

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155790	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/14/2015
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
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F 0000 Bldg. 00	<p>This visit was for the Recertification and State Licensure Survey. This visit included the Investigation of Complaint IN00180169 and Complaint IN00180125.</p> <p>Complaint IN00180169- Substantiated. No deficiencies related to the allegation are cited.</p> <p>Complaint IN00180125- Substantiated. No deficiencies related to the allegation are cited.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00181488.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00182160.</p> <p>Survey dates: September 1, 2 ,3 ,4, 7, 8, 9, 10, 11 and 14, 2015</p> <p>Facility number: 012548 Provider number : 155790 AIM number : 201023760</p> <p>Census Bed Type: SNF: 48 SNF/NF: 44 Total: 92</p>	F 0000	<p>This Plan of Correction is the center's credible allegation of compliance. Preparation and/of 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. The facility respectfully requests a desk review for this plan of correction.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0157 SS=D Bldg. 00	<p>Census Payor Type: Medicare: 36 Medicaid: 29 Other: 27 Total: 92</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality Review completed by 21662 on September 21, 2015.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as</p>				

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	<p>specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on interview and record review, the facility failed to notify a physician regarding an abnormal lab result in a timely manner for 1 of 5 residents reviewed for laboratory results. (Resident #297)</p> <p>Findings include:</p> <p>Resident #297's record was reviewed on 9/9/15 at 10:17 a.m. Diagnoses included, but were not limited to, Diabetes Mellitus, hypertension and anemia.</p> <p>The resident had the following physician orders: 8/27/15--CBC (Complete Blood Count) and BMP (Basic Metabolic Panel) in the morning.</p> <p>The resident's record lacked the CBC and BMP results, which were ordered on</p>	F 0157	<p>F157-</p> <p>1.Resident #297 labs were given to the doctor on9/9/15. New orders were initiated tocorrect the lab values.</p> <p>2.All patients with laboratory orders have thepotential to be affected by this practice. Therefore, we completed a 100% lab audit to ensure the doctors hadsigned off on all lab results.</p> <p>3.All patients have the potential to be affectedby the deficient practice. Therefore,all licensed nurses will be in-serviced on lab reporting and notification. A lab monitoring tool has been put in placefor use in the daily clinical meeting, Monday through Friday, where labs willbe monitored for orders, order entry, results back and notification. The Weekend Supervisor will follow up on thelab orders on the weekends. The unitmanager/designee will also complete achart audit to ensure</p>	10/06/2015	

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	<p>8/27/15. The resident's nursing progress notes lacked documentation, which indicated the laboratory results had been reported to the Physician or Nurse Practitioner (NP) prior to 9/9/15. On 9/9/15 at 4:30 p.m., those laboratory results were requested from the Director of Nursing Services (DNS).</p> <p>On 9/11/15 at 9:42 a.m., the DNS provided a copy of the CBC and BMP laboratory results and indicated at that time, those test results were the resident's laboratory results from 8/28/15. The laboratory results indicated: Last Reprint--9/9/15 at 4:33 p.m. Reported--8/28/15 at 10:11 a.m. Specimen Collected--8/28/15 at 6:47 a.m. Report Status--Final The laboratory results were signed by the Physician on 9/9/15.</p> <p>The resident's potassium level from the 8/28/15, laboratory result was 3.2 (Milliequivalents/Liter). A normal result was 3.5-5.5 mEq/L</p> <p>During an interview on 9/11/15 at 9:54 a.m., the DNS indicated the signed laboratory results indicated the Physician had reviewed the laboratory results. She indicated she was not sure if the laboratory results dated 9/9/15, were the first laboratory results the Physician or</p>		<p>the lab results are present on chart with MDnotification.</p> <p>4. The Director of Nursing Services will review the audits for any trends and implement any necessary new processes based on findings. The review of these audits will be presented to the Performance Improvement Committee monthly until the committee determines compliance has been met.</p>	

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	<p>NP had been notified about, but she would ask the Physician regarding the time frame of notification. She indicated there were no further lab results from 8/28/15, on the resident's record.</p> <p>During an interview on 9/11/15 at 11:03 a.m., the DNS indicated she had not heard back from the Physician or NP as to whether he had been notified regarding the laboratory results drawn on 8/28/15 prior to 9/9/15.</p> <p>On 9/14/15 at 10:32 a.m., LPN #1 indicated she was unable to locate any other signed copies from the Physician or NP for the 8/28/15, laboratory results, or one of them were notified of the laboratory results prior to the 9/9/15 date.</p> <p>A current policy titled "Notifications" dated 9/23/2003, revised date 4/28/2013, provided by the District Director of Clinical Operations on 9/14/15 at 2:05 p.m., indicated "... Policy: Staff informs the patient, consults with their attending physician, and notifies the patient's surrogates when... Treatment needs to be altered significantly; or Laboratory results or any other testing results returned from a contracted laboratory or an outside laboratory, or healthcare site...."</p>			

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F 0364 SS=D Bldg. 00	<p>3.1-5(a)(3)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation and interview, the facility failed to serve palatable foods at the appropriate temperature for 2 of 2 residents served food, which was reviewed for food quality. (Residents #244 and #26)</p> <p>Findings include:</p> <p>1. During an interview on 9/2/15 at 2:58 p.m., Resident #244 indicated the food served tasted bland. She indicated the hot dishes were served cold.</p> <p>2. During an interview on 9/2/15 at 4:00 p.m., Resident #26 indicated all the foods being served were breaded or covered with sauces or covered with spices and she had food intolerances and was unable to eat those foods. She indicated when the foods were not covered in sauces, spices and breading, they were so dry and tasteless she was unable to eat the food. She indicated the food was served cold.</p>	F 0364	<p>F364</p> <p>1. Resident #244 was reminded of the alternates available for each meal and provided a refrigerator to store specific items related to food preferences. The facility purchased specialty food items from the grocery store. Resident #244 did not voice any further food related concerns. Resident #244 discharged from the facility on 9/9/15. Resident #26 has been reminded of the alternate items available during each meal and provided a refrigerator to store items in her room. In addition, our dietary manager has met with patient regarding food preferences and sensitivity to sauces and spices. Resident #26 has voiced no other food related concerns.</p> <p>2. All patients have the potential to be affected by this practice therefore all patients will be interviewed in regards to the food temperature and palatability of our meal service.</p> <p>3. All other residents have the potential to be affected by these practices therefore 2 patient</p>	10/06/2015			

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F 0371 SS=F Bldg. 00	<p>3. On 9/8/15 at 1:29 p.m., the last tray served from the 4000 unit steam table was observed being served. The foods on the tray were tested for appropriate temperature, palatability and attractiveness. At that time the Registered Dietician was observed testing the temperature of the foods. The temperatures were as follows: The Bar-B-Q pork riblet temperature was 130 degrees Fahrenheit (F). The carrots temperature was 137 F.</p> <p>The palatability of the Bar-B-Q pork riblet was observed to be tender, moist, seasoned, but the riblet tasted lukewarm.</p> <p>During an interview at that time, the Registered Dietician indicated the pork riblet temperature was not at the appropriate temperature.</p> <p>3.1-21(a)(2)</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, interview and record review, the facility failed to ensure</p>	F 0371	<p>interviews will be conducted by the dietary manager or designee, on each unit 3 times weekly M-F, to ensure meals are served at the appropriate temperature and are palatable. In addition, staff has been re-educated regarding the policy and procedure for proper food temperatures.</p> <p>4. Results of resident interviews will be reviewed monthly times 3 months or until 90% threshold achieved.</p>	10/06/2015			

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	<p>food was stored and served under sanitary conditions for 1 of 1 kitchens. This deficient practice had the potential to affect 91 of 92 residents being served food from this kitchen.</p> <p>Findings include:</p> <p>1. The kitchen tour began on 9/1/15 at 11:39 a.m., with the General Manager of Culinary Services (GMCS) and the Registered Dietician (RD) in attendance.</p> <p>a. On 9/1/15 at 11:43 a.m., gluten free bread sitting on a shelf was observed wrapped closed without an open date. During an interview at that time Cook #3 indicated the bread package was a 16 ounce package, but only one loaf of bread was left in the package. He indicated the bread had been opened, but there was no open date on the bread.</p> <p>On 9/1/15 at 11:52 a.m., the Executive Director joined the kitchen tour at this time.</p> <p>b. On 9/1/15 at 12:02 p.m., the microwave oven had a large amount of yellow colored crumbled debris splattered on the sides, bottom, top and the door of the microwave. During an interview at that time the Prep Cook #4 indicated a resident's food exploded in</p>		<p>1. The gluten free bread sitting on the shelf without an open date was immediately disposed, the microwave containing debris was immediately cleaned by cook #4, the convection oven containing burnt colored debris was immediately cleaned, the metal pans were immediately removed and washed, the 35oz bag of Raisin Bran was disposed, the 35oz bag of Crisp Rice cereal was immediately disposed, and all the heating warmers were immediately cleaned. In addition, the General Manager of Culinary services was in-serviced on the policy and procedure for temping food and not temping food through the label.</p> <p>2. All patients have the potential to be affected therefore, the culinary department received in-servicing related to food temperature measurement and proper air drying techniques for all washed items. In addition, staff has been in-service regarding cleaning schedules for each unit and the kitchen. The General Manager of Culinary services or designee will conduct quick rounds daily M-F and submit findings to the Executive Director.</p> <p>3. All Culinary staff has been in-serviced regarding food temperature measurement and proper air drying techniques for washed items. In addition, the General Manager of Culinary services has developed and</p>		

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	<p>the microwave this morning when he cooked it for breakfast and he should have cleaned the microwave after he used it. The Administrator indicated at that time the Microwave oven was to be cleaned immediately after every use.</p> <p>c. On 9/1/15 at 12:03 p.m., the double convection oven had burnt on brown colored food debris on the ovens. The inside of the oven doors had brown colored burnt on debris. The GMCS indicated the oven should be deep cleaned weekly. He indicated he had been here for three weeks and he did not know where the deep cleaning schedule logs were located, but he had not seen any since he had been here.</p> <p>d. On 9/1/15 at 12:14 p.m., the following metal pans were observed to have clear beads of liquid on them. The GMCS indicated at that time the beads of clear liquid was water.</p> <p>2--deep square metal pans had beads of water in between the two pans and when the top pan was lifted the water ran down onto the second pan.</p> <p>4--shallow square metal pans had water between them and each time the top pans were lifted the water ran down onto the next pan.</p> <p>4--deep small square metal pans with beads of water between them and each</p>		<p>implemented cleaning schedulesto ensure the equipment on the units and in the kitchen remains clean. The General Manager of Culinary services willvalidate all cleaning schedules are completed daily M-F times 90 days or until90% threshold achieved and report findings to the Performance Improvementcommittee for review. In addition, theGeneral Manager of Culinary services/or designee will conduct quick roundsaudit M-F times 90 days or until 90% threshold is achieved and finding reportedto the Performance Improvement committee for review.</p>	

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	<p>time the top pans were lifted the water ran down onto the next pan, then dripped onto the metal shelf the pans were sitting on.</p> <p>4--shallow square metal pans with beads of water between them and each time the top pans were lifted the water ran down onto the next pan, then dripped onto the metal shelf they were sitting on.</p> <p>3--shallow rectangular metal pans with beads of water between them and each time the top pans were lifted the water ran down onto the next pans.</p> <p>During an interview at that time, the GMCS indicated the staff should let the metal pans air dry before the staff placed the pans on the shelves.</p> <p>e. On 9/1/15 at 12:29 p.m., the following was observed in the dry storage area. The GMCS indicated the following: A 35 ounce bag of Raisin Bran cereal was opened with 16 ounces left in the bag, but was not wrapped closed. A 35 ounce bag of Crisp Rice cereal was opened with 8 ounces left in the bag, but was not wrapped closed.</p> <p>During an interview at that time, the GMCS indicated the cereal bags should have plastic wrap over them to close them.</p>			

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	<p>On 9/1/15 at 12:23 p.m., the Administrator in Training (AIT) joined the kitchen tour.</p> <p>f. On 9/1/15 at 12:11 p.m., the following observations were made when observing the tray heating warmers:</p> <p>The 2000 nursing unit tray heating warmer unit had burnt on black, brown and white colored food and liquid debris on the bottom and sides at the bottom of the unit.</p> <p>The 3000 nursing unit tray heating warmer unit had burnt on black, brown and white colored food and liquid debris on the bottom and sides at the bottom of the unit.</p> <p>The 4000 nursing unit tray heating warmer unit had burnt on brown, black and white colored food and liquid debris on the top, bottom and the sides at the bottom of the unit.</p> <p>During an interview at that time the GMCS indicated he had the kitchen staff scrub the tray heating warmer units daily after lunch to try to get the burnt on food and liquid debris off, but some of the staff were better at scrubbing the burnt on debris off than others.</p>			

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	<p>2. On 9/8/15 at 12:13 p.m., the GMCS was observed taking these food temperatures. He was not observed using a probe wipe prior to taking the temperature of the Bar-B-Q pork riblets. He was observed to place the temperature probe into the pan of pork riblets and obtained the temperature. He sanitized the temperature probe after completing the temperature on the riblets. He was observed taking the temperature of the carrots, then he took the temperature of the beets.</p> <p>On 9/8/15 at 1:48 p.m., the GMCS indicated he had not cleaned the thermometer before he temped the Bar-B-Q pork riblets and he had used the same wipe between the carrots and beets.</p> <p>3. On 9/8/15 at 12:46 p.m., the GMCS sanitized the temperature probe with a probe wipe, then was observed piercing the middle of a Turkey Breast with the label and package intact to get the temperature of the Turkey Breast. After he took the temperature of the Turkey Breast, he was observed opening the Turkey Breast and cutting off a fourth of the Turkey Breast and served the Turkey Breast to the 4000 nursing unit. He indicated at that time to an unidentified kitchen staff member to wrap the Turkey Breast up and place it back into the</p>			

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	<p>walk-in cooler.</p> <p>On 9/8/15 at 1:48 p.m., the RD indicated the GMCS should not have taken the temperature of the whole Turkey Breast through the label and package, then served the Turkey Breast. She indicated that was not the standard of practice.</p> <p>A current document titled "Inservice: Wet Nesting" dated 9/1/15, provided by the GMCS on 9/1/15 at 1:54 p.m., indicated "The food code requires that items must be allowed to air dry before being stacked or stored. Stacking wet items, such as pans and dishes, prevents them from drying and might allow an environment where microorganisms can begin to grow. Stacking dishes before they are dried is called wet-nesting...."</p> <p>A current policy titled "Food Temperature Measurement" dated 2/28/14, provided by the GMCS on 9/14/15 at 12:03 p.m., indicated "... Procedure: 1. Sanitize a clean, calibrated food thermometer before use and between foods (or use a different clean, sanitized, calibrated food thermometer for each food). Use either of the following methods to sanitize: a. Immerse the thermometer stem into clean sanitizing solution at the proper concentration and contact time</p>			

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-BRIDGEWATER	STREET ADDRESS, CITY, STATE, ZIP CODE 14751 CAREY RD CARMEL, IN 46033
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F 0441 SS=D Bldg. 00	<p>recommended by the sanitizer manufacturer. Air dry before using. b. Use a 'foodservice compliant' alcohol prep pad/wipe. *Note: Reminder: these are single use and should only be used to sanitize a thermometer one time and then discarded... Additional considerations: 4. For soft packaged items, fold the package around the thermometer or place the thermometer between 2 packages until the reading stabilizes. 5. For hard packaged or frozen items, place the thermometer between 2 packages until the reading stabilizes...."</p> <p>3.1-21(a)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p>			

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	<p>(b) Preventing Spread of Infection</p> <p>(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>(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.</p> <p>Based on observation, interview and record review, the facility failed to properly disinfect a prefilled insulin pen prior to and following administration for 1 of 1 residents observed for insulin administration. (Resident #310)</p> <p>Findings include:</p> <p>During a medication administration observation on 09/10/15 at 9:12 a.m., Licensed Practical Nurse (LPN) #5 prepared a prefilled insulin pen for administration by pulling the cap off of the pen, removing the protective tab from the single-use needle, and screwing it onto the pre-filled insulin pen. LPN #5 continued to prepare other medications.</p>	F 0441	<p>F441-</p> <p>1. Resident#310 the nurse was stopped in the middle of the deficient practice and wiped the rubber stopper of the insulin pen with alcohol prior to administering the injection. Once the insulin pen was placed back into the bag and the deficient practice was discovered, the pen was removed from the cart, sanitized it per policy and put into a plastic bag.</p> <p>2. All patients with orders for insulin pens have the potential to be affected by this practice. 100% in-servicing will be completed for all licensed nurses on insulin pen administration and pen sanitation.</p> <p>3. The DNS reviewed the Insulin pen policy and procedure that was in place at time of the survey.</p>	10/06/2015			

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	<p>LPN #5 was stopped at that time. She indicated she should have wiped the rubber stopper of the insulin pen with an alcohol pad before screwing the single-use needle onto the pen. LPN #5 referred to the policy book and then again prepared the insulin pen for administration. After administration of the insulin, LPN #5 placed the insulin pen back in a plastic bag in the medication cart.</p> <p>During an interview on 9/10/15 at 3:58 p.m., the Director of Nursing Services (DNS) indicated LPN #5 should have wiped the insulin pen with a bleach wipe before placing it back in the cart.</p> <p>A current policy, titled "Insulin Pens: Medication Errors" dated 08/31/11, provided by the DNS on 09/10/15 at 11:30 a.m., indicated, "...7. Pull off the pen cap and wipe the rubber stopper with an alcohol pad. 8. Remove the protective tab from the single-use needle and screw it onto the pre-filled insulin pen... 17. Wipe insulin pen off before storing with a 10% bleach disposable cloth and return the pen to medication cart or designated storage area...."</p> <p>3.1-18(j)</p>		<p>Upon review it was determined that the policy was different than the manufacturer guidelines for sanitizing of the insulin pen prior to administration. The DNS reviewed the manufacturer guidelines with the medical director and the facility adopted the established manufacturer guidelines for sanitation.</p> <p>The SDC/designee will in-service the licensed nurses of the manufacturer's guidelines for proper sanitization of the insulin pen prior to administration. The SDC/designee will complete two insulin administration observations daily, five days a week x 3 months or until compliance has been determined.</p> <p>4. The DNS will audit the insulin pen administration observations for any trends as a facility or with any particular nurse that would require additional training and education. The results of these audits will be presented to the Performance Improvement Committee monthly. The Committee will determine when substantial compliance has been met.</p>		

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

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