

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155659		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 04/28/2011	
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG				STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HIGHWAY # 60 SELLERSBURG, IN47172			
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F0000	<p>This visit was for Investigation of Complaint IN00089340.</p> <p>Complaint IN00089340 - Substantiated. Federal/state deficiencies related to the allegations are cited at F241 and F323.</p> <p>Survey dates: April 27 and 28, 2011</p> <p>Facility number: 010613 Provider number: 155659 AIM number: 200221040</p> <p>Survey team: Jennie Bartelt, RN</p> <p>Census bed type: SNF: 15 SNF/NF: 78 Total: 93</p> <p>Census payor type: Medicare: 36 Medicaid: 41 Other: 16</p>			F0000	<p>This Plan of Correction is the facilities credible allegation of compliance.</p> <p>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>		

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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F0241 SS=D	<p>Total: 93</p> <p>Sample: 7</p> <p>These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed 5-1-11 Cathy Emswiller RN</p> <p>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 call lights and requests for help were answered timely to provide assistance for residents to use the toilet. The deficient practice affected 2 of 4 residents reviewed related to call light response in a sample of 7. (Residents C and G)</p> <p>Findings include:</p>	F0241	<p>It is the policy of this facility to promote care for residents in a manner and in an enviroment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Resident C has been discharged from the center so no corrective action could be taken. Social Services Director will assess Resident G for signs and symptoms of psychosocial decline. The DNS or designee will in-service nursing staff members</p>	05/23/2011	

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	<p>On 4/27/11 at 11:15 a.m., the Administrator provided paperwork including, but not limited to, a list of residents, with interviewable residents identified by yellow highlighting. Review of the list indicated Residents G and C were interviewable.</p> <p>1. On 4/27/11 at 2:20 p.m., Resident G was observed seated in her wheel chair next to her bed in her room. The resident was wearing a prosthesis to the left leg. During interview at this time, the resident indicated she was just getting accustomed to her leg prosthesis and was having some trouble with it. The resident indicated she needed the assistance of two to help her transfer from bed to the bedside commode observed next to her bed. She indicated her call light was not always answered timely. She indicated recently she had timed the call light response. She indicated she was sitting at the foot of her bed, waiting to use her bedside commode, and rang her call light at 6:05 a.m. She indicated the light was still on at 7:25 a.m., and no one had come to assist her. She indicated staff walked past the door to her room but did not stop. She indicated that later the aide assigned to her apologized and said he could not help her, because he was giving another resident a shower. She indicated she often timed call light response, and had sat as long as</p>		<p>assigned to Resident G regarding maintaining resident dignity with emphasis on timely response to call light and toileting needs.</p> <p>Residents who require assistance with toileting have the potential to be affected. Social Service Director or designee will identify through individual interviews those residents who feel they are not receiving timely call light response for toileting assistance advising the DNS of findings. DNS or designee, through record review and observation will identify non-interviewable residents not receiving timely call light response for toileting assistance. DNS or designee will in-service staff responsible for care of residents identified through this process.</p> <p>Staff Development Coordinator or designee will in-service nursing staff, by 5/23/11, on maintaining / enhancing resident dignity with an emphasis on timely response to call light and request for toileting assistance. This in-service will be added to new employee orientation for nursing staff. Social Service Director or designee will conduct random interviews 3 times per week for 3 months to ascertain if the residents are being treated in a manner that maintains or enhances dignity related call light response for toileting assistance and will report complaints or concerns to Executive Director for follow through. DNS or</p>		

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	<p>40 minutes for someone to come and assist her from the bedside commode back into bed or to the wheel chair. She indicated sometimes staff come in when she rings her call light, turn off the call light, and say they will get someone to assist and then don't return. The resident indicated she had not had bladder incontinence while waiting, because of a rectocele in the past, which causes her to use a special posture to empty her bladder, or she could not have waited. She indicated she had experienced "accidents with her bowels" due to waiting. The resident indicated some aides are very helpful, and when they are on duty, she knows she will get the help she needs. She indicated others are working to collect a paycheck.</p> <p>The clinical record for Resident G was reviewed on 4/28/11 at 12:55 p.m. The record indicated the resident was admitted 3/24/11 with diagnoses including, but not limited to, left below the knee amputation (BKA).</p> <p>The Comprehensive Care Plan Report, dated 4/1/11, indicated a problem of "Self-care deficit: bathing and personal hygiene requires assist r/t [related to] left BKA, COPD [chronic obstructive pulmonary disease], CHF [congestive heart failure], and leukemia." Approaches included, but were not limited to, "Assist with toileting PRN [as needed] to maintain continence."</p> <p>3. During interview on 4/27/11 at 4:20 p.m., Resident C was observed seated on her bed with</p>		<p>designee will conduct random audits of call light response time 5 times per week for a period of 3 months.</p> <p>Results of the above noted interviews and audits will be reported monthly to the Performance Improvement (P.I.) Committee for a period of 3 months. After 3 months the P.I. committee will determine if ongoing monitoring is necessary.</p> <p>The DNS or designee will be responsible to ensure this standard has been met.</p>				

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	<p>oxygen by nasal cannula to the nose. Two visitors were with the resident. The resident answered her phone as the interview began. The visitor, who identified herself as the resident's daughter, indicated the resident had fallen at the hospital, was admitted to the facility "yesterday," and had fallen this afternoon. She indicated the resident was not getting the help she needs. She indicated the resident had been up all night due to diarrhea. The resident completed her phone call and indicated she had been up to the bathroom several times during the night without help, because she had diarrhea, and an aide finally had to come to help clean her up.</p> <p>The clinical record for Resident C was reviewed on 4/27/11 at 4:40 p.m. and indicated the resident was admitted on 4/25/11.</p> <p>The Nursing Assessment/Full, dated 4/25/11, indicated the resident's Functional Status for Toilet Use was "Limited Assist" of one person.</p> <p>The Care Plan Update, dated 4/27/11, and signed by the Physical Therapist, indicated, "Problem: 1) Generalized weakness, 2) Decline in bed mobility, 3) Decline in transfer skills, 4) Decline in amb [ambulation] skills."</p> <p>On 4/28/11 at 2:05 p.m., Resident C was observed in her wheel chair in the hallway outside the facility's Greenhouse Room. Resident C was overheard talking with Case Manager #2 who stood next to the wheel chair. The resident indicated she was "hollering for the nurse all night," and then "messed my pants." Case Manager #2 instructed the resident to remember to use her call light.</p> <p>This federal tag related to Complaint IN00089340.</p>				

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F0323 SS=D	<p>3-1-3(t)</p> <p>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 the resident's call light was answered timely to provide supervision and assistance with transfers for 3 of 4 residents at risk for falls who were interviewed related to assistance with transfers in a sample of 7. (Residents G, C, and H)</p> <p>Findings include:</p> <p>On 4/27/11 at 11:15 a.m., the Administrator provided paperwork including, but not limited to, a list of residents, with interviewable residents identified by yellow highlighting. Review of the list indicated Residents G, C, and H</p>	F0323	<p>It is the policy of this facility to 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. Resident C and Resident H have been discharged from the center so no corrective action could be taken. DNS will review the clinical record of Resident G to determine current level of transfer assistance needed. The nursing staff assigned to Resident G will be in-serviced on the transfer status and current level of assistance necessary for this resident and the need for timeliness in responding to call light and request for transfer assistance. Residents requiring</p>	05/23/2011	

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	<p>were interviewable.</p> <p>1. On 4/27/11 at 2:20 p.m., Resident G was observed seated in her wheel chair next to her bed in her room. The resident was wearing a prosthesis to the left leg. During interview at this time, the resident indicated she was just getting accustomed to her leg prosthesis and was having some trouble with it. The resident indicated she needed the assistance of two to help her transfer from bed to the bedside commode observed next to her bed. She indicated her call light was not always answered timely. She indicated recently she had timed the call light response. She indicated she was sitting at the foot of her bed, waiting to use her bedside commode, and rang her call light at 6:05 a.m. She indicated the light was still on at 7:25 a.m., and no one had come to assist her. She indicated staff walked past the door to her room but did not stop. She indicated that later the aide assigned to her apologized and said he could not help her, because he was giving another resident a shower. She indicated she often times call light response and had sat as long as 40 minutes for someone to come and assist her from the bedside commode back into bed or to the wheel chair. She indicated sometimes staff come in when she rings her call light, turn off the call light, and say they will get someone to</p>		<p>transfer assistance have the potential to be affected. Social Service Director or designee will identify through individual interviews residents that feel call light was not answered timely to provide with transfer assistance and will advise DNS of findings. DNS or designee, through record review and observation will identify non-interviewable residents not receiving timely call light response for transfer assistance and will act accordingly to ensure assistance is provided. DNS or designee will in-service staff responsible for care of residents identified through this process. Staff Development Coordinator or designee will in-service nursing staff, by 5/23/11, on policy for call light response and on responding timely to resident request for transfer assistance. DNS or designee will conduct random resident interviews to ascertain if the residents are receiving timely assistance and response to transfer needs The random interviews will be conducted 3 times per week for a period of 3 months,. DNS or designee will conduct random audits of call light response time 5 times per week to ensure that residents are receiving timely assistance for transfers. This audit will be conducted for 3 months. Results of the above noted interviews and audits will be reported monthly to the Performance Improvement</p>		

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	<p>assist and then don't return. She indicated that she had sometimes requested the aide to pull the bedside commode next to her on the bed, and if the aide held the bedside commode steady, she would transfer herself to the commode. She indicated she realized there was a chance of falling when she did this, but "when ya gotta go, ya gotta go." The resident indicated she had not had bladder incontinence while waiting, because of a rectocele in the past, which causes her to use a special posture to empty her bladder. She indicated she had experienced "accidents with her bowels" due to waiting. The resident indicated some aides are very helpful, and when they are on duty, she knows she will get the help she needs. She indicated others are working to collect a paycheck.</p> <p>The clinical record for Resident G was reviewed on 4/28/11 at 12:55 p.m. The record indicated the resident was admitted 3/24/11 with diagnoses including, but not limited to, left below the knee amputation (BKA).</p> <p>The Comprehensive Care Plan Report, dated 4/1/11, indicated a problem of impaired physical mobility related to the left BKA. Approaches included, but were not limited to, "Keep call light in reach" and "Transfer with assist as needed."</p> <p>The Comprehensive Care Plan report, dated 4/1/11, also indicated a problem of "Potential for falls/injury related to weakness left BKA and use</p>		(P.I. Committee for a period of 3 months. After 3 months the P.I. committee will determine if ongoing monitoring is necessary. The DNS or designee will be responsible to ensure this standard has been met		

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	<p>of hypnotic." Approaches included, but were not limited to, "Keep call light within reach; demonstrate how to use it; encourage resident to use it. "</p> <p>The CNA Report Sheet was provided by Unit Manager #2 during the Initial Tour on 4/27/11 at 10:30 a.m. The assignment for Resident G, in the column for "Assist Device & Transfers indicated, "GB X 2." During interview on 4/28/11 at 12:30 p.m., Unit Manager #1 indicated the "GB X 2" meant the resident should be transferred using a gait belt and the assistance of two people for transfers.</p> <p>2. During interview on 4/27/11 at 3:00 p.m., Resident H was observed seated in a chair in her room, with her belongings packed. The resident indicated she was being discharged home. She indicated she had been at the facility for rehabilitation following surgery for a broken right arm in a car accident. The resident indicated on her second night in the facility she rang her call light for assistance up to the bedside commode. She indicated the aide came to the room and asked her if she could get up to the commode on her own, and then left the room. She indicated she was afraid, as she knew "if she fell out in the floor" she would really have a problem. She indicated "the girl on duty didn't help," and she managed on her own to get to the bedside commode and back into bed.</p> <p>The clinical record for Resident H was reviewed on 4/28/11 at 12:15 p.m. The record indicated the resident was admitted to the facility on 4/11/11 with a primary diagnosis of right arm fracture indicated on the hospital "Patient Transfer Form" dated 4/11/11.</p>				

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	<p>The Interim Plan of Care, dated 4/11/11, indicated "Problem/Need, @ risk for falls r/t [related to] weakness."</p> <p>The CNA Report Sheet was provided by Unit Manager #2 during the Initial Tour on 4/27/11 at 10:30 a.m. The assignment for Resident H, in the column for "Assist Device & Transfers indicated, "GB X 2." During interview on 4/28/11 at 12:30 p.m., Unit Manager #1 indicated the "GB X 2" meant the resident should be transferred using a gait belt and the assistance of two people for transfers.</p> <p>3. During interview on 4/27/11 at 4:20 p.m., Resident C was observed seated on her bed with oxygen by nasal cannula to the nose. Two visitors were with the resident. The resident answered her phone as the interview began. The visitor, who identified herself as the resident's daughter, indicated the resident had fallen at the hospital, was admitted to the facility "yesterday," and had fallen this afternoon. She indicated the resident was not getting the help she needs. She indicated the therapist returned the resident to the bedside in her wheel chair this afternoon, and the resident was exhausted. She indicated the resident had been up all night due to diarrhea. She indicated the resident had her call light on, but no one came, so the resident transferred herself to bed and fell in the process. The resident completed her phone conversation and stated, "The PT lady rolled me in." The resident indicated she had been up to the bathroom several times during the night without help, because she had diarrhea, and an aide finally had to come to help clean her up. The resident indicated she stumped one foot against the other when she fell getting back into bed after her therapy session.</p>						

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	<p>During interview on 4/27/11 at 4:40 p.m., Unit Manager #2 indicated therapy had returned Resident C to her room. UM #2 indicated the resident had her call light on, but got impatient and transferred herself. UM #2 indicated the resident was wearing slippery socks, and the resident had now been given gripper socks to wear. UM #2 indicated therapy is not allowed to assist residents back into bed.</p> <p>The clinical record for Resident C was reviewed on 4/27/11 at 4:40 p.m. and indicated the resident was admitted on 4/25/11.</p> <p>A Resident Progress Note for nursing indicated for 4/27/11 at 2:40 p.m., "Called to pt. [patient's] room by CNA upon entering room noticed pt sitting on floor. Therapy had returned pt to room, pt had turned call light on was sitting in w/c wanting to go to bed. Pt tried to transfer self to bed. Pt. stated, 'legs gave out.' Pt noted to have socks on...."</p> <p>The Nursing Assessment/Full, dated 4/25/11, indicated the resident was a high risk for falls due to visual deficits, medications, need to transfer/ambulate with a caregiver, use of a device for transfer/ambulation, recent decreased mobility, and previous falls within the past six months.</p> <p>The Interim Plan of Care, dated 4/25/11, indicated, "Problem/Need, @risk for falls r/t generalized weakness." Approaches included, but were not limited to, "Keep call light within reach."</p> <p>On 4/28/11 at 2:05 p.m., Resident C was observed in her wheel chair in the hallway outside the facility's Greenhouse Room. Resident C was overheard talking with Case Manager #2 who stood next to the wheel chair. The resident</p>				

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	<p>indicated she was "hollering for the nurse all night," and then "messed my pants." Case Manager #2 instructed the resident to remember to use her call light.</p> <p>This federal tag related to Complaint IN00089340.</p> <p>3.1-45(a)(2)</p>				