

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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F0000	<p>This visit was for the Investigation of Complaint IN00111184 and Complaint IN00112542.</p> <p>Complaint IN00111184- Substantiated, Federal/State deficiencies related to the allegations are cited at F225 and F226.</p> <p>Complaint IN00112542- Substantiated, Federal/State deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: July 25 and 26, 2012</p> <p>Facility number: 011049 Provider number: 155670 AIM number: 200258520</p> <p>Survey team: Anne Marie Crays, RN</p> <p>Census bed type: SNF/NF: 102 Total: 102</p> <p>Census payor type: Medicare: 17 Medicaid: 62 Other: 23 Total: 102</p>	F0000	<p>This Plan of Correction is submitted under the State and Federal Regulations and Statutes applicable to long-term care providers. This Plan of Correction does not constitute an admission on part of the facility. We request this Plan of Correction serve as our credible allegation of compliance. In addition, we are requesting this Plan of Correction be considered for desk review compliance. Should you have any questions, please feel free to contact me at (812) 473-4761. Sincerely, Kay Congelton HFA Executive Director</p>	
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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>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on July 30, 2012 by Bev Faulkner, RN</p>			

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F0225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>Based on interview and record review, the facility failed to immediately report an</p>	F0225	1.Resident A no longer resides at the facility. In-service and education was completed with the	08/08/2012			

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	<p>allegation of abuse to the Indiana State Department of Health, for 1 of 4 residents reviewed for abuse, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>On 7/25/12 at 4:30 P.M., the Director of Nursing [DON] indicated the facility had recently done an investigation into the alleged abuse of Resident A.</p> <p>On 7/25/12 at 5:00 P.M., the DON provided a binder which included the investigation into the incident on 6/26/12 regarding Resident A. The binder included: "Indiana State Department of Health Incident Report Form...Incident Date: 06/29/2012, Incident Time: 1830 [6:30 P.M.], Resident Name: [Resident A]...Brief Description of Incident: 2-second shift CNAs found [Resident A] on their first round at the beginning of the shift, in bed with a bruise and skin tear under her Rt. [right] Mandible [jaw]. The cnas [sic]reported it to the nurse and the nurse administered care and notified the ED [executive director]...Type of Injury/Injuries: 2.5 cm [centimeter] bruise, 1.0 cm skin tear...Preventive measures taken:...All staff in-servicing on Abuse and Abuse prevention." The faxed report was dated 6/30/12 at 11:58 A.M.</p>		<p>Administrator and DNS. <input type="checkbox"/></p> <p>2. The Administrator along with the Director of Nursing will investigate all allegations of abuse of residents. The facility will immediately notify the state agency of any allegation of abuse. Together with the information they gather and any other information gained during the investigation a determination will be made as to the validity of the alleged abuse and implementation of policies and procedures to include: immediately reporting an allegation of abuse. <input type="checkbox"/></p> <p>3. Education has been provided to staff on what is abuse, reporting of abuse, protecting residents during an investigation and conducting of an investigation of abuse allegations. Education has been completed with the ED &amp; DNS on Abuse policies and procedures with emphasis on immediate notification of allegations of abuse to the state agency. <input type="checkbox"/></p> <p>4. All allegations of abuse and resident, family and employee grievances will be audited monthly for timeliness and audit results presented to the Performance Improvement committee monthly for compliance in reporting to state agencies for 3 months or until 100% compliance is achieved as determined by the PI committee.</p>				

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	<p>The clinical record of Resident A was reviewed on 7/25/12 at 6:40 A.M. Diagnoses included, but were not limited to, Dementia.</p> <p>Resident Progress Notes included the following notations:</p> <p>6/26/12 at 3:42 P.M.: "Called to pt. [patient] rm [room]. CNAs reported pt to have S/T [skin tear] bleeding to [right] jaw [and] bruise to [right] cheek, [with] petechiae noted to neck [right] [and] cheek area blood dried to [right] index finger middle finger to both [left and right] hands. S/T area 1.5 irregular tear [and] bruise noted to be approx 4.5 x 4.5 to jaw cheek [and] neck areas...Pt kept repeating 'I hurt, I hurt...Administrator notified of area, [family member] notified of areas @ this time."</p> <p>On 7/26/12 at 8:45 A.M., during interview with the Administrator, she indicated she was working on 6/26/12 when the bruise and skin tear was observed on Resident A. The Administrator indicated it was reported to her that the resident stated, "She hit me, she hit me." The Administrator indicated the resident was unable to name any staff who might have hit her, and did not act afraid of any staff. The Administrator indicated the resident had a portable chest</p>						

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	<p>x-ray done at approximately the same time that the bruise was discovered, and it was thought that maybe the x-ray machine could have even "clipped" the resident. The Administrator indicated the resident's skin was very thin and fragile, and the resident had a history of picking at her skin, and it was thought the resident could have scratched at her neck. The Administrator indicated it was not reported to the state until the resident's family indicated they called the sheriff.</p> <p>On 7/26/12 at 11:20 A.M., during interview with the Director of Nursing (DON), she indicated two employees were suspended during the investigation, on 6/27/12. The DON indicated she was out of the facility during the incident, but was notified. She indicated she knew that "per the guidelines we were late in reporting" the incident. The DON indicated the facility did not think it was abuse after investigation, and probably wouldn't have turned the incident in, but "the daughter called the sheriff."</p> <p>On 7/26/12 at 1:15 P.M., during interview with the Administrator, she indicated she did wonder about reporting the incident to the ISDH earlier, but it was the corporation's policy for the Administrator to contact the corporation first, and the corporate consultant did not think it</p>						

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	needed to be reported.  This federal tag relates to Complaint IN00111184.  3.1-28(c)				

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F0226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to implement their policy to immediately report an allegation of abuse to the Indiana State Department of Health, for 1 of 4 residents reviewed for abuse, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>1. On 7/25/12 at 4:30 P.M., the Director of Nursing [DON] indicated the facility had recently done an investigation into the alleged abuse of Resident A.</p> <p>On 7/25/12 at 5:00 P.M., the DON provided a binder which included the investigation into the incident on 6/26/12 regarding Resident A. The binder included: "Indiana State Department of Health Incident Report Form...Incident Date: 06/29/2012, Incident Time: 1830 [6:30 P.M.], Resident Name: [Resident A]...Brief Description of Incident: 2-second shift CNAs found [Resident A] on their first round at the beginning of the</p>	F0226	<p>1.The allegation regarding resident A has been investigated by the state agency.</p> <p><input type="checkbox"/></p> <p>1.The Administrator along with the Director of Nursing will investigate all allegations of abuse of residents. The facility will immediately notify the state agency of any allegation of abuse. Together with the information they gather and any other information gained during the investigation a determination will be made as to the validity of the alleged abuse and implementation of policies and procedures to include: immediately reporting an allegation of abuse.<input type="checkbox"/></p> <p>2.Education has been provided to staff on what is abuse, reporting of abuse, protecting residents during an investigation and conducting of an investigation of abuse allegations. Education has been completed with the ED &amp; DNS on Abuse policies and procedures with emphasis on immediate notification of allegations of abuse to the state agency.<input type="checkbox"/></p> <p>3.All allegations of abuse and resident, family and employee</p>	08/08/2012			

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	<p>shift, in bed with a bruise and skin tear under her Rt. [right] Mandible [jaw]. The cnas[sic] reported it to the nurse and the nurse administered care and notified the ED [executive director]...Type of Injury/Injuries: 2.5 cm [centimeter] bruise, 1.0 cm skin tear...Preventive measures taken:...All staff in-servicing on Abuse and Abuse prevention." The faxed report was dated 6/30/12 at 11:58 A.M.</p> <p>The clinical record of Resident A was reviewed on 7/25/12 at 6:40 A.M. Diagnoses included, but were not limited to, Dementia.</p> <p>Resident Progress Notes included the following notations:</p> <p>6/26/12 at 3:42 P.M.: "Called to pt. [patient] rm [room]. CNAs reported pt to have S/T [skin tear] bleeding to [right] jaw [and] bruise to [right] cheek, [with] petechiaie noted to neck [right] [and] cheek area blood dried to [right] index finger middle finger to both [left and right] hands. S/T area 1.5 irregular tear [and] bruise noted to be approx 4.5 x 4.5 to jaw cheek [and] neck areas...Pt kept repeating 'I hurt, I hurt...Administrator notified of area, [family member] notified of areas @ this time."</p> <p>On 7/26/12 at 8:45 A.M., during</p>		<p>grievances will be audited monthly for timeliness and audit results presented to the Performance Improvement committee monthly for compliance in reporting to state agencies for 3 months or until 100% compliance is achieved as determined by the PI committee.</p> <p><input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/></p>	

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	<p>interview with the Administrator, she indicated she was working on 6/26/12 when the bruise and skin tear was observed on Resident A. The Administrator indicated it was reported to her that the resident stated, "She hit me, she hit me." The Administrator indicated the resident was unable to name any staff who might have hit her, and did not act afraid of any staff. The Administrator indicated the resident had a portable chest x-ray done at approximately the same time that the bruise was discovered, and it was thought that maybe the x-ray machine could have even "clipped" the resident. The Administrator indicated the resident's skin was very thin and fragile, and the resident had a history of picking at her skin, and it was thought the resident could have scratched at her neck. The Administrator indicated it was not reported to the state until the resident's family indicated they called the sheriff.</p> <p>On 7/26/12 at 11:20 A.M., during interview with the DON, she indicated two employees were suspended during the investigation, on 6/27/12. The DON indicated she was out of the facility during the incident, but was notified. She indicated she knew that "per the guidelines we were late in reporting" the incident. The DON indicated the facility did not think it was abuse after</p>			

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	<p>investigation, and probably wouldn't have turned the incident in, but "the daughter called the sheriff."</p> <p>On 7/26/12 at 1:15 P.M., during interview with the Administrator, she indicated she did wonder about reporting the incident to the ISDH earlier, but it was the corporation's policy for the Administrator to contact the corporation first, and the corporate consultant did not think it needed to be reported.</p> <p>2. On 7/25/12 at 5:00 P.M., the Director of Nursing provided the current facility policy on "Abuse Prevention," dated 4/28/09. The policy included: "...All alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law...including to the State survey and certification agency)...."</p> <p>This federal tag relates to Complaint IN00111184.</p> <p>3.1-28(a)</p>						

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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, interview, and record review, the facility failed to ensure a medication cart was locked while unattended, and to ensure medications were secured on top of the cart, for 1 of 6 medication carts observed.</p> <p>Findings include:</p> <p>1. On 7/25/12 at 5:45 P.M., a medication cart was observed at the end of a hallway on the 200 wing, with no staff in attendance. The medication cart appeared to be unlocked. Eleven (11) different insulin bottles for 11 residents were observed in a cardboard box on the side of the cart. One (1) insulin bottle was observed on the top of the cart. Three (3) separate cards of medications were observed on top of the cart; 2 cards of 30 tablets each of Glucosamine [an arthritis medication], and 1 card of 30 tablets of Digoxin [a heart medication]. An ointment labeled "Magic Butt cream" was also observed on top of the cart.</p>	F0323	<p>1. Written Performance Improvement was completed with LPN #1.</p> <p>2. The DNS and ED completed an audit of all medication carts and medication rooms to ensure they were secured. <input type="checkbox"/></p> <p>3. All nursing staff were in serviced on the policy for Medication Administration and Accidents and Supervision to Prevent Accidents. <input type="checkbox"/></p> <p>4. The DNS/Designee will complete facility rounds daily times one month, then twice weekly times one month, then weekly times one month for compliance with securing medications and maintaining an environment that is free of hazards. All findings will be addressed immediately and reviewed in monthly PI meetings. The PI committee will determine when 100% compliance is achieved or if further monitoring will need to be continued.</p>	08/08/2012

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	<p>After approximately 5 minutes, during which time the medications were observed and documented, LPN # 1 came out of a resident's room. LPN # 1 verified the medication cart was unlocked. LPN # 1 indicated, "I know, I know, I'm not supposed to do that." When queried regarding the reason all of the insulin bottles were out, LPN # 1 indicated, "I don't know, those are all of my insulins."</p> <p>On 7/25/12 at 5:50 P.M., the Director of Nursing [DON] was apprised of observing the medication cart unlocked and medications on top of the cart. The DON indicated she would immediately inservice the nursing staff to keep the medication cart locked and medications secure while unattended.</p> <p>2. On 7/25/12 at 7:10 P.M., the DON provided the current facility policy on "Accidents and Supervision to Prevent Accidents," dated 4/28/11. The policy included: "...Physical Plant Hazards...For a material to pose a safety hazard to a patient, it must be toxic, caustic, or allergenic; accessible and available in a sufficient amount to cause harm...they become hazardous when a vulnerable patient interacts with them:...Drugs and other therapeutic agents..."</p> <p>At that time, the DON also provided the</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155670	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  07/26/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-ANGEL RIVER	STREET ADDRESS, CITY, STATE, ZIP CODE 5233 ROSEBUD LN NEWBURGH, IN 47630
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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
	<p>current facility policy on "Medication Administration," dated 8/31/11. The policy included: "...Secure the cart. During a medication pass, medications must be under the direct observation of the person administering the medications or locked in the medication storage area/cart...."</p> <p>This federal tag relates to Complaint IN00112542.</p> <p>3.1-45(a)(1)</p>			