following diagnoses but not limited to: S/P CABG (Status Post Coronary Artery Bypass Graft), decreased mobility, hypertension, muscle weakness,</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>pure hypercholesterolemia, edema and atrial fibrillation.</p> <p>Review of Resident # G's 14 day MDS assessment, dated 1/19/12, indicated the resident's cognition was intact. The MDS also indicated Resident # G requires extensive assist of one staff member for transfers, ambulation in his room and with hygiene. The MDS further indicated the resident was continent of bowel and bladder.</p> <p>Resident # G's careplans were reviewed on 1/26/12 at 11:00 a.m.. Resident # G's carpelan, dated 1/13/12, indicated the resident is at risk for falls due to decreased mobility, and careplan, dated 1/13/12, indicated Resident # G required assist with ADL's (Activities of Daily Living) related to S/P CABG and decreased mobility.</p> <p>Interview on 1/25/12 at 2:40 p.m., with Unit Manager # 6 indicated Resident # G was alert and oriented.</p> <p>Interview on 1/25/12 at 2:50 p.m. ,with Social Services # 7, he indicated Resident # G was alert and oriented.</p> <p>The facility's policy and procedure titled "Call Light Use of," dated 9/26/03, was reviewed on 1/25/12 at 11:00 a.m. The</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>policy titled " ...Responding to a Call Light" indicated, 6. Identify the location of the light, and answer the resident promptly...Assist resident with his/her needs...."</p> <p>This Federal tag relates to Complaint # IN00102775</p> <p>3.1-3(t)</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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			
F0279 SS=D	<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, interview and record review, the facility failed to ensure a plan of care was implemented for total hip precautions for a resident needing specific precautions to be put into place to prevent her hip from being dislocated after surgery for 1 of 7 residents reviewed with total hip precautions in a sample of 7. Resident # B</p> <p>Findings include:</p> <p>During an observation of Resident # B's pressure ulcers on 1/24/12 at 10:05 a.m., accompanied by LPN # 2 and CNA # 3, the resident was observed to be turned on her right surgical hip with the assistance</p>	F0279	<p>1. Care plan for Resident B has been updated to include current interventions. 2. Residents requiring orthopedic precautions have the potential to be affected. Residents requiring these precautions will be reviewed for individualized interventions appropriate for their condition. 3. MDS Coordinators, Unit Managers, and Licensed Nurses have been educated on appropriate care planning for residents requiring orthopedic precautions. Residents requiring orthopedic precautions will be reviewed by IDT on admission, quarterly, and with significant change for appropriate care planning for orthopedic requirements per the RAI</p>	02/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(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>of both staff members. The resident was observed to have a very thin bed pillow between her legs.</p> <p>During an interview with LPN # 2 and CNA # 3 at this time regarding the resident's right hip surgery, if total hip precautions were to be followed and if the resident should have been turned onto her surgical right side. Both indicated they were not sure. Resident #B indicated the staff have always been turning her onto her right surgery side.</p> <p>Resident # B's record was reviewed on 1/24/12 at 10:30 a.m.. The resident's record indicated diagnoses of, but not limited to; diabetes, hip dislocation, urinary tract infection, depression and J (Jejunostomy) tube. The record indicated the resident was admitted on 1/11/12.</p> <p>Resident #B's admission MDS (Minimum Data Set) assessment, dated 1/19/12, indicated she had no cognition impairment, was alert and oriented, she needed the assistance of two staff for transfers, extensive assistance for dressing and bathing. The resident required total assistance with nutrition via tube feeding and had occasional incontinence of bowel and bladder.</p> <p>Review of a hospital discharge summary,</p>		<p>schedule. 4. MDS Coordinators/designee will audit all care plans for appropriate care planning for orthopedic precautions per the RAI schedule with results reviewed by the Performance Improvement Committee monthly X 3 months then quarterly thereafter.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>dated 1/2/12, indicated "... (stated age) unfortunate diabetic, gastroparesis with multiple complications, comes in after having severe pain in her hip after a hip fracture and replacement. Apparently while getting in and out of bed she somehow dislocated her hip...."</p> <p>Review of a Therapist evaluation, dated 1/12/12 on 1/24/12 at 11:00 a.m., indicated "... (R/T) (right) hip precautions...."</p> <p>During an interview with the Director of Nursing on 1/25/12 at 1:00 p.m., regarding what type of hip precautions the staff were supposed to be following, she stated "it depends on where the incision was located." The Director of Nursing indicated she was not sure of the type of precautions the resident needed.</p> <p>During an interview with RN # 9 on 1/25/12 at 1:30 p.m., regarding what type of precautions the resident needed for her hip, RN # 9 was not sure and indicated he would need to check.</p> <p>During an interview with Resident # B on 1/25/12 at 3:20 p.m., she was observed to have a pink abductor pillow between her legs and a few pillows propped along her right side. Resident #B stated "I've told the staff to get my abductor pillow out of</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>the closet because the doctor told me to make sure they keep it between my legs." Resident # B further indicated they are turning me on my left side now.</p> <p>During an interview with Therapist # 8 on 1/25/12 at 3:30 p.m., regarding the resident's hip precautions, she stated full hip precautions are needed as she was a total hip repair. She further indicated the resident needs to have an abductor pillow between her legs at all times or at least two good pillows at a minimum. Therapist # 8 indicated with total hip precautions the resident should never be turned on her surgical side, 90 degrees of flexion of the hip needed to be avoided, not to bend over at the waist to pick up anything , keep an abductor pillow in between her legs and never cross her legs.</p> <p>The resident's record lacked a plan of care indicating the total hip precautions that staff needed to be implementing.</p> <p>This Federal tag relates to Complaint # IN00102775</p> <p>3.1-35(a)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
--------------------	--	---------------	---	----------------------

--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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
F0280 SS=D	<p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>Based on observation, interview and record review, the facility failed to ensure the resident's plan of care was updated to include the current treatment to her left leg wound for 1 of 7 residents reviewed with care plans in a sample of 7. Resident # D</p> <p>Findings include:</p> <p>During an interview with alert and oriented Resident # D on 1/24/12 at 12 p.m., the resident was observed to have a below the knee amputation. The stump of her left leg was observed to be propped on a pillow. The tip of the stump was observed to have an open area slightly larger than a half dollar in size. The wound was open to air, reddened and dry.</p>	F0280	<p>1. Care plan for Resident D has been updated to include current interventions. 2. Residents requiring dressing changes have the potential to be affected. All residents requiring dressing changes be reviewed for individualized care plan interventions appropriate for their condition. 3. MDS Coordinators, Unit Managers, and Licensed Nurses have been educated on appropriate care planning for residents requiring dressing changes. All residents requiring dressing changes will be reviewed by Unit Managers for appropriate care planning for dressing changes 5x/wk through the clinical meeting. 4. MDS Coordinators/designee will audit all care plans for appropriate care planning for dressing changes per</p>	02/23/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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>The resident indicated her wound was supposed to be dressed with a bandage. She indicated the dressing was pulled off when the CNA "ripped her blankets off" around 7:30 or 8:00 in the morning. She indicated she asked the nurse to put it back on in the morning and they never came back to do it.</p> <p>Resident # D's record was reviewed on 1/25/12 at 8:40 a.m. The resident's record indicated diagnoses of, but not limited to; bilateral below the knee amputation, multiple rib fractures, pelvic fracture, pulmonary contusion, L5 (lumbar spine) fracture and a bladder rupture. The resident's record indicated she received multiple trauma after being hit by a car while she was in the street with her motorized wheelchair.</p> <p>Resident #D's admission MDS, dated 12/27/11, indicated the resident was alert and oriented, needed total assistance with bed mobility, and her hygiene and bathing needs, and was continent of bowel, and bladder.</p> <p>A physician's order, dated 1/16/12, indicated "Wet to dry dressing changes on (L) (left) BKA (below the knee amputation) stump wound bid (two times daily.)"</p>		<p>the RAI schedule with results reviewed by the Performance Improvement Committee monthly X 3 months then quarterly thereafter.</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(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>A care plan, dated 12/29/11, indicated "Problem: (Resident # D) is at risk for impaired skin integrity r/t (related to) poor mobility, multiple fx (fractures) bladder laceration, pelvic external fixator, unable to turn properly, bilateral BKA, has wound vac to left stump...Approach: wound vac to left stump as ordered. The resident's plan of care failed to be updated with the new dressing change to the resident's left stump as the wound vac was discontinued on the plan of care and nothing else had been added.</p> <p>This Federal tag relates to Complaint # IN00102775</p> <p>3.1-35(d)(2)(B)</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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			
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 ensure the physician's order was followed related to an open wound ordered to be treated and bandaged twice a day had been completed for 1 of 7 residents reviewed with a wound treatment in a sample of 7. (Resident # D)</p> <p>Findings include :</p> <p>During an interview with alert and oriented Resident # D on 1/24/12 at 12 p.m., the resident was observed to have a below the knee amputation. The stump of her left leg was observed to be propped on a pillow. The tip of the stump was observed to have an open area slightly larger than a half dollar in size. The wound was open to air, reddened and dry. The resident indicated her wound was supposed to be dressed with a bandage. She indicated the dressing was pulled off when the CNA "ripped her blankets off" around 7:30 or 8:00 in the morning. She indicated she asked the nurse to put it back on in the morning and they never came back to do it.</p> <p>An observation was made of Resident # D putting her call light on at 12:05 p.m., on</p>	F0282	<p>1. Resident D's dressing change order was clarified to include order for when dressing becomes dislodged. 2. Residents requiring dressing changes have the potential to be affected. Residents with dressing change orders will be reviewed for appropriate orders with changes made as needed. 3. Unit Managers and Licensed Nurses will be educated on following physician's orders regarding dressing changes. System changes to achieve compliance will be that nurses will request clarification for dressing change orders to include an order for when dressings become dislodged upon receipt of orders. Unit Managers will review new dressing change orders 5x/wk through clinical meeting. 4. Unit Managers/designee will audit all dressings for appropriate application 3x/wk. Results will be brought to the Performance Improvement Committee monthly X 3 months then quarterly thereafter.</p>	02/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>1/24/12 to again request her dressing to be put on her leg. The resident's call light was answered within a couple of minutes and was told by a therapist she would tell the nurse about the dressing needing to be put on. The therapist came back in and told Resident # D the nurse said she would be in, in 15 minutes, to apply her dressing. LPN # 5 did not return until 45 minutes later to apply the dressing to Resident # D's open wound.</p> <p>During an interview at that time with LPN # 5 regarding the 45 minute wait for the resident's dressing to be done and the resident's wound being undressed since morning, LPN # 5 had no reply.</p> <p>Resident # D's record was reviewed on 1/25/12 at 8:40 a.m. The resident's record indicated diagnoses of, but not limited to; bilateral below the knee amputation, multiple rib fractures, pelvic fracture, pulmonary contusion, L5 (lumbar spine) fracture and a bladder rupture. The resident's record indicated she received multiple trauma after being hit by a car while she was in the street with her motorized wheelchair.</p> <p>Resident #D's admission MDS, dated 12/27/11, indicated the resident was alert and oriented, needed total assistance with bed mobility, and her hygiene and bathing</p>			
--	--	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>needs, and was continent of bowel, and bladder.</p> <p>A physician's order, dated 1/16/12, indicated "Wet to dry dressing changes on (L) (left) BKA (below the knee amputation) stump wound bid (two times daily.)"</p> <p>A care plan dated 12/29/11 indicated "Problem: (Resident # D) is at risk for impaired skin integrity r/t (related to) poor mobility, multiple fx (fractures) bladder laceration, pelvic external fixator, unable to turn properly, bilateral BKA...."</p> <p>This Federal tag relates to Complaint # IN00102775</p> <p>3.1-35(g)(2)</p>			
--	---	--	--	--

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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			
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 observations, interviews and record review, the facility failed to ensure staff were implementing hip precautions for a resident with a recent total hip repair for 1 of 7 residents reviewed with hip precautions in a sample of 7. (Resident #B)</p> <p>Findings include:</p> <p>During an observation of Resident # B's pressure ulcers on 1/24/12 at 10:05 a.m., accompanied by LPN # 2 and CNA # 3, the resident was observed to be turned onto her right surgical hip with the assistance of both staff members. The resident was observed to have a very thin bed pillow between her legs.</p> <p>During an interview with LPN # 2 and CNA # 3 at this time regarding the resident's right hip surgery, if total hip precautions were to be followed and if the resident should have been turned onto her surgical right side. Both staff indicated they were not sure. Resident #B indicated the staff have always been turning her onto her right surgery side.</p>	F0309	<p>1. Resident B has been discharged. 2. Residents requiring orthopedic precautions have the potential to be affected. Therapy will review residents requiring orthopedic precautions for appropriate interventions with changes made as needed. 3. Nursing staff will be educated on execution of hip precautions. Systemic change that will be initiated is that residents requiring orthopedic precautions will be considered to require the most restrictive precautions for their condition until reviewed by therapy, at which time appropriate individual interventions will be communicated in writing to nursing staff. 4. Unit Managers/designee will perform observation audits on residents requiring orthopedic precautions 3x/wk with results brought to the Performance Improvement Committee monthly X 3 months then quarterly thereafter. The facility respectfully requests a desk review to determine if substantial compliance has been achieved.</p>	02/23/2012			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012	
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND				STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635			
(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 # B's record was reviewed on 1/24/12 at 10:30 a.m.. The resident's record indicated diagnoses of, but not limited to; diabetes, hip dislocation, urinary tract infection, depression and J (Jejunostomy) tube. The record indicated the resident was admitted on 1/11/12.</p> <p>Resident #B's admission MDS (Minimum Data Set) assessment, dated 1/19/12, indicated she had no cognition impairment, was alert and oriented, she needed the assistance of two staff for transfers, extensive assistance for dressing and bathing. The resident required total assistance with nutrition via tube feeding and had occasional incontinence of bowel and bladder.</p> <p>Review of a hospital discharge summary, dated 1/2/12, indicated "...A (stated age) unfortunate diabetic, gastroparesis with multiple complications, comes in after having severe pain in her hip after a hip fracture and replacement. Apparently while getting in and out of bed she somehow dislocated her hip...."</p> <p>Review of a Therapist evaluation, dated 1/12/12, on 1/24/12 at 11:00 a.m. indicated "...(R/T) (right) hip precautions...."</p> <p>During an interview with the Director of</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED  01/26/2012
NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND			STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635		
(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>Nursing on 1/25/12 at 1:00 p.m., regarding what type of hip precautions the staff were supposed to be following, she stated "it depends on where the incision was located." The Director of Nursing indicated she was not sure of the type of precautions the resident needed.</p> <p>During an interview with RN # 9 on 1/25/12 at 1:30 p.m., regarding what type of precautions the resident needed for her hip, RN # 9 was not sure and indicated he would need to check.</p> <p>During an interview with Resident # B on 1/25/12 at 3:20 p.m., she was observed to have a pink abductor pillow between her legs and a few pillows propped along her right side. Resident #B stated "I've told the staff to get my abductor pillow out of the closet because the doctor told me to make sure they keep it between my legs." Resident # B further indicated they are turning me on my left side now.</p> <p>During an interview with Therapist # 8 on 1/25/12 at 3:30 p.m., regarding the resident's hip precautions, she stated full hip precautions are needed as she was a total hip repair. She further indicated the resident needs to have an abductor pillow between her legs at all times or at least two good pillows at a minimum. Therapist # 8 indicated with total hip</p>				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155219	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  01/26/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTH BEND	STREET ADDRESS, CITY, STATE, ZIP CODE 52654 N IRONWOOD RD SOUTH BEND, IN 46635
--	--

(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>precautions the resident should never be turned on her surgical side, 90 degrees of flexion of the hip needed to be avoided, not to bend over at the waist to pick up anything , keep an abductor pillow in between her legs and never cross her legs.</p> <p>This Federal tag relates to Complaint # IN00102775</p> <p>3.1-37(a)</p>			
--	--	--	--	--