

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155218	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/11/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	STREET ADDRESS, CITY, STATE, ZIP CODE 2300 GREAT LAKES DR DYER, IN 46311
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F000000	<p>This visit was for the Investigation of Complaints IN00154644, IN00154663, IN00155443, IN00155716, IN00155823, & IN00155914.</p> <p>This visit was in conjunction with the Post Survey Revisit (PSR) to the Investigation of Complaints IN00152377, IN00152386, and IN00152823 completed on July 22, 2014.</p> <p>Complaint IN00154644- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00154663- Substantiated. Federal/State deficiencies related to the allegations are cited at F-310, F-323 and F-514.</p> <p>Complaint IN00155443- Substantiated. Federal/State deficiencies related to the allegations are cited at F-323 and F-514.</p> <p>Complaint IN00155716- Substantiated. Federal/State deficiencies related to the allegations are cited at F-323 and F-514.</p> <p>Complaint IN00155823- Substantiated. Federal/State deficiency related to the allegations is cited at F-323.</p>	F000000	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by to 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 the provisions of federal and state law require it.</i></p> <p><i>We respectfully request a Desk Review of this Plan of Correction. FORM CMS-2567(02-99) Previous Versions Obsolete Any deficiencystatement</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiencystatement 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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	<p>Complaint IN00155914- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Survey dates: September 9, 10, & 11, 2014</p> <p>Facility number: 000123 Provider number: 155218 AIM number: 100266720</p> <p>Survey Team: Janet Adams, RN-TC Heather Tuttle, RN (September 10 & 11, 2014)</p> <p>Census bed type: SNF/NF: 109 Total: 109</p> <p>Census payor type: Medicare: 29 Medicaid: 65 Other: 15 Total: 109</p> <p>Sample: 12</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>Quality review completed on September 15, 2014, by Janelyn Kulik, RN.</p>				

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F000310 SS=D	<p>483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems.</p> <p>Based on observation, record review, and interview, the facility failed to ensure each resident received continued restorative services for range of motion and ambulation for 2 of 3 residents reviewed for restorative therapy in the sample of 12. (Residents #P & #J)</p> <p>Findings include:</p> <p>1. On 9/10/14 at 2:20 p.m., Resident #P was observed ambulating while holding onto the hand rail in the hall with contact guard assist of one. Restorative CNA #2 was observed standing by the resident as she walked in the hallway.</p> <p>Interview with Restorative CNA #2 at</p>	F000310	Preparation and/or execution of this plan of correction does not constitute admission or agreement by to 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 the provisions of federal and state law require it. We respectfully request a DeskReview of this Plan of Correction.1. Resident P and Resident J have their restorative programs in place to occur at least 6 days per week. Education has been provided to the restorative aides regarding participation, documentation, reporting along with education on performing restorative interventions. The restorative	09/24/2014	

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	<p>that time, indicated the resident was usually able to walk at least 100 feet or more.</p> <p>Continued observation at that time, indicated the resident walked approximately 125 feet and then wanted to sit back in her wheelchair.</p> <p>Interview with Restorative CNA #2 on 9/10/14 at 2:28 p.m., indicated she usually worked from 7:00 a.m. until 3:00 p.m., however, today she came in at 6:00 a.m., and was to work until 2:00 p.m., because she was told she would be obtaining resident weights. She further indicated there were two CNAs who worked restorative, however, only one worked at a time. She indicated her partner worked on her days off during the week. The CNA indicated many times she was pulled from restorative to work the floor and help with showers and/or weights. She further indicated she had not completed any restorative services for any residents today except for Resident #P. The Restorative CNA then left and indicated it was time for her to go home.</p> <p>The record for Resident #P was reviewed on 9/10/14 at 11:20 a.m. The resident's diagnoses included, but were not limited to, cerebral palsy.</p>		<p>aides were also educated on reporting to RN reviewing the restorative program when refusals or participation does not occur. 2. Residents requiring restorative services have the potential to be affected by the deficient practice. Residents on therapy requiring restorative nursing or residents who are discharged from therapy to restorative nursing will have a program developed by therapy. Therapies will then present the program to the restorative nurse, educate the restorative aide and ensure the resident is informed of the change from therapy to restorative nursing. 3. C.N.A.'s providing the restorative services will be dedicated to the restorative program. A minimum of six days per week will be provided to each resident on restorative services. Therapy will work with the restorative aide for education and specific program needs for each resident. Restorative programs and splint services will be reviewed for appropriateness. Those which may not be appropriate for restorative services will be placed with nursing services and discontinued from restorative nursing. 4. The restorative programs will be audited for compliance by the Unit Managers and/or designee three times weekly for eight (8) weeks and then weekly for five (5) months or until 100% compliance is achieved. The</p>		

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	<p>Review of a Physical Therapy Discharge Summary dated 11/21/13 indicated the discharge recommendations were to provide a restorative aide for strengthening and ambulation.</p> <p>Review of an updated 8/2014 care plan indicated "Resident can benefit from restorative ambulation program to keep physical function from declining."</p> <p>Review of the 7/2014 restorative nursing log indicated the resident received restorative ambulation services for at least 15 minutes on 7/3, 7/5, 7/6, 7/9, and 7/29/14.</p> <p>Further review of the 7/2014 restorative nursing log indicated the letters NA (Not Applicable) were coded on 7/1, 7/8, 7/10, 7/11, 7/14, and 7/16/14.</p> <p>Review of the 8/2014 restorative nursing log indicated the resident received restorative ambulation services for at least 15 minutes on 8/7, 8/8, 8/12, 8/16, 8/17, 8/19, 8/24, 8/26, & 8/28/14.</p> <p>Further review of the 8/2014 restorative nursing log indicated the letters NA (Not Applicable) were coded on 8/25 and 8/29/14.</p> <p>Review of the 9/2014 restorative nursing</p>		audits will be provided to the Director of Nursing weekly. The results of the audits will be presented in the monthly PI meeting by the Director of Nursing for recommendations.		

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	<p>log indicated the resident received no restorative ambulation services for at least 15 minutes.</p> <p>Further review of the 8/2014 restorative nursing log indicated the letters NA (Not Applicable) were coded on 9/1 and 9/6/14.</p> <p>Interview with the Restorative Nurse on 9/10/14 at 1:20 p.m., indicated she had just taken over the restorative nursing program about three weeks ago. She indicated it was her expectation for the residents who were on restorative therapy to receive services at least five times a week unless it had been specified by the therapy department. She indicated she was told residents could receive restorative services up to six times a week.</p> <p>Interview with Restorative CNA #2 on 9/10/14 at 2:28 p.m., indicated if NA was coded on the resident's restorative log, it had meant she was pulled to the floor and restorative services were not provided for the resident on that day.2. During orientation tour on 9/9/14 at 9:18 a.m., Resident #J was observed in bed. The resident had a splint in place on his left hand.</p> <p>The record for Resident #J was reviewed</p>			

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	<p>on 9/10/14 at 2:40 p.m. The resident's diagnoses included, but were not limited to, Multiple Sclerosis, depressive disorder, and osteoporosis.</p> <p>Review of the 9/5/14 Minimum Data Set (MDS) annual assessment indicated the resident's BIMS (Brief Interview for Mental Status) score was (15). A score of (15) indicated the resident's cognitive patterns were intact. The assessment also indicated the resident had range of motion limitations of both of his upper and both of his lower extremities. The assessment also indicated the resident required extensive assistance (resident involved in activity, staff provide weight-bearing support) of two staff members for bed mobility, transfers, dressing, and personal hygiene.</p> <p>The resident's current care plans were reviewed. A care plan initiated on 1/12/14 indicated the resident required a Splint Restorative Nursing Program related to a flexed contracture of his left hand. The care plan was last updated with target goal date of 9/30/14. Care plan interventions included for range of motion to the left upper extremity one set of ten reps (repetitions) to be provided. The care plan indicated the range of motion was to be provided by the Restorative Nursing Program.</p>			

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	<p>The Restorative Nursing Program Flow Sheets for Resident #J were reviewed. The sheets indicated the resident had been receiving restorative therapy service since 1/2014. One entry was made for 8/2014. This entry was made on 8/28/14 and indicated the resident received passive range of motion to the left hand. One entry was made for 9/2014. This entry was made on 9/5/14 and indicted resident received range of motion.</p> <p>The daily entries on Restorative Nursing logs for 7/2014, 8/2014, and 9/2014 indicated the resident was to receive active and passive range of motion. There were no entries for 7/2/14, 7/10/14, 7/13/14, 7/15/14, 7/17/14- 7/22/14 and 7/24/14-7/27/14. There were no entries for 8/1/14- 8/6/14, 8/9/14-8/16/14, 8/18/14-8/22/14.</p> <p>When interviewed on 9/11/14 at 2:05 p.m., Resident #J indicated the staff put this splint on for him. The resident indicated the staff did not exercise his left hand or make repeated opening of fingers or moving his wrist around when applying the hand splint.</p> <p>Interview with Restorative CNA #2 on 9/10/14 at 2:28 p.m., indicated she usually worked from 7:00 a.m. until 3:00</p>			

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	<p>p.m., however, today she came in at 6:00 a.m., and was to work until 2:00 p.m., because she was told she would be obtaining resident weights. She further indicated there were two CNAS who worked restorative, however, only one worked at a time. She indicated her partner worked on her days off during the week. The CNA indicated many times she was pulled from restorative to work the floor and help with showers and/or weights. She further indicated she had not completed any restorative services for any resident today except for Resident #P. The Restorative CNA then left and indicated it was time for her to go home.</p> <p>Interview with the Restorative Nurse on 9/10/14 at 1:20 p.m., indicated she had just taken over the restorative nursing program about three weeks ago. She indicated it was her expectation for the residents who were on restorative therapy to receive services at least five times a week unless it had been specified by the therapy department. She indicated she was told residents could receive restorative services up to six times a week.</p> <p>When interviewed on 9/11/14 at 2:45 p.m., the facility Nurse Consultant indicated restorative nursing services should have been provided for the</p>			

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F000323 SS=D	<p>residents as per their plan of care.</p> <p>This Federal tag relates to Complaint IN00154663.</p> <p>3.1-38(a)(2)</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. Based on observation, record review, and interview, the facility failed to provide adequate supervision to prevent accidents related to bed alarms not attached for 1 of 4 residents reviewed for falls in the sample of 7. (Resident #L)</p> <p>Findings include:</p> <p>On 9/9/14 at 11:30 a.m., Resident #L was observed in a low bed. A cord was observed coming from an alarm mat under the resident's bed sheet. The cord was wrapped around a rail on the bed. The other end of the cord was dangling down towards the floor and not plugged or attached to anything. There was also a green alarm box attached to the same rail. The cord from the alarm mat was not plugged into the green alarm box at this</p>	F000323	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by to 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 the provisions of federal and state law require it. We respectfully request a DeskReview of this Plan of Correction.1. Resident L had her alarm in place immediately when identified and monitored subsequently. Staff attending to resident was re-educated on alarm usage and checking alarms on all residents during the shift for operation. 2. Current residents having alarms have been identified, C.N.A, care sheets are up to date and accurate. The need for alarms on present resident has been evaluated for appropriateness.</i></p>	09/24/2014	

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	<p>time. There were no staff members or visitors in the resident's room. The resident's roommate was not in the room.</p> <p>On 9/9/14 at 11:55 a.m., Resident #L was observed in a low bed. A cord was observed coming from an alarm mat under the resident's bed sheet. The cord was wrapped around a rail on the bed. The other end of the cord was dangling down towards the floor and not plugged or attached to anything. There was also a green alarm box attached to the same rail. The cord from the alarm mat was not plugged into the green alarm box at this time. There were no staff members or visitors in the resident's room. The resident's roommate was not in the room.</p> <p>On 9/9/14 at 12:20 p.m., the resident was observed in a low bed. A cord was observed coming from an alarm mat under the resident's bed sheet. The cord was wrapped around a rail on the bed. The other end of the cord was dangling down towards the floor and not plugged or attached to anything. There was also a green alarm box attached to the same rail. The cord from the alarm mat was not plugged into the green alarm box at this time. There were no staff members or visitors in the resident's room. The resident's roommate was not in the room.</p>		<p>Staff has been re-educated on visual observation of rooms to note corrections of anything not in place correctly or the need to be plugged in. 3. Alarms will be evaluated for effectiveness/appropriateness during AM clinical meetings by the Director of Nursing and the clinical IDT team on an as needed basis. Any new alarm placed will be updated on the audit sheet and added to the C.N.A. care sheets. Alarms will be audited up to five (5) times weekly for placement, function, on the resident along with care planned for the individual resident during Angel Care and/or designee rounds for four (4) weeks until 100% compliance achieved. Once compliance is achieved audits will be completed three (3) times weekly for the next five (5) months. Unit managers and/or designee will do a random audit twice weekly of the current alarms on each unit in addition to the previous audits to ensure 100% compliance. 4. Audits will be presented to the Director of Nursing weekly and resolve any concerns or issues immediately. The Director of Nursing will present the audits during the monthly PI meeting for recommendations.</p>				

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	<p>On 9/9/14 at 12:39 p.m., RN #2 was observed in the resident's room. The RN was seated in chair next to the resident's bed the resident was in bed. RN#2 was feeding the resident her lunch meal. A cord was observed coming from an alarm mat under the resident's bed sheet. The cord was wrapped around a rail on the bed. The other end of the cord was dangling down towards the floor and not plugged or attached to anything. There was also a green alarm box attached to the same rail. The cord from the alarm mat was not plugged into the green alarm box at this time.</p> <p>On 9/9/14 at 12:45 p.m., Director of Nursing #2 (Director of Nursing from another facility in the cooperation) was observed leaving the resident's room. Upon entering the resident's room at 12:46 p.m., Resident #L was observed in a low bed. A cord was observed coming from an alarm mat under the resident's bed sheet. The cord was wrapped around a rail on the bed. The other end of the cord was dangling down towards the floor and not plugged or attached to anything. There was also a green alarm box attached to the same rail. The cord from the alarm mat was not plugged into the green alarm box at this time. There were no staff members or visitors in the resident's room. The resident's roommate</p>						

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	<p>was not in the room.</p> <p>On 9/9/14 at 1:00 p.m., CNA #1 entered the resident's room. The resident remained in bed with the cord not attached to the alarm box. The CNA indicated the cord was not attached to the box at this time and should have been. The CNA attached to the green alarm box at this time.</p> <p>The record for Resident #L was reviewed on 9/9/14 at 12:00 p.m. The resident's diagnoses included, but were not limited to, vascular dementia, anxiety state, and diabetes mellitus.</p> <p>Review of the 9/5/14 Fall Risk assessment indicated the resident's score was 75.0. This score indicated the resident was at high risk for falls.</p> <p>A care plan initiated on 7/14/14 indicated the resident had an actual fall. Care plan interventions added on 7/14/14 included for the resident to have a bed alarm.</p> <p>The CNA Assignment Sheet on the unit was reviewed on 9/9/14 at 12:50 p.m. The sheet indicated the resident was to have a low bed, bed alarm, and a floor mat in place.</p> <p>The 9/5/14 Post Fall Evaluation note was</p>						

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F000514	<p>483.75(l)(1)</p> <p>reviewed. The note indicated the resident had a fall on 9/5/14 (no time listed). The note indicated the resident leaned over in her chair, fell to the floor, and hit her head. The note also indicted first aide was completed and the resident was sent to the hospital.</p> <p>The 9/2014 Progress Notes were reviewed. An entry made by Nursing on 9/5/14 at 5:02 p.m. indicated the resident returned from the hospital with a 6 x 5 (measurement type used not indicated) raised area noted on her forehead.</p> <p>When interviewed on 9/10/14 at 3:00 p.m., the facility Administrator indicated the resident's alarm box should have been connected.</p> <p>This Federal tag relates to Complaints IN00154663, IN00155443, IN00155716, and IN00155823.</p> <p>3.1-45(a)(2)</p>				

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SS=D	<p>RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Based on record review and interview, the facility failed to ensure clinical records were accurate and complete related to documentation of the follow up assessment of the need for oxygen use and follow up assessments after falls for 2 of 12 residents reviewed for clinical record documentation in the sample of 12. (Residents #E and #H)</p> <p>Findings include:</p> <p>1. The record for Resident #E was reviewed on 9/9/14 at 12:10 p.m. The resident's diagnoses included, but were not limited to, dementia, high blood pressure, and heart disease. The 9/2014 Physician Order Statement indicated there was an order for the resident to receive oxygen at 2 liters per nasal</p>	F000514	<p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by to 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 the provisions of federal and state law require it. We respectfully request a DeskReview of this Plan of Correction.1. Resident E and resident H could not have medical record corrected due to documentation compliance guidelines. Neither resident showed a change in status related to the omission of pertinent documentation. 2. All residents have the potential to be affected by omissions of documentation. Licensed nursing staff has been re-educated on adequate and completion of documentation such as 72 hour</i></p>	09/24/2014			

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	<p>cannula as needed.</p> <p>The 7/1/14 quarterly Minimum Data Set assessment indicated the resident's BIMS (Brief Interview for Mental Status) was (10). A score of (10) indicated the resident's cognitive patterns were moderately impaired. The assessment also indicated the resident required the assistance of staff for bed mobility, transfers, dressing, and toileting.</p> <p>The 8/2014 Treatment Record was reviewed. There was an order on the Treatment Record for the resident to have oxygen at 2 liters per nasal cannula as needed. The treatment was not signed out on any day in August 2014.</p> <p>The 8/2014 Progress Notes were reviewed. An entry made Nursing on 8/16/14 at 5:43 a.m. indicated the staff attempted to get the resident up for the day and the resident was confused and unable to follow directions and answer questions from staff. The entry also indicated the resident was breathing in and out of her mouth, audible wheezing was heard, and her oxygen saturation level was 90%. Oxygen was started at 2 liters per minute to assist resident with breathing and the head of her bed was elevated. The next entry was made on 8/16/14 at 9:00 p.m. there was no</p>		<p>follow up, documentation guidelines and correct/incorrect documentation. Audits of resident's charts and pertinent documentation began immediately on a daily basis to review and identify concerns. Any concerns were addressed immediately with the individual nurses. 3. Resident charts being audited daily in clinical meeting for accurate and timely pertinent documentation by the Director of Nursing and IDT team. Unit Managers, Respiratory Therapy and/or designee will audit resident charts at least four (4) times weekly for accuracy and timeliness as well as the weekend nurse manager to review pertinent documentation a minimum of once (1) per weekend and address concerns immediately. Any concerns will be discussed with the individual nurse and may include disciplinary action as needed. 4. The audits will be ongoing but for not less than six (6) consecutive months to ensure 100% compliance. The Director of Nursing will then present the findings of the audits to the PI monthly meeting for recommendations.</p>				

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	<p>documentation of the resident's respiratory status or oxygen use in this entry. The next entry was made on 8/17/14 at 7:07 a.m. There was no documentation of the resident's respiratory status of oxygen use in this entry. The next entry was made on 8/17/14 at 12:24 p.m. This entry indicated the resident's oxygen saturation level was 98% on room air(without any supplemental oxygen in place).</p> <p>2. The closed record for Resident #H was reviewed on 9/10/14 at 12:10 p.m. the resident's diagnoses included, but were not limited to, chronic kidney disease, CVA (stroke), and high blood pressure.</p> <p>A Post Fall Evaluation note was completed on 8/29/14 at 4:28 a.m. The note indicated the resident fell on 8/29/14 at 4:00 a.m. The note indicated the resident was noted lying on her back on the floor and no open, red or bruised areas were noted.</p> <p>Review of the 8/2014 Progress Notes indicated an entry was made by Nursing on 8/29/14 at 4:12 a.m. This entry indicted the resident was lying on the floor on her back, complained of pain to the right lower extremity, and no open or reddened areas were noted. An entry</p>			

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	<p>made on 8/29/14 at 2:53 p.m. indicated the resident had made no attempts to transfer herself, no injuries were noted, and the resident denied pain or discomfort. The next entry related to any assessments following the fall was made on 8/31/14 at 1:33 p.m. This entry indicated the resident was irritable and denied pain or discomfort.</p> <p>When interviewed on 9/10/14 at 4:30 p.m., the Director of Nursing indicated follow up documentation of an assessment was to be completed by the Nurses once a shift for 72 hours after a change in condition or a fall.</p> <p>This Federal tag relates to Complaints IN00154663, IN00155443, and IN00155716.</p> <p>3.1-50(a)(1) 3.1-50(a)(2)</p>				