

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/14/2012
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-MUNCIE	STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303
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F0000	<p>This visit was for the Investigation of Complaints IN00103683 and IN00103787.</p> <p>Complaint IN00103683- Unsubstantiated, due to lack of evidence. Complaint IN00103787- Substantiated, federal/state deficiencies related to the allegations cited at F224, and F282.</p> <p>Survey dates: February 13, 14, 2012</p> <p>Facility number: 000146 Provider number: 155242 AIM number: 100291200</p> <p>Surveyor: Jeri Curtis, RN</p> <p>Census bed type: SNF/NF: 153 Total: 153</p> <p>Census payor type: Medicare: 33 Medicaid: 107 Other: 13 Total: 153</p> <p>Sample: 5 Supplemental sample: 1</p> <p>These deficiencies also reflect state</p>	F0000		
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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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	findings cited in accordance with 410 IAC 16.2 .  Quality review completed on February 16, 2012 by Bev Faulkner, RN			

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F0224 SS=D	<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 observation, record review, and interview, the facility failed to implement its policy regarding the prohibition of mistreatment by allowing staff to hold the limbs for a treatment, which was being resisted, by 1 resident (Resident B), among the sample of 5, reviewed for neglect and mistreatment.</p> <p>Findings include:</p> <p>During the 7:10 A.M., 2/13/2012, entrance tour, Resident (B) was observed seated on the edge of the bed. Resident (B) was assisted to stand and transfer from the bed to a wheel chair with assistance of 2 Certified Nursing Assistants (CNAs #1 and #2). The resident's hearing aides and dentures were placed prior to the transfer.</p> <p>Registered Nurse (RN #1) who was conducting the tour, pointed to the bilateral lower leg discoloration and indicated it was vascular. RN #1 also indicated, "age spots" on the bilateral lower forearms.</p> <p>RN #1 indicated the family had recently been concerned about the spots on the left forearm following an in and out</p>	F0224	<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. I. LPN #1 and C.N.A.'s #3 and #4 were suspended at the time the allegation was made and the investigation was conducted. Based on the investigation findings; progressive disciplinary action was completed with L.P.N. #1 and C.NA.'s #3 and #4. II. Facility wide interviews with residents and skin assessments on all residents were completed to ensure no other similar concerns were present. None were identified. III. Nursing center staff will continue to receive education relative to abuse prevention and resident rights; with initial employee orientation and periodically thereafter. Performance Improvement Tools have been developed to monitor skin sweep audit outcomes and daily nursing progress note audits. The nurse</p>	03/08/2012			

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	<p>catheterization procedure.</p> <p>The Director of Nursing (DoN) and Administrator were interviewed at 8:20 A.M., 2/13/2012, and indicated the family members (#1 and #2 )of (Resident B) had alleged staff had been mean to the resident during an in/out cath (catheterization).</p> <p>The DoN indicated family members (#1 and #2) had observed discoloration on the left arm the evening after the cath.</p> <p>The DoN indicated family members (#1 and #2) believed the discoloration was bruising.</p> <p>The DoN indicated family members (#1 and #2) had been told Resident (B) was screaming and resistive to the in/out catheter procedure.</p> <p>The DoN indicated during an investigation of the reportable incident, the staff members involved, Licensed Practical Nurse (LPN#1), and CNAs (#3 and 4), had said Resident (B) had resisted and had screamed. The DoN indicated LPN #1 had said she did not stop because she was half way through the procedure when Resident (B) started resisting.</p> <p>The DoN provided the 2/7/2012, reportable incident on the in/out cath procedure on 2/13/2012. Documentation indicated Resident (B) had told family members (#1 and #2), "they were mean to</p>		<p>managers, or designee, will complete audits. Daily skin assessment sweeps will be completed for all residents for 30 days. Nursing managers will continue with daily, on scheduled days of work, audits of nursing progress notes. The E.D., or designee, will review grievances as received to identify, investigate and provide individualized follow through for any indications of resident mistreatment. IV. E.D. and D.N.S., or designee, will review findings weekly and report to Performance Improvement Committee monthly for 6 months to determine need for continued monitoring thereafter. The E.D. is responsible for overall compliance. V. March 15, 2012 is the date for compliance for the completion of systemic changes.</p>				

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	<p>me." Documentation indicated a full body assessment with an injury of discoloration consistent with disease process. The staff members involved were suspended pending an investigation. Education was provided to the staff on who to inform of any questions regarding care.</p> <p>Documentation indicated Resident (B) had been interviewed and had no concerns and was not fearful of any staff. Documentation indicated the nursing staff received education relative to abuse prevention on hire and periodically. Inservicing was completed on behaviors, policy, and the procedure for in/out cath.</p> <p>CNA #3 was interviewed by telephone at 9:30 A.M., 2/13/2012, and indicated she had worked on another hall the night of 2/7/2012, and CNA #4 had asked her to come to Walnut Hall to assist with toileting Resident (B). CNA #3 indicated LPN #1 had told them instead of toileting they were to put Resident (B) into bed for a cath specimen that was needed. CNA #3 indicated they had explained the procedure to (Resident B). CNA #3 indicated Resident (B) would not keep her legs open and she and CNA #4 each put a hand on a thigh. CNA #3 indicated Resident (B) screamed when the catheter was inserted and flailed out. CNA #3 indicated LPN #1 had said</p>						

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	<p>they needed the specimen and proceeded with the procedure.</p> <p>CNA #3 indicated Resident (B) continued screaming and kicked out at them. CNA #3 indicated she and CNA #4 had stood back after the procedure was completed. CNA #3 indicated she had been called to the office that afternoon and RN #1 had said a second shift nurse (LPN #2) had found bruising of unknown origin. CNA #3 indicated RN #1 had said they had found bruising on a forearm, 1 leg, and 1 ankle. CNA #3 indicated she was suspended for an investigation and told not to work on the hall again.</p> <p>LPN #1 was interviewed by telephone at 9:35 A.M., 2/13/2012, and indicated Resident (B) had been restless at 2:00 A.M., 2/7/2012, and was gotten up into a recliner. LPN #1 indicated at 5:00 A.M., Resident (B) had needed to be toileted. LPN #1 indicated she had been aware a cathed urine specimen was required and had decided to obtain it at that time. LPN #1 indicated both CNAs (#3 and 4) had held a leg. LPN #1 indicated she was almost done with the cath when Resident (B) started screaming, and hitting out at the CNAs.</p> <p>LPN #1 indicated she was later reprimanded and re-trained for not stopping the procedure when Resident (B) resisted. LPN #1 indicated she did not see</p>			
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	<p>bruising following the cath and had not worked the hall since the incident. LPN #1 indicated CNA #3 had also been reprimanded and had returned to work and CNA #4 had been terminated. LPN #1 indicated she believed the side CNA #4 had been holding had, "bruising."</p> <p>The record of Resident (B) was reviewed at 10:20 A.M., 2/13/2012, and indicated an 11/09, admission. The 1/18/12, Minimum Data Set (MDS) assessment indicated cognitive impairment. The 2/7/2012, 5:00 A.M., nursing note, documented by LPN #1, indicated a urinalysis and culture were obtained by an in/out cath. The urine was described as cloudy, milky, without odor. LPN #1 documented Resident (B) tolerated the procedure well. A 2/7/2012, weekly non-pressure skin condition report, documented by RN (#1) indicated 3 new red areas on the left arm, measuring (#1) 1 by 1 with .1 centimeter (cm) depth, (#2) 2 by 2.5 by .1 cm, and (#3) 2 by .5 by .1 cm depth. Documentation indicated areas to the right arm were observed to be red without bruising, warmth, or complaint of pain.</p> <p>During a second interview at 10:00 A.M., 2/13/2012, the DoN indicated she had re-educated staff that when a resident says</p>			
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	<p>stop, they should stop. The DoN indicated staff should have stopped the cath process the night of 2/7/2012, and attempted again later.</p> <p>The DoN indicated she did not believe anything willful had occurred. The DoN indicated family member #2 had arranged to be present on day shift during the cath because of an earlier poor tolerance with a the same procedure at a hospital. The DoN indicated LPN #1 was unaware of that and had taken advantage to obtain the cath specimen with the resident's need to void on night shift.</p> <p>The DoN indicated their assessment showed discolored areas which could have been from holding onto the top of an extremity or from the resident hitting against the bed. The DoN indicated all three staff members involved had said they had not held Resident (B) down.</p> <p>Family member #1 was interviewed by telephone at 10:15 A.M., 2/13/2012, and indicated she was upset due to an in/out cath procedure which she believed had resulted in bruising caused when staff had held Resident (B) down. Family member #1 indicated a second shift nurse, LPN #2, had circled several areas of bruising on a wrist later in the day. Family member #1 said Resident (B) had been wakened at 5:00 A.M. without the hearing aides in place, and the cath procedure completed.</p>			
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	<p>Family member #1 indicated the afternoon of 2/7/2012, LPN #2 had measured 5 spots on the right shin, and bruises on the left arm. Family member #1 indicated she believed Resident (B) had been, "accosted by staff."</p> <p>Family members #1 and #2 arrived at the facility and were interviewed in the conference room at 10:45 A.M., 2/13/2012. Each indicated concerns with missing teeth, glasses, and hearing aides on several occasions since 12/2011. Family member #2 indicated when she arrived the afternoon of 2/7/2012, Resident (B) could not bear weight and complained of pain to the knees. Family member #2 indicated the knees were red with pressure points and Resident (B) cried all afternoon.</p> <p>Family member #2 indicated she had asked LPN #2 to assess Resident (B). Family member #2 said LPN #2 had examined the arms, said they were pressure points, and had drawn circles about them.</p> <p>Family member #2 indicated she believed the hearing aides were not in place during the cath and Resident (B) would not have been able to understand what was happening. Family member #2 placed her hand over her mouth and spoke to demonstrate what would be heard without the hearing aide.</p>						

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	<p>The words of Family Member #2 were unintelligible. Family member #2 indicated she also believed staff had accosted Resident (B), and held her down. Family member #2 indicated she feared possible reprisal to Resident (B) because of the report.</p> <p>LPN #2 was interviewed at 3:10 P.M., 2/13/2012, with RN #1 in attendance. LPN #2 indicated Family member #2 had been in to visit the afternoon of 2/7/2012, and was upset due to missing teeth. LPN #2 indicated she had gone to the room to investigate and had done an assessment of Resident (B). LPN #2 indicated she had found 3 red marks on one arm and a fourth on the left arm. LPN #2 indicated she had measured the marks and documented them on a skin tracking sheet. LPN #2 indicated she had also obtained measurements on the leg areas to appease the family. LPN #2 indicated she did not recall using the words pressure points to describe the areas on the arms. LPN #2 indicated when Family member #2 had asked if the area on the wrist was a thumb print, she had replied it could or could not be.</p> <p>CNA #4, who had worked the second shift 2/7/2012, was interviewed at 3:25</p>						

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	<p>P.M., 2/13/2012, with RN #1 in attendance. CNA # 4 indicated Family member #1 had asked her the names of the staff on duty on third shift 2/7/2012. CNA #4 indicated she had been with family members #1 and 2 and had seen red marks on the arm of Resident (B) which could have been finger prints. CNA #4 indicated she had reported the information to LPN #2.</p> <p>The facility's 10/25/11, Abuse Policy was received from the DoN and reviewed 2/13/2012.</p> <p>Abuse was defined as verbal, sexual, physical, and mental, corporal punishment, involuntary seclusion, and neglect of a patient as well as mistreatment, neglect, and misappropriation of property, which were strictly prohibited.</p> <p>This federal tag relates to Complaint IN00103767.</p> <p>3.1-27(a)(3)</p>						

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F0282 SS=D	<p>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 record review and interview, the facility failed to ensure care plan interventions were followed for a resident (Resident B) who resisted care during an in and out catheterization procedure for 1 of 5 residents among the sample of 5.</p> <p>Findings include:</p> <p>The record of Resident (B) was reviewed at 10:20 A.M., 2/13/2012, and indicated an 11/09, admission.</p> <p>The 2/7/2012, 5:00 A.M., nursing note, documented by LPN #1, indicated a urinalysis and culture were obtained by an in/out cath. The urine was described as cloudy, milky, without odor. LPN #1 documented Resident (B) tolerated the procedure well.</p> <p>A 2/7/2012, weekly non-pressure skin condition report, documented by RN (#1) indicated 3 new red areas on the left arm, measuring (#1) 1 by 1 with .1 centimeter (cm) depth, (#2) 2 by 2.5 by .1 cm, and (#3) 2 by .5 by .1 cm depth.</p> <p>Documentation indicated areas to the right arm were observed to be red without bruising, warmth, or complaint of pain.</p> <p>An 8/11/11, care plan concern, renewed through 2/2012, indicated a refusal of</p>	F0282	<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> <p>I. Process has been put in place so that family member of Resident B must be present for any invasive procedures , injections or lab draws. II. Facility wide interviews with resident and skin assessments on all residents were completed to ensure no other similar concerns were present. None were identified. III. Nursing center staff will continue to receive education with initial employee orientation and periodically thereafter; relative to behavior management and resident rights including but not limited to each residents individualized plan of care. Performance Improvement Tools have been developed to monitor skin sweep audit outcomes and daily nursing progress note audits. The nurse managers, or designee, will complete audits.</p>	03/08/2012			

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	<p>treatments. The goal was for the resident to accept treatments as scheduled. Interventions included conversing with the resident to determine the why for refusal, and offering another time for the care.</p> <p>The Director of Nursing (DoN) and Administrator had been interviewed at 8:20 A.M., 2/13/2012, and indicated the family members (#1 and #2 )of (Resident B) had alleged staff had been mean to the resident during 2/7/2012, in/out cath (catheterization). The Don indicated during an investigation, the staff members involved, Licensed Practical Nurse (LPN#1), and CNAs (#3 and #4), had said Resident (B) had resisted and had screamed. The DoN indicated LPN #1 had said she did not stop because she was half way through the procedure when Resident (B) started resisting.</p> <p>LPN #1 was interviewed by telephone at 9:35 A.M., 2/13/2012, and indicated Resident (B) had been restless at 2:00 A.M., 2/7/2012, and was gotten up into a recliner. LPN #1 indicated at 5:00 A.M., Resident (B) had needed to be toileted. LPN #1 indicated she had been aware the physician had ordered a cathed urine specimen and had decided to obtain it at that time.</p>		<p>Daily skin assessment sweeps will be completed for all residents for 30 days. Nurse managers will continue with daily, on scheduled days of work, audits of nursing progress notes. The E.D., or designee will review grievances as received to identify, investigate and provide individualized follow through for any indication of resident mistreatment. IV. E.D. and D.N.S., or designee, will review findings weekly and report to Performance Improvement Committee monthly for 6 months to determine need for continued monitoring thereafter. The E.D. is responsible for overall compliance. V. March 15, 2012 is the date for compliance for completion of systemic changes. VI.</p>		

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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-MUNCIE				STREET ADDRESS, CITY, STATE, ZIP CODE 4301 N WALNUT ST MUNCIE, IN 47303			
(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>LPN #1 indicated both CNAs (#3 and #4) had held a leg. LPN #1 indicated she was almost done with the cath when Resident (B) started screaming, and hitting out at the CNAs.</p> <p>LPN #1 indicated she was later reprimanded and re-trained for not stopping the procedure when Resident (B) resisted.</p> <p>During a second interview at 10:00 A.M., 2/13/2012, the DoN indicated following the 2/7/2012, incident, she had re-educated staff when a resident says stop, they should stop. The DoN indicated staff should have stopped the cath process the night of 2/7/2012, and attempted again later.</p> <p>The facility's 5/28/08, Comprehensive Plan of Care Policy was provided by the Unit Manager on 2/14/2012.</p> <p>Protocols indicated the care plan identified resident centered problems/needs/strengths.</p> <p>Guideline (d) indicated staff interventions that addressed the means to use in which the goal was to be obtained.</p> <p>Guideline (e) indicated disciplines were to be identified to assist with the implementation of the interventions.</p> <p>This federal tag relates to complaint IN00103787.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155242	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  02/14/2012
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	3.1-35(g)(2)			