

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155664	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  04/01/2016
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NAME OF PROVIDER OR SUPPLIER  KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254
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F 0000  Bldg. 00	<p>This visit was for the Investigation of Complaint IN00193928.</p> <p>This visit was in conjunction with the Recertification and State Licensure Survey.</p> <p>Complaint IN00193928-substantiated. Federal/State findings cited at F314.</p> <p>Survey Dates: March 28, 29, 30, 31, and April 1, 2016</p> <p>Facility number: 010666 Provider number: 155664 AIM number: 200229930</p> <p>Census bed type: SNF: 89 Total: 89</p> <p>Census payor type: Medicare: 21 Medicaid: 57 Other: 11 Total: 89</p> <p>Sample: 8</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC</p>	F 0000	<p>The submission of this plan of correction does not indicate an admission of Kindred Transitional Care and Rehabilitation- Eagle Creek that the findings and allegations contained herein are an accurate and true representation of the quality of care provided to the residents of Eagle Creek. This facility recognizes it's obligation to provide legally and medically necessary care and service to its residents in an economic and efficient manner. The facility herby maintains it is in substantial compliance with the requirements of participation for residential health care facilities. To this end, this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only. The facility respectfully request from the Department a desk review for paper compliance.</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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F 0314 SS=G Bldg. 00	<p>16.2-3.1.</p> <p>Quality review completed 04/04/2016 by 29479.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>Based on observation, interview, and record review, the facility failed to ensure interventions to prevent a resident identified at risk for developing pressure from developing a stage 4 (full thickness tissue loss) pressure ulcer and failed to ensure interventions were implemented as ordered to reduce pressure and facilitate wound healing for 2 of 3 residents reviewed for pressure ulcers</p>	F 0314	<p>F – 314</p> <p>1.Resident C's right outer ankle pressure ulcer is a stage 3 as of 4/8/2016. Resident C's sacrum is healed as of 4/8/2016 and has a preventative treatment of calmoseptine Q shift and PRN. The plan of treatment continues with Low air loss mattress, turning the resident every two hours and the prevalon boot with a pillow. All interventions have been updated on the C.N.A.</p>	04/21/2016

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	<p>(Resident C and Resident D).</p> <p>Findings include:</p> <p>1. During an interview on 3/29/16 at 2:48 p.m., Unit Manager (UM) #20 indicated Resident C had a stage 4 (full thickness tissue loss) pressure ulcer on his outer right ankle and a stage 2 (partial thickness loss) pressure ulcer on his sacrum.</p> <p>On 3/29/16 at 12:18 p.m., Resident C was lying on his back on a low air loss (LAL) mattress with his left knee bent and his left foot on the bed. Resident C's right foot was in a prevalon (pressure reducing) boot, but was not floated to prevent the foot from pressing against the mattress. A pillow was observed on the floor by the side of the bed.</p> <p>On 3/29/16 at 2:14 p.m., Resident C was lying on his back on the LAL mattress without his heels floated to prevent them from pressing against mattress. A prevalon boot on his right foot.</p> <p>On 4/1/16 from 9:14 a.m. to 9:29 a.m., a dressing change was observed with the Wound Care Nurse (WCN) and Certified Nursing Assistant (CNA) #21. A quarter sized open wound was observed on the outer lateral ankle. The wound base was</p>		<p>assignment sheet. Family and MD are aware of current plan of care. Resident D was admitted to Methodist Hospital from dialysis with chest pain on 4/2/2016.</p> <p>2.All residents at risk for developing pressure have been identified. A Norton Plus Scale for Predicting Risk of pressure ulcers has been completed on all residents. All residents identified at risk or with pressure have interventions implemented per the plan of care and MD order. All pressure reducing interventions have been updated to the plan of care and the C.N.A. assignment sheet.</p> <p>3.All nursing staff have been educated on Prevention and Treatment of Pressure Ulcers and Non-Pressure wounds. All Licensed nurses have been educated on Comprehensive care plans.</p> <p>4.The DNS/IDT will complete audits three times a day for 30 days, then twice daily for 30 days, then daily for 30 days to validate pressure reducing interventions are implemented and on the C.N.A. sheet and care plans. These audits will be 7 days a week and on all three shifts. Then the DNS/IDT will complete audits daily for ninety days. All findings will be reported to the PI committee at the 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>bright red with a white dot in center. The outer edges were raised and pink. The depth of the wound was approximately 0.25 centimeters (cm). A moderate amount of bloody drainage drained from the wound base after the dressing was removed. Resident C ' s sacrum had a white area approximately the size of a pen tip. No open area was observed and the surrounding tissue was pink in color. The WCN indicated the pressure area on the sacrum was almost resolved.</p> <p>On 3/30/16 at 3:51 p.m., Resident C's record was reviewed. The form titled, "Patient nursing evaluation Part 1 (with Braden)," dated 10/16/15, indicated Resident C was at risk for skin breakdown due to being chair bound and having a diagnosis of diabetes.</p> <p>The admission Minimum Data Set (MDS) assessment, dated 10/23/15, indicated Resident C did not have pressure ulcers, but was at risk for developing pressure ulcers. The resident required extensive assistance of 2 people for bed mobility and transfers, and required extensive assistance of 1 person for dressing, eating, toileting, personal hygiene, and bathing. The MDS indicated Resident C was always incontinent of bowel and bladder.</p>			

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	<p>The Braden Scale for Predicting Pressure Sore Risk, dated 11/9/15, indicated Resident C had a score of 16 and was at risk for skin impairment due to occasionally being moist, being chairfast, having slightly limited mobility, and friction from moderate to maximum assistance in moving.</p> <p>The care plan titled, "Potential for Skin /tissue integrity," initiated 10/19/15, indicated staff were to perform weekly skin assessments and change Resident C's position when "toileting, uploading, shifting weight, ambulating or return to bed for rest."</p> <p>A "Weekly Skin Check," dated 11/24/15, indicated Resident C had a change in skin condition and a new suspected pressure ulcer to the right foot.</p> <p>A "Weekly Pressure Ulcer BWAT (Bates-Jensen Wound Assessment Tool) Report," dated 11/25/15 indicated Resident C had an unstageable (full thickness loss with depth obscured by slough or eschar) pressure ulcer to the right outer ankle that measured 1.5 centimeters (cm) in length by 0.5 cm in width. The treatment ordered was skin prep (liquid forming dressing) daily and cover with a foam dressing.</p>			

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	<p>A report from the wound clinic, dated 12/10/15, indicated Resident C had an unstageable pressure ulcer on his right lateral ankle from a foot drop brace and velcro straps. The wound note indicated, "...Original cause of wound was Pressure Injury...The wound measures 1.7 cm length x (by) 3.6 cm width x 0.1 cm depth...There is a large...amount of necrotic tissue within the wound bed including Eschar (dead tissue) and Adherent Slough (yellow fibrinous tissue)...Post debridement Stage noted as Category/Stage 3 (full thickness skin loss)...."</p> <p>A wound clinic note, dated 12/17/15, indicated an unstageable pressure ulcer on his right ankle measured 2 cm in length by 3.3 cm in width by 0.2 cm in depth, and had a large amount of necrotic tissue within wound. The wound note indicated the plan of treatment would include a low air loss mattress, turning the resident every 2 hours, and a prevalon boot.</p> <p>The wound clinic note, dated 12/31/15, indicated Resident C had an unstageable pressure to his right outer ankle and measured 2.2 cm length by 3.9 cm width by 0.1 cm depth. The wound note indicated the wound had a large amount of necrotic tissue present. The wound</p>			

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	<p>note indicated, "PLEASE FLOAT THE ANKLE AND FOOT OFF OF THE BED EVEN IF THE PREVALON BOOT IS ON. PLACE A PILLOW UNDER THE LEG FROM THE KNEE TO JUST ABOVE THE ANKLE. HIS LATERAL ANKLE SHOULD NOT BE TOUCHING ANY SURFACES. THIS IS KEY TO HEALING HIM."</p> <p>A "Weekly Pressure Ulcer BWAT Report," indicated the pressure ulcer to the right outer ankle was documented as stage 4 (full thickness tissue loss) on 3/14/16 and measured 1.5 cm in length by 1.5 cm in width by 0.3 cm in depth.</p> <p>The "Weekly Pressure Ulcer BWAT Report," indicated Resident C acquired a stage 2 (partial thickness) pressure ulcer to his sacrum on 12/25/15. The record indicated the pressure ulcer measured 2 cm in length by 0.5 cm in width by 0.1 cm in depth and Calazime (ointment) was ordered every shift and as needed.</p> <p>Wound measurements documented on the "Weekly Pressure Ulcer BWAT Report," indicated the pressure ulcer to his sacrum were:</p> <p>a. 1/1/16: 2.0 cm in length by 0.5 cm in width by 0.1 cm in depth.</p> <p>b. 1/8/16: 2.0 cm in length by 2.0 cm in width by 0.1 cm in depth.</p>			

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	<p>c. 1/22/16: 2.0 cm in length by 1.3 cm in width by 0.1 cm in depth.</p> <p>d. 1/29/16: 1.5 cm in length by 1.3 cm in width by 0.1 cm in depth.</p> <p>e. 2/5/16: 1.5 cm in length by 1.5 cm in width by 0.1 cm in depth.</p> <p>f. 2/12/16: 1.4 cm in length by 1.4 cm in width by 0.1 cm in depth.</p> <p>g 2/19/16: No measurements were documented.</p> <p>h. 2/29/16: 1.6 cm in length by 1.2 cm in width by 0.1 cm in depth.</p> <p>i. 3/7/16: 2.0 cm in length by 1.5 cm in width.</p> <p>j. 3/14/16: 0.7 cm in length by 0.7 cm in width by 0 cm in depth.</p> <p>k. 3/24/16: 0.2 cm in length by 0.2 cm in width by 0.1 cm in depth</p> <p>An "Actual alteration in skin integrity" care plan, initiated 2/15/16, indicated, "...Administer medications per physician order...Monitor for signs and symptoms of infection and report to physician for care and treatment or debride...Pressure redistribution to bed/chair...provide meals per physician order...RD will monitor and evaluate nutritional intake and condition of wound and make recommendations as indicated..."</p> <p>The Wound Care Specialists of Indiana (WCS) note, dated 3/17/16, indicated Resident C had a stage 2 pressure ulcer to</p>			

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	<p>his sacrum and measured 0.5 cm in length by 0.5 cm width by 0.1 cm depth. The WCS note indicated Resident C had a stage 4 (full thickness tissue loss) pressure ulcer to the right lateral ankle with tendon exposed, undermining present with a maximum distance of 0.3 cm, and the wound measured 1.5 cm length by 2 cm width by 0.2 cm depth. The wound note ordered Prisma (medicated dressing) to be applied to the wound bed.</p> <p>The Wound Care Specialists of Indiana (WCS) note, dated 3/24/16, indicated Resident C had stage 2 pressure ulcer to his sacrum and measured 0.2 cm in length by 0.2 cm width by 0.1 cm depth. The WCS note indicated Resident C had a stage 4 (full thickness tissue loss) pressure ulcer to the right lateral ankle with tendon exposed, undermining present with a maximum distance of 0.2 cm, and the wound measured 1.8 cm length by 1.8 cm width by 0.2 cm depth.</p> <p>Physician orders indicated pressure reducing devices were ordered for the bed and chair on 10/16/15. On 12/3/15, a physician's order indicated, "Prevalon boot to R (right) foot as tolerated to off load heel. Ankle to be floated...Pillow/Boot..." The physician's recapitulation order, dated 12/24/15,</p>			

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	<p>indicated a low air loss mattress was ordered. On 2/18/15, a physician's order indicated, "Float the Ankle and foot off the bed even if the prevalon boot is on. Place a pillow under the leg from the knee to just above the ankle. His lateral ankle should not be touching any surfaces." The physician orders, as of review date 3/30/16, indicated Resident C had orders including, but not limited to the following: "Cleanse area with normal saline, pat dry, apply skin prep to outer edges of wound, apply fluffed gauze with hydrogel (ointment) to wound bed. Cover with kerlix and secure with tape every day shift for open area...Cleanse area, pat dry, apply calmoseptine (moisture barrier cream) to coccyx/buttocks every shift...Enteral Feed, every 4 hours related to Dysphagia...weekly weights...Protein Modular liquid one time a day healthy shot 74 ml bottle once daily via G (gastrostomy) tube...."</p> <p>The 100 hall CNA Daily Assignment sheet, provided by CNA #31 on 3/31/15 at 9:31 a.m., did not indicate pressure ulcer interventions for Resident C.</p> <p>During an interview on 4/01/16 at 9:31 a.m., Certified Nursing Assistant (CNA) #21 and CNA #22 indicated Resident C required extensive assistance of 2 people for turning and repositioning. CNA #22</p>			

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	<p>indicated Resident C was able to move and kick his left leg, but he was unable to move his right leg.</p> <p>During an interview on 4/01/16 at 9:59 a.m., the Wound Care Nurse (WCN) indicated she was unsure how the pressure area on Resident C's his right ankle had developed. The WCN indicated Resident C's care plan should have been updated to include interventions in place for reducing pressure.</p>				