

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/16/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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F0000	<p>This visit was for a Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN000117871.</p> <p>Complaint IN000117871- Unsubstantiated due to lack of evidence.</p> <p>Survey Date: November 7, 8, 9, 11, 13, 14, 15, 16, 2012</p> <p>Facility Number: 000564 Provider Number: 155484 AIM Number: 100285610</p> <p>Survey Team: Mary Weyls, RN-TC Teresa Buske, RN November 7, 8, 9, 13, 14, 15, 16, 2012 Laura Brashear, RN November 7, 8, 9, 13, 14, 15, 16, 2012</p> <p>Census Bed Type: SNF/NF: 141 Total: 141</p> <p>Census Payor Type: Medicare: 42 Medicaid: 80 Other: 19 Total: 141</p>	F0000	Kindred Transistional Care and Rehabilitation - Southwood is respectfully requesting a desk review instead of an onsite revisit.	

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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2</p> <p>Quality review completed on November 27, 2012 by Bev Faulkner, RN</p>				

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F0282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to follow physician's orders for 1 of 3 residents reviewed who met the criteria for nutrition in that a resident with a gastrostomy tube [gt] with a general physician's order to contact the Gastroenterologist to replace a dislodged g-tube was not done. Residents #87.</p> <p>Findings include:</p> <p>1. Resident #87's clinical record was reviewed on 11/14/12 at 3:34 p.m. An admission date was noted of 3/7/12 and readmission date of 4/20/12. The resident's diagnoses included, but were not limited to senile dementia, esophageal reflux, depressive disorder, renal failure and hypertension.</p> <p>A physician's order was noted, dated 6/8/12, for tube feeding of Jevity 1.2 at 100 cc per hour per gastrostomy tube from 6:00 p.m. to 6:00 a.m. daily. A physician's order was also noted, dated 5/6/12, for regular</p>	F0282	Resident #87 received new G-tube 11/19/12. Care plan and MAR have been updated to reflect current MD orders. All residents who have a G-tube have the potential to be affected, therefore, this plan of correction applies to those residents. The SDC will in-service nursing staff regarding the updating of care plans to reflect MD orders, including but not limited to G-tube care and then follow through with plans of care as ordered. They will also notify physician of any changes that may altar current Plan of Care and make changes accordingly. A random audit will be completed on the above three times per week by the DNS/designee to ensure compliance for 6 month and on going to insure continued compliance. The results of the audit will be discussed at the PI meeting on a monthly basis until full compliance has been achieved. The DNS/Designee is responsible for continued compliance with this standard.	12/16/2012			

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	<p>mechanical soft diet.</p> <p>A physician's order was noted, dated 11/6/12, to "place Foley catheter in gastrostomy tube site, notify the Gastroenterologist [GI] doctor in a.m., run tube feeding through tube related to resident pulled out." A nursing note, dated 11/14/12 at 11:56 a.m., was noted of the GI doctor called for appointment due to the resident pulling the gt out.</p> <p>Unit Manager, LPN #6 was interviewed on 11/14/12 at 3:53 p.m. The LPN indicated the GI doctor was called on 11/7/12 and as of 11/14/12 the facility had not heard back from the physician or attempted to make contact with the GI physician. The Foley catheter continued to be in use for the feeding tube. The LPN could not provide any written documentation of any attempts to reach the GI physician.</p> <p>3.1-35(g)(2)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, record review and interview, the facility failed to ensure a resident with a pressure sore received services to promote healing for 1 of 3 (#127) residents reviewed with pressure sores in that the resident entered the facility with a pressure area, and did not receive physician orders and/or treatment to the area until 13 days after re-admission.</p> <p>Findings include:</p> <p>On 11/15/12 at 9:05 a.m., LPN #1 provided a treatment to a pressure area on Resident #127's left heel.</p> <p>Resident #127's clinical record was reviewed on 11/15/12 at 8:30 am.</p> <p>Documentation indicated the resident</p>	F0314	<p>Heel protectors were implemented on admission to facility for Resident #127. Resident has orders in place per MD. The SDC has counseled and will in-service staff involved in the care of resident #127. The SDC will in-service nursing in regards to receiving treatment orders upon admission. The DNS/Designee will review the provision of care of all residents with pressure ulcers and address any discrepancies noted as a result of this review. The SDC will in-service nursing staff in the delivery of necessary treatment and services to promote healing of pressure ulcers. The DNS/Designee will monitor through observation on all shifts and report results through PI at least monthly for (6) six months then quarterly on-going. The DNS/Designee is responsible for continued compliance.</p>	12/16/2012			

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	<p>was transferred to the hospital on 10/11/12 and returned to the facility on 10/18/12.</p> <p>A report from the hospital titled "Discharge Instructions," dated 10/18/12, indicated the resident was to receive "Mepilex to heel..., turn frequently" and "off loading pressure boots." The Discharge Summary was not signed by a physician.</p> <p>A "Pressure Ulcer Report," dated 10/19/12, indicated the resident had an area on the left heel measuring 1 cm X 1 cm with 0 depth. The documentation indicated the area was a Stage 1.</p> <p>On 10/25/12 "left heel 2 cm X 2 cm X 0 depth , non-blanchable erythema & or intact skin. On 10/30/12 "Lt heel 3 cm X 3 cm , suspected deep tissue injury. Adherent soft black eschar, full thickness skin loss involving damage or necrosis of subcutaneous tissue may extend down to but not through underlying fascia..."</p> <p>A physician's telephone order was noted, dated 10/31/12, indicating the resident's left heel was to be cleansed with normal saline and an application of "Granulex tid (three times a day) to left heel till healed, heel protector boots to bilateral feet."</p>			

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	<p>Documentation to indicate the physician was notified for treatment orders for the resident's left heel prior to 10/31/12 was lacking.</p> <p>During interview of the 200A Unit Manager, LPN #6, the Unit Manager indicated heel boots had been implemented on admission, but physician's orders were not received or any treatments implemented for the resident's left heel until 10/31/12.</p> <p>The most recent documentation of the left heel, was dated 11/13/12, indicating the size of the area on the resident's left heel measured 3.75 cm X 3 cm unstageable.</p> <p>3.1-40(a)(2)</p>			

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F0441 SS=D	<p>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 and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>During observation, interview and record review, the facility failed to</p>	F0441	The SDC will in-service LPN #1 and all other nurses assigned to	12/16/2012			

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	<p>ensure proper glove changing to prevent contamination for 1 of 1 resident (Resident #127) observed receiving a dressing change; in that the nurse failed to remove gloves after cleansing a wound, and prior to touching a can of Granulex and placing a clean dressing.</p> <p>Findings include:</p> <p>On 11/15/12 at 9:05 p.m., LPN #1 provided a dressing change to Resident #127's left heel. The LPN removed a dry dressing from a dry wound on the left heel, changed gloves and cleansed the wound with a gauze soak with normal saline. With the same glove, picked up a can of Granulex and sprayed on a gauze and placed the gauze on the wound, wrapped with Kling, placed tape on the Kling, and placed the resident's heel boot back on.</p> <p>During interview of LPN #1 on 11/15/12 at 9:15 a.m., the LPN indicated the can of Granulex and tape would be placed back into the treatment cart with other treatment supplies.</p> <p>Review of a facility policy received on 11/16/12 at 12:18 p.m., from the DON, titled "Hand</p>		<p>resident #127 on proper hand washing between doffing and donning of gloves when providing care. Other residents were not identified. The DNS/Designee will, through observation, identify residents receiving care without staff performing proper hand washing. The DNS/Designee will provide individualized in-servicing and/or counseling to staff members identified through this process. The SDC will in-service the current nursing personnel on the proper hand washing techniques between doffing and donning gloves when providing care. The DNS/Designee will observe current nursing personnel performing a return demonstration of hand washing techniques. The DNS/Designee will rein-service and/or counsel any employee identified as not performing hand washing as delineated by the facility policy and procedure. The SDC will provide instruction on proper hand washing techniques and return demonstration for all new personnel during orientation. The DNS/Designee will monitor direct observation of nursing staff perform hand washing and doffing and donning of gloves using proper techniques while providing care on all shifts for 6 months. The DNS/Designee will report results to PI meeting monthly times 6 months then quarterly on going. The DNS/Designee is responsible for</p>				

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	<p>Hygiene/Handwashing" documentation indicated handwashing was expected "After touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn."</p> <p>3.1-18(l)</p>		continued compliance.	

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F0505 SS=D	<p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. Based on record review and interview, the facility failed to ensure the physician notification policy was followed for 1 of 20 residents reviewed for potential physician notification; in that Resident #115 with an abnormal laboratory result was not reported to the physician via phone call as indicated in the facility policy.</p> <p>Findings include:</p> <p>1. Upon review of Resident #115's clinical record on 11/15/12 at 11 a.m., a pharmacy recommendation was noted, dated 10/14/12, of " This resident is receiving Theo-Dur [bronchodilator] 200 mg [milligram] Q [every] 12 H [hours]. Please order a theophylline level every 6 months to monitor therapy." Documentation indicated the physician responded on 10/24/12 of check level one time now only.</p> <p>The theophylline level was completed on 10/29/12 with a result of 5.4. The result was indicated to be low and that normal range was 10.0-20.0 ug/ml.</p>	F0505	Resident #115's MD was again notified of abnormal lab. The MD does not want to make any adjustment to medication dosage at this time. All residents have the potential to be affected, therefore, this plan of correction applies to all residents. For all residents - all labs normal or abnormal will be called in to the primary physician when received. The SDC will in-service the nursing staff to fax the labs to MD office and then follow-up with a call to primary MD or the on-call MD if primary unavailable. The shift receiving initial results will notify MD and document MD notification in the nurses notes. The DNS/Deisgnee will follow up on all lab results daily to make sure physician notification has been done. The DNS/Designee will conduct random audits and report to PI monthly for 6 months then at least quarterly to insure compliance. The DNS/Designee is responsible for continued compliance.	12/16/2012

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	<p>Upon interview of LPN Unit Manager #7 on 11/16/12 at 10 a.m., LPN indicated the result had been faxed to the physician on 10/29/12 and that the physician had not wanted any changes to the medication. The LPN indicated when the physician does not call back with changes then they assume there were no changes. The LPN indicated "That is how they do it with lab results." The LPN indicated a follow telephone call had not been placed to the physician regarding the low theophylline level.</p> <p>Documentation was lacking of the physician acknowledging the low laboratory result and/or being aware of the low theophylline level.</p> <p>Upon review of the facility's policy and procedure, titled "Guidelines for Physician Notification of Change of Condition/Clinical Problems in Center Residents" [no date] on 11/16/12 at 12:20 p.m., the documentation indicated non-immediate (medium alert within 6-8 hours) -" Any drug level above therapeutic level, OR Any sub-therapeutic level in someone with related symptoms, before giving next dose..." Upon review of current policy and procedure titled "Laboratory, Radiology, and Other Diagnostic Services," dated 8/31/12,</p>			

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	<p>on 11/16/12 at 10 a.m. indicated "....Promptly notifying the attending physician of the findings: ...2) Medium alert-within 6-8 hours, or 3) Low alert-within 24-72 hours..."</p> <p>Upon review of policy and procedure titled "Documentation Do's and Don'ts Reference Guide" [no date] on 11/16/12 at 12:20 p.m., documentation indicated " Test results, Consultations- Do's: 1. Document review of lab, radiology, and other reports and note the date, time, and method of physician notification. Document physician response. If an abnormal test report was faxed to the physician, documentation should reveal that there was a follow-up telephone call..."</p> <p>3.1-49(f)(2)</p>			