STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED
	155659		05/10/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG	7823 OLD HWY # 60 SELLERSBURG, IN 47172

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00198816 and IN00199156. Complaint IN00198816 - Substantiated. Federal/State deficiencies related to the allegation are cited at F282. Complaint IN00199156 - Substantiated. No deficiencies related to the allegations are cited. Survey date: May 9 and 10, 2016 Facility number: 010613 Provider number: 155659 AIM number: 200221040 Census bed type: SNF: 17 SNF/NF: 68 Total: 85 Census payor type: Medicare: 31 Medicaid: 44 Other: 10 Total: 85 Sample: 4	F 0000	This Plan of Correction is the center's credible allegation of compliance Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged of conclusions set forth in the statement of deficiencies The plan of correction is prepared and/or executed solely because it I required by the provision of federal ad state law We request that our plan ofcorrection, monitoring tools and review of systemic changes we have made beconsidered for a paper compliance desk review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds 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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	This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed by 34233 on May 12, 2016			
F 0282 SS=D Bldg. 00	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on interview and record review, the facility failed to follow a residents plan of care for 2 staff assistance with ADL's [Activities of Daily Living], upon readmission to the facility, after a fall from bed which resulted in a left hip fracture. (Resident #C) Findings include: The clinical record for Resident #C was reviewed on 5/9/16 at 11:30 a.m. Diagnosis included, but was not limited to, multiple sclerosis. The nurses note, dated 4/22/2016 at 9:03 p.m., included, but was not limited to, the following: "...Staff was called to the room by the CNA [Certified Nursing	F 0282	It is the policy of this facilityto provided or arranged services that are provided by qualified persons inaccordance with each resident's written plan of care. Resident # A late loss ADLs wererevaluated, care plan reviewed and revised, and care sheets updated. All residents have apotential to be affected. 100 percent late loss ADLs were revaluated, care plansreviewed and revised. A care plan audit was conducted on all residents toreflect their current status per the IDT team. Care sheet were updated. SDC or designee has educatedIDT and floor staff on late loss ADL coding, care plans, revision of care plansand interventions. IDT team will audit, updateand	05/27/2016

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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-SELLERSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 7823 OLD HWY # 60 SELLERSBURG, IN 47172	

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	Assistant], who indicated that Patient was on the floor...The CNA indicated that he had the Patient rolled onto her right side, and as he turned to get the brief, the Patient appeared to "tense" up, and her legs rolled out of the right side of the bed...In an effort to prevent this incident from occurring in the future, a new intervention to have 2 staff members present while providing peri [incontinent] care will be put into place upon Patients arrival to facility...." The incident report, dated 4/23/16, included, but was not limited to, the following: "...Incident Date: 04/22/2016...Incident Time: 09:01 PM...Brief Description of Incident...4/23/2016 Resident rolled out of bed during care and ultimately sustained a left hip fracture. All fall prevention interventions and precautions were in place at time of incident. CNA was in room with resident and witnessed fall...Follow up added -- 4/27/2016...Upon her return to the facility...Care in pairs will be instituted as an intervention to reduce the likelihood of falls...." The care plan for Resident #C included, but was not limited to, the following: "...Focus...fractured left hip, ORIF [Open Reduction Internal Fixation]...Revision		revise care plans Monday - Friday during the IDT meeting for any new ordersor change in condition. Care plans will be updated quarterly per schedule, orduring any care plan meeting as scheduled. MDS or designee will audit LateLoss ADL documentation 5 x weekly for 30 days, then 3 x weekly for 30 days, thentwice weekly for 30 days to validate appropriate documentation is available forLate loss ADLs. Audit results will be reviewed in monthly Quality Assurancemeeting to achieve 100% compliance as determined by Quality Assurance committee. The Director of Nursing is responsible to ensure compliance with this standard	

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	on: 04/28/2016...Interventions/Tasks... [Resident #C's first name] is to receive Care in Pairs for all ADL's and routine care...Date Initiated: 04/25/2016...." The CNA assignment sheet, dated 5/9/2016, included, but was not limited to, the following: "...ROOM...[Resident #C's room number]...PATIENT... [Resident #C's name]...PRECAUTIONS: Interventions for risks...CARE IN PAIRS...." The document titled, "Late Loss ADLS [a grid that documents how much assistance was needed/used by CNA's during care] dated 4/19/16 - 5/4/16, indicated, between 4/28/16 and 5/4/16, one CNA assisted Resident #C 7 out of 21 times with bed mobility and 11 out of 21 times with toilet use. During an interview on 5/10/16 at 1:34 p.m., the DON (Director of Nursing) indicated ADL care provided to Resident #C should be done in pairs. This Federal tag relates to Complaint IN00198816 3.1-35(g)(2)			