

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction with the Investigation of Complaint IN00158975.</p> <p>Survey dates: November 13, 14, 17, 18, 19, 20, 21, 24, and 25, 2014</p> <p>Facility number: 000101 Provider number: 155193 AIM number: 100291290</p> <p>Survey team: Dorothy Plummer, RN-TC Marsha Smith, RN Karyn Homan, RN (November 13, 2014)</p> <p>Census bed type: SNF/NF: 159 Total: 159</p> <p>Census payor type: Medicare: 47 Medicaid: 104 Other: 8 Total: 159</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F000000	<p>Ms. Kim Rhoades Indiana State Department of Health Long Term Care Division 2 North Meridian Street, Section 4B Indianapolis, Indiana 46204 December 10, 2014 RE: Survey Event ID: TBN111 Dear Ms. Rhoades: Attached you will find the completed Plan of Correction and attachments for our Annual Licensure Survey dated November 25, 2014. We request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (317) 888-4948. Sincerely, Steve Tanner HFA Executive Director</p>	
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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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F000156 SS=E	<p>Quality review completed on December 05, 2014; by Kimberly Perigo, RN.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p>						

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	<p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to</p>			

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	<p>residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>Based on record review and interview, the facility failed to ensure residents were provided with ongoing education regarding their resident rights during their stay at the facility for 5 of 5 residents interviewed. (Residents #1, #195, #98, #150, and #53)</p> <p>Findings include:</p> <p>On 11/25/14 at 5:10 p.m., the Executive Director indicated a copy of Residents' Rights was given to every resident upon admission. He indicated a poster with Residents' Rights was on a wall in the facility.</p> <p>On 11/21/14 at 10:00 a.m., Resident #1 indicated he was not aware of his rights as a resident of the facility. He indicated resident rights had not been discussed during Resident Council meetings. A quarterly Minimum Data Set (MDS) assessment, dated 10/20/14, indicated Resident #1 was independent in his ability to make decisions.</p> <p>On 11/24/14 at 11:17 a.m., when asked if she was aware of her rights as a resident</p>	F000156	<p>1.Residents #1 expired. Residents #195, 98, 150 and 53 were given a copy of the Resident Rights and receipt has been acknowledged in writing.</p> <p>2.All residents have the potential to be affected. Social services have provided all residents with a copy of Resident Rights and a written receipt acknowledging receipt has been placed in the resident's medical record.</p> <p>3.In-servicing has been completed with Social services and activities departments on Resident Rights and discussing with the resident in a language that the resident understands.</p> <p>4.The SSD will audit all admissions weekly for 3 months to validate receipt of the resident rights. The Activities Director will address monthly in resident council any concerns or questions regarding resident rights. All findings will be reported in monthly PI meeting and the PI committee will determine if 100% compliance has been achieved or if any further monitoring is required.</p>	12/25/2014

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	<p>at the facility, Resident #195 indicated, "I have no idea." A quarterly MDS assessment, dated 11/2/14, indicated Resident #195 was independent in her ability to make decisions.</p> <p>On 11/24/14 at 11:05 a.m., when asked if she was aware of her rights as a resident at the facility, Resident #98 indicated, "No, not really. What are they?" A quarterly MDS assessment, dated 10/13/14, indicated Resident #98 was moderately impaired in her ability to make decisions.</p> <p>On 11/24/14 at 11:07 a.m., when asked if she was aware of her rights as a resident at the facility, Resident #150 indicated, "No, I'm not familiar with resident rights. I didn't even know we had any rights." A quarterly MDS assessment, dated 10/7/14, indicated Resident #150 was independent in her ability to make decisions.</p> <p>On 11/24/14 at 11:16 a.m., when asked if she was aware of her rights as a resident at the facility, Resident #53 indicated, "I don't know." A quarterly MDS assessment, dated 10/6/14, indicated Resident #53 was independent in her ability to make decisions.</p> <p>Residents #1, #195, #98, #150 and #53</p>			

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F000221 SS=D	<p>did not indicate they knew where the Residents Rights poster was located. They indicated they did not remember anyone on the staff discussing Resident Rights with them.</p> <p>3.1-4(a)</p> <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>Based on interview and record review, the facility failed to assess the need for a restraint on a quarterly basis for a resident having a physical restraint for 1 of 1 residents reviewed for restraints. (Resident #2)</p> <p>Findings include:</p> <p>The clinical record review of Resident #2, completed on 11/25/14 at 9:08 a.m., indicated the resident had diagnoses including, but not limited to, cerebral palsy.</p> <p>A review of the recapitulation of physician's orders for November 2014, indicated the resident had an order for a reclining wheelchair (w/c) with a lap tray</p>	F000221	<p>1. Resident #2 has had an assessment completed for the need of a restraint on 11/22/2014.</p> <p>2. All other residents with a restraint have the potential to be affected. An audit of all residents with a restraint has been completed to validate an assessment for the need of the restraint has been completed quarterly or with significant change.</p> <p>3. The nursing managers have been educated and in-serviced on Restraints and frequency of assessments at least quarterly and/or with significant change to determine the least restrictive device is to be used.</p> <p>4. The DNS/Designee will audit all residents with an order for a restraint device upon initiation, quarterly and with significant change weekly for 30 days, then twice a month for 30 days, then once a month for 30 days and</p>	12/25/2014

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F000241 SS=D	<p>and a seat belt when out of bed.</p> <p>A plan of care dated 6/19/14, indicated the resident had impaired physical mobility related to cerebral palsy and scoliosis. Interventions included, but were not limited to, up in reclining w/c with self releasing seat belt and lap tray to allow for upright positioning.</p> <p>A review of Physical Restraint Evaluations in the record indicated the resident was assessed 2/22/14 and 8/22/14 for use of the physical restraint.</p> <p>During an interview with the Director of Nursing (DON) on 9/25/14 at 9:32 a.m., the DON indicated the assessments were updated every 6 months for the restraints.</p> <p>On 11/25/14 at 9:37 a.m., the DON provided a policy titled Restraints, dated 4/28/09, and indicated the policy was the one currently used by the facility. The policy indicated, "...8...a. Assess and review at least quarterly and/or with a significant change...."</p> <p>3.1-3(w)</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</p>		then quarterly. All findings will be reported to the PI committee and the PI committee will determine when 100% compliance is achieved or if further monitoring is required.	

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	<p>maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation, interview, and record review, the facility failed to maintain an environment free of postings of signs of clinical or care information for 2 of 4 residents reviewed for dignity. (Resident #278 and Resident # 53)</p> <p>Findings include:</p> <p>1. The clinical record review of Resident #53, completed on 11/20/14 at 11:50 a.m., indicated the resident had diagnoses including, but not limited to, amputation of the right leg.</p> <p>During a Stage 1 interview on 11/17/14 at 5:11 p.m., Resident #53 indicated two handwritten signs were placed on the wall and on the closet by therapy. The signs instructed staff to assist the resident with applying a prosthesis on Tuesday, Thursday, Saturday, and Sunday. The resident indicated the signs, "Kind of bothers me and the staff doesn't pay any attention to them. I haven't been able to wear my prosthesis for some time now because of a sore place on my stump."</p> <p>During a review of the Certified Nursing Assistant Caresheet dated 11/18/14,</p>	F000241	<p>1. Resident #278 and #53 have had all signs removed from their room. Clinical information has been included in resident #278 and #53's care plan and on the C.N.A. assignment sheets.</p> <p>2. All residents have the potential to be affected. An audit of every room was completed to validate the environment is free of postings of clinical or care information.</p> <p>3. All staff have been educated on Quality of Life with emphasis on dignity and an environment free of postings of signs of clinical or care information.</p> <p>4. The DNS/Designee will audit all rooms weekly to validate an environment free of signage for 30 days, then twice a month, then monthly. All findings will be reported in the monthly PI meeting and the PI committee will determine when 100% compliance has been achieved or if further monitoring is required.</p>	12/25/2014

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	<p>indicated the resident required assistance with the prosthesis on Monday, Wednesday, and Fridays.</p> <p>During an interview with Unit Manager (UM) #2 on 11/20/14 at 10:00 a.m., UM #2 indicated the signs were placed by therapy and UM #2 would speak with therapy about it.</p> <p>2. The clinical record review of Resident #278, completed on 11/20/14 at 1:35 p.m., indicated the resident had diagnoses including, but were not limited to, traumatic brain injury.</p> <p>During a Stage 1 observation on 11/13/14 at 3:30 p.m., the resident was noted to have a handwritten sign posted on the bulletin board at the bedside indicating, "Please place [name of resident] splints on at 0800 [8:00 a.m.] and remove at 2100 [9:00 p.m]."</p> <p>A plan of care dated 10/15/14, indicated the resident had an contractures and was at risk for contractures (fixed high resistance to passive stretch of a muscle) related to impaired functional range of motion of ankles and wrists. Interventions included, but were not limited to, restorative splinting program for both ankles and wrists.</p>			

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F000248 SS=D	<p>A second plan of care dated 10/15/14, indicated the resident was at risk of developing further impairment in functional joint mobility related to inactivity from impaired cognition. Interventions included, but were not limited to, apply devices to affected joints as ordered.</p> <p>A review of the recapitulation of physician's orders for November 2014, lacked orders for devices to affected joints.</p> <p>During an interview with Unit Manager (UM) #2 on 11/20/14 at 10:00 a.m., UM #2 indicated the family had requested the sign as a reminder to staff to apply the splints.</p> <p>During an interview with the Director of Nursing (DON) on 11/24/14 at 1:05 p.m., the DON indicated the facility did not have a specific policy related to the posting of signs containing clinical information in residents' rooms.</p> <p>3.1-3(t)</p> <p>483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES</p>						

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	<p>The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.</p> <p>Based on observation, record review, and interview, the facility failed to ensure a resident was provided with activities of interest, for 1 of 3 residents who met the criteria for review of activities. (Resident #278)</p> <p>Findings include:</p> <p>The clinical record of Resident #278 was reviewed on 11/20/14 at 3:57 p.m. Diagnoses for the resident included, but were not limited to, traumatic brain injury, persistent vegetative state, and respiratory failure.</p> <p>On 11/20/14 at 2:55 p.m., the Activity Director (AD) indicated Resident #278's a Aunt told him the resident used to like rap and country music, and especially liked to watch the television show Roseanne. The Activity Director indicated, "We try to have these on for him, it should be on the Certified Nursing Assistant (CNA) Care Sheet."</p> <p>A care plan, dated 10/22/14, indicated, "[name of resident] is dependent on staff</p>	F000248	<p>1.The C.N.A. sheet for resident #278 has been updated to include information for his activities of interest regarding music and television. Upon interview of resident #114 (roommate) he stated he was turning off the television for resident #278 and the music. The AD has been validating daily the television are turned on in resident #278's room and his view is unobstructed.</p> <p>2.All residents have the potential to be affected. An audit has been completed on all residents to validate the Pleasant and Meaningful assessment has been completed to identify the residents' activities of interest, a care plan includes the activities of interest, the C.N.A. sheets are current with information regarding the residents' activities of interest for participation. Residents needing 1:1 activity time have been identified and a plan for their activities of interest included in the care plan.</p> <p>3.All nursing, social services and activities staff have been educated on Developing Activity Programs with emphasis on personnel participation with implementing assistance to activities or with activities of interest.</p> <p>4.The AD/Designee will audit</p>	12/25/2014

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	<p>for activities, sensory stimulation, r/t [related to] physical limitations." The goal was Resident #278 would maintain involvement in sensory stimulation activities through review date.</p> <p>Interventions included, "[name of resident] preferred activities per family are listening to rap, country and relaxation music...When [name of resident] is awake turn on TV to news or channel 49 to watch Roseanne...turn on rap, country, relaxation music in room to provide sensory stimulation."</p> <p>A Pleasant and Meaningful Activities Assessment, dated 10/22/14, indicated Resident #278 enjoyed family and friends time, listening to rap, country and relaxation music, and watching television.</p> <p>No music or television was on during observations of Resident #278 in his room, on 11/13/14 at 5:00 p.m., 11/14/14 at 12:01 p.m., 11/17/14 at 11:17 a.m., 11/19/14 at 9:45 a.m., 11/20/14 at 10:22 a.m., and 11/20/14 at 3:39 p.m.</p> <p>A CNA care sheet, dated 11/18/14, did not contain any information regarding television or music for Resident #278.</p> <p>On 11/20/14 at 3:39 p.m., the television was observed to be 10 or 11 feet away</p>		<p>daily for 30 days all residents on 1:1 activities for validation the activity has occurred, then three times a week for 30 days and then twice a week for 30 days. All findings will be reviewed in monthly PI meeting. The PI committee will determine when 100% compliance is achieved or if further monitoring is required</p>	

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	<p>from the resident, partially obscured by a bedside table. No music discs were observed in the room.</p> <p>On 11/20/14 at 4:14 p.m., the AD indicated Resident #278 did not receive any 1:1 activity time, because family was in every day. The AD indicated no residents in the facility were receiving any 1:1 activity time, which was time activity staff would spend with a resident who was unable to participate in any facility activity programs due to physical or mental limitations.</p> <p>On 11/21/14 at 3:40 p.m., Resident #278's roommate (Resident #114) indicated Resident #278 had visitors, "maybe once a week."</p> <p>On 11/21/14 at 3:45 p.m. Unit Manager #2 indicated she had never seen Resident #278 have any visitors.</p> <p>On 11/21/14 at 3:50 p.m., Registered Nurse #3 indicated the resident had a visitor about once a week.</p> <p>On 11/25/14 at 9:00 a.m., the AD provided a policy, dated 6/30/06, titled Developing Activity Programs, and indicated it was the policy currently used by the facility. The policy indicated, "Rationale An activity program is</p>						

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F000278 SS=D	<p>developed based on the resident's individual needs and preferences. They are designed to enhance the well being of each resident....Sensory strengths: Small group and individual activity sessions should incorporate sensory stimuli...There are some individual activities that can also have a goal of human connections..providing a list of preferred activities to staff members..."</p> <p>3.1-33(a)</p> <p>483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a</p>			

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	<p>resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>Based on record review and interview, the facility failed to ensure Minimum Data Set assessments were accurately coded to reflect the status of a resident with a pressure ulcer (Resident #262), a resident with functional limitations (Resident #278), and a resident with a multi-drug resistant organism. (Resident #119)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #262 was reviewed on 11/20/14 at 11:00 a.m. Diagnoses included, but were not limited to, peripheral vascular disease and a stroke with paralysis.</p> <p>Resident #262 was readmitted to the facility on 6/4/14. A Pressure Ulcer Report, dated 6/16/14, indicated the resident had a Stage 1 pressure ulcer on his coccyx (base of the spinal column).</p> <p>A readmission Minimum Data Set (MDS) assessment, dated 6/21/14, indicated Resident #262 did not have a pressure ulcer. The assessment was electronically signed by RN #11, which</p>	F000278	<p>1. Resident #262 had a modified MDS accepted on 11/21/2014 to reflect the pressure ulcer. Resident #119 had a modification submitted to the current quarterly MDS to reflect his accurate isolation status. The MDS for resident #278 could not be modified. The MDS coordinator is auditing all ADL coding for accuracy and completeness.</p> <p>2. All residents have the potential to be affected. An audit of all MDS for accurate ADL coding, pressure ulcers and isolation status has been completed.</p> <p>3. Education has been completed with the MDS Coordinators on accurate MDS coding.</p> <p>4. The DDCM/Designee will validate the accuracy of the MDS before submission for any resident with a pressure ulcer and isolation status for 3 months. The DDCM/Designee will validate the accurate ADL coding for 3 residents a week prior to the MDS submission. All findings will be reported in monthly PI meeting and the PI committee will determine when 100% compliance is achieved.</p>	12/25/2014

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	<p>indicated, "I certify that the accompanying information accurately reflects resident assessment information for this resident..."</p> <p>On 11/20/14 at 2:30 p.m., MDS Coordinator #10 indicated the readmission MDS dated 6/21/14, should have indicated Resident #262 had a pressure ulcer.</p> <p>2. The clinical record of Resident #278 was reviewed on 11/20/14 at 3:57 p.m. Diagnoses for the resident included, but were not limited to, traumatic brain injury, persistent vegetative state, and respiratory failure.</p> <p>An admission Minimum Data Set assessment, dated 7/7/14, indicated Resident #278 needed extensive assistance from staff for bed mobility, eating, and toileting.</p> <p>An Activities of Daily Living flowsheet for July, 2014, indicated from 7/1/14 through 7/7/14, Resident #278 required "Total Dependence" for bed mobility, eating, and toileting.</p> <p>On 11/21/14 at 3:00 p.m., MDS Coordinator #10 indicated the assessment period for Resident #278's admission MDS assessment was 7/1/14 through</p>			

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	<p>7/7/14 and coding for bed mobility, toileting, and eating would be based on the Activities of Daily Living flowsheet.</p> <p>This admission MDS assessment was electronically signed by MDS Coordinator #10, which indicated, "I certify that the accompanying information accurately reflects resident assessment information for this resident..." It was further electronically signed by RN #12, "Verifying Assessment Completion."</p> <p>3. The clinical record review of Resident #119, completed on 11/19/14 at 3:00 p.m., indicated the resident had diagnoses including, but not limited to, surgical wound infection on the coccyx (base of the spinal column) .</p> <p>The resident was admitted to the facility on 8/30/14, and was placed into contact isolation due to Methicillin Resistant Staphylococcus Aureus (MRSA, a type of organism/bacteria resistant to multiple drugs) infection in the surgical wound.</p> <p>A review of the recapitulation of physician's orders dated 8/30/14, indicated the resident was receiving ampicillin-Sulbactam Solution (an antibiotic) intravenously (IV) every 6 hours for MRSA in the peri-rectal</p>						

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	<p>wound.</p> <p>An Admission Minimum Data Set (MDS) assessment completed 9/6/14, did not assess the resident as having a multi-drug resistant organism (MDRO) as an active diagnosis. The assessment was electronically signed by MDS #12 on 9/18/14, verifying assessment completion.</p> <p>A plan of care dated 9/10/14, indicated the resident had a wound infection with MRSA. Interventions included, but were not limited to, contact isolation.</p> <p>A Quarterly Minimum Data Set (MDS) assessment completed 10/25/14, did not assess the resident as having a multi-drug resistant organism (MDRO) as an active diagnosis. This quarterly MDS assessment was electronically signed by MDS Coordinator #10, which indicated, "I certify that the accompanying information accurately reflects resident assessment information for this resident..." It was further electronically signed by RN #12, "Verifying Assessment Completion."</p> <p>A review of the recapitulation of physician's orders dated 11/24/14, indicated the resident continued to receive antibiotic medications to treat the</p>				

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F000279 SS=D	<p>wound infection.</p> <p>During an interview with MDS Coordinator #10 on 11/20/14 at 3:00 p.m., the MDS Coordinator #10 indicated the resident was admitted with MRSA and should have been coded on all of the MDS assessments as having a MDRO infection.</p> <p>3.1-31(i)</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to ensure a care plan</p>	F000279	1.Resident #30 had a care plan for anticoagulation initiated on 11/24/2014.	12/25/2014			

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	<p>was developed for a resident receiving an anticoagulant medication for 1 of 5 residents reviewed for unnecessary medication use. (Resident #30)</p> <p>Findings include:</p> <p>The clinical record of Resident #30 was reviewed on 11/19/14 at 11:58 a.m. Diagnoses for the resident included, but were not limited to, deep vein thrombosis (blood clot) and Alzheimer's disease.</p> <p>Recapitulated physician's orders for November, 2014, with an original order date of 10/6/14, indicated Resident #30 was to receive Coumadin daily. Coumadin is an anticoagulant medication used to help prevent blood clots. Side effects can include unusual bleeding, bruising, and hemorrhage. (life threatening blood loss)</p> <p>A care plan which addressed Resident #30 being at risk for these side effects was not found in the resident's record.</p> <p>On 11/24/14 at 11:15 a.m., the Director of Nursing indicated Resident #30 was taken off Coumadin in September, 2014, so her anticoagulant care plan had been discontinued. When the resident was restarted on Coumadin on 10/6/14, the care plan was not put back in place as it</p>		<p>2. An audit was completed of all residents' on anticoagulants to validate the care plans were developed. Any resident without a care plan have had their plan of care updated to reflect their current status.</p> <p>3. All licensed nurses have been educated on developing care plans with change in condition.</p> <p>4. The DNS/Designee will audit 5 care plans a week for 3 months to validate accuracy, then care plans will be reviewed quarterly, annually and with significant change. All findings will be reported to the PI committee monthly in the monthly PI meeting. The PI committee will determine when 100% compliance is achieved or if continued monitoring is required.</p>				

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F000282 SS=E	<p>should have been.</p> <p>3.1-35(b)(1)</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <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 observation, interview, and record review, the facility failed to accurately record intake totals for 2 of 2 residents reviewed for fluid restrictions, (Resident #98 and Resident #53), failed to ensure splints were applied to prevent further contractures (fixed resistance of a muscle) for a resident in a persistent vegetative state (Resident #278), and failed to ensure a resident was provided meaningful activities as indicated in the written plan of care for 1 of 11 residents meeting the criteria for review of activities. (Resident #278)</p> <p>Findings include:</p> <p>1. The clinical record review for Resident # 98, completed on 11/24/14 at 12:04 p.m., indicated the resident had diagnoses including, but not limited to, end stage renal disease.</p> <p>A review of the recapitulation of</p>	F000282	<p>1. Resident #98 and #53 fluid intakes have been reviewed by the RD for accuracy related to the MD order for fluid restrictions. The Resident and MD have been updated on fluid intakes over the fluid restriction. Resident # 278 splint schedule has been added to the C.N.A. assignment sheet for the C.N.A. to apply bilateral splints. The C.N.A. sheet for resident # 278 has been updated with the activities of interest.</p> <p>2. An audit has been completed for all residents on fluid restrictions to validate accuracy with totaling fluid intakes. An audit of all residents with an order for splints to validate they are applied per MD orders. An audit has been completed on all residents to validate the Pleasant and Meaningful assessment has been completed to identify the residents' activities of interest, a care plan includes the activities of interest, the C.N.A. sheets are current with information regarding the residents' activities of interest for participation.</p>	12/25/2014

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	<p>physician's orders for November 2014, indicated Resident #98 had a fluid restriction of 1000 ml (milliliters) in 24 hours.</p> <p>A review of the Medication Administration Record (MAR) for November 2014, indicated intake was to be recorded each shift and totaled by the night shift.</p> <p>On 11/1/14, no intake was recorded for the evening or night shifts. On 11/2/14, a zero was recorded for fluid intake on the day shift, evening shift, and night shift. The total fluid intake for 11/2/14 was recorded as 1300 ml.</p> <p>On 11/3/14, fluid intakes were recorded as day shift 480 ml, evening shift 240 ml, and night shift 480 ml for a total of 1140 ml. The total should have been 1200 ml.</p> <p>On 11/8/14, fluid intakes were recorded as day shift 120 ml, evening shift 240 ml, and night shift 120 ml for a total of 1260 ml. The total should have been 480 ml.</p> <p>On 11/19/14, the fluid intake was recorded as days shift 480 ml, evening shift 240 ml, and night shift 240 ml for a total of 1160. The total should have been 960 ml.</p>		<p>3. Education has been completed with all nursing and activity employees on Intake, Splints and activities of interest.</p> <p>4. The DNS/Designee will audit all residents intakes that have an order for fluid restrictions daily for 30 days, then three times a week for 30 days, then weekly for 30 days. An audit of all residents with an MD order for splints will be completed daily for 30 days to validate they are applied per MD order, then three times a week for 30 days, then twice weekly for 30 days. The AD/Designee will audit daily for 30 days all residents on 1:1 activities for validation the activity has occurred, then three times a week for 30 days and then twice a week for 30 days. All findings will be reviewed in monthly PI meeting. The PI committee will determine when 100% compliance is achieved or if further monitoring is required</p>	

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	<p>During an interview with the Director of Nursing (DON) on 11/24/14 at 1:05 p.m., the DON indicated the totals were not correct as the staff had not used the tools available to total the fluid intakes and a learning opportunity was indicated.</p> <p>2. The clinical record review for Resident #53, completed on 11/20/14 at 2:04 p.m., indicated the resident had diagnoses including, but not limited to, end stage renal disease.</p> <p>A review of the recapitulation of physician's orders for November 2014, indicated Resident #53 had a fluid restriction of 1500 ml (milliliters) in 24 hours.</p> <p>A review of the Medication Administration Record (MAR) for November 2014, indicated intake was to be recorded each shift and totaled by the night shift.</p> <p>On 11/1/14, a zero was recorded for fluid intake for all 3 shifts. The 24 hour total of fluid intake was recorded as 1440 ml.</p> <p>On 11/2/14, fluid intakes were recorded as 120 ml on the day shift, 800 ml on the evening shift, and 800 ml on the night shift. The total fluid intake for 11/2/14 was recorded as 1500 ml. The total</p>			

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	<p>should have been 1720 ml.</p> <p>On 11/3/14, fluid intakes were recorded as day shift 480 ml, evening shift 480 ml, and night shift 480 ml for a total of 1450 ml. The total should have been 1440 ml.</p> <p>On 11/8/14, fluid intakes were recorded as day shift 0 ml, evening shift lacked documentation of fluid intake, and night shift intake was 120 ml for a total of 1560 ml.</p> <p>On 11/16/14, the fluid intake was recorded as days shift 600 ml, evening shift 600 ml, and night shift 600 ml for a total of 1440. The total should have been 1800 ml.</p> <p>During an interview with the Director of Nursing (DON) on 11/20/14 at 4:37 p.m., the DON indicated the totals were not correct as the staff had not used the tools available to total the fluid intakes and a learning opportunity was indicated.</p> <p>3. The clinical record review of Resident #278, completed on 11/20/14 at 1:35 p.m., indicated the resident had diagnoses including, but were not limited to, traumatic brain injury.</p> <p>During a Stage 1 observation on 11/13/14 at 3:30 p.m., the resident was noted to</p>						

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	<p>have a handwritten sign posted on the bulletin board at the bedside indicating, "Please place [name of resident] splints on at 0800 [8:00 a.m.] and remove at 2100 [9:00 p.m.]." Resident #278 did not have splints on either hand/wrist.</p> <p>A plan of care dated 10/15/14, indicated the resident had a contracture and was at risk for contractures (fixed high resistance to passive stretch of a muscle) related to impaired functional range of motion of both ankles and wrists. Interventions included, but were not limited to, restorative splinting program bilateral ankles and wrists.</p> <p>A second plan of care dated 10/15/14, indicated the resident was at risk of developing further impairment in functional joint mobility related to inactivity from impaired cognition. Interventions included, but were not limited to, apply devices to affected joints as ordered.</p> <p>A review of the recapitulation of physician's orders for November 2014, lacked orders for devices to affected joints.</p> <p>During an interview with Unit Manager (UM) #2 on 11/20/14 at 10:00 a.m., UM #2 indicated the family had requested the</p>			

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	<p>sign as a reminder to staff to apply the splints.</p> <p>During an observation of the resident on 11/24/14 at 10:00 a.m., the resident had rolled washcloths in the hands and splints were not in place to the hands/wrists.</p> <p>4. The clinical record of Resident #278 was reviewed on 11/20/14 at 3:57 p.m. Diagnoses for the resident included, but were not limited to, traumatic brain injury, persistent vegetative state, and respiratory failure.</p> <p>On 11/20/14 at 2:55 p.m., the Activity Director (AD) indicated Resident #278's aunt told him the resident used to like rap and country music, and especially liked to watch the television show Roseanne. The Activity Director indicated, "We try to have these on for him, it should be on the Certified Nursing Assistant (CNA) Care Sheet."</p> <p>A care plan, dated 10/22/14, indicated, "[name of resident] is dependent on staff for activities, sensory stimulation, r/t [related to] physical limitations." The goal was Resident #278 would maintain involvement in sensory stimulation activities through review date. Interventions included, "[name of resident] preferred activities per family</p>						

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	<p>are listening to rap, country and relaxation music...When [name of resident] is awake turn on TV to news or channel 49 to watch Roseanne...turn on rap, country, relaxation music in room to provide sensory stimulation."</p> <p>A Pleasant and Meaningful Activities Assessment, dated 10/22/14, indicated Resident #278 enjoyed family and friends time, listening to rap, country and relaxation music, and watching television.</p> <p>No music or television was on during observations of Resident #278 in his room, on 11/13/14 at 5:00 p.m., 11/14/14 at 12:01 p.m., 11/17/14 at 11:17 a.m., 11/19/14 at 9:45 a.m., 11/20/14 at 10:22 a.m., and 11/20/14 at 3:39 p.m.</p> <p>A CNA care sheet, dated 11/18/14, did not contain any information regarding television or music for Resident #278.</p> <p>On 11/20/14 at 3:39 p.m., the television was observed to be 10 or 11 feet away from the resident, partially obscured by a bedside table. No music discs were observed in the room.</p> <p>On 11/20/14 at 4:14 p.m., the AD indicated Resident #278 did not receive any 1:1 activity time because family was</p>						

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	<p>in every day. The AD indicated no residents in the facility were receiving any 1:1 activity time, which is time activity staff would spend with a resident who is unable to participate in any facility activity programs due to physical or mental limitations.</p> <p>On 11/21/14 at 3:40 p.m., Resident #278's roommate (Resident #114) indicated Resident #278 had visitors, "maybe once a week."</p> <p>On 11/21/14 at 3:45 p.m. Unit Manager #2 indicated she had never seen Resident #278 have any visitors.</p> <p>On 11/21/14 at 3:50 p.m., Registered Nurse #3 indicated the resident had a visitor about once a week.</p> <p>On 11/25/14 at 9:00 a.m., the AD provided a policy, dated 6/30/06, titled Developing Activity Programs, and indicated it was the policy currently used by the facility. The policy indicated, "Rationale An activity program is developed based on the resident's individual needs and preferences. They are designed to enhance the well being of each resident....Sensory strengths: Small group and individual activity sessions should incorporate sensory stimuli...There are some individual</p>						

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F000364 SS=E	<p>activities that can also have a goal of human connections..providing a list of preferred activities to staff members..."</p> <p>3.1-35(g)(2)</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Based on observation, record review, and interview, the facility failed to ensure hot foods were maintained at 135 degrees F. (Fahrenheit) on the steam table during a meal service. This had the potential to affect 157 of 168 residents who received their meals from the facility kitchen.</p> <p>Findings include:</p> <p>During an observation on 11/21/14 at 11:10 a.m., after the last resident was served, the following food temperatures were taken:</p> <p>Mechanical soft beef - 110 degrees F. Fish - 128 degrees F. Pureed fish - 116 degrees F.</p> <p>On 11/21/14 at 1:10 p.m., Cook #1 indicated she knew the steam table</p>	F000364	<p>1.The 157 residents were not harmed. The steam table water temperature was set to the proper setting.</p> <p>2.All residents served meals from the kitchen have the potential to be affected. The Cooks and dietary manager have been in-serviced on the proper holding temperatures.</p> <p>3.All dietary employees have been in-serviced on proper food holding temperatures.</p> <p>4.The DM/Designee will audit the food temperatures and steam table water temperatures daily before serving, during service and after for 3 months. All findings will be reported in the monthly PI meeting to the PI committee will determine when 100% compliance is achieved or if further monitoring is required.</p>	12/25/2014

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F000431 SS=E	<p>temperatures of the mechanical beef, fish and pureed fish were not warm enough.</p> <p>On 11/21/14 at 1:20 p.m., the Dietary Manager indicated 157 residents received their meals from the facility kitchen.</p> <p>On 11/24/14 at 8:30 a.m., the Dietary Manager provided an undated policy, titled Food Handling Guidelines, and indicated it was the current policy used by the facility. The policy indicated, "Foods should be held hot for service at a temperature of 140 degrees F. or higher."</p> <p>3.1-21(i)(3)</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws,</p>			

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	<p>the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>Based on observation, interview, and record review, the facility failed to ensure narcotic counts were complete and accurate for 4 of 10 medication carts reviewed for medication storage. (100 Hall Cart #1, 100 Hall Cart #2, 100 Hall Cart #3, and 200 Hall Cart #1)</p> <p>Findings include:</p> <p>1. A review of the 100 Hall Cart #1 on 11/20/14 at 10:45 a.m., indicated missing signatures and counts on the Shift to Shift Narcotic Sheet and Card Verification form for the month of November 2014.</p> <p>The form lacked a signature for the oncoming nurse on 11/1/14 and 11/2/14, for the night shift.</p> <p>On 11/2/14, the form lacked numbers in</p>	F000431	<p>1. Medication carts #1, 2, and 3 on 100 hall and 200 hall cart #1 were reconciled for accuracy with 2 licensed nurses on 11/20/2014.</p> <p>2. All residents with narcotics stored on 100 hall medication carts 1, 2, and 3 and 200 hall cart #1 had the potential to be affected. There were no further discrepancies for narcotic storage.</p> <p>3. All Licensed nurses have been in-serviced on the Inventory Control of Controlled Substances policy.</p> <p>4. An audit of the narcotic count for all medication carts will be completed by the DNS/Designee daily for 30 days, then three times a week for 30 days, then twice weekly for 30 days. All findings will be reported in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if further</p>	12/25/2014

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	<p>the Start Card/Sheet Count column as well as the Final Card/Sheet column for the evening and night shift.</p> <p>On 11/3/14, the form lacked a signature for the oncoming nurse for the day shift.</p> <p>The form lacked signatures and counts for 11/6/14, on the night shift for the off going nurse and the on coming nurse.</p> <p>On 11/7/14, counts and signatures were missing for day shift for the off going as well as the on coming nurse.</p> <p>The evening shift on 11/7/14, lacked a signature of the off going nurse. The first signature on 11/7/14, was a nurse coming on shift at 4:00 p.m.</p> <p>On 11/10/14, the form lacked numbers in the Start Card/Sheet Count column as well as the Final Card/Sheet column for the day shift.</p> <p>On 11/12/14, the form lacked numbers in the Start Card/Sheet Count column as well as the Final Card/Sheet column for all 3 shifts. The form also lacked signatures for the on coming nurse from night shift 11/11/14 through evening shift 11/12/14, and lacked signatures for the off going nurse for the day shift and the evening shift.</p>						

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	<p>2. A review of the 100 Hall Cart #2 on 11/20/14 at 10:55 a.m., indicated missing signatures and counts on the Shift to Shift Narcotic Sheet and Card Verification form for the end of the month of October 2014 and into November 2014.</p> <p>The form lacked numbers in the Start Card/Sheet Count column as well as the Final Card/Sheet column for the day shift 10/30/14 through evening shift 11/2/14, indicating narcotic counts were not completed for 10 shifts.</p> <p>The form indicated 7 additional shifts were completed before the next narcotic count was completed on 11/4/14.</p> <p>The form lacked numbers in the Start Card/Sheet Count column as well as the Final Card/Sheet column from day shift 11/7/14 through day shift 11/10/14, indicating the narcotic counts were not completed for 10 shifts.</p> <p>The form lacked numbers in the Start Card/Sheet Count column as well as the Final Card/Sheet column from evening shift 11/15/14 through evening shift 11/17/14, indicating the narcotic counts were not completed for 7 shifts.</p> <p>3. A review of the 100 Hall Cart #3 on</p>			

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	<p>11/20/14 at 11:00 a.m., indicated missing signatures and counts on the Shift to Shift Narcotic Sheet and Card Verification form for the month of November 2014.</p> <p>The form lacked numbers in the Start Card/Sheet Count column as well as the Final Card/Sheet column from day shift 11/1/14 through day shift 11/3/14, indicating the narcotic counts were not completed for 6 shifts.</p> <p>During an interview with Unit Manager #2 on 11/20/14 at 10:45 a.m., UM #2 indicated the staff were supposed to count the cards and sheets to compare to the amount of medication available for the resident and then sign the form to indicate the count was completed.</p> <p>4. During an observation of the 200 Hall Cart #1 on 11/20/14 at 11:30 a.m., the amount of liquid hydrocodone-apap (a medication used to treat pain) available in the bottle was not consistent with the amount noted on the Controlled Substance Record.</p> <p>Registered Nurse #5 indicated the narcotic reconciliation was completed at 6:00 a.m., on 11/20/14 and no discrepancies were noted. Upon observation of the bottle of medication and the Record, RN #5 indicated the</p>			

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	<p>previous nurse had made an error in calculation when recording the amount remaining in the bottle.</p> <p>On 11/18/14 at 8:00 p.m., the amount remaining in the bottle was recorded as 403 ml (milliliters). A dose of 10 ml was given on 11/19/14 at 8:00 p.m. The amount recorded on the sheet was noted as 493 ml. Another 10 ml dose was administered on 11/20/14 at 5:00 a.m., and the amount remaining was recorded as 483 ml.</p> <p>Upon observation of the bottle with RN #5 and Unit Manager (UM) #4, the amount remaining in the bottle was noted to be 383 ml. RN #5 corrected the count on the Record and UM #4 signed as a witness to the correction.</p> <p>A review of the Shift to Shift Narcotic Sheet and Card Verification form indicated a shift to shift reconciliation was completed one time each day 11/17, 11/18, 11/19, and 11/20/14. No discrepancies were noted on the form.</p> <p>During an interview with the Director of Nursing on 11/24/14 at 10:30 a.m., the DON indicated the expectation was to have staff reconcile the controlled substances with each shift change, but no less than 1 time per day.</p>			

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F000441 SS=D	<p>On 11/24/14 at 10:30 a.m., the DON provided the Inventory Control of Controlled Substances policy dated 12/01/2007, and indicated the policy was the one currently used by the facility. The policy indicated, " ...1.2 Facility should ensure that the incoming and outgoing nurses count all Schedule II controlled substances and other medications with a risk of abuse or diversion at the change of each shift or at least once daily and document the results on the ' Controlled Substance Count Verification/Shift Count Sheet ' ...2. Facility should ensure that Facility staff count all Schedule III-V controlled substances in accordance with Facility policy and Applicable Law.... "</p> <p>3.1-25(e)(3)</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents</p>			
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	<p>infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation, interview, and record review, the facility failed to ensure sanitizing or hand hygiene was performed during the administration of medications for 3 of 7 residents observed during medication administration. (Resident #38, Resident #93, Resident #168 and Registered Nurse #6)</p> <p>Findings include:</p> <p>During an observation of medication administration on 11/21/14 at 4:35 p.m.,</p>	F000441	<p>F 441 INFECTION CONTROL</p> <p>1.Resident # 6, 38, 93, and 168 have no infection and were not harmed.</p> <p>2.RN #6 completed performance improvement and education on medication administration with emphasis on hand hygiene during medication administration.</p> <p>3.All licensed nurses have been in-serviced on hand hygiene with Medication Administration.</p> <p>4.The DNS/Designee will observe medication administration with 3 nurses a</p>	12/25/2014

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	<p>Registered Nurse (RN) #6 was observed to prepare and then administer medications to Resident #93. RN #6 failed to perform hand hygiene prior to the preparation of the medications or after the resident had taken the medications.</p> <p>RN #6 was observed on 11/21/14 at 4:40 p.m., to prepare and administer medications to Resident #38. RN #6 failed to perform hand hygiene prior to the preparation of the medications or after the resident had taken the medications.</p> <p>RN #6 was then observed to prepare and administer medications to Resident #168 at 5:00 p.m., on 11/21/14. RN #6 failed to perform hand hygiene prior to the preparation of the medications or after the resident had taken the medications.</p> <p>During an interview with RN #6 on 11/21/14 at 5:15 p.m., RN #6 indicated hand sanitizer was not available on the medication cart nor did the staff member have sanitizer in a pocket of the uniform. RN #6 indicated hand sanitizer should have been used during the medication administration.</p> <p>On 11/13/14 at 3:28 p.m., the Director of Nursing (DON) provided the policy</p>		<p>day for appropriate hand hygiene three times a week for 30 days, then twice weekly for 30 days, and then once a week for 30 days. These observations will occur across all shifts seven days a week. All findings will be reported in monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if further monitoring is required.</p>	

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F000465 SS=D	<p>General Dose Preparation and Medication Administration dated 12/01/2007, and indicated the policy was the one currently used by the facility. The policy indicated, " ...2. Prior to preparing or administering medications, authorized and competent Facility staff should follow Facility's infection control policy (e.g. handwashing).... "</p> <p>On 11/24/14 at 10:30 a.m., the DON provided the policy Hand Hygiene/Handwashing dated 8/31/11, and indicated the policy was the one currently used by the facility. The policy indicated, "Hand hygiene is to be performed...between patient contacts, and when otherwise indicated to avoid transfer of microorganisms to other patients or environments..."</p> <p>During an interview with the DON on 11/25/14 at 11:30 a.m., the DON provided inservice training provided to the staff dated 11/7/14. The Attendance Roster contained the signature of RN #6.</p> <p>3.1-18(l)</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional,</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155193	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 11/25/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-GREENWOOD	STREET ADDRESS, CITY, STATE, ZIP CODE 377 WESTRIDGE BLVD GREENWOOD, IN 46142
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	<p>sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to ensure the environment was sanitary and free of odors in 1 of 3 hallways in the facility. (100 Hall)</p> <p>Findings include:</p> <p>During an initial tour of the facility on 11/13/14 at 10:05 a.m., the center hall of the 100 hallway was observed to have an odor of urine from the middle of the hallway to the exit doors at the end of the hallway.</p> <p>On 11/14/14 at 9:20 a.m., the center hall of the 100 hallway was observed to have an odor of urine from the middle of the hallway to the exit doors at the end of the hallway.</p> <p>During an interview with Resident #33 on 11/14/14 at 9:51 a.m., a strong urine odor was noted in the room. A towel was noted on the floor in the middle of the room near the privacy curtain. The towel appeared to be wet with a yellow colored fluid. Social Services #7 entered the room and spoke to the roommate. Social Services #7 donned gloves and removed the towel from the floor into a plastic bag indicating the roommate was known to</p>	F000465	<p>F 465 ENVIRONMENT</p> <p>1. Residents on 100 hall were not harmed. The odor on 100 center hall was resolved daily as it was detected. Resident #33 is incontinent of urine and wears an adult brief, however resident urinates on the floor, in a urinal, and on other inappropriate items in the room. The resident has had his mattress replaced and his room is cleaned twice daily routinely and has had a deep clean in the last 30 days. There have been no concerns from resident #33's roommate regarding odors or any resident residing or visiting on 100 hall. Review of Grievances and concerns for the facility over the past 90 days have no concerns regarding odors in any area of the facility.</p> <p>2. All residents residing on the center 100 hall have the potential to be affected. All residents residing on 100 hall have been interviewed for concerns with odors. Any findings will be investigated and resolved.</p> <p>3. All staff have been educated on sanitary environment with emphasis on odors.</p> <p>4. An audit of all units daily for 30 days for odors, then three times a week for 30 days, then weekly for 30 days. All findings will be reported in the monthly PI meeting and the PI committee will determine when 100% compliance is achieved or if</p>	12/25/2014

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	<p>throw towels on the floor. The odor in the room was not as strong once the bag was removed from the room.</p> <p>On 11/18/14 at 9:17 a.m., a strong urine odor was noted on the center hall of the 100 Hall way. The odor was noted from the fire doors to the emergency exit at the end of the hallway.</p> <p>During an observation of residents on the 100 Hall way on 11/20/14 at 10:15 a.m., an odor of urine was noted in the center hall. Unit Manager (UM) #2 indicated the odor was transient and usually was gone after the morning care was completed.</p> <p>On 11/20/14 at 11:20 a.m., an odor of urine was noted in the center hallway of the 100 Hall from the fire doors to the exit at the end of the hallway. The Environmental Services Director and the Maintenance Director indicated the odor was noticeable at that time.</p> <p>During an interview with the Executive Director (ED) on 11/20/14 at 1:30 p.m., the ED indicated the staff had determined the source of the odor on the 100 Hall was related to a resident spilling urine on the floor and the staff were working with the resident to eliminate the odor.</p>		further monitoring is required.	

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

PRINTED: 12/18/2014

FORM APPROVED

OMB NO. 0938-0391

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	3.1-19(f)				