STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/12/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD	101 POTTERS LN CLARKSVILLE, IN 47129

(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
F000000	This visit was for a Recertification and State Licensure survey. Survey Dates: November 5, 6, 7, 10, 11, and 12, 2014. Facility number: 000166 Provider number: 155265 AIM number: 100267080 Survey team: Gloria J. Reisert, MSW/TC (11/5, 11/6, 11/7, 11/10, and 11/12/14) Jenny Sartell, RN (11/5, 11/6, 11/7, 11/10, and 11/12/14) Joshua Emily, RN Trudy Lytle, RN (11/6, 11/7, 11/10, and 11/12/14) Gwen Pumphrey, RN (11/6, 11/7, 11/10, 11/11 and 11/12/14) Census bed type: SNF: 10 SNF/NF: 97 Total: 107 Census payor type: Medicare: 15 Medicaid: 68 Other: 24 Total: 107	F000000	Please accept this plan of correction as the center's credible allegation of compliance. Preparation and/or executions of this plan of correction does not constitute admsission 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. Please note this facility respectfully requests paper compliance review for this survey.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on November 17, 2014 by Randy Fry RN.			
F000328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. Based on observation, interview, and record review the facility failed to ensure residents receiving breathing treatments were accurately assessed. This deficient practice affected two of two residents observed for breathing treatments. (Resident #99 and Resident #23). Findings include: 1. On 11/11/14 at 12:08 a.m., LPN #3 was observed administering medications to Resident #99. LPN #3 entered the residents room, set up nebulizer for the	F000328	Facility respectfully requests a paper compliance review for this survey.1. Resident # 99 and Resident # 23 will be evaluated by NP on 11/21/14.2. All Residents who recieve nebulizer therapy have the potential to be affected.. An in-service will be provided for all licensed nurses on Nebulizer Therapy.3. Nebulizer Therapy instructions will be added to MAR and requirements to document.4. Monitoring will be done 5 times a week for 30 days, then 3 times a week for 30 days, then weekly for 30 days by	12/05/2014

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	treatment, and began to administer the medication. She asked the resident "Have you had any shortness of air?" She then left the room and indicated the resident was able to self administer the breathing treatment. On 11/11/14 at 12:10 a.m., the Medication Administration Record [MAR] for November 2014 was reviewed. The MAR lacked documentation of an assessment of pre and post assessments for the breathing treatment. On 11/11/14 at 12:15 a.m., LPN #3 indicated residents receiving a breathing treatment should be assessed by listening to lung sounds and asking if the resident had any issues with breathing. Then LPN #3 indicated she would assess Resident #99. After entering Resident #99's room, LPN #3 asked the resident how he was tolerating the treatment and left the room. When asked where the assessment would be documented, she reviewed the MAR and indicated, ,"I don't see where we document on the MAR. I'm not sure." 2. On 11/11/14 at 12:13 p.m., LPN #3 entered Resident #23's room to		DNS/Designee to ensure compliance. Results will be reported monthly to Performance Improvement Committee. As an ongoing practice nebulizer therapy will be monitored monthly as a part of the facility performance improvement program. 5. Date of completion 12/5/14	

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	administer medications by mouth. Resident #23 was observed to be self administering a breathing treatment. LPN #3 indicated the resident had a physician order to self administer the breathing treatment. On 11/11/14 at 12:14 a.m., the Medication Administration Record [MAR] for November 2014 was reviewed. The MAR lacked documentation of an assessment of pre and post assessments for the breathing treatment. On 11/12/14 at 7:52 a.m., the Director of Nursing Services [DNS] was interviewed. She indicated residents should be assessed before and after administration of a breathing treatment. She indicated the facility previously documented on the MAR and she was unaware the documentation was not available. She indicated all residents receiving breathing treatments would have the documentation added to their MAR so nurses could document pre and post treatment assessments. A copy of the policy titled, "Nebulizer Therapy" was provided by the DNS ON 11/12/1/4 at 7:53 a.m. The policy indicated,"... 8. Assess patient's breath sounds, respiratory rate, and heart rate			

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	prior to initiating therapy. 19. Assess therapy for efficacy noting breath sounds, respiratory rate and heart rate post treatment." 3.1-47(a)(6)			
F000329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Based on interview and record review, the facility failed to implement behavior monitoring and response to anti-anxiety and anti-depressant medication increases	F000329	Facility respectfully requests paper compliance review for this survey.1. Resident # 73 was evaluated by Psych services and NP on 11/20/14.2.	12/05/2014

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	for 1 of 5 resident's reviewed for unnecessary medications. (Resident #73) Findings include: The Clinical Record for Resident #73 was reviewed on 11/10/14 at 11:30 a.m. Diagnoses included, but were not limited to depression and anxiety. The Minimum Data Set quarterly assessment, dated 8/29/14, was reviewed on 11/10/14 at 11:16 a.m. It indicated Resident #73 had the following: Feeling down, depressed, or hopeless, 7-11 days; Poor appetite or overeating, 12-14 days; Feeling tired or having little energy, 7-11 days; Feeling bad about yourself-or that you are a failure or have let yourself or your family down, 7-11 days. It also indicated no behaviors. The Careplan for Resident #73 was reviewed on 11/10/14 at 1:15 p.m. It included, but was not limited to the following: "Focus...(resident name) has the potential for altered mood secondary to depression, and anxiety; thoughts of being better off dead-no SI (suicidal ideation), and loss of husband. Requires use of psychoactive meds (medicine)...Goals...(resident name) will not exhibit S/S (signs/symptoms) of depression/anxiety and will actively		all residents on psychoactive medication have the potential to be affected. In-service education on psychoactive medication will be conducted for all licensed nurses.3. Systemic changes will include implementation of a behavior monitoring log for all residents recieving psyco-active medications.4. Audits will be completed 5 times weekly for 30 days, then 3 times weekly for 30 days, then weekly for 30 days. Audits will then be conducted monthly as a part of the facility performance improvement plan. Results will be reported monthly to Facility Performance Improvement Committee.5. Date of Completion 12-5-14	

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	participate in tx (treatment) plan...Interventions...Monitor for side effects...Monitor and report mood/behavior changes or decline...". The Physician's Order, dated 8/18/14 at 5:00 p.m., indicated to increase Ativan (anti-anxiety medication) to 0.5 mg (milligrams) po (by mouth) BID (twice a day) for anxiety. The Physician's Order, dated 9/17/14 at 2:00 p.m., indicated to increase Lexapro (anti-depressant) to 20 mg QAM (every morning). The Nurses Notes were reviewed from 8/18/14 through 11/6/14 and lacked documentation regarding Resident #73's response to the change in medication. During an interview with Medical Records on 11/10/14 at 2:00 p.m., she indicated there was not a Behavior Monitoring Flowsheet for Resident #73. During an interview with the Social Services Director on 11/12/14 at 8:46 a.m., she indicated that depression, at times, was not considered a behavior per say. On 11/12/14 at 10:30 a.m., review of the document titled Monthly Behavior			

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	Monitoring Flowsheet included, but was not limited to the following: "...Individual Behavior and Possible Side Effects Code Key...Applicable to: ...Antipsychotic...Antianxiety...Antidepressant..." The Policy and Procedure, dated 8/31/12, was provided by the Director of Nursing on 11/10/14 at 2:30 p.m. It included, but was not limited to the following: :Psychoactive Drug Use...Medical Symptom: An indication or characteristic of a physical or psychological condition...Procedure...5. Implement a behavior monitoring log or similar mechanisms to document need for and response to drug therapy...Documentation Guidelines...4. Document evaluation of patient response to psychoactive drug, effectiveness of psychoactive drug...". On 11/12/14 at 11:00 a.m., during an interview with the Director of Nursing, she indicated anti-depressants and anti-anxiety medications fall under the policy and procedures for psychoactive drug use. 3.1-48(a)(3) 3.1-48(a)(4)			

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F000371 SS=E	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, facility staff failed to use proper hand washing hygiene, label open and not completely used food products and drinks, store food at least six inches off the floor, store food from only approved sources in the kitchen, follow recommendations indicated on food products for storage location, and store residents ice serving containers and serving cart in a location to prevent cross contamination. This deficient practice had the potential to affect 104 of 107 residents receiving meals from the kitchen. Findings include: During the Brief Kitchen Sanitation Tour, with Dietary Aid #1, on 11/05/14 at 9:12 a.m., the following was observed: 1. There were cinnamon rolls being stored in an undated zip lock bag in the	F000371	Facility respectfully requests paper compliance review for this survey1. No specific resident identified.2. All residents have the potential to be affected. The cinnamon rolls had been used for morning meal and was immediately dated as such. The bag of potatoes was immediately picked up and stored properly, box of potato pearls, whipped topping, water bottle, trays of poured drinks, and jelly was immediately discarded. the styrofoam cup was also removed and discarded. The serving cart and ice containers was re-washed prior to use and the serving cart was relocated away from paper towel dispenser.3. In-service education will be provided to all Dietary Staff on Storage of Food and Proper Handwashing.4. Executive Director/designee will conduct daily rounds Monday through Friday to ensure food is stored properly and handwashing procedure is being followed for 30 days. Rounds will then be	12/05/2014

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	freezer. 2. There was an open, half used bag of potatoes stored directly on the floor in the dry food storage room. 3. There was an opened box of potato pearls in the dry storage room with no date indicating when the box was opened. 4. There was a half empty employee ' s bottle of water, stored on the top shelf, of the walk-in refrigerator next to an opened and undated bag of whipped topping. 5. There was an opened, half used, large jar of concord grape jelly being stored on the shelf. The label on the jar indicated that after opening it should be stored in the refrigerator. The date on the jar indicated it was opened on 10/3/2014. 6. On a two tiered metal food cart, there was an employee's half full styrofoam cup with red lipstick around the rim of the cup, being stored on the bottom shelf. There was no lid covering the styrofoam cup. On the top shelf above the Styrofoam cup, was a steam table pan of carrots, and another steam table pan of gravy, which was to be served to the residents. 7. In the reach-in refrigerator, there were		conducted weekly by Executive Director/designee as an ongoing practice with results being reported to the facility Performance Improvement Committee monthly.	

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	two trays of various types of poured drinks in cups, which were undated. The cups were sealed in plastic wrap. The two trays of cups were on top of one another on a shelf. 8. Directly underneath the paper towel dispenser at the hand washing station, on a serving cart, were two ice containers inside one another, which were to be used for the lunch service. There were two ice scoops inside of the ice containers. Also on the cart were three pitchers of various drinks that were to be served to the residents. The pitchers were sealed in plastic wrap. The staff were using the paper towel dispenser while washing their hands. Their hands were wet and dripping onto the serving cart and ice containers. An interview with the Dietary Aid # 1 at the time of the kitchen tour, indicated the concord grape jelly had been on the shelf since it was opened on 10/3/2014. She indicated the half empty bottle of water stored in the walk-in refrigerator was an employees and it should not be in the walk in refrigerator. She indicated the half empty styrofoam cup being stored on the two tiered shelf, was Cook #7's and should not have been there. She indicated the undated cups of various liquids being stored in the reach-in			

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	refrigerator were left over drinks from that morning and the prior evening's meal services. She indicated this was her best guess of when the drinks had been poured but was unsure. She indicated the cups should have been dated. She indicated the cinnamon rolls kept in the zip lock bag stored in the freezer should have had an open date on the bag. She also indicated that the ice containers and serving cart, directly underneath paper towel dispenser, were to be used for the lunch time meal service that day. During a follow up observation in the kitchen on 11/12/2014 beginning at 10:00 a.m., the following was observed: 1. At 10:00 a.m., Dietary Aid #2 was observed to wash her hands for ten seconds, and when reaching towards the paper towel dispenser, she put her dripping wet hands over the serving cart and ice containers that were to be served to the residents. 2. At 11:30 a.m., Dietary Aid #2 was observed to wash her hands for seven seconds, and when reaching towards the paper towel dispenser, she put her dripping wet hands over the serving cart and ice containers that were to be served to the residents.			

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	3. At 11:45 a.m., Dietary Manager #3 was observed to wash her hands, and when reaching towards the paper towel dispenser, she put her dripping wet hands over the serving cart and ice containers that were to be served to the residents. 4. At 11:47 a.m., Dietary Manager #4 was observed to wash her hands, and when reaching towards the paper towel dispenser, she put her dripping wet hands over the serving cart and ice containers that were to be served to the residents. 5. At 11:53 a.m., the Assistant Dietary Manager #5 was observed to wash her hands, and when reaching towards the paper towel dispenser, she put her dripping wet hands over the serving cart and ice containers that were to be served to the residents. 6. At 11:53 a.m., Dietary Manager #4 was observed to wash her hands, and when reaching towards the paper towel dispenser, she put her dripping wet hands over the serving cart and ice containers that were to be served to the residents. During an interview on 11/10/14 at 10:09 a.m., the Assistant Dietary Manager #5 confirmed all the above issues. The Assistant Dietary Manager #5 indicated no clean kitchen items, or the serving cart			

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	should have been placed under the paper towel dispenser at the hand washing station in the kitchen. She indicated the improper placement of the serving cart and ice containers, under the paper towel dispenser could have led to cross contamination and was unsanitary. She indicated employee drinks should only be stored in the office or the break room. She indicated cups without lids should not be stored on the kitchen floor. She indicated all food opened and kept for later use should have an open date on package. She indicated all food should be kept six inches off the floor. She indicated once a jelly jar had been opened it should be stored in the refrigerator, and all food should be stored according to the label on the package. Dietary Manager #4 and the Reserve Director for (the facility) were present during the interview and confirmed the above issues. During an interview on 11/10/14 at 10:58 a.m., Cook #7 indicated hands should be washed for sixteen seconds. The policy and procedure dated 02/28/2014 and titled, " Personal Hygiene and Handling Food, " was provided by the Administrator on 11/12/2014 at 10:14 a.m. The policy indicated, beverages in covered cups with			

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	straws may be allowed in designated areas away from food preparation. The policy and procedure dated 08/31/2014 and titled, " Food and Supply Storage, " was provided by the Administrator on 11/10/2014 at 11:50 a.m. The policy indicated, food should be stored six inches off the floor. The policy also indicated food from non-approved sources should not be stored in the kitchen, such as staff food, or food brought by families. The policy also indicated food products that are opened and not completely used or prepared at the facility and stored, should be labeled as to its contents and used by dates. The policy indicated the facility should follow recommendations when indicated on the product for storage time and storage location. The policy and procedure dated 08/31/2011 and titled, " Hand Hygiene/Handwashing, " was provided by the Administrator on 11/12/2014 at 8:43 a.m. The policy indicated, while washing hands, the hands should be rubbed together with vigorous friction for 20 seconds or the amount of time it takes to sing " Happy Birthday " through twice. 3.1-21(i)(3)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155265	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 11/12/2014
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-WEDGEWOOD		STREET ADDRESS, CITY, STATE, ZIP CODE 101 POTTERS LN CLARKSVILLE, IN 47129	

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