

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155249	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/19/2012
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-FORT WAYNE	STREET ADDRESS, CITY, STATE, ZIP CODE 6006 BRANDY CHASE COVE FORT WAYNE, IN 46815
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F0000	<p>This visit was for the Investigation of Complaints IN00115272 and IN00116140.</p> <p>IN00116140-Unsubstantiated due to lack of evidence.</p> <p>IN00115272-Substantiated. Federal/state deficiencies related to the allegations are cited at F309 and F314.</p> <p>Survey dates: September 17, 18, 19, 2012</p> <p>Facility number: 000153 Provider number: 155249 AIM number: 100266910</p> <p>Survey team: Ann Arme y, RN</p> <p>Census bed type: SNF/NF: 121 Total: 121</p> <p>Census payor type: Medicare: 9 Medicaid: 92 Other: 20 Total: 121</p> <p>Sample: 5</p>	F0000	<p>This serves as the Allegation of Compliance for Kindred Transitional Care & Rehabilitation-Fort Wayne for the recent complaint survey dated 9/19/12. Kindred-Fort Wayne asserts that all corrections described on this Plan of Correction have been implemented. In regards to the specific deficiencies, we have outlined our corrective actions and continued interventions to assure compliance with regulations and our plan of action. The staff of Kindred-Fort Wayne is committed to delivering high quality health care to its residents to obtain their highest level of physical, mental, and psychosocial functioning. We respectfully submit Kindred-Fort Wayne is in substantial compliance as set forth below, we are confident that it will be found in substantial compliance with regulations upon re-survey. The statements made on the plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.</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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	<p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on September 21, 2012 by Bev Faulkner, RN</p>			

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F0309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>Based on interview and record review, the facility failed to obtain a treatment order for a non-pressure wound. This deficiency affected 1 of 3 residents, whose wound treatments were reviewed, in a sample of 5. (Resident #B)</p> <p>Findings include:</p> <p>The closed clinical record of Resident #B was reviewed on 9/18/12 at 10:00 a.m., and indicated the resident was admitted to the facility from the hospital on 8/14/12 and was discharged to home on 8/30/12.</p> <p>The Hospital transfer information, dated 8/14/12, indicated the resident had a wound on her right foot. Hospital orders indicated the resident was to receive the antibiotic, Keflex 500 mg four times daily. There were no treatment orders from the hospital for the wound of the right foot.</p> <p>Admission nursing notes, dated 8/14/12 at</p>	F0309	<p>1. Resident #B no longer resides at the nursing center, therefore, no further corrective action could be taken for this resident.</p> <p>2. All residents with wounds have the potential to be affected; therefore this plan of correction applies to those residents. An audit has been conducted to ensure that all residents with wounds have corresponding physician orders for treatments. Any identified concerns were promptly addressed.</p> <p>3. Licensed nurses will be educated relative to provision of care/services for highest well-being, including but not limited to obtaining treatment orders for wounds. A performance tool has been developed to monitor to ensure presence of treatment orders for wounds. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled work days, for 30 days. Any concerns will be immediately addressed with the responsible individual(s).</p>	10/09/2012			

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	<p>11:00 p.m., indicated the resident had right ankle bruising and discoloration, measuring 3 1/4 inches in length by 2 1/2 inches in width, with edema and small amount of drainage. The note indicated the area was "covered in bandage."</p> <p>The Weekly Non-Pressure Skin Condition Report, dated 8/14/12, indicated an area on the right ankle/foot was not open and a dry dressing was in place.</p> <p>The Physician's History and Physical, dated 8/17/12, indicated the resident had a wound on her right foot.</p> <p>Subsequent Weekly Non-Pressure Skin Condition Reports, indicated the following: On 8/20/12, the area on the right foot/ankle measured 3 cm by 4.5 cm and there was a partial thickness loss of skin with scant blood tinged drainage. On 8/27/12, the area on the right foot/ankle measured 2 cm by 2.5 cm and there was a partial thickness loss of skin with scant blood tinged drainage.</p> <p>Although nursing notes indicated a dry clean dressing was in place, there was no order for the dry dressing. Thus, the frequency of the dressing changes was not specified or documented in the treatment record.</p>		<p>Thereafter, Director of Nursing, or designee, will monitor for the presence of treatment orders randomly during the week prior to monthly PI committee meeting, on at least 5 residents, for a minimum of 5 months. Any concerns will be immediately addressed with the responsible individual(s).</p> <p>4. Director of Nursing will review findings weekly and report findings to PI committee monthly for six months.</p>				

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	<p>The area on the right foot was assessed to be open (to have a partial thickness loss of skin) on 8/20/12, but there was no documentation the physician was consulted or that a treatment order was obtained for the area until 8/30/12, the day the resident was discharged from the facility.</p> <p>On 8/30/12, a treatment order was obtained for Bacitracin, three times daily with a clean dry dressing.</p> <p>On 9/18/12 at 3:00 p.m., LPN #10, who had worked on Resident #B's unit, was interviewed. LPN #10 indicated Resident #B had an area on the right inner foot at the base of the great toe. LPN #10 indicated the area was covered with a clean dry dressing and looked like a shoe had rubbed the resident's foot. She indicated she noticed the scab on the right foot had come off so she called the DON (Director of Nursing) to check the foot and an order was obtained for a treatment.</p> <p>On 8/19/12 at 2:50 p.m., the DON (Director of Nursing) indicated she talked to the nurse, who worked, when Resident #B was admitted to the facility and the nurse indicated the physician was aware the area on the right foot was being covered with a dry dressing, when the</p>			
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	<p>admission orders were reviewed with the physician. The DON indicated the nurse did not write an order or note the treatment on the treatment record.</p> <p>The Policies for Pressure Ulcer/Non-Pressure Ulcer Assessment, dated 8/31/12 and Prevention and Treatment of Pressure Ulcers and Non-pressure Related Wounds, dated 8/31/12, were provided by the ADON (Assistant Director of Nursing) on 9/19/12 at 10:30 a.m., and indicated the following: "Non-pressure wounds interventions and treatment is based on patient assessment, discussed with the physician and physician orders are obtained..."</p> <p>This Federal tag relates to Complaint IN00115272.</p> <p>3.1-37(a)</p>				

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F0314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to assure a resident with a Stage III pressure area, received a nutritional assessment and weekly monitoring. This deficiency affected 1 of 3 residents, whose wound treatments were reviewed in a sample of 5. (Resident #E)</p> <p>Findings include:</p> <p>On 9/17/12 at 9:15 a.m., during the orientation tour, LPN #10 indicated Resident #E had a pressure ulcer.</p> <p>The clinical record of Resident #E was reviewed on 9/18/12 at 1:30 p.m., and indicated the resident was readmitted to the facility from the hospital on 9/1/12, with diagnoses which included but were not limited to, insulin dependent diabetes mellitus, peripheral vascular disease, obesity and bilateral above the knee</p>	F0314	<p>1. Resident #E has been assessed by the Registered Dietician with necessary interventions implemented.</p> <p>2. All residents with wounds have the potential to be affected; therefore this plan of correction applies to those residents. An audit has been conducted to ensure that all residents with wounds have nutritional assessments present, and have weekly monitoring documented. Any identified concerns were promptly addressed.</p> <p>3. Licensed nurses will be educated relative to treatment/services to prevent/heal pressure sores, including but not limited to ensuring nutritional assessments on residents with wounds are obtained and wounds are monitored weekly. A performance tool has been developed to monitor to ensure presence of nutritional</p>	10/09/2012			

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	<p>amputations.</p> <p>The Admission Nursing Skin Evaluation and the Weekly Non-Pressure skin Condition Report, dated 9/1/12, indicated the resident had two non-pressure abrasions; one area on the stump above the amputation and one area on the left posterior flank (left side of back in the skin fold). Treatment orders were present on admission. Tegaderm foam was to be applied to the right lower extremity and changed every seven days and Carradres Dressing was to be applied to the left flank fold and changed every three days.</p> <p>The admission nursing evaluation, dated 9/1/12, indicated the resident was at risk for developing pressure sores.</p> <p>On 9/6/12 at 10:00 a.m., nursing notes indicated "CNA (Certified Nursing Assistant) called writer to room. Writer found several pressure areas.... MD/NP (Medical Doctor/Nurse Practitioner) notified..."</p> <p>Physician orders, dated 9/6/12, indicated "Apply Santyl and cover c (with) dry dressing (change) dly (daily) to L (left) buttock wound. The order also indicated prealbumin and liver function laboratory tests were to be done.</p>		<p>assessments and documentation of weekly monitoring for wounds. Director of Nursing, or designee, shall be responsible for completion of these Performance Improvement tools daily, on scheduled work days, for 30 days. Any concerns will be immediately addressed with the responsible individual(s). Thereafter, Director of Nursing, or designee, will monitor for the presence of nutritional assessments on residents with wounds and for presence of documentation of weekly monitoring of wounds during the week prior to monthly PI committee meeting, on at least 5 residents, for a minimum of 5 months. Any concerns will be immediately addressed with the responsible individual(s).</p> <p>4. Director of Nursing will review findings weekly and report findings to PI committee monthly for six months.</p>		

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	<p>On 9/6/12, a temporary problem care plan was developed on which included the treatment orders.</p> <p>A care plan for "risk for impaired skin integrity," dated 9/13/12, indicated the resident was to be free from red or open areas through the next review.</p> <p>The care plan included the following interventions:</p> <ul style="list-style-type: none"> Encourage food and fluid intake, Keep linen clean dry and wrinkle free, Turn every two hours as needed, Pressure reducing mattress on bed, Observe resident's skin with pericare, showers, baths, admission skin assessments and as needed, Report and document any red or open areas, Elevate feet off bed, Notify the physician as needed, Provide incontinent care promptly, Medications as ordered, Side rails as needed for repositioning, Position oxygen and Foley catheter tubing so as not to cause pressure, Treatment to pressure ulcers as ordered. <p>Nurse Practitioner notes, dated 9/6/12, indicated Resident #E had a stage III pressure ulcer on the left lower buttocks and a stage II pressure area adjacent to the stage III area.</p>						

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	<p>The Weekly Pressure Ulcer Report, dated 9/6/12, indicated the resident had pressure areas including but not limited to: A stage III sacral/coccygeal area measuring 5.5 cm by 3 cm, with loosely adherent yellow slough and purulent exudate; and A stage II sacral/coccygeal area measuring 2 cm by 0.5 cm, with bloody exudate.</p> <p>The laboratory report, dated 9/10/12, indicated Resident #E's prealbumin was low at 16.6 (normal range 18.0-35.7)</p> <p>A Medical Nutrition Therapy Assessment was completed by the registered dietician on 9/5/12, before the pressure areas developed.</p> <p>A second nutritional progress note, dated 9/12/12, indicated the resident was having difficulty chewing meat and was concerned with constipation. There was no mention of the stage III pressure ulcer in the 9/12/12 note.</p> <p>The RD's notes were reviewed with the DON (Director of Nursing) on 9/18/12 at 3:00 p.m.</p> <p>There were no nutritional interventions implemented after the stage III pressure ulcer developed on 9/6/12.</p>			

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	<p>On 9/19/12 at 9:15 a.m., the RD (Registered Dietician) was interviewed. The RD indicated she did not know Resident #E had a stage III pressure area when she made her 9/12/12 note and she had not been informed about the area until 9/18/12. She indicated she worked thirty hours per week and was supposed to get a weekly skin report but the last skin report she received was on 8/31/12 because the wound nurse had not been working. The RD indicated she assessed the resident on 9/18/12, after she learned about the pressure area and recommended protein powder three times daily, 4 ounces of yogurt at breakfast and dinner, as well as, cottage cheese with fruit at lunch.</p> <p>On 9/18/12, Physician's orders were written for Zinc Sulfate 220 mg each day, Vitamin C 500 mg twice daily and Protein Powder one scoop three times daily for wound healing.</p> <p>The wounds on the buttocks were initially assessed on the Weekly Pressure Ulcer Report on 9/6/12. The next assessment on the Weekly Pressure Ulcer Report was dated 9/17/12, eleven days later. The 9/17/12 Pressure Ulcer Report indicated the resident had the following areas: A stage III sacral/coccygeal area measuring 2.5 cm by 3 cm, with no</p>						

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	<p>slough and bloody exudate; and A stage II sacral/coccygeal area measuring 2 cm by 0.5 cm, with bloody exudate.</p> <p>On 9/19/12 at 9:30 a.m., the ADON (Assistant Director of Nursing) was interviewed. She indicated pressure ulcers were to be assessed every seven days and she was unsure why the area had not been assessed for eleven days.</p> <p>On 9/19/12 at 2:00 p.m., the wounds on Resident #E's buttocks were observed with LPN #10. Resident #E was lying on a specialized mattress.</p> <p>Both areas on the left buttocks had formed a T-shaped wound measuring approximately 2 cm at the length and top of the T with a width of approximately 0.5 cm. The majority of wound bed was pink/red with a small area of white tissue. LPN #10, who worked on Resident #E's unit, indicated the area was healing and had improved.</p> <p>The Policies for Pressure Ulcer/Non-Pressure Ulcer Assessment, dated 8/31/12 and Prevention and Treatment of Pressure Ulcers and Non-pressure Related Wounds, dated 8/31/12, were provided by the ADON (Assistant Director of Nursing) on 9/19/12 at 10:30 a.m. and indicated the</p>			

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	<p>following:</p> <p>"Pressure ulcer/non-pressure ulcer assessment is completed at least weekly to determine the progress of healing, the presence of possible complications...,the presence of pain...and the status of the area surrounding the ulcer...</p> <p>18. Refer to Interdisciplinary Team, if.. c....stage III or IV pressure ulcers,...</p> <p>22. Consultation and communication with ancillary services such as physical therapy, occupational therapy, nutritional services and speech and are (sic) documented in the patient record..."</p> <p>This Federal tag relates to Complaint IN00115272.</p> <p>3.1-40(a)(2)</p>				