

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/08/2016
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaints IN00206441, IN00206566, IN00207369, and IN00207432.</p> <p>Complaint IN00206441 - Substantiated - No deficiencies related to the allegations are cited.</p> <p>Complaint IN00206566 - Substantiated - Findings are cited at F241.</p> <p>Complaint IN00207369 - Unsubstantiated - Due to lack of evidence.</p> <p>Complaint IN00207432 - Substantiated - Findings are city at F241 and F282.</p> <p>Survey dates: September 7 and 8, 2016</p> <p>Facility number: 010613 Provider number: 155659 AIM number: 15106131</p> <p>Census bed type: SNF: 14 SNF/NF: 62 Total: 76</p> <p>Census payor type: Medicare: 24</p>	F 0000	The facility would like to request a desk review for this survey Thank you	
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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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F 0241 SS=D Bldg. 00	<p>Medicaid: 44 Other: 8 Total: 76</p> <p>Sample: 10</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed by 34233 on September 9, 2016</p> <p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on record review and interview, the facility failed to ensure a resident was treated with dignity and respect for personal feelings in that a staff member made an inappropriate and a racial comment with a resident. This affected 1 of 4 residents reviewed for Resident Rights. (Resident #J).</p> <p>Findings include: The clinical record for Resident #J was</p>	F 0241	<p>Issue: F241- Based on recordreview and interview, the facility failed to ensure a resident was treated withdignity and respect for personal feelings in that a staff member made aninappropriate and racial comment with a resident. This affected 1 of 4 residents reviewed forResident Rights (Resident #J)</p> <p>1.Plan of correction: (immediate actions)</p> <p>1.Social Service to evaluate for mental/emotional</p>	09/23/2016

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	<p>reviewed on 9/8/16 at 11:00 a.m.</p> <p>Diagnoses included, but were not limited to: hemiplegia and hemiparesis affecting left side following cerebrovascular disease, heart failure, morbid obesity, and chronic obstructive pulmonary disease.</p> <p>The 8/29/16 Quarterly Minimum Data Set (MDS) assessment indicated the resident scored a 14/15 on the Brief Interview Mental Status (BIMS) - able to make daily decision making with good recall; had no behavior issues, and occasionally felt depressed and down.</p> <p>On 9/8/16 at 9:48 a.m., a confidential interview indicated CNA (Certified Nursing Assistant) #1 was "snobby and a racist" in the way she interacted with residents and staff and indicated to "Go ask Resident [name of resident]."</p> <p>During an interview on 9/8/16 at 10:10 a.m., Resident #J indicated he/she had no issues with any other staff member except CNA #1. Resident #J indicated CNA #1 was not happy when he/she wrote his/her name on a water pitcher. Resident #J indicated CNA #1 "yelled" it did not belong to him/her and said it belonged to the facility. Recently CNA #1 told another CNA to close the blinds to the outside because those "Mexicans" were out there. Resident #J indicated this</p>		<p>anguishrelated to this incident on Resident #J and follow up as indicated.</p> <p>2.Employee educated on diversity and cultural items,specifically with communication</p> <p>2.Others at risk: All residents are at risk:</p> <p>1.Interviewable residentsinterviewed to ensure no other concerns noted. Any concerns will be addressedimmediately.</p> <p>3.Education & Systemic Change:</p> <p>1.Staff to be educated on cultural sensitivity andcommunication</p> <p>2.Angel Round Tool updated to include asking residents howstaff treat them (residents), that will be asked 5x/week by department leadersto all residents, with concerns addressed daily</p> <p>4.Ongoing Monitoring of Efficacy:</p> <p>1.Designated Department Leaders to do Angel Rounds daily5x/week to ensure no residents have concerns with staff comments or treatmentthey receive. This monitoring ison-going and will have no stop date. Concerns will be addressed by the IDT, daily in morning meeting andreviewed through the grievance system monthly in</p>	

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F 0282 SS=D Bldg. 00	<p>offended him/her because one of his/her family member's were Hispanic. Resident #J indicated he/she told CNA #3 what was going on with CNA #1 after the CNA #3 heard the resident telling CNA #1 to just leave him/her alone.</p> <p>In an interview with the Administrator on 9/8/16 at 11:10 a.m., he indicated that what the CNA said was inappropriate in reference to the workers outside.</p> <p>During an interview on 9/8/16 at 11:40 a.m., the Social Worker indicated Resident #J was "very sweet and got along with everyone". The Social Worker was not aware Resident #J had an issue with CNA #1.</p> <p>This Federal tag relates to Complaints IN00206566 and IN00207432.</p> <p>3.1-3(t)</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. Based on record review and interview, the facility failed to follow the resident's physician order as written related to obtaining an Ultrasound of the abdomen</p>	F 0282	<p>QA meeting.</p> <p>Issue: F 282- Based on record review and interview, the facility failed to follow the resident's physician</p>	09/23/2016			

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	<p>for 1 of 4 residents reviewed for physician orders. (Resident #H).</p> <p>Findings include:</p> <p>The clinical record for Resident #H was reviewed on 9/7/16 at 8:35 a.m. Diagnoses included, but were not limited to: spinal fusion, hepatitis C, and spinal osteomyelitis.</p> <p>During an interview on 9/7/16 at 8:20 a.m., Resident #H indicated he/she was having pain and the Nurse Practitioner ordered an ultrasound of his/her abdomen a week ago. Resident #H further indicated the ultrasound was never scheduled and had not been done.</p> <p>During an interview with LPN #1 on 9/7/16 at 8:30 a.m., she pulled the physician orders up on the screen and indicated she did not see an order for an ultrasound to be performed.</p> <p>Review of the Physician orders and Progress Notes for the months of August and September, 2016, indicated a progress note was written by the Nurse Practitioner (NP) on 8/30/16. The progress note indicated Resident #H complained of having left lower quadrant pain. The NP subsequently wrote an order for a "LLQ (left lower quadrant)</p>		<p>order as written related to obtaining an ultrasound of the abdomen for 1 of 4 residents reviewed for physician's orders. (Resident #H)</p> <p>1. Plan of correction: (immediate actions)</p> <p>1. The resident was discharged home the day that this was found. Nurse Practitioner was aware and decided there was no longer a need for the ultrasound. Resident was to follow up with his primary MD after discharge</p> <p>2. Others at risk:</p> <p>All residents are at risk:</p> <p>1. 100% audit of all labs/test completed with no further incidents noted.</p> <p>3. Education & Systemic Change:</p> <p>1. 1:1 education with the nurse that failed to follow through on the order was done. Re-education with all nurses on the P&P of following physicians orders</p> <p>2. Lab audit tool implemented</p> <p>4. Ongoing Monitoring of Efficacy:</p> <p>1. DNS or designee to do lab/test audits 5x/week for a minimum of 6 months to ensure the same deficient practice does not occur. Findings will be addressed immediately and reviewed monthly in QA</p>	

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	<p>U/S (ultrasound) + (positive) pain/tenderness." No documentation of the ultrasound having been performed could be located in the computer or the clinical record.</p> <p>On 9/7/16 at 2:00 p.m., a request was made to the Medical Records Nurse for a copy of the ultrasound report.</p> <p>On 9/8/16 at 8:30 a.m., the Director of Nursing (DON) indicated she thought the ultrasound had been canceled but would check.</p> <p>On 9/8/16 at 10:30 a.m., the DON presented a copy of the physician order dated 9/7/16 which indicated "D/C (discontinue) LLQ U/S. Pain resolved/Pt (patient) d/cing home @ (at) noon."</p> <p>Review of the progress note, dated 9/7/26 9:55 a.m., LPN #1 indicated "Patient informed of new order for abdomen ultrasound, patient denies any abdominal pain or discomfort at this time. Patient states [he/she] is discharging home today @ [at]12:00 p.m. and if they [ultrasound company] do not come before 12:00, [he/she] will not have the ultrasound done." This conversation with the resident regarding the ultrasound occurred 9 days after the order had been received.</p>		meeting.	

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	<p>On 9/8/16 at 2:08 p.m., in an interview with the resident who had been discharged to home on 9/7/16, indicated that Resident #H was mad when the nurse came to tell him about the ultrasound because he felt they waited too long and that it was too late since he was going home. Resident #H further indicated he/she did tell the nurse to forget doing the test if the test could not be done in the facility before he/she left at noon that day.</p> <p>This Federal tag relates to Complaints IN00207432.</p> <p>3.1-35(g)(2)</p>				