

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 09/18/2015
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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 Complaints IN00181773 and IN00181885.</p> <p>Complaint IN00181773 - Substantiated. Federal/State deficiencies related to the allegations are cited at F333.</p> <p>Complaint IN00181885 - Substantiated. Federal/State deficiencies related to the allegations are cited at F282.</p> <p>Survey dates: September 17 and 18, 2015</p> <p>Facility number : 000058 Provider number: 155133 AIM number: 100283340</p> <p>Census bed type: SNF/NF: 141 Total: 141</p> <p>Census payor type: Medicare: 18 Medicaid: 103 Other: 20 Total: 141</p> <p>Sample: 5</p>	F 0000	<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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F 0282 SS=D Bldg. 00	<p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR was completed by 34849 on September 24, 2015.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on interview and record review, the facility failed to ensure physician's orders were followed, as written, related to treatment of pressure ulcers for 1 of 6 residents reviewed for physician orders. (Resident #E)</p> <p>Findings include:</p> <p>The closed clinical record for Resident #E was reviewed on 09/17/2015 at 1:15 P.M. The MAR (Medication Administration Record)/TAR (Treatment Administration Record) was to be initialed by a nurse each time a treatment or medication was given.</p>	F 0282	<p>It is the practice of the facility to provide or arrange by the facility, a qualified person in accordance with each resident's written plan of care</p> <p>Resident #E no longer resides at the facility. Those residents with written physician treatment orders have the potential to be affected by the alleged deficient practice. Systemic changes that have been implemented to correct the alleged deficient practice are re-education of the licensed nursing staff on the importance of accurate and thorough documentation of treatments rendered. The licensed nursing staff have been educated to complete a peer-to-peer TAR audit at shift change. The</p>	10/06/2015

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	<p>Resident #E's MAR/TAR for July, 2015 indicated:</p> <ol style="list-style-type: none"> The physician's order for skin prep, which was to be applied to a suspected deep tissue injury on the right heel each shift, was not signed off in the TAR by staff on July 17 and 22 on the 7:00 P.M. to 7:00 A.M. shift and on July 20, 25, and 26 of the 7:00 A.M. to 7:00 P.M. shift. The physician's order for skin prep, which was to be applied to a suspected deep tissue injury on the left heel each shift, was not signed off in the TAR by staff on July 17 and 22 on the 7:00 P.M. to 7:00 A.M. shift and on July 20, 25, and 26 of the 7:00 A.M. to 7:00 P.M. shift. The physician's order to cleanse the right heel with normal saline and paint (apply to area) with betadine, which was to be done each shift, was not signed off in the TAR by staff on July 30 and 31 on the 7:00 A.M. to 7:00 P.M. shift. The physician's order to cleanse the left heel with normal saline and paint with betadine, which was to be done each shift, was not signed off in the TAR by staff on July 30 and 31 on the 7:00 A.M. to 7:00 P.M. shift. <p>The MAR/TAR for August, 2015</p>		<p>unitmanager/designee will audit the TAR records daily for 5 of 7 days per week for 60 days and then 3 of 7 days for 90 days then weekly indefinitely. Any nurse that continues to be non-compliant with documentation requirements will be addressed through the Performance Improvement process. The DNS is responsible for oversight of this plan of correction. The DNS will review the audits for any trends or additional education needs. The results of these audits will be reviewed at the monthly Performance Improvement committee indefinitely.</p>				

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	<p>indicated:</p> <p>5. The order to cleanse the right heel with normal saline and paint with betadine, which was to be done each shift, was not signed off in the TAR by staff on August 1 and 2 on the 7:00 A.M. to 7:00 P.M. shift.</p> <p>6. The order to cleanse the left heel with normal saline and paint with betadine, which was to be done each shift, was not signed off in the TAR by staff on August 1 and 2 on the 7:00 A.M. to 7:00 P.M. shift.</p> <p>During an interview on 09/18/2015 at 11:35 A.M., a family member of Resident #E indicated the resident was not receiving the scheduled treatments for her pressure ulcers.</p> <p>During an interview on 09/18/2015 at 2:23 P.M., CNA (Certified Nursing Assistant) #1 indicated Resident #E had skin issues during her stay in the facility and was supposed to get treatments, as well as, have her heels floated (elevated on a pillow).</p> <p>3.1-35(g)(1)</p>			

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F 0333 SS=G Bldg. 00	<p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to ensure a prescribed medication (Flomax) was administered, as ordered by the physician, for 1 of 5 residents reviewed for medications (Resident #B). This deficient practice resulted in Resident #B having to be rescheduled for a cystoscope and voiding trial and continue with a Foley catheter (urinary catheter) longer than planned, requiring surgical intervention related to complications from the Foley catheter.</p> <p>Findings include:</p> <p>Resident #B's closed, clinical record was reviewed on 09/17/2015 at 11:40 A.M. Diagnoses included, but were not limited to, hypertension, malignant neoplasm of the kidney, acquired absence of kidney, and urinary retention.</p> <p>Review of the office note from Urologist #2, dated 07/06/2015, indicated Resident #B was diagnosed with benign prostatic hyperplasia(BPH) with obstruction, acute cystitis, and kidney cancer with a note to start Flomax 0.4 milligram (mg) by mouth.</p>	F 0333	<p>It is the practice of the facility to ensure that residents are free of any significant medication errors Resident # B is currently receiving all of the correct medications per the physician orders. Resident #B is still under the supervision of the urologist. All residents with written physician medication orders have the potential to be affected by the alleged deficient practice. Systemic changes have been implemented to correct the alleged deficient practice. The unit managers have had re-education to request a reprint of a resident's physician order recapitulation of orders upon return from the hospital if the resident re-admits at the end of the month after the pharmacy has already provided the facility with the resident's orders for the end of month review process. The process of two nurse verification of admission/re-admission physician orders will continue with a third review by nurse management to verify all medications are transcribed as ordered. Any nurse that continues to be non-compliant with documentation requirements will be addressed through the Performance Improvement</p>	10/06/2015			

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	<p>Review of Resident #B's hospital discharge instructions, dated 07/29/2015, indicated Resident #B was to continue the Flomax 0.4 mg by mouth every day.</p> <p>Review of Resident #B's "Admission orders Record", dated 07/29/2015, indicated the resident's medications, included but were not limited to, Flomax 0.4 mg daily at 9:00 P.M.</p> <p>Review of Resident #B's medication record indicated the resident did not receive the medication, Flomax 0.4 mg, from 08/01/2015 through 08/12/2015 and also on 08/24/2015.</p> <p>Review of the Urologist #2 office note, dated 08/13/2015, indicated Resident #B was an established patient, who was there for an enlarged prostate follow-up evaluation and "Pt (patient) isn't on Flomax due to error by NSP (nursing facility) after being discharged from the hospital, currently he is on watchful waiting for his lower urinary tract symptoms". The orders indicated urine culture and sensitivity and a CT of the abdomen and pelvis with and without IV contrast. The resident was scheduled for a return visit in two weeks for the cystoscope and voiding trial. The medication orders were to restart Flomax 0.4 mg by mouth at bed time.</p>		<p>process. The DNS/designee will randomly audit 5 physician orders per unit as applicable daily depending on volume of orders received. The DNS/designee will audit at a minimum of three admission/re-admission orders per week for accuracy. The DNS is responsible for oversight of this plan of correction. The DNS will review the audits for any trends or additional education needs. The results of these audits will be reviewed at the monthly Performance Improvement committee indefinitely.</p> <p>The facility disputes the facts in the 2567 regarding F 333.</p> <p>The events surrounding Resident B were as follows:</p> <p>Resident B is an 82 year old male who was admitted to our facility from an outside geriatric psychiatric facility (Facility F) on 6/4/2015. Resident B has pertinent diagnoses of Dementia with behavioral disturbance, anxiety, renal cell carcinoma with metastasis to aorta now in remission s/p left nephrectomy and open heart surgery, BPH, HTN. During his stay he had periods of increased anxiety which his daughter stated was out of character for him. On 6/21/15, it was noted that he had a distended bladder. An indwelling catheter was placed and a return of 2700 ml of urine was returned. The urine was</p>	

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	<p>Review of the letter written by the Urologist #2 , dated 08/28/2015, indicated the medication mistake for Resident #B, "created unnecessary confusion for everyone involved and the patient had to be rescheduled".</p> <p>Review of the Computed Tomography (CT), dated 09/11/2015 and compared to the CT dated 08/22/2015, indicated there was a radiopaque density compatible with a Foley catheter which was seen within the urinary bladder extending through the prostatic urethra and into the mid penile urethra. This was compatible with a fracture of the Foley catheter causing a retained foreign body. There was a second portion of the catheter within the urinary bladder.</p> <p>During an interview, on 09/17/2015 at 11:00 A.M., Urologist #2 indicated due to the medication Flomax not being given on 08/01/2015 through 08/12/15, the resident had to be sent back to the facility and transported on a later date. This delay caused the resident's catheter to be in place longer then originally planned. The Urologist #2 indicated Resident #B had complications related to the Foley Catheter and will require an open surgical procedure to remove two fractured, fragmented pieces of the Foley catheter</p>		<p>sent for urinalysis and wasfound with normal urinary flora. On6/22/15, a request was made for a urology consult due to retaining largeamounts of urine. Resident hadappointment with Urologist (Dr. S) scheduled for 7/6/2015.</p> <p>On 6/28/15, resident sustained several falls over a 24 hourperiod and was sent to the ER for evaluation after a hematoma to his foreheadand increased anxiety. Resident wasdiagnosed with a urinary tract infection was subsequently returned to thefacility and started on Cipro 500 mg by mouth twice daily for 14 days.</p> <p>On 7/6/2015, resident returned from appointment with Dr. Sand orders to start Flomax 0.4 mg were given and to return in 2 weeks forcystoscopy and voiding trial. The followup appointment was scheduled for 7/28/2015 per Dr. S office.</p> <p>On 7/28/2015 resident was sent to the ER for evaluationafter laboratory results were received showing the resident had a criticalhemoglobin of 6.3 and hematocrit of 19.3 with no obvious blood loss noted. He was admitted for observation overnight andreceived a transfusion of 2 units of packed red blood cells and returned to thefacility. During the recapulation ofResident B's monthly medication administration record, his order for Flomax0.4mg was not transcribed to the August medication record. Resident B was rescheduled for hisappointment with Dr. S while resident was in the hospital per his</p>		

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	<p>from the resident's urinary bladder and mid penile urethra.</p> <p>During an interview on 09/18/2015 at 10:56 A.M., the Director of Nursing (DON) indicated Resident #B's medication order for Flomax 0.4 mg, was not transferred onto the August medication administration record (MAR) from the July MAR, after Resident #B returned from the hospital.</p> <p>Admission Minimum Data Set (MDS) assessment, dated 06/11/2015, indicated a Brief Interview for Mental Status (BIMS) score of 99, indicating Resident #B was severely cognitively impaired. MDS assessment further indicated that Resident #B required extensive, one person physical assist for toileting. MDS assessment indicated Resident #B had no indwelling catheter.</p> <p>The 30 day Prospective Payment System MDS assessment, dated 07/02/2015, indicated a BIMS score of 99, indicating Resident #B was severally cognitively impaired. MDS assessment further indicated that Resident #B required extensive, two person physical assist for toileting. MDS assessment indicated Resident #B had an indwelling caterer.</p> <p>3.1-25(b)(9)</p>		<p>office. Resident B was to return to see Dr. S on 8/13/2015 for a cystoscopy and a voiding trial. On 8/13/2015, the Director of Nursing Services received a phone call from Dr. S expressing his frustration with the facility having "wasted histime" due to Resident B could not be seen to have the cystoscopy and voiding trial and would have to be rescheduled because it was determined that Resident B had missed his Flomax 0.4 mg from August 1, 2015 through August 12, 2015 due to the transcription error. The Director of Nursing Services transcribed orders received by Dr. S verbally to restart Flomax at 0.4mg by mouth x 1 when he returned from his appointment and then to continue Flomax 0.4mg by mouth nightly. Dr. S's medical assistant stated that there would be other orders sent with the resident for his voiding trial. Resident B returned to the facility with orders to start Flomax 0.8mg, CT of pelvis and abdomen with contrast and return to office in 2 weeks for cystoscopy and voiding trial. Resident B's appointment was rescheduled for 8/27/2015 per the office. Resident B had his CT completed on 8/22/15 which showed:</p> <p>1. Apparent diffuse bladder wall thickening and enhancement with mild surrounding inflammatory changes, suggestive of cystitis. Correlate with urinalysis. 2. Status post left radical nephrectomy 3. New mild right renal pelvicaliectasis 4. Unchanged 5cm</p>				

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	3.1-48(c)(2)		<p><i>simple rightrenal cyst.</i></p> <p>Resident returned from his appointment on 8/27/15 with nonew orders. However, Resident B did havea new indwelling catheter in. Nursing staff called Dr. S office forinstructions or orders with no return call until 9/2/15 when resident wasstarted on Ceftin 500 mg by mouth twice daily for 10 days. On 9/11/15, Resident B had pulled on his indwelling catheterand had it in his hand when the nurse examined the resident it was noted thatthe bulb was not intact on the end of the catheter and was thought to beretained in the resident's bladder. Theresident was sent to the ER and was confirmed by CT without contrast that: <i>1. There are two fragments compatible withfractured Foley catheters within the right urinary bladder and within the midpenile urethra to the urinary bladder. Urologic consultation would be recommended.</i> A 18 Fr coude catheterwas replaced in the resident's bladder in the ER and the ER physician afterconsulting with Dr. S stated he was to follow up on 9/18/15 for removal of thefragmented foley. 9/15/15 facility nurse called Dr. S office and inquiredabout when the appointment would be as we only had a date of 9/18/15 and theoffice stated that he had no new orders and his only order was to change hiscatheter monthly on the 27th and follow up in one year. On 9/15/15 Resident B's daughter contactedDr.</p>	

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			<p>S office and confirmed appointment for 9/18/15 at 1:00pm. On 9/15/15 Facility received orders to obtain urine specimen. Resident B's appointment was cancelled by Dr. S office on 9/17/15 with no reason given. On 9/19/15 resident was started on Bactrim DS by mouth twice daily for 7 days related to a urinary tract infection. On 9/23/15 resident's daughter was notified by Dr. S that the procedure was not going to be done due to resident currently has a urinary tract infection that he is being treated for. Resident still as of this date, October 2, 2015, does not have an appointment to have the catheter pieces removed from his bladder despite having a negative urinalysis on 9/28/15. Dr. S's office will not return calls to the facility regarding Resident B. The facility has spoke with Resident B's daughter and resident will be referred to a different urologist as soon as possible to consult regarding treatment.</p> <p>The events that led up to the incident where the resident pulled his catheter out and pieces of the catheter were retained in his bladder have no correlation to the 12 days of missed Flomax. Resident B has been on antibiotic therapy for treatment of his urinary tract infections since his admission and at least one documented occasion prior to his admission in May 2015 and up to October 1, 2015 eight (8) separate times with seven (7) different</p>	

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			antibiotics treating different bacteria. The resident was not able to have his indwelling catheter removed due to urinary retention after being on Flomax at double the dose theurologist had ordered initially. The catheter was replaced in Dr. S's office on 8/27/15 and the resident returned back to the facility with the expectation that he would follow up in one year. Therefore, it was determined that the resident could not have his indwelling catheter removed. The fact that Dr. S believed that the missed doses of Flomax caused harm to the resident was not discussed with the Director of Nursing Services nor the resident's daughter. The cause of the resident removing the catheter is his diagnosis of dementia. Resident B has accidentally removed his indwelling catheter on at least 6 separate occasions including the time period he has been on his Flomax.	