

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155484	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  08/10/2016
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB-SOUTHWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 2222 MARGARET AVE TERRE HAUTE, IN 47802
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaints IN00206176, IN00206230, and IN00206361.</p> <p>Complaint IN00206176 - Unsubstantiated, due to lack of evidence.</p> <p>Complaint IN00206230 - Substantiated, State deficiency related to the allegations is cited at F309.</p> <p>Complaint IN00206361 - Substantiated, No deficiencies related to the allegations are cited.</p> <p>Survey dates: August 8, 9, 10, 2016</p> <p>Facility number: 000564 Provider number: 155484 AIM number: 100285610</p> <p>Census bed type: SNF/NF: 107 Total: 107</p> <p>Census payor type: Medicare: 14 Medicaid: 71 Other: 22 Total: 107</p>	F 0000		
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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 0309 SS=D Bldg. 00	<p>Sample: 6</p> <p>This deficiency reflects state findings in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed 8/12/16 by 29479.</p> <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 record review and interview, the facility failed to ensure skin treatments were applied and documented for 1 of 3 residents reviewed for skin/wound care (Resident D).</p> <p>Findings include:</p> <p>1. The record for Resident D was reviewed on 8/8/16 at 2:25 p.m. Resident D's diagnoses included, but were not limited to, diabetes mellitus, anxiety, and congenital renal failure.</p> <p>A physician's order, dated 6/10/16, indicated Gentamycin Cream (an antibiotic preparation for topical administration) was to be applied to the</p>	F 0309	<p>Facility respectfully request a desk review for paper compliance. Resident #D was not harmed as a result of this error. Licensed staff were re-educated on following physician orders, delivery of treatments with emphasizing on documenting the treatments were delivered. Physician/NP and family were notified of the treatment administration error. All residents have the potential for treatment error. All licensed staff were re-educated on following physician orders, delivery of treatments with emphasizing on documenting the treatments were delivered. All other current wound treatments reviewed. Physician/NP notified of any missed/not documented treatments. In order</p>	08/24/2016

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	<p>left foot second toe for abscessed toenails twice a day until healed. This was discontinued on 6/27/16. A physician's order, dated 6/28/16, indicated Gentamycin Cream was to be administered topically to the third toe left foot for abscessed toenails twice a day. This was discontinued on 7/25/16.</p> <p>The June, 2016, TAR (Treatment Administration Record) did not indicate the treatment had been done on day shift June 23, 25, or 26, 2016. The record did not indicate the treatment had been done on June 18, 19, 22, or 23, 2016.</p> <p>The July, 2016, TAR indicated the treatment had not been done on day shift on July 4, 5, 6, 7, 9, 10, 17, 19, 20, 21, 23, 24, or 25, 2016. The TAR indicated the treatment had not been done on evening shift on July 2, 3, 6, 7, 13, 14, 15, 17, 19, 20, 22, 23, or 24, 2016.</p> <p>The June and July, 2016, TARs did not indicate a reason the entries were not documented.</p> <p>During an interview on 8/9/16 at 1:30 p.m., Unit Manager #1 indicated if Resident D said the treatment hadn't been done, and there was no documentation of it being done, it may not have been done. Unit Manager #1 also indicated the</p>		<p>for this deficient practice not to re-occur, SDC/Designee will continue current practice of physician ordered treatments being followed and documented. Treatment administration records will be reviewed 2 times per week by DNS/Designee to ensure continued compliance. Facility has employed an additional licensed Unit Manager that will continue the Treatment reviews on the 2p-10p shift. Result of reviews will be reported to the DNS. Any concerns will be addressed at the time of discovery. DNS will report review results monthly to the facility Performance Improvement Meeting for 6 months then quarterly thereafter.</p>	

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	<p>resident had a doctor's appointment on 6/26/16, and that may have caused the treatment not to be done that day.</p> <p>The DNS (Director of Nursing Services) indicated during an interview on 8/10/16 at 10:30 a.m. that she herself had occasionally done some treatments to help out, had told the nurses she had done them. She indicated she had not documented that the treatments were done, but thought the nurses would document them.</p> <p>A current facility policy, dated 1/9/06, was provided by the DNS on 8/10/16 at 9:00 a.m. The policy, titled "Treatment Administration Record [TAR]", indicated "Purpose of the Form: To record treatment provided either by a physician's order or by nursing order on admission and/or monthly. To record reasons for treatment being held or not administered, and to record the response to treatment...Instructions for use:...1. Initial the appropriate box to verify treatment was given. 2. Circle initials if treatment was held/refused and note reason on the reverse side...."</p> <p>This federal tag relates to Complaint IN00206230.</p> <p>3.1-37(a)</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/26/2016

FORM APPROVED

OMB NO. 0938-0391

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