

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155378	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 08/30/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-PARKWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 1001 N GRANT ST LEBANON, IN 46052
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F0000	<p>This visit was for the Investigation of Complaint IN00113712.</p> <p>Complaint IN00113712 - Substantiated. Federal/State deficiency related to the allegations is cited at F242.</p> <p>Survey Dates: August 29 and 30, 2012</p> <p>Facility number: 000468 Provider number 155378 AIM number 100290270</p> <p>Survey Team: Vanda Phelps, R.N.</p> <p>Census bed type: SNF/NF 112 Total 112</p> <p>Census payor type: Medicare 12 Medicaid 61 Other 39 Total 112</p> <p>Sample: 5</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p>	F0000		

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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	Quality review 9/06/12 by Suzanne Williams, RN			

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F0242 SS=E	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, interviews and record review, the facility failed to consistently follow the choices residents made on their selective menus. This impacted 4 of 4 sampled residents who were on selective menus in a total sample of 5 residents (Residents C, E, R and T), plus 2 of 2 additional residents whose families were interviewed (Residents P and Z).</p> <p>Findings include:</p> <p>1. Resident E was identified as reliably interviewable by LPN #1 during the orientation tour of 8/29/12 at 10:30 a.m. and on a list of reliably interviewable residents prepared by the Social Service Director on 8/29/12. During an interview of Resident E on 8/30/12 at 1 p.m., she indicated the facility food tasted OK, but her diet was very restrictive and she was often disappointed when she didn't receive what she'd chosen but was instead given</p>	F0242	<p>The corrective action taken for the residents found to have been affected by the deficient practice was:</p> <p>Resident E has been discharged to home. Residents C, R, T, P and Z are still residing in the facility. A review of residents receiving a selective menu will be done to ensure correct information has been received by the dietary department.</p> <p>The corrective action taken for those residents having the potential to be affected by the same deficient practice is:</p> <p>All residents have the potential to be affected,</p>	09/29/2012			

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	<p>something else. She said many times she could not tolerate what was sent. "For example today," and she motioned toward the tray table. Her lunch tray was still on her overbed tray table. Observation noted a plate with lasagna, Italian vegetables (which included two kinds of beans) and garlic bread. The plate was undisturbed. She indicated she couldn't tolerate the spices in lasagna and garlic bread and there were beans in the mixed vegetables. There was an empty dish of cottage cheese and an empty ice cream cup. She indicated she'd asked a nurse aide to see if there was glazed ham available. The aide returned with news there was no ham left. When asked if she's like something else, she replied, "No, I'm OK. I ate a piece of chicken I saved from last night and the cottage cheese and ice cream, so I'm good." She indicated the chicken had been on her overbed tray table since last evening and further indicated she'd kept it "just in case." "This stuff happens all the time." At 5 p.m., Resident E indicated she felt OK, but was getting "really gassy."</p> <p>Clinical record review for Resident E was completed on 8/30/12 at 4:40 p.m. It indicated her diagnoses included severe diverticulitis, which had resulted in a pelvic abscess of the colon, for which she had been hospitalized and was receiving</p>		<p>thus this plan of correction applies to all residents receiving the selective menus.</p> <p>The measures put in place and systemic change made to ensure the deficient practice does not recur is:</p> <p>Staff in-service will be done on how to assist residents with their choices with the selective menu process. Dietary staff will be in-service on following menus and recipes, on food preparation, and food delivery. A review of residents who receive the selective menu will be done and the list will be updated as needed. A review of theses residents likes and dislikes will also be done and the list will be updated as needed.</p> <p>To ensure the deficient practice does not recur, the monitoring system established is:</p>				

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	<p>intravenous antibiotics in the facility. She was hospitalized seven days and had surgery to insert a drain into the abscess. Her 8/17/12 initial RAI (Resident Assessment Instrument) indicated she was cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15/15. Her diet order was for a "soft diet, no nuts, no skins or seeds, selective menu." She also received nutritional supplements three times daily.</p> <p>The Food Service Supervisor was interviewed on 8/30/12 at 1:55 p.m. She indicated they had ham left over after meal service was finished. The resident could have had it and didn't understand why the aide didn't get it for her. She indicated she was aware there were problems with the selective menu process and they were "working on it."</p> <p>An interview with LPN # 14 on 8/30/12 at 2:37 p.m. indicated she happened to be in the main dining room and overheard a nurse aide asking if there was any ham available. She heard dietary staff tell her no, they were out. She did not know if the aide was asking on behalf of Resident E or not, but did know an aide had been told they had run out of ham.</p> <p>2. Twelve staff members were individually interviewed the afternoon of</p>		<p>A performance improvement tool has been developed that the Dietary Manager or designee, will utilize to monitor daily, on scheduled days of work, for 3 weeks, compliance with implementation of measures to monitor residents selective menu choices are being honored.</p> <p>Dietary Manager or designee, will review findings weekly and report to PI committee monthly for 6 months to determine need for continued monitoring thereafter.</p> <p>Substantial compliance will be achieved and will continue to be monitored quarterly to ensure that compliance is maintained.</p> <p>Completion Date: September 29, 2012</p>				

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	<p>8/30/12 between 1:25 and 4:20 p.m. Eleven of the twelve indicated the most common complaints they received from residents and families were about food. Specifically about not receiving what they'd ordered on their selective menus. The staff were as follows: LPNs # 12, 14, 15 and 20; CNAs #10, 14, 15, 17, 22, an Activity Assistant, and the Program Coordinator for the dementia unit.</p> <p>3. Three of three residents (C, T and E) interviewed indicated they had rarely received what they'd ordered on the selective menus. Resident T indicated, "They're always running out and send things I can't eat or dislike." (Residents C and T were interviewed on 8/29/12, Resident E on 8/30/12.)</p> <p>4. Three of three family members were interviewed and also mentioned the same problem. One stated, "If they're going to have a selective menu, they should be sure they have the food on hand." Family members included R, P and Z and were interviewed on 8/29/12 between 8 and 8:45 p.m.</p> <p>This federal tag relates to complaint IN00113712.</p> <p>3.1-3(u)(1) 3.1-3(u)(3)</p>				

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