

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 05/18/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
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F0000	<p>This visit was for the Investigation of Complaint IN00107690 .</p> <p>Complaint IN00107690 - Substantiated. Federal/state deficiencies related to the allegations are cited at F309, F323, F514 and F516.</p> <p>Survey dates: May 17 and 18, 2012</p> <p>Facility number: 010613 Provider number: 155659 AIM number: 200221040</p> <p>Survey team: Jennie Bartelt, RN, TC Donna Groan, RN (May 18, 2012) Avona Connell, RN (May 18, 2012)</p> <p>Census bed type: SNF: 19 SNF/NF: 70 Total: 89</p> <p>Census payor type: Medicare: 41 Medicaid: 33 Other: 15 Total: 89</p> <p>Sample: 11</p>	F0000	<p>This Plan of correction is the center's credible allegation of compliance. 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>	

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

TITLE

(X6) DATE

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

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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on May 24, 2012 by Bev Faulkner, RN</p>			

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F0309 SS=D	<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, record review, and interview, the facility failed to ensure a non-pressure wound was assessed and orders for treatment were obtained for 1 of 3 residents reviewed related to wounds in a sample of 11 residents. (Resident E)</p> <p>Findings include:</p> <p>The clinical record for Resident E was reviewed on 5/17/12 at 3:15 p.m. The resident's diagnoses included, but were not limited to, paraplegia and diabetes. The resident received care weekly at a local wound care center.</p> <p>The Treatment Record for May 2012 indicated the resident had four wounds requiring dressing changes: right Achilles, left and right lateral feet, and right heel.</p> <p>Observation of dressing changes for Resident E's foot and leg wounds was completed on 5/18/12 at 11:10 a.m. LPN #10 completed the dressing changes and</p>	F0309	It is the policy of this facility that each resident receive 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. Resident E had all wounds measured and treatment orders for each non-pressure area have been received and implemented. All residents with non-pressure areas have the potential to be affected. An audit of all residents' non-pressure areas for measurements and treatments has been completed. The SDC/designee will in-service all nurses on Non-Pressure Ulcer Prevention and Care (Attachment B) with emphasis on measuring and receiving treatment orders for each area. The DNS/Designee will complete rounds (Attachment A) to verify non-pressure areas have measurements and treatment orders on 10 residents a week for 30 days, then 5 residents a week for 30 days then on 3 residents a week for 30	06/04/2012			

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	<p>the Director of Nursing (DON) and RN #5 assisted with positioning. During the dressing change to the right Achilles, a fifth wound was observed, located superior to the wound being dressed. The wound was round, about the size of a nickel, and appeared soft and yellowish. During interview at this time, LPN #10 indicated she had observed the wound at the last dressing change (5/16/12), and she did not know if the wound was being followed at the wound care center. She indicated she had not been dressing the wound, except to cover it with the film used to adhere the sponge for the wound vac system to the resident's right heel wound. The DON indicated the physician should be called for wound care orders and that a gauze sponge should be placed on the wound under the film, until the physician's orders were received. The DON indicated, "Let's get measurements," and as she measured the wound, she indicated it measured 1.8 cm by 1.2 cm, length by width.</p> <p>During interview on 5/18/12 at 11:30 a.m., the DON indicated the wound appeared to be covered with slough, and, "it looks like it needs debridement to me." She indicated she had spoken with the wound care center staff and had been told the staff was concerned about the area on 5/7/12, and it had just opened this week.</p>		<p>days. All findings will be reviewed in the PI monthly meeting until 100% compliance is achieved. The DNS will be responsible to ensure compliance with this standard</p>				

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	<p>She indicated on 5/14/12 the wound care center had decided to begin painting the area with Betadine. She indicated the information had not been communicated as an order to the facility. The DON also indicated she thought the wound was a venous wound.</p> <p>During interview on 5/18/12 at 7:20 p.m., the DON indicated wound assessment documentation had been completed for the wound, and physician's orders for care had been obtained and would be started the following day. She provided a Weekly Non-pressure Skin Condition Report, dated 5/18/12, indicating a wound to the "right outer ankle" with the description, "Area is located right below the ankle. Area was noted at wound care center on 5/14/12." The wound was described as a "Diabetic Neuropathic Ulcer" with length by width by depth of 1.8 X 1.2 X 0.1 cm with partial thickness skin loss, yellow/tan color, no exudate, no odor, and no signs and symptoms of infection. The Summary of Care and Treatment of Wound section indicated, "Area was noted on visit to wound care center. Treatment obtained on this date and initiated on this day. Family and res [resident] notified of new orders." The DON also provided a copy of the physician's order, dated 5/18/12, for, "Cleanse area to rt [right] outer ankle area</p>			

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	[symbol for with] NS [normal saline], pat dry, apply Betadine et [and] cover [symbol for with] bordergauze [sic] qd [every day]." 3.1-37(a)			

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F0323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Based on observation, record review, and interview, the facility failed to ensure staff supervision was increased to prevent falls for 1 of 4 residents reviewed related to multiple falls in a sample of 11. (Resident C)</p> <p>Findings include:</p> <p>Review of the clinical record for Resident C was completed on 5/18/12 at 4:45 p.m. The resident was admitted 3/26/12.</p> <p>The care plan, dated 3/27/12, indicated, "Focus: [Name of resident] has had falls r/t [related to] unsteady gait, dementia, inability to follow safety interventions." Interventions, dated 3/27/12, indicated the call light was to be in reach, the room well lit and uncluttered, physical therapy consulted, cognition and safety awareness monitored, and assistance provided with all mobility and ambulation.</p> <p>Nursing Progress Notes on 3/30/12 at 1:30 p.m., indicated, "This nurse heard res [resident] call out for help...found res</p>	F0323	<p>It is the policy of this facility to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Resident C was discharged home from facility. All residents with the potential to fall are at risk. Implementation of fall interventions according to the needs of each individual resident from the outcomes of the fall risk assessment, and nursing assessment has been initiated and will be revised as necessary.</p> <p>Fall intervention rounds were initiated twice daily by the IDT for validation of interventions and communication with floor staff of interventions. All nursing staff will be in-serviced on the Policy and Procedures for Accidents and Supervision to Prevent Accidents. (Attachment C) In the daily IDT morning meeting fall intervention rounds will be reviewed, this will continue to be an ongoing practice of the facility for 3 months. The DNS will review the audits and analysis of accidents in monthly PI meeting until 100% compliance is</p>	06/04/2012	

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	<p>sitting in bathroom floor in front of toilet....Stated she lost her balance and fell hitting head on wall. Also states she hit right knee on floor....Assisted to toilet by two staff. Res wearing rubber sole shoes...No w/c [wheel chair] or walker with res. in bathroom...Res placed on two hour toileting schedule. Call light in reach alert able to voice needs...."</p> <p>Interventions on the care plan for falls, dated 4/1/12, indicated next to "assist with all mobility, ambulation--4/1/2012 - now made supervision." An intervention, dated 4/2/12, indicated the toileting program was every two hours and as needed.</p> <p>Nursing Progress Notes on 4/4/12 at 4:04 a.m., indicated, "Res found at 0345 [3:45 a.m.] in doorway to restroom in her room by CNA that notified this nurse. Res. was sitting on her bottom with her feet out in front of her...Res. alert and able to voice needs. Res was not wearing shoes and stated her feet slid out from under her. Res. stated she was going to the bathroom. Urine was on the floor were [sic] she fell....New order for pull tab alarm written. Call light in reach."</p> <p>Interventions on the care plan for falls, dated 4/4/12, indicated, "Pull tab alarm to be in place while pt [patient] is in bed as</p>		<p>achieved or the PI committee determines compliance after 3 months of review. Any resident falls will be reviewed in the daily IDT morning meeting for appropriate interventions, this is an ongoing practice. The DNS will be responsible to ensure compliance with this standard.</p>				

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	<p>reminder to call for assist to BR [bathroom]; Keep walker w/i [within] reach of bed; Monitor that she has non-skid socks on in bed. Check frequently as she may remove them."</p> <p>Nursing Progress Notes on 4/13/12 at 8:27 a.m., indicated, "@0553 [5:53 a.m.] Pt [patient]was found in bathroom on floor. LPN found pt. She was sitting in front of toilet, legs extended, back against wall. No s/s [signs and symptoms] of acute distress. Pt said she lost her balance near toilet. Her right shoulder scraped toilet paper holder leaving small skin tear on right scapula...." Documentation failed to indicate if the tab alarm was sounding.</p> <p>The Post Fall Evaluation, Part I, dated 4/13/12 at 7:19 a.m., indicated with check marks, "Interventions in Place at Time of Fall" were the call bell in place and low bed. No check mark was next to: "Alarm."</p> <p>During interview on 5/18/12 at 7:15 p.m., the District Director of Clinical Operations indicated she could not determine if the resident's alarm was sounding at the time of the fall.</p> <p>Interventions on the care plan for falls, dated 4/13/12, indicated, "Anticipate res Am [morning] care routine. CNA to</p>			

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	<p>assist res upon waking approximately 5:00 - 5:30 a.m., with ADLs [activities of daily living]." An intervention, dated 4/17/12, indicated, "4/13/12 start to try to anticipate her needs by getting her up and toileting between 5 and 5:30 q [every] AM and assisting her with AM care and ADLs."</p> <p>Nursing Progress Notes on 4/20/12 at 6:07 p.m., indicated, "Pt was found by aid [sic] in room sitting on floor with feet straight out in front of body....Pt stated, 'I was turning around with the walker and just done [sic] it to [sic] fast...."</p> <p>Interventions on the care plan for falls, dated 4/20/12, indicated, "Educate Pt to slow down when ambulating."</p> <p>Nursing Progress Notes on 4/30/12 at 1:00 p.m., indicated, "Res found in bathroom in front of toilet in bathroom. Walker in front of res....States she lost her balance when pulling down pants in attempt to go to bathroom. Wearing rubber sole shoes. Right knee red blanchable....Res currently on 2 hour toileting schedule. Was toileted @ 11:30 prior to lunch. Pathway clear in bathroom no objects in res' path....Res assisted to toilet from floor by two staff members...." Nursing Progress Notes indicated the resident was sent to the emergency room</p>						

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	<p>for x-rays and CT (computerized tomography) of the head upon family request.</p> <p>Interventions on the care plan for falls, dated 5/1/12, indicated, "Motion sensor alarm in BR to alert staff when resident goes in BR."</p> <p>A physician's order, dated 5/1/12, indicated, "Discharge home per family request."</p> <p>This federal tag relates to Complaint IN00107690.</p> <p>3.1-45(a)(2)</p>			

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F0514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on interview and record review, the facility failed to ensure documentation in the clinical record was complete for 1 of 11 residents reviewed related to clinical records in a sample of 11. (Resident H)</p> <p>Findings include:</p> <p>During interview completed on 5/17/12 at 5:20 p.m., Resident H indicated he was a paraplegic due to an injury in an automobile accident several years earlier. He indicated he had recently been in the hospital due to a bleeding ulcer and pneumonia, and had come to the facility for rehab since he had lost strength during his hospitalization. He indicated prior to hospitalization, he had been able to lift himself from wheel chair to bed without assistance. He indicated he had not been at the facility too long when the shower</p>	F0514	<p>It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Resident H was not harmed. The shower stretcher has been replaced. MD notified of event and an assessment was completed per staff nurse without findings of resident H. All residents with an event requiring documentation of assessment will be reviewed in the a.m. IDT meeting for appropriate assessment and documentation. The SDC/Designee completed in servicing with nursing staff on Documenting in a Patient's Medical Record (Attachment D) with emphasis on any event or occurrence. The DNS/designee will review events daily in morning</p>	06/04/2012			

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	<p>stretcher broke. Resident H described the incident as follows: At least one aide, whose name he could not remember, or maybe two aides, but he was not sure about it, were in the room when he was ready to transfer himself from the shower stretcher into bed. Two nursing students were also in the room observing care at the time. He indicated he was transferring himself from the stretcher into the bed, and as he pushed down on the PVC pipe frame of the shower stretcher to lift himself from the shower stretcher over onto the bed, he heard the PVC pipe cracking and breaking. He indicated he was able to maneuver himself by rolling over onto the bed to avoid falling onto the floor. He indicated the incident scared him, and he was glad the facility had a new, sturdier shower stretcher. He indicated he was glad he did not fall to the floor, since the broken PVC pipe could have stabbed into his body.</p> <p>The clinical record for Resident H was reviewed on 5/18/12 at 4:00 p.m. The record indicated the resident was admitted to the facility on 4/18/12. No documentation in the record indicated any information about the incident or of an assessment of the resident following the incident.</p>		<p>meeting. Follow up investigations will be completed (Attachment E) and documentation audited for accuracy and completeness five times a week for 30 days, then 3 times a week for 30 days, then 1 time a week for 30 days. The results of audits will be reviewed in the monthly PI meeting for 100% compliance in documentation for 3 months. The DNS will be responsible to ensure compliance with this standard.</p>				

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	<p>During the Exit Conference on 5/18/12 at 7:45 p.m., the District Director of Clinical Operations (DDCO) indicated she had been able to determine who Resident H's nurse was when the shower stretcher broke. The DDCO indicated she had spoken with the nurse who told her she had talked with the resident after the incident, and the resident said he was okay, and no assessment was completed. The DDCO indicated the nurse did not document any information related to the interaction with the resident.</p> <p>This federal tag relates to Complaint IN00107690.</p> <p>3.1-50(a)(1)</p>			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
F0516 SS=E	<p>483.75(l)(3), 483.20(f)(5) RELEASE RES INFO, SAFEGUARD CLINICAL RECORDS A facility may not release information that is resident-identifiable to the public.</p> <p>The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>The facility must safeguard clinical record information against loss, destruction, or unauthorized use.</p> <p>Based on observation, record review, and interview, the facility failed to ensure records were stored to avoid potential water damage from overhead sprinklers for 1 of 1 medical records storage room observed. The deficient practice had the potential to affect current residents whose clinical records had been thinned into overflow files, and residents discharged in the last six months whose discharge records were not safe from potential water damage.</p> <p>Findings include:</p> <p>On 5/17/12 at 12:25 p.m., the Medical Records Office was observed in the accompaniment of the Medical Records Clerk. During the observation, the Administrator entered the Medical Records Office. Lateral metal file</p>	F0516	<p>It is the policy of this facility to safeguard clinical record information against loss, destruction or unauthorized use. All recently discharged records in the process of being broken down have been moved to either file boxes, metal file cabinets or metal file shelves. All completed discharge records have been filed in metal file cabinets. All overflow records have been field in metal file cabinets and/or boxes. The Medical Records Clerk has been in-serviced on the policy and procedure for Medical Records Storage Areas. (Attachment F) The Executive Director will check the medical records storage area twice a week for 90 days to ensure records are stored properly. (Attachment G) The results will be reviewed in the monthly PI meeting. The Executive Director will be</p>	06/04/2012			

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	<p>cabinets were observed along one wall of the room. During interview at this time, the Medical Records Clerk indicated the lateral file cabinets contained medical records of discharged residents, and that every six months medical records of discharged residents are sent from the facility to the facility's storage company. She indicated that soon the discharged records for January through June 2011 would be removed from the cabinets and sent to the storage company.</p> <p>Also observed in the room was a table with thirteen stacks of file folders. On top of each stack was a paper with a handwritten list of names. The Medical Records Clerk indicated these file folders were records of discharged residents and would be placed in the lateral metal file cabinets after the January through June 2011 discharged records were sent out. On another table were observed stacks of file folders, which the Medical Records Clerk indicated were overflow records for current residents at the facility. On a cart were observed stacks of file folders, which the Medical Records Clerk indicated were records of the most recently discharged residents, whose records she was still gathering documentation into.</p> <p>Nozzles of the facility's sprinkler system</p>		responsible to ensure compliance with this standard.	

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	<p>were observed overhead in the room above the tables with stacks of records.</p> <p>The facility's policy related to Medical Records Storage Areas was provided on the work table on 5/18/12 at 8:30 a.m. Review of the policy indicated the following in the section on Storage Rooms, "...9. The storage room environment should not cause damage to the records and documents (such as moisture or rodents)." The Section on Storage Boxes indicated, "11. Storage boxes may be used to store inactive discharge records and other resident-specific documents. It is optimal to use metal files or cabinets although storage boxes are acceptable....13. Storage boxes purchased should be of adequate quality and durability for record/document storage purposes...."</p> <p>This federal tag relates to Complaint IN00107690.</p> <p>3.1-50(d)</p>						