

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00175354.</p> <p>Complaint IN00175354 - Substantiated. Federal/state deficiencies related to the allegations are cited at F223, F225, F226, F309 and F441.</p> <p>Survey dates: June 17, 18 and 19, 2015</p> <p>Facility number: 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 145 Total: 145</p> <p>Census payor type: Medicare: 18 Medicaid: 98 Other: 29 Total: 145</p> <p>Sample: 5</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance.</p> <p>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</p>	
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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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F 0223 SS=D Bldg. 00	<p>483.13(b), 483.13(c)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. Based on observation, interview and record review, the facility failed to prevent verbal and emotional abuse for 1 of 5 residents reviewed for abuse. (Resident E)</p> <p>Findings include:</p> <p>Resident E was interviewed in her room on the Moving Forward unit, located in the far southeast corner of the facility, on 6/17/2015 at 2:10 p.m. with Family Member # 4 present. She indicated during night shift on 6/15/2015, she requested her scheduled evening medications because she wished to "go to bed early." Resident E indicated she pushed her call light twice with a Certified Nursing Assistant (CNA) answering approximately 20 minutes later each time. Each time, the CNA indicated she would notify the nurse of her request. Resident E indicated she</p>	F 0223	<p>F223 FREE FROM ABUSE/INVOLUNTARY SECLUSION (Re:Allegation facility failed to prevent verbal and emotional abuse for 1 of 5residents reviewed, Resident E) The facility disputesthe facts in the complaint. Resident E was interviewed by Unit Manager #1 at about 1:55pm on 6/17/15. Present in room was resident and familymember, presumably Family Member # 4 mentioned in the complaint. The resident had voiced concern over thenight shift nurse being rude to her and she did not want that nurse to take care of her. The resident had stated she asked for her night medication at about 7:15pm because she was tired and wanted to go to bed. She stated that she puther light on 3 times with a CNA answering those call lights. Resident first stated it was "last night" and</p>	07/16/2015	

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	<p>waited another 20 minutes before pushing the call light a third time. Resident E indicated, "[Name of RN (Registered Nurse) # 3] was furious. She said I had interrupted her three times...I asked her why she was being so rude to me. She said, 'If you're going to interrupt me, this is the way it's going to be.' She was shaking, she was so mad. I apologized and she was on again last night [6/16/2015] and I said I wouldn't bother her. I didn't [bother her] and we had a real good night and she wasn't mean to me." Resident E indicated she felt "afraid [staff] would be mean to her" if she reported the abuse.</p> <p>Resident E's Family Member # 4 indicated, "When I came in last night [6/16/2015], her call light was on and she was crying and miserable, laying in feces." She indicated when she entered the hall to look for assistance, RN # 3 was outside Resident E's door at the medication cart, looked at the call light flashing over her door, and indicated, "I know. I'm getting her her meds now." Resident E's Family Member # 4 indicated to RN # 3, "She's laying in her own feces." RN # 3 indicated, "I know." Family Member # 4 indicated the resident had expressed concerns regarding staff treatment, but was afraid they [staff] would be mean to her if Resident E</p>		<p>then stated it was "the other night". The resident stated the first and second time the light was answered, the CNA told her she would let the nurse know and the third time she said that the nurse would be there as soon as she got done with a resident in the next room. The resident stated that it was almost 8:00pm and the nurse was mad and stood in the doorway and asked her "what do you want now? You've interrupted me 3 times already". The resident stated she asked the nurse when she could have her medication and that the nurse had stated that she was not allowed to get her medication until 8:00pm because it was due at 9:00pm and if she gave it earlier than one hour before it was due or one hour after it was due she could lose her license. The resident stated it was about 8:00pm and the nurse did get her medication and there were no other issues noted. The resident stated the same nurse took care of her the next night and there were no issues. The Unit Manager exited the room and the surveyor immediately entered the room. The family member remained in the room with the resident. The Unit Manager immediately reported the</p>	

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	<p>reported the abuse.</p> <p>Unit Manager # 1 was seen exiting Resident E's room moments prior to the above interview. Both Resident E and Family Member # 4 indicated they informed Unit Manager # 1 of RN # 3's treatment of Resident E.</p> <p>Resident E's clinical record was reviewed on 6/17/2015 at 4:00 p.m. Admission Minimum Data Set (MDS) assessment, dated 6/15/2015, indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15; indicating she was cognitively intact. The resident was non-ambulatory and required extensive, 2+ person physical assist for all activities of daily living (ADLs), including toileting, hygiene, and transfers. She was frequently incontinent of bowel and bladder.</p> <p>On 6/17/2015 at 4:45 p.m., Unit Manager # 1 indicated she reported the allegations [after leaving Resident E's room] regarding RN # 3 and Resident E to the Director of Nursing Services (DNS) and Executive Director (ED).</p> <p>Staffing Sheet for 6/17/2015, provided by the ED on 6/17/2015 at 12:05 p.m., indicated RN # 3 was scheduled to work on 6/17/2015 from 7:00 p.m. to 7:00 a.m.</p>		<p>incident to the Director of Nursing Services and the incident was immediately reported to the Administrator. As the Unit Manager was leaving the resident's room, the surveyor entered the room. The resident, family member and surveyor remained in the room along with JD, who is a State employee for Adult Protective Services. JD arrived and entered the resident's room after the Unit Manager had left the unit to speak with the Director of Nursing Services. Family Member # 4 apparently has worked with JD for about a month with Adult Protection Services. JD is not the guardian for the resident. The surveyor did not report the resident and family member allegations to the Administrator or to the Director of Nursing Services. The employee identified as RN # 3 was called by the Director of Nursing Services as well as the Staffing Coordinator at about 2:15pm and a message left to call the facility to discuss events that occurred on the unit the last couple of days and that she was not to report to work until she returned a call to the Director of Nursing Services. The Staffing Coordinator removed RN # 3 from the schedule. When the</p>				

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	<p>on the Moving Forward unit.</p> <p>During an unannounced tour of the facility on 6/17/2015 at 7:05 p.m., no staff was observed at the front desk and the reception-area lights were out. RN # 5 and Licensed Practical Nurse (LPN) # 5 were observed near the Harmony Way nurses' station, located on the southwest end of the facility. Both indicated that they did not know who was in charge and management staff left at 6:00 p.m.</p> <p>On 6/17/2015 at 7:12 p.m., RN # 1 and RN # 6 were observed at the Moving Forward nurses' station. RN # 1 indicated that Unit Manager # 1 was providing care to Resident E in her room. The door was observed to be shut.</p> <p>On 6/17/2015 at 7:15 p.m., RN # 3 was observed on the Moving Forward unit at the medication cart on the central hall (Rooms 514 - 529), two doors down from Resident E's room. She was the only staff member observed in that hallway from 7:12 p.m. until 7:17 p.m. She indicated she came on duty at 7:00 p.m. and was scheduled to work until 7:00 a.m. the following morning. When queried as to whether or not she was able to pass scheduled evening medications in a timely manner, she indicated, "It depends on how many interruptions there are."</p>		<p>employee did not return a call to the facility by 6:00pm, another message was left for the employee that she was suspended and to contact the Director of Nursing Services immediately. RN #3 stated she had not checked her messages prior to leaving her house for work. When the staffing sheets were provided to the surveyor at about 12:00pm on 6/17/15, the Administrator nor the Director of Nursing Services were aware of the allegations until the initial report was received by the Unit Manager at 1:55pm on 6/17/2015. RN # 3 was scheduled to work Moving Forward until she was removed from the schedule and suspended pending the investigation. At that time, a new schedule was written and her position replaced. LPN # 5 and RN # 5 both stated that surveyor arrived on the Harmony Way unit and spoke to RN # 5 asking what she would do if she saw two residents fighting. RN # 5 responded to the question and the surveyor left the unit and walked toward the Moving Forward unit without any further questions. At the Moving Forward nursing station was RN # 1, RN # 3 and two other RNs. Unable to</p>				

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	<p>RN # 3 clarified, "It depends on how many call lights there are."</p> <p>On 6/17/2015 at 7:18 p.m., the Assistant Director of Nursing (ADON) was observed approaching the Harmony Way nurses' station from the northwest hallway, near the main dining room/facility entrance and was notified of the unannounced visit and exit.</p> <p>On 6/18/2015 at 10:25 a.m., the ED indicated RN # 3 was suspended the previous night pending the abuse investigation. She indicated facility staff left voice messages for RN # 3 "not to come in" for her scheduled shift on 6/17/2015, "but she came in anyway".</p> <p>A copy of the Time Card Lite Report for 6/17/2015 through 6/18/2015 at 4:32 p.m. was provided by the ED on 6/18/2015 at 4:45 p.m. The document indicated, "Employee: [RN # 3]...Home Labor Level: Charge Nurse RN...Date: Wed [Wednesday] 6/17/15. In Punch: 06:52 PM. Out Punch: 08:28 PM..." The time card indicated RN # 3 was allowed to work for 1 hour and 36 minutes on 6/17/2015. RN # 3 was allowed to work a full shift on the day of the alleged abuse, 6/15/2015, and returned to work the following day, for a full shift, on 6/16/2015.</p>		<p>determine who RN # 6 is since there were two other RNs on the unit other than RN #1 and RN #3, who have been identified. See attached floorplan indicating the position of hallways identified in the complaint. On 6/17/15 RN #3 was at the Moving Forward nursing station along with RN #1, RN #6 and RN not identified in the complaint. At approximately 7:10pm RN #3 was between the nurse's station and the double fire doors where RN #1 kept the medication cart after his shift. RN #3 was not actually at the medication cart. RN #3 noticed the state surveyor walking towards her from the direction of the Harmony Way hall and the surveyor stopped at RN #3 and introduced herself. The surveyor asked RN #3, "Do you feel like you have sufficient time during your shift to pass your medications?" RN #3 responded "I feel like most of the time we do pretty well in general with passing medications. It depends on what kinds of interruptions there are." The surveyor asked what kind of interruption there are and RN #3 felt it was about examples that could cause medications to not be passed timely. RN #4 stated "at times</p>				

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	<p>A copy of the current Abuse Policy and Procedure, provided by the ED on 6/17/2015 at 12:05 p.m., included, but was not limited to, "POLICY: Verbal...and mental abuse are strictly prohibited. For All Abuse Allegations: ...2. If allegation against staff, suspend pending allegation [sic]."</p> <p>A copy of the current Resident Rights Policy and Procedure, provided by the ED on 6/18/2015 at 2:00 p.m., included, but was not limited to, "Staff in the Center [facility] is expected to protect and promote each resident's rights, including the right to a dignified existence, self-determination.... Resident Rights include the resident's right to: a. Exercise his or her rights;... e. Participate in decisions and care planning;..."</p> <p>This Federal tag relates to the Investigation of Complaint IN00175354.</p> <p>3.1-27(a)(1) 3.1-27(b)</p>		<p>medications can be delayed due to resident's call light activity if it were heavy, incidents, emergencies or needs that could take more time than usual." The surveyor also asked if she could state what the different types of abuse were and RN #3 responded with: seclusion, misappropriation of property, physical abuse, sexual abuse, verbal abuse, emotional abuse or neglect (not necessarily in that order). The surveyor said "thank you". RN #3 watched the surveyor walk towards Resident E's room past RN #1 and she reached up to knock on the closed door and just before she did RN #1 stopped her and informed her that the resident was receiving care by Unit Manager #1. The surveyor said "OK" and then turned and walked down the hallway back towards Harmony Way. Then at approximately 7:15pm, the Unit Manager #1 exited Resident E's room and approached RN #3 and escorted her to the Director of Nursing Services (DNS) office. On the way to the DNS office, the ADON was directly in front of Unit Manager #1 and RN #3 walking from Harmony Way towards the Generations unit by the main dining when</p>		

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			<p>the DNS met all 3. By the time Unit Manager #1 and RN #3 walked to the Harmony Way unit, the surveyor had already exited the building. This was approximately 7:18pm. At 7:20pm the surveyor had left the facility property and was no longer in the parking lot. At no time was RN #3 alone in a hallway as alleged in the complaint (allegedly from 7:12pm to 7:17pm). No residents were present in the hallway. RN #3 denies she made a statement to the surveyor that she was scheduled to work from 7pm to 7am and nothing surrounding that comment was made. Statements from RN #1, RN #6 and unidentified RN are attached. RN #3 was not performing duties on the floor on 6/17/2015 as she was in the office with the Director of Nursing Services, ADON and Unit Manager #1. She remained on suspension after leaving the office pending results of the investigation. RN #3 was allowed to work her scheduled shift on 6/15/15 and did return the next day for a full shift on 6/16/15. RN #3 was not suspended until the allegation was made and the investigation started which was on 6/17/15. To state that she was "allowed" to work infers that</p>	

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			<p>the facility was aware of the allegation and allowed an accused employee (RN #3) to work when the facility was not aware of any issues until 6/17/15. The employee was allowed to remain clocked in while being interviewed regarding the alleged incident on 6/17/15. It is the policy of the facility that hourly (non-exempt) employees are paid for any time where they are performing duties for the facility whether directly or indirectly involving resident care. Statements from three separate RNs (RN #1, RN #6 and other RN not identified in complaint) as well as RN #3 substantiate that the employee had neither taken report or obtained the keys to the medication cart prior to the Unit Manager escorting RN #3 to the Director of Nursing Services for an interview. RN #3 was not on the schedule to work when the surveyor entered the building for an unannounced visit. The MAR was checked and found that RN #3 had not signed out any medication. The charting was checked and found no documentation entered by RN #3 for the night shift of 6/17/15. The complaint states that the door to Resident E's room was shut. The daily</p>		

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			<p>staffingsheet was for 6/17/15 was clearly marked that RN # 3 was suspended and another RN was in place RN # 3. This information was given to the surveyor in the AM on 6/18/15 showing the suspension and replacement of RN #3. Referring to page 8 paragraph 2: "On 6/17/2015 at 7:12pm RN#1 and RN #6 were observed at the Moving Forward nursing station. RN #1 indicated that Unit Manager #1 was providing care to Resident E in her room." Refer to attached floor plan indicating location of nurse's station in relation to hallways and resident rooms. Previously stated on Page 4, paragraph 4: "RN #3 was observed at the medication cart on the central hall (rooms 514 to 529)...She was the only staff member observed in that hallway from 7:12pm until 7:17pm." 3 separate nurses (RN #1, RN #6 and RN not identified in complaint were present as well as RN #3 and have provided statements that RN #3 was never in the hallway alone. Refer to the attached floor plan indicating the location of the nurse's station in relation to hallways and resident rooms. It is not possible that at 7:12pm, two nurses, RN #1 and RN #6 were at the nurse's station and RN #3 was in the hallway alone.</p>	

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			<p>First being that RN #1 was not at the nurse's station, he was at the medication cart. Refer to floor plan marking location of medication cart. There was another RN also at the nurse's station not identified in the complaint. After receiving the 2567, the facility spoke with Resident E regarding allegation starting on page 3 at top of page regarding statement from Resident E's Family Member #4 that when she came in last night 6/16/15 her call light was on and she was crying and miserable, laying in feces"</p> <p>.....Resident E was interviewed and gave the following statement regarding these events: "This whole thing was blown out of proportion. My daughter is the one who did all of this. She works for Adult...something like protection for kids but adults...oh yeah..adult protection services. All of these people started showing up and I didn't invite them, I didn't know them. It was my daughter and her boss and that Board of Health lady. He kinda scared me. He had this gun and badge (pointing to her right side). It wasn't that big of a deal and she made it into one." When asked about the incident surrounding her incontinence and crying Resident E stated "I was</p>		

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			<p>incontinent of stool. It was painful and burning me. I was not crying though. I only waited about 10 minutes total. I did talk to my daughter about it onlybecause she happened to walk in right before the nurse and aide did. I was worried about it getting into my backound.” Resident E went onto explaineverything that has happened to her since she’s been sick and described howtraumatic it was for her to have all of these things happen and that shethought she was going to die before she came to the facility. Resident E denied being “abused” or “feelingabused” or fearful of being retaliated against. Resident E denied being scared or worried about any staff members at allstating “Oh no, they’ve been great.” Resident E denied troubles with getting her call light answered. When asked if anyone has been rude or feltlike anyone has been mean to her she stated “No. I really like (names of RNs, and names ofCNAs)! They are gems. I’m not scared or anything even of the nursethat lady from the Board of Health talked about. It was a communication thing and it’s over.I’m over it.”</p> <p>F223 (483.13) FREE FROM ABUSE/INVOLUNTARY SECLUSION (Re:Allegation</p>	

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			<p>facility failed to prevent verbal and emotional abuse for 1 of 5 residents reviewed, Resident E). I. Resident E was interviewed by Social Services as well as Director of Nursing Services and provided emotional support by Psychologist. Resident E denies she was or is fearful of RN #3 or any staff member and states that the issue was "blown out of proportion by my daughter". Resident denies being fearful to speak to staff regarding the incident stating "No one will know if I don't say something." Resident stated she does not feel "abused" and that she has "gotten over it". Resident stated it was a communication problem and it's resolved. She states she did not notify staff of the incident because she felt it was not a big deal. The investigation found that the allegation of abuse was unsubstantiated and the employee, RN #3, was allowed to return to work. II. All residents residing on Moving Forward have the potential to be affected by the alleged deficient practice. All residents residing on the Moving Forward Unit were interviewed for potential abuse and all residents denied they were treated roughly by staff, yelled at or been treated rudely by staff or felt afraid of any staff member or resident. Information regarding Resident's rights are posted in large bold print at front entrance. All nurse's stations</p>	

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			<p>have a box located on the wall with grievance forms where any resident, family member or others may fill out the grievance and place in the box. The number for Kindred's Corporate Compliance is posted in large boldprint at the front entrance.</p> <p>Residents admitted to the facility are provided with information regarding their Rights in the admission packet.</p> <p>Resident's concerns and grievances are followed up within a 72 hour time period. The facility maintains a zero tolerance policy regarding abuse and violations of resident rights. All employees receive Abuse and Resident rights in-service upon hire and at least annually. RN #3 has attended Abuse and Resident Rights in-service.</p> <p>III. All staff will receive mandatory Abuse and Resident rights education. Included in the education were ways to prevent, identify and report abuse allegations and violations of resident's rights. All employees will be informed of their suspension by phone or in person depending on the situation. Any employee who does not cooperate with an abuse investigation will be terminated. The Director of Nursing Services or designee will inform the employee of the suspension pending the results of the investigation. Any employee that the Director of Nursing Services or</p>	

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F 0225 SS=D Bldg. 00	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing,		designee does not speak with personally, will be met in the parkinglot of the facility by a member of the management team and not allowed into thepremises. Any employee with anallegation of abuse which is found to be unsubstantiated will be compensatedfor time off. Any employee with anallegation of abuse which is to be found substantiated will be terminated andtheir licensure, if applicable, will be reported to the appropriate licensingboard. IV. Social Services Directoror designee will randomly interview no less than 10 residents per monthregarding their perception of staff treatment. Interviews will continue indefinitely. Any positive responses during interviews (indicating allegation ofabuse) or any witnessed or other reportable allegation of abuse will result infurther investigation including notifying the Executive Director and Directorof Nursing Services of the allegation, suspension of the employee if a specificemployee is named and investigation will proceed per facility policy withreporting to Indiana State Board of Health per policy. Date of completion : July 16, 2015	

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	<p>neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on observation, interview and record review, the facility failed to provide protection from the potential for future abuse by allowing an employee to start work following an allegation of</p>	F 0225	F225INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (Re: Allegation facility failed to provide protection from the potential for future abuse by allowing an employeeto start work following an	07/16/2015

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	<p>verbal and emotional abuse for 1 of 5 residents reviewed for abuse. (Resident E)</p> <p>Findings include:</p> <p>Resident E was interviewed in her room on the Moving Forward unit on 6/17/2015 at 2:10 p.m. with Family Member # 4 present. She reported verbal and emotional abuse by Registered Nurse (RN) # 3, which occurred on 6/15/2015.</p> <p>Unit Manager # 1 was seen exiting Resident E's room moments prior to the above interview. Both Resident E and Family Member # 4 indicated they informed Unit Manager # 1 of RN # 3's treatment of Resident E.</p> <p>On 6/17/2015 at 4:45 p.m., Unit Manager # 1 indicated she reported the allegations regarding RN # 3 and Resident E to the Director of Nursing Services (DNS) and Executive Director (ED) after leaving Resident E's room.</p> <p>Staffing Sheet for 6/17/2015, provided by the ED on 6/17/2015 at 12:05 p.m., indicated RN # 3 was scheduled to work on 6/17/2015 from 7:00 p.m. to 7:00 a.m. on the Moving Forward unit.</p> <p>During an unannounced tour of the</p>		<p>allegation of verbal and emotional abuse, ResidentE.)</p> <p>The facility disputesthe facts in the complaint. Resident Ewas interviewed by Unit Manager #1 at about 1:55pm on 6/17/15. Present in room was resident and familymember, presumably Family Member # 4 mentioned in the complaint. The resident had voiced concern over thenight shift nurse being rude to her and she did not want that nurse to takecare of her. The resident had stated sheasked for her night medication at about 7:15pm because she was tired and wantedto go to bed. She stated that she puther light on 3 times with a CNA answering those call lights. Resident first stated it was "last night" andthen stated it was "the other night". The resident stated the first and second time the light was answered,the CNA told her she would let the nurse know and the third time she said thatthe nurse would be there as soon as she got done with a resident in the nextroom. The resident stated that it wasalmost 8:00pm and the nurse was mad and stood in the doorway and asked her"what do you want now? You've interrupted me 3 times already". The residentstated she asked the nurse when she could have her medication and that thenurse had stated that she was not allowed to get her medication until 8:00pmbecause it was due at 9:00pm and if she gave it earlier</p>				

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	<p>facility on 6/17/2015 at 7:05 p.m., no staff was available at the front desk to announce the visit. RN # 5 and Licensed Practical Nurse (LPN) # 5 were observed near the Harmony Way nurses' station, located on the southwest end of the facility. Both indicated that they did not know who was in charge and that management staff left at 6:00 p.m.</p> <p>On 6/17/2015 at 7:12 p.m., RN # 1 and RN # 6 were observed at the Moving Forward nurses' station. RN # 1 indicated that Unit Manager # 1 was providing care to Resident E in her room.</p> <p>On 6/17/2015 at 7:15 p.m., RN # 3 was observed on the Moving Forward unit at the medication cart, two doors down from Resident E's room. She indicated she came on duty at 7:00 p.m. and was scheduled to work until 7:00 a.m. the following morning. No other nursing/other staff was observed in the hallway.</p> <p>On 6/17/2015 at 7:18 p.m., the Assistant Director of Nursing (ADON) approached the Harmony Way nurses' station from the hallway near the main dining room/facility entrance.</p> <p>On 6/18/2015 at 10:25 a.m., the ED indicated RN # 3 was suspended pending</p>		<p>than one hour before it was due or one hour after it was due she could lose her license. The resident stated it was about 8:00pm and the nurse did get her medication and there were no other issues noted. The resident stated the same nurse took care of her the next night and there were no issues. The Unit Manager exited the room and the surveyor immediately entered the room. The family member remained in the room with the resident. The Unit Manager immediately reported the incident to the Director of Nursing Services and the incident was immediately reported to the Administrator. As the Unit Manager was leaving the resident's room, the surveyor entered the room.</p> <p>The resident, family member and surveyor remained in the room along with JD, who is a State employee for Adult Protective Services. JD arrived and entered the resident's room after the Unit Manager had left the unit to speak with the Director of Nursing Services. Family Member # 4 apparently has worked with JD for about a month with Adult Protection Services. JD is not the guardian for the resident. The surveyor did not report the resident and family member allegations to the Administrator or to the Director of Nursing Services.</p> <p>The employee identified as RN # 3 was called by the Director of</p>				

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	<p>the abuse investigation. She indicated facility staff left voice messages for RN # 3 "not to come in" for her scheduled shift on 6/17/2015, "but she came in anyway."</p> <p>A copy of the Time Card Lite Report for 6/17/2015 through 6/18/2015 at 4:32 p.m. was provided by the ED on 6/18/2015 at 4:45 p.m. The document indicated, "Employee: [RN # 3]...Home Labor Level: Charge Nurse RN...Date: Wed [Wednesday] 6/17/15. In Punch: 06:52 PM. Out Punch: 08:28 PM...." (Indicating RN # 3 had worked one hour and 36 minutes on 6/17/2015.)</p> <p>A copy of the current Abuse Policy and Procedure, provided by the ED on 6/17/2015 at 12:05 p.m., included, but was not limited to, "POLICY: Verbal...and mental abuse are strictly prohibited. For All Abuse Allegations: ...2. If allegation against staff, suspend pending allegation [sic]."</p> <p>A copy of the current Resident Rights Policy and Procedure, provided by the ED on 6/18/2015 at 2:00 p.m., included, but was not limited to, "Staff in the Center [facility] is expected to protect and promote each resident's rights, including the right to a dignified existence, self-determination.... Resident Rights include the resident's right to: a.</p>		<p>Nursing Services as well as the Staffing Coordinator at about 2:15pm and a message left to call the facility to discuss events that occurred on the unit the last couple of days and that she was not to report to work until she returned a call to the Director of Nursing Services. The Staffing Coordinator removed RN # 3 from the schedule. When the employee did not return a call to the facility by 6:00pm, another message was left for the employee that she was suspended and to contact the Director of Nursing Services immediately. RN #3 stated she had not checked her messages prior to leaving her house for work.</p> <p>When the staffingsheets were provided to the surveyor at about 12:00pm on 6/17/15, the Administrator nor the Director of Nursing Services were aware of the allegations until the initial report was received by the Unit Manager at 1:55pm on 6/17/2015. RN # 3 was scheduled to work Moving Forward until she was removed from the schedule and suspended pending the investigation. At that time, a new schedule was written and her position replaced.</p> <p>LPN # 5 and RN # 5 both stated that surveyor arrived on the Harmony Way unit and spoke to RN # 5 asking what she would do if she saw two residents fighting. RN # 5 responded to the question and</p>				

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	<p>Exercise his or her rights;... e. Participate in decisions and care planning;..."</p> <p>This Federal tag relates to the Investigation of Complaint IN00175354.</p> <p>3.1-28(c)</p>		<p>thesurveyor left the unit and walked toward the Moving Forward unit without anyfurther questions. At the Moving Forwardnursing station was RN # 1, RN # 3 and two other RNs. Unable to determine who RN # 6 is since therewere two other RNs on the unit other than RN #1 and RN #3, who have beenidentified.</p> <p>See attached floorplan indicating the position of hallways identified in the complaint.</p> <p>On 6/17/15 RN #3 wasat the Moving Forward nursing station along with RN #1, RN #6 and RN notidentified in the complaint. At approximately 7:10pm RN #3 was between thenurse's station and the double fire doors where RN #1 kept the medication cartafter his shift. RN #3 was not actuallyat the medication cart. RN #3 noticedthe state surveyor walking towards her from the direction of the Harmony Way halland the surveyor stopped at RN #3 and introduced herself. The surveyor asked RN #3, "Do you feel likeyou have sufficient time during your shift to pass your medications?" RN #3responded "I feel like most of the time we do pretty well in general withpassing medications. It depends on what kinds of interruptions there are." The surveyor asked what kind of interruptionthere are and RN #3 felt it was about examples that could cause medications tonot be passed timely. RN #4 stated</p>		

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			<p>"attimes medications can be delayed due to resident's call light activity if itwere heavy, incidents, emergencies or needs that could take more time thanusual." The surveyor also asked if she could state what the different types ofabuse were and RN #3 responded with: seclusion, misappropriation of property,physical abuse, sexual abuse, verbal abuse, emotional abuse or neglect (notnecessarily in that order). The surveyorsaid "thank you". RN #3 watched the surveyor walk towards Resident E's roompast RN #1 and she reached up to knock on the closed door and just before she didRN #1 stopped her and informed her that the resident was receiving care by UnitManager #1. The surveyor said "OK" and then turned and walked down the hallwayback towards Harmony Way. Then at approximately 7:15pm, the UnitManager #1 exited Resident E's room and approached RN #3 and escorted her tothe Director of Nursing Services (DNS) office. On the way to the DNS office,the ADON was directly in front of Unit Manager #1 and RN #3 walking from Harmony Way towardsthe Generations unit by the main dining when the DNS met all 3. By the timeUnit Manager #1 and RN #3 walked to the Harmony Way unit, the surveyor hadalready exited the building. This wasapproximately 7:18pm. At 7:20pm thesurveyor</p>	

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			<p>had left the facility property and was no longer in the parkinglot. At no time was RN #3 alone in ahallway as alleged in the complaint (allegedly from 7:12pm to 7:17pm). No residents were present in the hallway. RN #3 denies she made a statement to thesurveyor that she was scheduled to work from 7pm to 7am and nothing surroundingthat comment was made. Statements from RN #1, RN #6 and unidentified RN areattached.</p> <p>RN #3 was notperforming duties on the floor on 6/17/2015 as she was in the office with theDirector of Nursing Services, ADON and Unit Manager #1. She remained on suspension after leaving theoffice pending results of the investigation. RN #3 was allowed to work her scheduled shift on 6/15/15 and did returnthe next day for a full shift on 6/16/15. RN #3 was not suspended until the allegation was made and theinvestigation started which was on 6/17/15. To state that she was "allowed" to work infers that the facility wasaware of the allegation and allowed an accused employee (RN #3) to work whenthe facility was not aware of any issues until 6/17/15. The employee was allowed to remain clocked inwhile being interviewed regarding the alleged incident on 6/17/15. It is the policy of the facility that hourly(non-exempt) employees are</p>	

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			<p>paid for any time where they are performing duties for the facility whether directly or indirectly involving resident care. Statements from three separate RNs (RN #1, RN#6 and other RN not identified in complaint) as well as RN #3 substantiate that the employee had neither taken report or obtained the keys to the medication cart prior to the Unit Manager escorting RN # 3 to the Director of Nursing Services for an interview. RN # 3 was not on the schedule to work when the surveyor entered the building for an unannounced visit. The MAR was checked and found that RN #3 had not signed out any medication. The charting was checked and found no documentation entered by RN #3 for the night shift of 6/17/15. The complaint states that the door to Resident E's room was shut. The daily staffing sheet was for 6/17/15 was clearly marked that RN # 3 was suspended and another RN was in place RN # 3. This information was given to the surveyor in the AM on 6/18/15 showing the suspension and replacement of RN #3.</p> <p>Referring to page 8 paragraph 2: "On 6/17/2015 at 7:12pm RN#1 and RN #6 were observed at the Moving Forward nursing station. RN #1 indicated that Unit Manager #1 was providing care to Resident E in her room." Refer to attached floor plan indicating location of nurse's station in relation to hallways and</p>	

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			<p>resident rooms.</p> <p>Previously stated on Page 4, paragraph 4: "RN #3 was observed at the medication cart on the central hall (rooms 514 to 529)....She was the only staff member observed in that hallway from 7:12pm until 7:17pm." 3 separate nurses (RN #1, RN #6 and RN not identified in complaint were present as well as RN #3 and have provided statements that RN #3 was never in the hallway alone. Refer to the attached floor plan indicating the location of the nurse's station in relation to hallways and resident rooms. It is not possible that at 7:12pm, two nurses, RN #1 and RN #6 were at the nurse's station and RN #3 was in the hallway alone. First being that RN #1 was not at the nurse's station, he was at the medication cart. Refer to floor plan marking location of medication cart. There was another RN also at the nurse's station not identified in the complaint.</p> <p>After receiving the 2567, the facility spoke with Resident E regarding allegation starting on page 3 at top of page regarding statement from Resident E's Family Member #4 that when she came in last night 6/16/15 her call light was on and she was crying and miserable, laying in feces".....Resident E was interviewed and gave the following statement regarding these events: "This whole thing was blown out</p>	

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			<p>ofproportion. My daughter is the one whodid all of this. She works forAdult...something like protection for kidsbut adults...oh yeah..adult protection services. All of these people started showing up and I didn't invite them, I didn't know them. It was my daughter andher boss and that Board of Health lady. He kinda scared me. He had thisgun and badge (pointing to her right side). It wasn't that big of a deal and she made it into one." When asked about the incident surrounding herincontinence and crying Resident E stated "I was incontinent of stool. It was painful and burning me. I was not crying though. I only waited about 10 minutes total. I did talk to my daughter about it onlybecause she happened to walk in right before the nurse and aide did. I was worried about it getting into my backwound." Resident E went onto explaineverything that has happened to her since she's been sick and described howtraumatic it was for her to have all of these things happen and that shethought she was going to die before she came to the facility. Resident E denied being "abused" or "feelingabused" or fearful of being retaliated against. Resident E denied being scared or worried about any staff members at allstating "Oh no, they've been great." Resident E denied troubles</p>	

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			<p>with getting her call light answered. When asked if anyone has been rude or feltlike anyone has been mean to her she stated "No. I really like (names of RNs, and names ofCNAs)! They are gems. I'm not scared or anything even of the nursethat lady from the Board of Health talked about. It was a communication thing and it's over.I'm over it."</p> <p>F225 INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS (Re:Allegation facility failed to provide protection from the potential for futureabuse by allowing an employee to start work following an allegation of verbaland emotional abuse, Resident E.)</p> <p>1.Resident E was interviewed by Social Services aswell as Director of Nursing Services and provided emotional support byPsychologist. Resident E denies she wasor is fearful of RN #3 or any staff member and states that the issue was "blownout of proportion by my daughter". Resident denies being fearful to speak to staff regarding the incidentstating "No one will know if I don't say something." Resident stated she doesnot feel "abused" and that she has "gotten over it". Resident stated it was a communicationproblem and it's resolved. She statesshe did not notify staff of the incident because she felt it was not big deal.The</p>	

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			<p>investigation found that the allegation of abuse was unsubstantiated and the employee, RN #3, was allowed to return to work on 6/22/15 at the conclusion of the investigation.</p> <p>2. All residents residing in the facility have the potential to be affected by the alleged deficient practice. All residents residing on the unit where Resident E resides were interviewed for potential abuse and all residents denied they were treated roughly by staff, yelled at or been treated rudely by staff or felt afraid of any staff member or resident.</p> <p>Information regarding Resident's rights are posted in large bold print at front entrance. All nurse's stations have a box located on the wall with grievance forms where any resident, family member or others may fill out the grievance and place in the box. The number for Kindred's Corporate Compliance is posted in large bold print at the front entrance. Residents admitted to the facility are provided with information regarding their Rights in the admission packet.</p> <p>Resident's concerns and grievances are followed up within a 72 hour time period. The facility maintains a zero tolerance policy regarding abuse and violations of resident rights. All employees receive Abuse and Resident rights in-service upon hire and at least annually. RN #3 has attended Abuse and Resident</p>	

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			<p>Rightsin-servicing.</p> <p>3. Employees will receive mandatory Abuse and Resident rights education. Included in the education were ways to prevent, identify and report abuse allegations and violations of resident's rights. All employees will be informed of their suspension by phone or in person depending on the situation. Any employee who does not cooperate with an abuse investigation will be terminated. The Director of Nursing Services or designee will inform the employee of the suspension pending the results of the investigation. Any employee that the Director of Nursing Services or designee does not speak with personally, will be met in the parking lot of the facility by a member of the management team and not allowed into the premises. Any employee with an allegation of abuse which is found to be unsubstantiated will be compensated for time off. Any employee with an allegation of abuse which is to be found substantiated will be terminated and their licensure, if applicable, will be reported to the appropriate licensing board.</p> <p>4. Social Services Director or designee will randomly interview no less than 10 residents per month regarding their perception of staff treatment. Interviews will continue indefinitely. Any positive responses (indicating allegation of abuse) will</p>	

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F 0226 SS=D Bldg. 00	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on observation, interview and record review, the facility failed to implement policy and procedure to protect a resident from potential [future] verbal and emotional abuse, immediately following the report of abuse and/or during an abuse investigation, for 1 of 5 residents reviewed for abuse. (Resident E).</p> <p>Findings include:</p> <p>Resident E was interviewed in her room on the Moving Forward unit on</p>	F 0226	<p>result infurther investigation including notifying the Executive Director and Directorof Nursing Services of the allegation, suspension of the employee if employeef a specific employee is named and investigation will proceed per facilitypolicy with reporting to Indiana State Board of Health per policy.</p> <p>Date of completion : July 16, 2015</p> <p>F226DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES (Re: Allegation facility failed toimplement policy and procedure to protect a resident from potential (future)verbal and emotional abuse, immediately following the report of abuse and/orduring an abuse investigation, Resident E.) The facility disputesthe facts in the complaint. Resident Ewas interviewed by Unit Manager #1 at about 1:55pm on 6/17/15. Present in room was resident and familymember, presumably</p>	07/16/2015

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	<p>6/17/2015 at 2:10 p.m. with Family Member # 4 present. She reported verbal and emotional abuse by Registered Nurse (RN) # 3, which occurred on 6/15/2015.</p> <p>Unit Manager # 1 was seen exiting Resident E's room moments prior to the above interview. Both Resident E and Family Member # 4 indicated they informed Unit Manager # 1 of RN # 3's treatment of Resident E.</p> <p>On 6/17/2015 at 4:45 p.m., Unit Manager # 1 indicated she reported the allegations regarding RN # 3 and Resident E to the Director of Nursing Services (DNS) and Executive Director (ED) after leaving Resident E's room.</p> <p>Staffing Sheet for 6/17/2015, provided by the ED on 6/17/2015 at 12:05 p.m., indicated RN # 3 was scheduled to work, from 7:00 p.m. on 6/17/2015 to 7:00 a.m. on 6/18/2015, on the Moving Forward unit.</p> <p>During an unannounced tour of the facility on 6/17/2015 at 7:05 p.m., no staff were observed at the front desk to announce the visit and the reception-area lights were out. RN # 5 and Licensed Practical Nurse (LPN) # 5 were observed near the Harmony Way nurses' station, located on the southwest end of the</p>		<p>Family Member # 4 mentioned in the complaint. The resident had voiced concern over thenight shift nurse being rude to her and she did not want that nurse to takecare of her. The resident had stated sheasked for her night medication at about 7:15pm because she was tired and wantedto go to bed. She stated that she puther light on 3 times with a CNA answering those call lights. Resident first stated it was "last night" andthen stated it was "the other night". The resident stated the first and second time the light was answered,the CNA told her she would let the nurse know and the third time she said thatthe nurse would be there as soon as she got done with a resident in the nextroom. The resident stated that it wasalmost 8:00pm and the nurse was mad and stood in the doorway and asked her"what do you want now? You've interrupted me 3 times already". The residentstated she asked the nurse when she could have her medication and that thenurse had stated that she was not allowed to get her medication until 8:00pmbecause it was due at 9:00pm and if she gave it earlier than one hour before itwas due or one hour after it</p>		

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	<p>facility. Both indicated that they did not know who was in charge and that management staff left at 6:00 p.m.</p> <p>On 6/17/2015 at 7:12 p.m., RN # 1 and RN # 6 were observed at the Moving Forward nurses' station. RN # 1 indicated that Unit Manager # 1 was providing care to Resident E in her room. Resident E's door was observed to be shut.</p> <p>On 6/17/2015 at 7:15 p.m., RN # 3 was observed on the Moving Forward unit at the medication cart, two doors down from Resident E's room. She indicated she came on duty at 7:00 p.m. and was scheduled to work until 7:00 a.m. the following morning. No other nursing/other staff was observed in the hallway.</p> <p>On 6/17/2015 at 7:18 p.m., the Assistant Director of Nursing (ADON) approached the Harmony Way nurses' station from the hallway near the main dining room/facility entrance.</p> <p>On 6/18/2015 at 10:25 a.m., the ED indicated RN # 3 was suspended pending the abuse investigation. She indicated facility staff left voice messages for RN # 3 "not to come in" for her scheduled shift on 6/17/2015, "but she came in anyway."</p>		<p>was due she could lose her license. The residentstated it was about 8:00pm and the nurse did get her medication and there wereno other issues noted. The residentstated the same nurse took care of her the next night and there were no issues.The Unit Manager exited the room and the surveyor immediately entered theroom. The family member remained in theroom with the resident. The Unit Manager immediately reported the incident tothe Director of Nursing Services and the incident was immediately reported tothe Administrator. As the Unit Mangerwas leaving the resident's room, the surveyor entered the room. The resident, familymember and surveyor remained in the room along with JD, who is a State employeefor Adult Protective Services. JDarrived and entered the resident's room after the Unit Manager had left theunit to speak with the Director of Nursing Services. Family Member # 4 apparently has worked withJD for about a month with Adult Protection Services. JD is not the guardian for the resident. The surveyor did not report the resident andfamily member allegations to the Administrator or to the Director of</p>				

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	<p>A copy of the Time Card Lite Report for 6/17/2015 through 6/18/2015 at 4:32 p.m. was provided by the ED on 6/18/2015 at 4:45 p.m. The document indicated, "Employee: [RN # 3]...Home Labor Level: Charge Nurse RN...Date: Wed [Wednesday] 6/17/15. In Punch: 06:52 PM. Out Punch: 08:28 PM..." (Indicating RN # 3 worked 1 hour and 36 minutes on 6/17/2015.)</p> <p>A copy of the current Abuse Policy and Procedure, provided by the ED on 6/17/2015 at 12:05 p.m., included, but was not limited to, "POLICY: Verbal...and mental abuse are strictly prohibited. For All Abuse Allegations: ...2. If allegation against staff, suspend pending allegation [sic]."</p> <p>A copy of the current Resident Rights Policy and Procedure, provided by the ED on 6/18/2015 at 2:00 p.m., included, but was not limited to, "Staff in the Center [facility] is expected to protect and promote each resident's rights, including the right to a dignified existence, self-determination.... Resident Rights include the resident's right to: a. Exercise his or her rights;... e. Participate in decisions and care planning;..."</p> <p>This Federal tag relates to the</p>		<p>NursingServices. The employee identified as RN # 3 was called by the Director of Nursing Services as well as the Staffing Coordinator at about 2:15pm and a message left to call the facility to discuss events that occurred on the unit the last couple of days and that she was not to report to work until she returned a call to the Director of Nursing Services. The Staffing Coordinator removed RN # 3 from the schedule. When the employee did not return a call to the facility by 6:00pm, another message was left for the employee that she was suspended and to contact the Director of Nursing Services immediately. RN #3 stated she had not checked her messages prior to leaving her house for work. When the staffingsheets were provided to the surveyor at about 12:00pm on 6/17/15, the Administrator nor the Director of Nursing Services were aware of the allegations until the initial report was received by the Unit Manager at 1:55pm on 6/17/2015. RN # 3 was scheduled to work Moving Forward until she was removed from the schedule and suspended pending the investigation. At that time, a new schedule was written and</p>		

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	Investigation of Complaint IN00175354. 3.1-28(a)		herposition replaced. LPN # 5 and RN # 5both stated that surveyor arrived on the Harmony Way unit and spoke to RN # 5asking what she would do if she saw two residents fighting. RN # 5 responded to the question and thesurveyor left the unit and walked toward the Moving Forward unit without anyfurther questions. At the Moving Forwardnursing station was RN # 1, RN # 3 and two other RNs. Unable to determine who RN # 6 is since therewere two other RNs on the unit other than RN #1 and RN #3, who have beenidentified. See attached floorplan indicating the position of hallways identified in the complaint. On 6/17/15 RN #3 wasat the Moving Forward nursing station along with RN #1, RN #6 and RN notidentified in the complaint. At approximately 7:10pm RN #3 was between the nurse's station and the double fire doors where RN #1 kept the medication cartafter his shift. RN #3 was not actuallyat the medication cart. RN #3 noticedthe state surveyor walking towards her from the direction of the Harmony Way halland the surveyor stopped at RN #3 and introduced herself. The surveyor asked	

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			<p>RN #3, "Do you feel like you have sufficient time during your shift to pass your medications?" RN #3 responded "I feel like most of the time we do pretty well in general with passing medications. It depends on what kinds of interruptions there are." The surveyor asked what kind of interruptions there are and RN #3 felt it was about examples that could cause medications to not be passed timely. RN #4 stated "at times medications can be delayed due to resident's call light activity if it were heavy, incidents, emergencies or needs that could take more time than usual." The surveyor also asked if she could state what the different types of abuse were and RN #3 responded with: seclusion, misappropriation of property, physical abuse, sexual abuse, verbal abuse, emotional abuse or neglect (not necessarily in that order). The surveyor said "thank you". RN #3 watched the surveyor walk towards Resident E's room past RN #1 and she reached up to knock on the closed door and just before she did RN #1 stopped her and informed her that the resident was receiving care by Unit Manager #1. The surveyor</p>	

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			<p>said "OK" and then turned and walked down the hallway back towards Harmony Way. Then at approximately 7:15pm, the Unit Manager #1 exited Resident E's room and approached RN #3 and escorted her to the Director of Nursing Services (DNS) office. On the way to the DNS office, the ADON was directly in front of Unit Manager #1 and RN #3 walking from Harmony Way towards the Generations unit by the main dining when the DNS met all 3. By the time Unit Manager #1 and RN #3 walked to the Harmony Way unit, the surveyor had already exited the building. This was approximately 7:18pm. At 7:20pm the surveyor had left the facility property and was no longer in the parking lot. At no time was RN #3 alone in a hallway as alleged in the complaint (allegedly from 7:12pm to 7:17pm). No residents were present in the hallway. RN #3 denies she made a statement to the surveyor that she was scheduled to work from 7pm to 7am and nothing surrounding that comment was made. Statements from RN #1, RN #6 and unidentified RN are attached. RN #3 was not performing duties on the floor on 6/17/2015 as she was</p>	

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			<p>in the office with the Director of Nursing Services, ADON and Unit Manager #1. She remained on suspension after leaving the office pending results of the investigation. RN #3 was allowed to work her scheduled shift on 6/15/15 and did return the next day for a full shift on 6/16/15. RN #3 was not suspended until the allegation was made and the investigation started which was on 6/17/15. To state that she was "allowed" to work infers that the facility was aware of the allegation and allowed an accused employee (RN #3) to work when the facility was not aware of any issues until 6/17/15. The employee was allowed to remain clocked in while being interviewed regarding the alleged incident on 6/17/15. It is the policy of the facility that hourly (non-exempt) employees are paid for any time where they are performing duties for the facility whether directly or indirectly involving resident care. Statements from three separate RNs (RN #1, RN #6 and other RN not identified in complaint) as well as RN #3 substantiate that the employee had neither taken report or obtained the keys to the medication cart prior to the Unit Manager escorting RN #3 to</p>	

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			<p>the Director of Nursing Services for an interview. RN # 3 was not on the schedule to work when the surveyor entered the building for an unannounced visit. The MAR was checked and found that RN #3 had not signed out any medication. The charting was checked and found no documentation entered by RN #3 for the night shift of 6/17/15. The complaint states that the door to Resident E's room was shut. The daily staffing sheet was for 6/17/15 was clearly marked that RN # 3 was suspended and another RN was in place RN # 3. This information was given to the surveyor in the AM on 6/18/15 showing the suspension and replacement of RN #3. Referring to page 8 paragraph 2: "On 6/17/2015 at 7:12pm RN#1 and RN #6 were observed at the Moving Forward nursing station. RN #1 indicated that Unit Manager #1 was providing care to Resident E in her room." Refer to attached floor plan indicating location of nurse's station in relation to hallways and resident rooms. Previously stated on Page 4, paragraph 4: "RN #3 was observed at the medication cart on the central hall (rooms 514 to 529)...She was the only staff member observed in that hallway from 7:12pm until</p>	

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			<p>7:17pm." 3 separate nurses (RN #1, RN #6 and RN notidentified in complaint were present as well as RN #3 and have providedstatements that RN #3 was never in the hallway alone. Refer to the attached floor plan indicatingthe location of the nurse's station in relation to hallways and residentrooms. It is not possible that at7:12pm, two nurses, RN #1 and RN #6 were at the nurse's station and RN #3 wasin the hallway alone. First being thatRN #1 was not at the nurse's station, he was at the medication cart. Refer tofloor plan marking location of medication cart. There was another RN also at the nurse's station not identified in thecomplaint. After receiving the2567, the facility spoke with Resident E regarding allegation starting on page3 at top of page regarding statement from Resident E's Family Member #4 that when she came in last night 6/16/15 hercall light was on and she was crying and miserable, laying in feces"ResidentE was interviewed and gave the following statement regarding these events: "This whole thing was blown out ofproportion. My daughter is the one whodid all of this. She works forAdult...something like protection for kidsbut</p>	

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			<p>adults...oh yeah..adult protection services. All of these people started showing up and I didn't invite them, I didn't know them. It was my daughter and her boss and that Board of Health lady. He kinda scared me. He had this gun and badge (pointing to her right side). It wasn't that big of a deal and she made it into one." When asked about the incident surrounding her incontinence and crying Resident E stated "I was incontinent of stool. It was painful and burning me. I was not crying though. I only waited about 10 minutes total. I did talk to my daughter about it only because she happened to walk in right before the nurse and aide did. I was worried about it getting into my backwood." Resident E went onto explain everything that has happened to her since she's been sick and described how traumatic it was for her to have all of these things happen and that she thought she was going to die before she came to the facility. Resident E denied being "abused" or "feeling abused" or fearful of being retaliated against. Resident E denied being scared or worried about any staff members at all stating "Oh no, they've been</p>	

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			<p>great.” Resident E denied troubles with getting her call light answered. When asked if anyone has been rude or feltlike anyone has been mean to her she stated “No. I really like (names of RNs, and names ofCNAs)! They are gems. I’m not scared or anything even of the nursethat lady from the Board of Health talked about. It was a communication thing and it’s over.I’m over it.”</p> <p>F226 DEVELOP/IMPLEMENT ABUSE/NEGLECT POLICIES (Re:Allegation facility failed to provide protection from potential (future) verbaland emotional abuse, immediately following the report of abuse and/or during anabuse investigation, Resident E.)</p> <p>1.Resident E was interviewed by Social Services aswell as Director of Nursing Services and provided emotional support byPsychologist. Resident E denies she wasor is fearful of RN #3 or any staff member and states that the issue was “blownout of proportion by my daughter”. Resident stated she does not feel “abused” and that she has “gotten overit”. Resident stated it was acommunication problem and it’s resolved. The investigation found that theallegation of abuse was unsubstantiated and the employee, RN #3, was allowed toreturn to work. RN #3 was suspendedpending the results of</p>	

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			<p>the investigation. The facility followed policy regarding suspension of employee accused of abuse.</p> <p>2.All residents residing in the facility have thepotential to be affected by the alleged deficient practice. All residents residing on the Moving ForwardUnit were interviewed for potential abuse and all residents denied they weretreated roughly by staff, yelled at or been treated rudely by staff or feltafraid of any staff member or resident. Information regarding Resident'srights are posted in large bold print at front entrance. All nurse's stations have a box located onthe wall with grievance forms where any resident, family member or others mayfill out the grievance and place in the box. The number for Kindred's Corporate Compliance is posted in large boldprint at the front entrance.</p> <p>Residentsadmitted to the facility are provided with information regarding their Rightsin the admission packet.</p> <p>Resident'sconcerns and grievances are followed up within a 72 hour time period. The facility maintains a zero tolerancepolicy regarding abuse and violations of resident rights. All employees receive Abuse andResident rights in-servicing upon hire and at least annually. RN #3 has attended Abuse and Resident Rightsin-servicing.</p> <p>3.Employees were offered</p>	

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			<p>mandatory Abuse and Resident rights education. Included in the education were ways to prevent, identify and report abuse allegations and violations of resident's rights. All employees will be informed of their suspension by phone or in person depending on the situation. Any employee who does not cooperate with an abuse investigation will be terminated. The Director of Nursing Services or designee will inform the employee of the suspension pending the results of the investigation. Any employee that the Director of Nursing Services or designee does not speak with personally, will be met in the parking lot of the facility by a member of the management team and not allowed into the premises. Any employee with an allegation of abuse which is found to be unsubstantiated will be compensated for time off. Any employee with an allegation of abuse which is to be found substantiated will be terminated and their licensure, if applicable, will be reported to the appropriate licensing board.</p> <p>4. Social Services Director or designee will randomly interview no less than 10 residents per month regarding their perception of staff treatment. Interviews will continue indefinitely. Any positive responses (indicating allegation of abuse) will result in further investigation including notifying</p>	

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F 0309 SS=E Bldg. 00	<p>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.</p> <p>Based on observation, interview and record review, the facility failed to ensure the highest level of physical well-being for 2 of 5 residents reviewed regarding dressing changes (Resident E), transportation to physician's appointments (Residents B and E) and administering medications as ordered (Residents B and E).</p> <p>Findings include:</p> <p>1. Resident E was interviewed on 6/17/2015 at 2:10 p.m. in her room with Family Member # 4 present. Both indicated concerns regarding dressings not being changed as ordered and</p>	F 0309	<p>the Executive Director and Director of Nursing Services of the allegation, suspension of the employee if employee if a specific employee is named and investigation will proceed per facility policy with reporting to Indiana State Board of Health per policy. Date of completion : July 16, 2015</p> <p>F309 (483.25) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING The facility disputes the facts listed in the complaint. Resident E admitted to the facility on the evening of 6/5/2015 with a tunneled central venous catheter(CVC) for administration of long term antibiotics to treat a lumbar spine abscess, psoas muscle abscess, and abscess of the right thigh/hip. Resident E also required wound care treatment for surgical wounds due to her admission diagnoses. Resident E also has other medical diagnoses. Resident E had orders upon discharge from the</p>	07/16/2015

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	<p>concerns about the resident not having follow-up appointments with the physician. Resident E was observed with a right subclavian PICC (peripherally inserted central catheter) covered with a clear dressing, dated 6/13/2015.</p> <p>Resident E's clinical record was reviewed on 6/17/2015 at 4:00 p.m. Diagnoses included, but were not limited to, sepsis (blood infection), methicillin-sensitive Staphylococcus aureus (MSSA), lumbar spine abscess, psoas muscle (centrally located on either side of the lumbar spine) abscess of right thigh/hip, soft-tissue infection, and Clostridium difficile (C-diff). The resident was admitted to the facility on 6/5/2015 following hospitalization for sepsis, spinal surgery and hip wound surgery. She was diagnosed with C-diff on 6/12/2015.</p> <p>Admission Minimum Data Set (MDS) assessment for Resident E, dated 6/15/2015, indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15; indicating she was cognitively intact. The resident was non-ambulatory and required extensive, 2+ person physical assist for all activities of daily living (ADLs), including toileting, hygiene, and transfers. She was frequently incontinent of bowel and bladder.</p>		<p>hospital dated 6/5/2015 for a wound vac treatment @125mmHg, change three times weekly. The days were Monday, Wednesday and Friday on the night shift. On June 17, 2015, a copy of the medication record was given to the surveyor and it indicated that there had not been a change of her wound vac since June 12th. However, the DNS examined the dressing present on the resident on 6/17/15 and the wound vac dressing had a date of 6/15/15 on the dressing to the wound vac as well as the dry dressing on her back and to the right of the back wound. They were intact. Resident E stated she remembers getting her dressings changed but, could not recall who provided the care. The DNS provided education to the nurse responsible for signing off the treatment record and the treatment record was corrected to indicate that the dressing was changed. The dressing was completed as ordered. This would have been found by the facility staff during routine audits of charts and corrected. Resident E had an assessment of her central venous catheter site by the nurse upon admission and the dressing was noted to be clear</p>				

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	<p>Admission Nursing Assessment for Resident E, dated 6/5/2015, indicated the resident had 11 sutures (stitches) to her mid-lower back surgical site.</p> <p>Resident E's Discharge Instructions/Physician's Orders from the hospital, dated 6/5/2015, indicated, "Dressing Changes for wound vac [wound vacuum: device used to conduct negative pressure wound therapy] 3 x [times] per week".</p> <p>June, 2015 Medication Administration Record (MAR) for Resident E, indicated the 6/15/2015 scheduled dressing change was not provided and the dressing had not been changed since 6/12/2015.</p> <p>Physician's Order for Resident E, dated 6/5/2015, indicated, "PICC LINE Dressing Changes every 7 days."</p> <p>Resident E's June, 2015 Central Line Catheter Treatment Record indicated, "Change catheter site dressing: 24 hours post PICC insertion, On admission, Q [every] week with transparent drsg [dressing],... PRN (as needed)." The only central line dressing change documented was on 6/13/2015.</p> <p>Physician's Order for Resident E, dated</p>		<p>with the insertion site visible and the date of "6/5/15" on the dressing. The nurse was able to assess the site without noting any s/s of infection. Resident denied pain. The site was able to be assessed without any issues. Due to the fact that the site was able to be seen through the dressing and the date on the dressing being 6/5/15, the dressing was not changed. The Director of Nursing Services agrees with the nurse in that changing the dressing could have potentially increased the risk of infection rather than leaving the dressing on, which was not loose, wet or soiled. The dressing was scheduled to be changed on the night shift between 7pm and 7am on 6/12/2015. The dressing was changed after midnight, which actually made the date June 13, 2015 and dated as such due to being changed after midnight. There were no orders for PICC line dressing changes due to the fact that she has a tunneled central venous catheter. See attachments regarding the placement of the CVC at the hospital to show that it is not a PICC (peripherally inserted central catheter). See attached guidelines from the CDC (Centers for Disease Control)</p>				

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	<p>6/5/2015, indicated, "Cefazolin [antibiotic] 2 gm [grams]. Administer IV [intravenously] every 6 hours. [Diagnosis] Sepsis & MSSA." Scheduled dose times indicated, "12:00 a.m., 6:00 a.m., 12:00 p.m., and 6:00 p.m."</p> <p>June, 2015 Medication Administration Record (MAR) indicated Resident E did not receive scheduled doses 6/11/2015 at 12:00 p.m., 6/12/2015 at 6:00 p.m., and 6/18/2015 at 12:00 a.m. Nurse's Medication Notes (on reverse side of MAR) indicated, "6/18/2015 [12:00 a.m.]: Cefazolin dose missed R/T [related to] res [resident] workload [and] too close to next dose."</p> <p>Resident E's Discharge Instructions from the hospital, dated 6/5/2015, indicated, "Follow Up Visits: Who: [Neurosurgeon]...When: Call as soon as possible for an appointment in 4 weeks.... Who: [Spine Center]...Comments: Please make an appt [appointment] with your primary care physician (PCP) to have your crani [cranial/skull] staples discontinued on 6/6/15. If you do not have a PCP...make an appointment to have your staples removed at this time.... Who: [Infectious Disease Physician]...When: Call as soon as possible for an appointment in 3</p>		<p>regarding "Guidelines for the Prevention of Intravascular Catheter-Related Infections". The recommendation from the CDC are: 8. <i>Replace transparent dressings used on tunneled or implanted CVC sites no more than once per week (unless the dressing is soiled or loose), until the insertion site is healed. 14. Monitor catheter sites visually when changed the dressing or by palpation through an intact dressing on a regular basis, depending on the clinical situation of the individual patient. If patients have tenderness at the insertion site, fever without obvious source, or other manifestations suggesting local or bloodstream infection, the dressing should be removed to allow thorough examination of the site.</i>" The facility will be amending the policy for implanted Central Venous Catheter sites to coordinate with the CDC guidelines. See attachments regarding changing policy and procedures. Upon admission to the facility, Resident E had orders for cefazolin 2 grams IV every 6 hours. The MAR indicated a circled dose on 6/11/2015 at 12:00pm with explanation on back of MAR stating "6/11/15 12:00pm</p>		

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	<p>weeks...."</p> <p>Resident E was interviewed on 6/18/2015 at 3:17 p.m. She indicated she told "a couple" of staff members she was concerned that she had not had a follow-up with her spine surgeon. She indicated, "It's kind of aggravating because I was so looking forward to making sure everything was o.k."</p> <p>Moving Forward Unit Manager # 1 was interviewed on 6/18/2015 at 3:35 p.m. She indicated nurses are responsible for scheduling transportation and ensuring residents get to scheduled appointments and/or treatments. Unit Manager # 1 pulled out an 8 x 10 book-style calendar at the nurses' station and indicated the calendar was used to communicate to nurses when appointments were scheduled so that they could arrange transportation. She flipped through June, July, and August, 2015 of the calendar and indicated there were no appointments scheduled for Resident E.</p> <p>Resident E's surgical sites were observed with Unit Manager # 1 on 6/18/2015 at 3:50 p.m. with Family Member # 6 present. Unit Manager # 1 palpated and observed Resident E's neck and head. Resident E indicated, "What are you doing?" Unit Manager # 1 indicated,</p>		<p>cefazolin 2 gm refused-pt stated she thought it causeddiarrhea-called MD no response yet". Thesurveyor received this information while she was present in the building. The facility did not have the opportunity toaddress this upon exit. On 6/12/15 at 6:00pm, themedication was not signed off on the medication record, however the nurse didnot sign the medication record and this was identified by the facility prior tothe surveyor entering the building for complaint. The nurse did administer the antibiotics asordered. The medication record wascorrected to reflect the administration of the medication. The nurseresponsible no longer works for the facility however, the medication record wascorrected before her employment ended. The dose for 6/18/15 was missed andidentified by the facility and the MD and resident notified prior to thesurveyor discovering the error on 6/18/15. The nurse was counseled, re-educated and MD aware with no changesmade. The Director of Nursing Servicesreviewed the delivery records for the cefazolin and found that the correctamount of cefazolin was present in the building and that</p>				

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	<p>"I'm looking for your crani staples." Resident E indicated, "I don't have anything [staples/surgical sites] up there." Unit Manager # 1 removed the mid-lower back dressing to reveal an approximately 5 inch red surgical wound with sutures intact. Unit Manager # 1 indicated the sutures were not dissolvable and would need to be removed.</p> <p>On 6/18/2015 at 3:55 p.m., the Assistant Director of Nursing (ADON) indicated no follow-up appointments were scheduled for [Neurosurgeon], [Spine Center] or [Infectious Disease Physician].</p> <p>On 6/19/2015 at 1:04 p.m., the Director of Nursing Services (DNS) indicated the facility did not have a written policy and/or procedure for transporting residents to and from follow-up appointments/scheduled treatments.</p> <p>2. Resident B's clinical record was reviewed on 6/17/2015 at 12:00 p.m. Diagnoses included, but were not limited to, pneumonia, MRSA (methicillin-resistant Staphylococcus aureus) in sputum, tracheostomy (an opening surgically created through the neck into the trachea [windpipe]; a tube is inserted to provide an airway), and COPD (chronic obstructive pulmonary disease).</p>		<p>there were no otherdoses missed. Resident E's discharge instructionsindicated several follow up appointments upon discharge. There was an order to make and appointmentwith Resident E's primary care physician to have "crani-staples" discontinuedon 6/6/15. Resident E admitted to thefacility with no crani-staples present. The admission nursing assessment shows that there were no crani-staplespresent. The review of the medicalrecords from the hospital, which were provided to the surveyor confirmed thatthere were no crani staples present, nor were there any staples present. That order was discontinued on 6/8/15 due tothe fact that there were no crani-staples present. Resident E had appointmentsscheduled for follow up with MD #2, with General Surgery on 6/18/2015 at11:00am. She left the building at about 9:00am and attended her appointment (whilethe surveyor was still present in the facility) and returned to the facilitywith a request for a follow up on July 30, 2015 at 9:00am. She did not miss her scheduled 6/18/2015appointment and the surveyor was aware of that fact</p>		

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	<p>Admission Minimum Data Set (MDS) assessment for Resident B, dated 6/4/2015, indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15; indicating the resident was cognitively intact. The resident was non-ambulatory and required extensive, 2+ person physical assist for all activities of daily living (ADLs), including toileting, hygiene, and transfers. He was continent of bowel and bladder. The resident received oxygen, suctioning, tracheostomy care, IV medications, and was on isolation precautions for an active infectious disease.</p> <p>Resident B's June, 2015 Physician's Orders indicated, "3 ml [milliliter] Duoneb [nebulizer breathing treatment] mini neb [nebulizer] tx [treatment] TID [three times daily] & Q [every] 2 H [hours] prn [as needed] - COPD."</p> <p>Resident B's June, 2015 Medication Administration Record (MAR) indicated, "Duoneb 3 ml mini neb tx TID for COPD." Scheduled times indicated, "5:00 a.m., 1:00 p.m., and 9 p.m." Resident B's 6/17/2015 1:00 p.m. dose was initialed by RN # 1 [to indicate the medication had been administered].</p> <p>Resident B and Family Member # 3 were</p>		<p>as she was in the building. Resident E was confused as to which surgeon she was to see. Resident E thought she was going to see the surgeon who performed the surgery on her back however, that appointment had been scheduled by the facility with facility #1 for 6/30/2015 at 11:45am with MD #1. Resident E had an appointment scheduled by the facility to follow up with Infectious Disease, MD #3 for July 7, 2015 at 10:00am. The appointment could not be scheduled the week before due to holiday office hours and availability for the physician. The appointments were on the medication record and were waiting for information from Resident E's spouse because he wanted to go with her. The facility had the appointments on the schedule and this information was shared with the surveyor during the survey. She made copies and notes on the discharge information. (see attachment #8) Resident E had expressed her disappointment with her condition and the fact that she had to wait so long before she could see if she was getting better. She is disappointed that her recovery will take so long - not that she's missed her appointments. Resident has</p>		

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	<p>interviewed on 6/17/2015 at 12:10 p.m. The resident and Family Member # 3 both indicated the resident had not received his scheduled 1:00 p.m. nebulizer treatment.</p> <p>On 6/17/2015 at 2:45 p.m., Resident B and Family Member # 3 indicated he had still not received his scheduled 1:00 p.m. nebulizer treatment.</p> <p>RN # 1 was interviewed on 6/17/2015 and indicated he did not administer Resident B's nebulizer treatment, and stated, "Yes, I signed it off and didn't give it."</p> <p>Resident B was and Family Member # 3 were interviewed on 6/17/2015 at 12:10 p.m. Family Member # 3 indicated the resident missed his scheduled 8:00 a.m. follow-up physician's appointment with ENT (Ear, Nose and Throat Physician). Family Member # 3 indicated, "They [facility staff] said there was a foul up with transportation and they had to reschedule the appointment." Family Member # 3 indicated the appointment was re-scheduled for 3:00 p.m. that same day.</p> <p>On 6/17/2015 at 2:55 p.m., Family Member # 3 exited Resident B's room and notified RN # 1 that transportation</p>		<p>not missed her scheduled followup appointments. The ADNS as well as the DNS gave this information to the surveyor while she was in the building. On 6/18/15 at 3:50pm, Unit Manager#1, Resident E and Family Member #6 were present in the room with the surveyorwhile Unit Manager #1 inspected Resident E's head and neck for the presence of crani-staples. The reason Unit Manager #1 went into the roomwith the surveyor was because the surveyor had insisted that the Unit Managerprove to her that there were no staples present. This could have been avoided had the surveyorasked the Resident, reviewed the medical records from the hospital or looked atthe skin assessment. The Unit Managerdenies making a statement or inference that there were sutures present thatwere not dissolvable and would need to be removed. (See attachments # 6 and #7which show the resident's wounds and there are no wounds on her head nor arethere any mentioning of "crani-staples" or any other types of staples present.) Regarding statement on 6/18/15 at3:55pm that ADON indicated no follow up appointmentswere scheduled for Neurosurgeon, Spine</p>		

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	<p>had not arrived. RN # 1 indicated, "Let me call them [transportation] and see where they're at." Transportation/ambulance service arrived at 3:07 p.m. to transport the resident.</p> <p>On 6/17/2015 at 3:18 p.m., Unit Manager # 1 indicated, "Transportation was not set up" for Resident B's 8:00 a.m. ENT appointment.</p> <p>Moving Forward Unit Manager # 1 was interviewed on 6/18/2015 at 3:35 p.m. She indicated Nursing is responsible for scheduling transportation and ensuring residents get to scheduled appointments and/or treatments. She indicated an 8 x 10 book-style calendar at the nurses' station and indicated the calendar was used to communicate up-coming appointments to staff.</p> <p>On 6/19/2015 at 1:04 p.m., the Director of Nursing Services (DNS) indicated the facility did not have a written policy and/or procedure for transporting residents to and from follow-up appointments/scheduled treatments.</p> <p>A copy of General Dose Preparation and Medication Administration Policy and Procedure was provided by the Executive Director on 6/17/2015 at 1:31 p.m. Procedures indicated, "...Administer</p>		<p>Center or Infectious Disease did nottake place. The surveyor was given theappointment information on two separate occasions on 6/18/15 by the Director ofNursing Services explaining that the Neurosurgeon and the Spine Surgeon and Spine Centershe had been referring to were the same physician. The neurosurgeon, Facility#1, is who performed her back surgery and the general surgeon is MD #2 who shesaw on the morning of 6/18/15. When thefacility called to make the appointments with the Neurosurgeon, it was explainedat that time, MD #1 was with Facility #1 and listed on the hospital dischargesummary however, she would be following up with MD #4 who is involved with hereafter care. Both MD #1 and MD #4 work @Facility #1. (see attachment #8) On 6/17/2015 at 12:10pm Resident Band Family member # 3 had both indicated to the surveyor that he had notreceived his 1:00pm nebulizer treatment. On 6/17/2015 at 2:45pm Resident Band Family member # 3 had indicated to surveyor that he had not received his1:00pm nebulizer treatment. However, the surveyor was in the residents roomfrom</p>		

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	<p>medications within timeframes specified by Facility policy..... Document necessary medication administration/treatment information...."</p> <p>During an interview with Corporate Nurse Consultant # 2 on 6/18/2015 at 2:15 p.m., she indicated the facility did not have a policy and/or procedure regarding timeframes for medication administration. She indicated the window was "an hour before or an hour after" the scheduled dose.</p> <p>This Federal tag relates to the Investigation of Complaint IN00175354.</p> <p>3.1-37(a)</p>		<p>approximately 12:10pm until about 3:05pm with the door shut. RN #1 did not state "Yes, I signed it off and didn't give it". He stated that he had not given it due to her being in the room and had received a one time order to administer the nebulizer treatment when Resident B returned from his doctor's appointment. RN #1 was in the process of documenting the scheduled dose when the surveyor pointed to the medication administration record and questioned why it wasn't given. On 6/17/2015 at 12:10pm Resident Band Family Member #3 had indicated to the surveyor that he "missed" his scheduled 8:00am follow-up appointment with ENT due to a "foul-up" with transportation. The same day the surveyor stated that she spoke with the Unit Manager #1 at 3:18pm and that she indicated that transportation was not set up for his 3:00pm appointment. However, there was an attempt to schedule transportation when the appointment was scheduled and the transportation service from (local hospital) stated they would have to let us know closer to the appointment date about availability of a bariatric stretcher transport because</p>		

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			<p>they have a limited number available. On the morning of the appointment the nurse was aware of the transport of a bariatric stretcher not being available and he rescheduled the appointment for 3:00pm. The transportation company was late arriving to the building and the facility notified the ENT doctor and the resident was transported to his appointment without further issues. The resident did not miss his appointment. The nurse working that day was fully aware of the situation and it wasn't pointed out to the facility by the surveyor. The nurse had kept the resident and his family aware of the appointment time changes.</p> <p>I. Resident B no longer resides in the facility as his rehabilitation had ended and he discharged home with home health care. Resident B and Resident E and their physicians were aware of medication not administered at the time on the medication administration record and an order was already received by their MD's to address the medication being administered at a different time. There was no negative outcome from either of these facility identified issues. Resident E's dressings were changed according to physician's orders. Resident E did not have any adverse outcome related to the</p>	

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			missing documentation. The documentation for Resident E has been corrected. Resident B and Resident E did not miss any of their appointments. II. All of the residents residing in the facility have the potential to be affected by the alleged deficiencies. III. All licensed nurses will receive mandatory education regarding documentation of medication, documentation and notification regarding changes in medication times and education regarding documentation of treatments on the treatment administration record. All licensed nurses will receive mandatory education regarding scheduling and transportation of residents to and from their appointments. IV. The Director of Nursing Services or designee will audit medication and treatment records to ensure that documentation is present for administration of medications and treatments 3 times per week for 30 days, 2 times per week for 30 days and 1 time per week for 6 months. Any issues identified will be immediately corrected. If issues are identified, the audits will return to more frequent intervals. The Director of Nursing Services or designee will ensure that transportation appointments are on the schedule for that unit and documentation present to show at a minimum, where the resident is going, who is transporting, confirmation	

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F 0441 SS=E Bldg. 00	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p>		<p>number, and family notification. The documentation will be audited 5 times per week for completeness during the Interdisciplinary Team Meeting indefinitely. Any issues identified will be immediately corrected. The results of the audits will be discussed during the Performance Improvement Committee monthly and the Performance Improvement Committee will determine if audits can be discontinued. Date of completion: July 16, 2015</p>	

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	<p>(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.</p> <p>(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. Based on observation, interview and record review, the facility failed to provide adequate handwashing for 2 of 4 residents observed for hand washing (Residents E and F), failed to provide infectious disease/isolation precaution education and personal protective equipment (PPE) for 2 of 4 residents observed for isolation precautions (Residents B and E), failed to post proper isolation precaution signage outside two resident rooms for 2 of 4 residents reviewed for isolation precautions (Resident B and C), failed to ensure that one resident was not in isolation any longer than required for 1 of 4 residents reviewed for isolation precautions (Resident B), and failed to prevent cross-contamination for 2 of 4 residents reviewed for infection control (Residents C and F).</p> <p>Findings include:</p>	F 0441	F 441 483.65INFECTION CONTROL, PREVENT SPREAD, LINENS Facility disputes allegations in complaint in thatthere was no documentation regarding improper staff hand washing and improperplacement of bedpan for Resident E. The information derived was from familyinterview and after staff and resident interviews it was determined that familywas not present during time period alleged. The Director of Nursing Services provided educationto Resident E regarding her isolation precautions and what she should expect. Resident stated "I'm aware. Several nurseshave already told me this." When asked how long she has known about herisolation precautions resident stated "since the nurse told me about me havingCDiff". Resident E	07/16/2015			

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	<p>A copy of the current CNA (Certified Nursing Assistant) Assignment/Resident Care Sheet for Moving Forward was provided during the initial tour by Unit Manager # 1 on 6/17/2015 at 11:59 a.m. Resident B's Resident Care Sheet indicated, "droplet precautions - MRSA [methicillin-resistant Staphylococcus aureus] sputum [saliva]." Residents D, E and F were not indicated to have any isolation precautions.</p> <p>1. During an initial tour on 6/17/2015 at 11:50 a.m. with the Assistant Director of Nursing (ADON), the Moving Forward Unit Manager (Unit Manager # 1) indicated Resident E was under contact precautions for methicillin-resistant Staphylococcus aureus (MRSA) and Clostridium difficile (C-diff). An over-the-door storage systems holding Protective Personal Equipment (PPE), including gowns, gloves, and masks was observed on Resident E's door, with a sign indicating, "Please see nurse before entering."</p> <p>Resident E was interviewed on 6/17/2015 at 2:10 p.m. in her room with Family Member # 4 present. The resident indicated staff routinely place her bedpan on the over-bed table when they assist with toileting and do not clean the table</p>		<p>stated that she wasnot sure if her family was aware but, they wear the gowns and gloves when theycome in. The Director of Nursing Services spoke with afamily member of Resident E and the time period that was alleged that staff didnot wear PPE was before the resident was placed on isolation precautions andtherefore would not have been necessary. The Director of Nursing services spoke with allstaff members providing care for resident since admission and the employee thatwas alleged to have made the remark regarding transmission stating "the onlyway you'll get it is if you eat her feces" does not match the description of any of our employees in the building. Resident does not recall this incidentoccurring. The Director of Nursing services interviewed staffmembers present on 6/18/2015 at 3:17pm and all staff stated that trays wouldhave been picked up from meal served at noon by about 1:30pm and that residenthas not been known to have wipes or any barrier creams at the bedside. No residents have wipes to staff's knowledgeas the facility does not provide that product and their use is discouraged dueto</p>				

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	<p>after. Resident B indicated, "I eat on that [over-bed table]." Resident E indicated she did not receive any education on C-diff or isolation precautions. The resident indicated, "They said they would bring me something [printed information], but they never did." Resident E indicated that staff routinely did not don personal protective equipment (PPE) or wash their hands before, during or after providing care. The resident indicated that LPN (Licensed Practical Nurse) # 4 routinely does not wash hands, wear gloves, or sterilize the ports of her PICC (peripherally inserted central line IV) before accessing it.</p> <p>Resident E's Family Member # 4 indicated gowns were routinely not available and staff reported being "out" on numerous occasions. She indicated she and her family members disinfected Resident E's over-bed table "every day" due to concerns about infection control and observing staff utilize her over-bed table during assistance with toileting, not disinfecting it, and then serving her meals on the table. Resident E's Family Member # 4 indicated she frequently witnessed staff provide care without the indicated PPE and staff routinely did not wash their hands before, during, or after providing care. She indicated, on</p>		<p>potential plumbing issues if flushed. Unit Manager denies making alleged statement in complaint. The Director of Nursing Services interviewed the Nurse Practitioner present on 6/18/2015 and it would have been impossible for the surveyor to observe hand washing for seven seconds when the door to the resident's room was closed as well as the door to the resident's bathroom when the Nurse Practitioner washed her hands. On 6/19/2015 there allegedly were no gowns available in the over-door storage isolation unit. Several Management staff members as well as Corporate Nursing staff members were present on the unit when the surveyor was present and at no time were there any isolation units without required PPE. Resident B was admitted to the facility from acute care hospital with transmission based droplet precautions due to MRSA in sputum. Resident B and family members were educated regarding need for PPE and the documentation of such is present in the nursing notes. Also present in the nursing notes is documentation of family's non-compliance. Unable to determine if family member # 4 and # 5 are same family</p>				

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	<p>6/5/2015, she witnessed LPN # 4 access Resident E's PICC line without washing his hands or wearing gloves. She indicated, "He still doesn't wear gloves." Family Member # 4 indicated Resident E called her on 6/12/2015 and indicated, "You might not want to come back...I have C-diff." Family Member # 4 indicated staff instructed her and other family members, who visit daily, "they would bring us some information [regarding C-diff and infection control], but they never did." When Resident E's family member asked staff about isolation precautions and if she was at risk of contracting C-diff, she indicated, "The CNA told me, "The only way you'll get it is if you eat her feces. A lot of our residents have it [C-diff]."</p> <p>Resident E's clinical record was reviewed on 6/17/2015 at 4:00 p.m. Diagnoses included, but were not limited to, sepsis (blood infection), methicillin-sensitive Staphylococcus aureus (MSSA), lumbar spine abscess, psoas muscle (centrally located on either side of the lumbar spine) abscess of right thigh/hip and soft-tissue infection, and Clostridium difficile (C-diff). The resident was admitted to the facility on 6/5/2015 following spinal surgery and wound surgery on 5/20/2015. She was diagnosed with C-diff on 6/12/2015.</p>		<p>member as a small child was described as family member # 4 and # 5. In surveyor's own statement Resident B's Family Member # 3 stated "they just told us we should wear gowns". However, surveyor stated that Family Member #3 and Family Member #5 were observed without gowns, gloves or masks. Family Member #3 stating that they were simply told to wear gowns and not wearing the gown in the presence of the surveyor would in and of itself prove the Family's non-compliance with isolation precautions. Resident B's Family Member #1 stating that staff walk in and out of resident rooms without washing their hands was not reasonable or validated during the survey. The Family Member would not have been able to visualize staff washing their hands in other resident's rooms as the restrooms are located in each individual resident's room and others are not able to visualize the sink unless they are in the restroom with the staff member. Therefore, Family Member #1 would not be able to state with any reason of certainty that staff walk in and out of resident rooms without washing their hands. Family Member #1</p>	

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	<p>Admission Minimum Data Set (MDS) assessment, dated 6/15/2015, indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15; indicating Resident E was cognitively intact. The resident was non-ambulatory and required extensive, 2+ person physical assist for all activities of daily living (ADLs), including toileting, hygiene, and transfers. She was frequently incontinent of bowel and bladder.</p> <p>A care plan, initiated 6/17/2015, indicated, "Focus: [Resident E] has C. Difficile. Interventions: CONTACT ISOLATION: Wear gowns and gloves when changing contaminated linen...Educate/family/staff regarding preventative measures to contain the infection."</p> <p>Resident E was interviewed on 6/18/2015 at 3:17 p.m. A partially capped tube of Moisture Barrier Paste and a bag of moist wipes were observed on the over-bed table with a Styrofoam drinking cup and a partially eaten plate of food. Resident E indicated the Moisture Barrier Paste and wipes were used for incontinence care and indicated, "I had it over here (bedside table to the resident's left side), but they moved it over here (to the over-bed table on the resident's right).</p>		<p>stating thatfamily did not receive education can not be substantiated and Family Member #1is per her own statement a Licensed Practical Nurse employed with a localhospital and would therefore, because of her licensure, know about isolationprocedures. Signage has always beenposted on the resident's door indicating that Visitors are to see the Nursebefore entering the room. Unable to identify Resident B's Family member # 2. However, if Resident B's Family Member #2 isstating that they never received education, it would not be reasonable that shewould look for PPE to wear if she didn't know about it. It should be noted that the facility has purchasedPPE in large amounts because the staff use it to care for residents withtransmission based precautions. Staffstock isolation equipment as needed and extra supplies are located on theunit and in the supply room. On 6/17/2015 at 3:30pm, the statement that the ADONdid not know what kind of education residents and families received regardinginfectious disease and/or isolation precautions is misleading in that the ADON actuallystated "I have not been</p>	

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS				STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201			
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	<p>Unit Manager # 1 entered the room and indicated, "They should go back over there [pointing to the bedside table to the resident's left]."</p> <p>On 6/18/2015 at 3:15 p.m. NP (Nurse Practitioner) # 1 was observed at Resident E's bedside. She was observed removing her gloves and performing hand washing for seven seconds before exiting the room.</p> <p>On 6/19/2015 at 12:15 p.m. & 12:45 p.m., Resident E's room was observed with no gowns available in the over-door storage isolation unit.</p> <p>2. During an initial tour on 6/17/2015 at 11:50 a.m. with the Assistant Director of Nursing (ADON), the Moving Forward Unit Manager (Unit Manager # 1) indicated Resident B was under droplet precautions for MRSA in his sputum. An over-the-door storage system, holding Protective Personal Equipment (PPE), including gowns, gloves, and masks, was observed on Resident B's door, with a sign indicating, "Please see nurse before entering."</p> <p>Resident B was interviewed on 6/17/2015 at 12:10 p.m. The resident was observed in bed with a tracheostomy (an opening surgically created through the neck into</p>		<p>involved in that education yet but, I will get it foryou."</p> <p>Resident B had a sputum sample collected the nextday on 6/10/2015. On or about 6/14/15,the facility was notified of need to recollect the sputum due to insufficientamount collected for testing. On 6/16/15the sputum was recollected and sent to the lab that day. On 6/17/15 at 2:28pm the Unit Managerindicated to the surveyor that she could not locate the sputum culture results andat 2:39pm indicated the sputum culture was obtained and provided the surveyorwith a preliminary report with the date of 6/17/15 and time of 2:37pm stating"Moderate Mixed bacteria consistent with normal respiratory flora". This report was a preliminary report. The final report was received and reviewed bythe Nurse Practitioner on 6/19/15 at about 12:00pm and a new order received todiscontinue the isolation precautions. The final result was not received until 6/19/15 and the resident wasremoved from isolation after housekeeping had been notified to deep clean theresident's room due to being removed from isolation. See attached information from various medicalreferences</p>				

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	<p>the trachea [windpipe]; a tube is inserted to provide an airway) and was observed to cough multiple times throughout the interview. Resident B indicated, "I don't know [whether staff routinely wear PPE while caring for him]." Family Member # 3 and Family Member # 5, a small child, were observed at the bedside. Neither family member was wearing a gown, gloves or mask. Family Member # 3 indicated, "[There were] not really any special precautions [regarding isolation precautions]. They just told us we should wear gowns. Family Member # 3 indicated staff "usually" have gloves on, but "not always the gown or mask" when providing care. During the observation, the small child was moving throughout the resident's room, touching the over-bed table, resident, bed, and bed linens, and was within three feet of Resident B.</p> <p>During an observation on 6/17/2015 at 12:30 p.m., the same small child was observed curled up, sleeping on a chair with her head on a pillow. Family Member # 4 indicated Resident B provided the child with his own pillow. Neither family member was wearing a gown, gloves, or mask.</p> <p>Resident B's Family Member # 1 was interviewed on 6/17/2015 at 5:30 p.m.</p>		<p>regarding common practice for obtaining sputum samples: "The hardest part of a sputum culture is often obtaining enough material in a sputum sample for testing"..... The expected time for results is "48 to 72 hours for bacteria and up to 1 week (7 days) for fungi." It would be unreasonable to expect the facility to have culture result for a sputum sample in 24 hours. The resident was removed from isolation as soon as the results were reviewed, order received and housekeeping had deep cleaned Resident B's room. On 6/19/2015 at 12:15pm and at 12:45pm allegedly there were no gowns available in the over-door storage isolation unit for Resident B. Several Management staff members as well as Corporate Nursing staff members were present on the unit when the surveyor was present and at no time were there any isolation units without required PPE. Family Member #3 has been non-compliant with isolation equipment. On the outside of Resident C's door was an information sign stating "Visitors and Personnel Please Speak to Nurse Before Entering". Under the wording was a large STOP sign. The paper was in</p>		

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	<p>She indicated concerns that staff routinely did not don PPE when providing care for the resident and that staff, "walk in and out of [resident] rooms without washing their hands." The family member indicated gowns were routinely not available to visitors. Family Member # 1 indicated the facility did not provide the family or the resident with education/information regarding infectious disease or isolation precautions.</p> <p>Resident B's Family Member # 2 was interviewed on 6/17/2015 at 4:10 p.m. She indicated she had concerns regarding infection control practices in the facility. She indicated, "People [staff] go in [Resident B's room] without gowns and gloves and then go into other rooms. Nobody's washing their hands." Family Member # 2 indicated gowns have not been available "numerous days" and family has had to "repeatedly ask" staff for gowns. Family Member # 2 indicated the facility did not provide education/information regarding infectious disease or isolation precautions.</p> <p>Resident B's clinical record was reviewed on 6/17/2015 at 12:00 p.m. Diagnoses included, but were not limited to, pneumonia, MRSA (methicillin-resistant</p>		<p>theisolation unit on the door to indicate to Visitors and Personnel to speak withthe nurse before they enter in order to obtain information on what PPE is requiredprior to entering the room. Documentationthat is visible on the isolation unit did not indicate "DropletPrecautions". The identification to thepublic (passersby, other residents, visitors or staff) of the type of isolationthe resident is on is a violation of privacy. The resident was in contactprecautions for Clostridium Difficile and the information signage (STOP sign)would have been sufficient enough to alert visitors and staff to ask the nursewhat PPE is required before entering the room. The Unit Manager #1 , CNA #10 and CNA #11 entered the resident's roomwearing the appropriate isolation equipment of gowns and gloves. CNA #10, CNA #11 and Unit Manager #1 provideda written statement regarding events that occurred in the room while providingincontinence care to Resident C. CNA #10changed her gloves and washed her hands for no less than 20 seconds when sheremoved her gloves. CNA #10 did not openany drawers as linen</p>				

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	<p>Staphylococcus aureus) in sputum, tracheostomy and COPD (chronic obstructive pulmonary disease).</p> <p>Admission Minimum Data Set (MDS) assessment for Resident B, dated 6/4/2015, indicated a Brief Interview for Mental Status (BIMS) score of 15 of 15; indicating he was cognitively intact. The resident was non-ambulatory and required extensive, 2+ person physical assist for all activities of daily living (ADLs), including toileting, hygiene, and transfers. He was continent of bowel and bladder. The resident received oxygen, suctioning, tracheostomy care, IV (intravenous) medications, and was on isolation precautions for an active infectious disease.</p> <p>Physician's Orders for Resident B, dated 5/28/2015, indicated, "Droplet precautions D/T [due to] MRSA pneumonia."</p> <p>A care plan for Resident B, initiated 6/1/2015, indicated, "Focus: Isolation Precautions droplet R/T [related to] Infectious Disease MRSA in sputum...Interventions: Administer medications per physician orders. See medication records. Monitor for effectiveness and side effects."</p>		<p>needed to provide incontinent care to the resident wasbrought into the room. There are no“clean linen drawers” in any of the resident’s rooms. Linen was brought into the room to provideincontinence care. Resident C has beenincontinent of stool since admit and therefore was not given a bedpan. Therewere no bedpans stored in the resident’s drawer. After providing incontinencecare the surveyor indicated “good job”. Which would be reasonable to assumethat there were no issues noted with care. CNA #11 and Unit Manager # 1 providedstatements that the linen was brought into the room and that at no time did CNA#10 open a drawer to remove “clean linen”. Presumably equipment in an isolation room for Clostridium Difficile isconsidered contaminated and not clean. Regarding care for Resident F: Unable to identifywho the two CNAs # 7 and # 8 are specifically. However, in addition to CNA # 9, there were 2 other CNAs present duringcare. One of the CNAs # 7 or #8 is no longer employed with the facility. The remaining CNA, either #7 or #8 will</p>				

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	<p>The same care plan was updated on 6/17/2015 to include the following additional interventions: "...Determine appropriate barriers to apply based on isolation precaution category and activities to be performed e.g., masks, gowns, gloves."</p> <p>On 6/17/2015 at 3:30 p.m., the ADON indicated she did not know what kind of education residents and families received regarding infectious disease and/or isolation precautions, stating, "I'm not usually involved in that".</p> <p>Physician's Orders for Resident B, dated 6/9/2015 at 6:05 p.m. indicated, "Obtain sputum sample. If negative D/C [discontinue] isolation. Hx [history]: MRSA sputum."</p> <p>June, 2015 Medication Administration Record (MAR) for Resident B, indicated the sputum culture was obtained 6/10/2015.</p> <p>Health Status Note for Resident B, dated 6/16/2015 at 6:10 p.m., indicated, "Sputum culture sent to lab."</p> <p>During an interview on 6/17/2015 at 2:28 p.m., Unit Manager # 1 indicated she could not locate the sputum culture results. At 2:39 p.m., she indicated</p>		<p>beidentified by #7/8 from this point forward. CNA #9 and #7/8 provided a written statement regarding care for Resident F. The resident was transferred from her wheelchair to her bed via use of mechanical lift. The sheet and the lift sling were removed out from underneath the resident after transfer. Resident had a sheet on top of the sling. The sheet was removed and placed in a bag as the sheet was soiled with crumbs of food from lunch meal and snacks. The sling was placed on the wheelchair. The sheet was not soiled with urine, feces or drainage from the resident's wound. The resident is not incontinent of stool or urine and has an indwelling urinary catheter. At no time was the sling wet or soiled with feces. There was nothing placed in a drawer in the resident's room. All CNAs washed their hands for no less than 20 seconds with warm water, soap and friction prior to leaving the room.</p> <p>1. Residents and families currently on isolation received re-education verbally and in writing regarding the infection and instructions regarding donning and doffing PPE.</p> <p>2. Facility Licensed Nursing staff will complete a skill competency observation and check-off</p>				

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	<p>Resident B's sputum culture was collected 6/16/2015 and provided a copy of the report, which indicated, "17 June 2015 [2:37 p.m.]. Source: Sputum...Moderate Mixed bacteria consistent with normal respiratory flora [negative for MRSA]."</p> <p>Physician's Orders for Resident B, dated 6/19/2015 [untimed], indicated, "May D/C [discontinue] isolation."</p> <p>On 6/19/2015 at 12:50 p.m., Unit Manager # 1 walked into Resident B's room and indicated, "All clear [indicating to Resident B and his family member that he could be removed from isolation]."</p> <p>On 6/19/2015 at 12:15 p.m., Resident B's room was observed with no gowns available in the over-door isolation unit. Resident B's Family Member # 3 was observed at Resident B's bedside without a gown, gloves, or mask.</p> <p>On 6/19/2015 at 12:45 p.m., Resident B's room was observed with no gowns available in the over-door isolation unit.</p> <p>3. During an initial tour on 6/17/2015 at 11:50 a.m. with the Assistant Director of Nursing (ADON), the Moving Forward Unit Manager (Unit Manager # 1) indicated Resident C was under contact</p>		<p>regarding proper hand washing techniques, isolation protocols for Clostridium Difficile infections and isolation protocols for all other multi-drug resistant organisms. Nursing staff have received mandatory education regarding MDRO and Clostridium Difficile to include modes of transmission and how to prevent infection. Nursing staff have received mandatory education on how to provide family education regarding MDRO and Clostridium Difficile. Facility staff have received mandatory education regarding hand washing and infection control practices per facility policy. Facility staff will complete skill competency no less than yearly. Newly hired facility staff will receive education and complete skill competency during new hire orientation.</p> <p>3. The Staff Development Coordinator will monitor for hand washing techniques with a minimum of 3 staff members 5 days a week for 4 weeks, then 3 observations per week for 4 weeks then 1 observation a week for 4 weeks then monthly thereafter for a total of 6 months of monitoring. Any concerns will be immediately addressed. The Director of Nursing Services or designee will ensure that residents and visitors that admit or are placed on isolation precautions during admission for any transmission based infection receive education</p>		

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	<p>isolation for C-diff. An over-the-door storage system, holding Protective Personal Equipment (PPE), including gowns, gloves, and masks, was observed on Resident C's door. A sign on the door indicated, "Droplet Precautions [with instructions to don gloves, gown, mask]."</p> <p>Incontinence care was observed for Resident C on 6/17/2015 at 12:35 p.m. CNA #10, CNA # 11, and Unit Manager # 1 all donned gowns and gloves. Resident C was incontinent of a large, loose stool. CNA # 10 was observed providing incontinence care to resident C. She was observed not to change her gloves, open the clean linen drawer, and reach in for clean linen. Resident C's bed pan was stored, un-bagged, in the clean linen drawer.</p> <p>Following care, Unit Manager # 1 was interviewed regarding isolation precautions and the "Droplet Precautions" sign on Resident C's door. She indicated, "It was the wrong sign."</p> <p>4. During an initial tour on 6/17/2015 at 11:50 a.m. with the Assistant Director of Nursing (ADON), the Moving Forward Unit Manager (Unit Manager # 1) indicated Resident F was under contact isolation for MRSA in a wound. An over-the-door storage system, holding</p>		<p>verbally and in writing regarding reasons for isolation precautions and proper PPE donning and doffing. The Director of Nursing Services or designee will perform random audits of staff members entering and exiting isolation rooms to ensure that proper PPE is donned and doffed during care 3 days a week for 30 days, 2 days a week for 90 days and weekly indefinitely if there is a resident in isolation. Any concerns noted will be immediately addressed. The results of the audits will be reported monthly to the Performance Improvement Committee. The committee will determine if the audits can be discontinued. Date of completion: July 16, 2015</p>				

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	<p>Protective Personal Equipment (PPE), including gowns, gloves, and masks, was observed on Resident F's door.</p> <p>Incontinence care was observed for Resident F on 6/17/2015 at 3:40 p.m. Upon entering the resident's room, CNA # 9 indicated Resident F was on isolation precautions for MRSA in a wound. Resident F was assisted from her wheelchair to the bed with a mechanical lift and was observed to be incontinent of loose stool which had soaked through and soiled the sheet covering the resident's lift sling. CNA # 9 was observed removing the lift sling from the soiled sheet, balling it up, and placing it the resident's clean linen drawer.</p> <p>Following incontinence care, CNA # 7 was observed removing her gown and washing her hands for 10 seconds. CNA # 8 followed and was observed washing her hands for 11 seconds.</p> <p>Resident F's clinical record was reviewed on 6/18/2015 at 1:50 p.m. Diagnoses included, but were not limited to, Escherichia coli (E.Coli) and MRSA in wound.</p> <p>A care plan, initiated 6/12/2015, indicated, "Focus: [Resident F] has E. Coli & MRSA in wound. Interventions:</p>			

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	<p>...Contact Isolation."</p> <p>A copy of the current Infection Prevention and Control Program Policy and Procedure was provided by the ED on 6/18/2015 at 2:00 p.m. The components included, but were not limited to, "...11. b. Special attention is provided to patients at risk for infections, such as those who: 1. Are immobilized; 2. Have invasive devices or procedures;... 4. Have recently transferred from a hospital.... c.2. Provide adequate access to toilet facilities with appropriate sanitation before and after patient use, 3. Instruct patients in hygiene and handwashing, as appropriate to their functional status.... 12. If a patient with an active infection, the patient will be placed in the appropriate transmission-based precautions. 13. Patients with identified Multi-drug resistant organisms (MDRO) are isolated only to the degree needed to prevent transmission of the infecting organism."</p> <p>A copy of the current Transmission-Based Precautions Policy and Procedure was provided by the ED on 6/18/2015 at 2:00 p.m.. The components included, but were not limited to, "PROCEDURE: ...6. update care plan.... 8. Instruct staff on good hand washing and using the appropriate</p>			

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	<p>personal protective equipment (PPE) when exposure is anticipated.... 11. Place and maintain an adequate supply of appropriate personal protective equipment by the isolation room at the door or use an over-the-door storage system (e.g., masks, gowns, gloves, goggles, etc.).... Contact Precautions: ...a. Post the appropriate precaution notice immediately visible location outside the room.... For a patient that has an active C-diff infection should be placed on Enteric Contact Precautions: ...2. Staff should gown and glove before entering the room to prevent accidental contact with contaminated environment from the spores of C-diff. 3. Hand Hygiene - is the most important method of control to prevent transmission.... 4. Gloves: Wear gloves whenever touching the patient's intact skin or surfaces and articles in close proximity to the patient.... 5. Gowns: Don gown if exposure is anticipated. Remove gown and observe hand hygiene before leaving the patient-care environment.... 10. ...bedpans should be...stored in a designated location after each use, i.e., covered in the bottom drawer.... Droplet Precautions: ...2. Perform hand hygiene before and after touching the patient and after contact with respiratory secretions and contaminated objects/materials.... 4. Post the Droplet Precaution notice</p>			

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	<p>immediately visible outside the room. 5. Staff and visitors don a surgical mask when exposure is anticipated or within 3 feet of the patient's immediate environment....</p> <p>A copy of the current Hand Hygiene/Handwashing Policy and Procedure was provided by the ED on 6/18/2015 at 2:00 p.m. The policy indicated, "...Hand hygiene is to be performed: ...After toileting, assisting others w/ toileting.... Before taking part in a medical or surgical procedure.... Between tasks and procedures on the same patient when 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.... Intermittently after gloves are removed...and when otherwise indicated to avoid transfer of microorganisms to other patients or environments.... Procedure: 1. Wet hands.... 2. Rub hands together with vigorous friction for 20 seconds...."</p> <p>This Federal tag relates to the Investigation of Complaint IN00175354.</p> <p>3.1-18(b)(1) 3.1-18(b)(2) 3.1-18(j)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/22/2015

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155133	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/19/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-COLUMBUS	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MIDWAY ST COLUMBUS, IN 47201
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	3.1-18(l)			