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 09/30/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION-DYER	2300 GREAT LAKES DRIVE DYER, IN46311

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F0000	This visit was for the Investigation of Complaint IN00097219. Complaint IN00097219 - Substantiated. Federal/State deficiencies related to the allegations are cited at F323. Survey dates: September 28, 29, & 30, 2011 Facility number: 000123 Provider number: 155218 AIM number: 100266720 Survey team: Janet Adams, RN, TC Lara Richards, RN September 30, 2011 Kathleen Vargas, RN September 30, 2011 Census bed type: SNF/NF: 135 Total: 135 Census payor type: Medicare: 34 Medicaid: 76 Other: 25 Total: 135 Sample: 10	F0000		

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 Quality review 10/03/11 by Suzanne Williams, RN			
F0323 SS=D	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 record review and interview, the facility failed to provide adequate supervision to prevent accidents related to not utilizing two staff members for a transfer according to the resident's needs identified on the CNA assignment document, for 1 of 7 residents reviewed for two person assist with transfers in the sample of 10. (Resident #E) Findings include: The closed record for Resident #E was reviewed on 9/27/11 at 12:30 p.m. The resident's diagnoses included , but were not limited to, high blood pressure, dementia, osteoporosis, general osteoarthrosis, edema, chronic ischemic heart disease, and depressive disorder. Review of the 4/26/11 Minimum Data Set (MDS) annual assessment indicated the resident's transfer status was coded as	F0323	F 323 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Resident E no longer resides in this facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken. A full facility review of all C.N.A. assignment sheets was completed to ensure transfer information was current for all residents. No other issues were identified through this audit. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: All care staff will be re-educated on utilizing the C.N.A. assignment	10/14/2011

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	needing extensive assistance of two or more persons. A fall risk assessment completed on the 1/3/11 Partial Nursing Assessment indicated the resident's score was (16). Scores of 14 or higher indicated the resident was at high risk for falls. Review of the 5/11 Physician Order Statement indicated there were orders for the resident to have a low bed in place with a mat on the floor next to the bed, and a pull tab alarm was to be used when the resident was in bed. The 5/7/11 Nurses' Notes were reviewed. An entry made on 5/7/11 at 4:30 p.m., indicated the nurse was called to the resident's room by the CNA. The resident was observed sitting on the floor, and the CNA stated the resident was lowered to the floor during an attempted transfer from the bed to the wheel chair. A head to toe assessment was completed. The resident complained of pain, and pain medication was given as ordered. The next entry was made at 5:00 p.m. and indicated the Nurse Practitioner was paged. An entry made at 5:30 p.m. indicated the Nurse Practitioner was notified of the incident and the resident's condition, and orders were obtained for an X-ray to be done of the right tibia and fibula (bones in the leg). An entry made		sheets for resident transfer information. Nursing Administration will validate compliance via direct observation of 10 resident transfers weekly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur: A performance improvement tool has been developed that evaluates proper transfer technique as evidenced by adherence to the documentation provided on the C.N.A. assignment sheet. Nursing Administration will complete the PI tool weekly for 8 weeks, monthly for a quarter and quarterly thereafter with results being forwarded to the PI committee for further review and subsequent plans of correction developed as deemed necessary. .	

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	at 9:30 p.m. indicated the X-ray was obtained at the facility. The 5/8/11 Nurses' Notes were reviewed. An entry made at 12:30 a.m. indicated the X-ray results were back and they were abnormal. The Nurse Practitioner was notified. Orders were obtained to send the resident to the hospital emergency room. Review of the hospital X-ray results indicated an X-ray was taken of the right knee on 5/8/11 at 2:42 a.m. The X-ray results indicated there was a lucency traversing through the proximal lateral aspects of the tibia and this could be caused by non displaced fracture. An X-ray of the right tibia and fibula were taken as this time also. The X-ray results indicated there were moderate degenerative changes of the right knee and the bones were demineralized. The results also indicated there was no evidence of an acute fracture. Review of the 5/11/11 Nurse Practitioner progress note indicated an X-ray of the resident's right knee showed lucency through the proximal lateral aspects of the tibia which could be secondary to a non displaced fracture. The progress note also indicated the above was discussed with a an Orthopedic Physician after he reviewed the X-rays. The Orthopedic Physician			

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	indicated it was unlikely a fracture. The facility investigation report was reviewed. The report indicated while a CNA was assisting the resident with a transfer from the bed to the wheel chair, the resident began to slip and was eased to the floor by the CNA. The resident was sent to the hospital emergency room and returned with a knee immobilizer. Interviews were obtained from two CNAs. CNA #1's interview indicated she had worked on the resident's unit the evening of the incident. The CNA indicated at the beginning of her shift she asked CNA #2 to explain the routine of the residents on the unit as she (CNA #2) was one of the regular aides who worked on the unit. CNA #1 indicated she answered a call light in Resident E's room when the resident's alarm was going off and provided care to the resident. The call light for Resident E's room was on again later and CNA #1 answered the light and the resident was dangling a foot out of the bed. The CNA assisted the resident to a sitting position and then checked her assignment sheet to check the resident's transfer status and the transfer section was "blank." CNA #1 called for the nurse and the resident became agitated and yelling, trying to stand. The CNA asked the resident if she (CNA #1) could transfer her herself and the resident said "yes."			

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	The CNA started to transfer the resident. The resident started yelling out and grabbed the arm of wheel chair and turned so that she was facing the wheel chair and the CNA tried to correct her. The resident screamed out that she was pain and her legs were giving out and the resident was lowered to the floor. CNA #2 was interviewed by the facility Administrator on 5/9/11. The CNA indicated she informed CNA #1 that she usually transfers Resident #E by herself. It depends on the day and sometimes Resident #E is weaker then other times. CNA #2 also told her the resident is weaker then at other times and CNA #1 should have someone in with her. CNA #2 indicated she was just following information the other aides had told her related to transferring Resident #E. When interviewed on 9/29/11 at 9:45 a.m., the facility Administrator indicated she interviewed CNA #1 and CNA #2 related to the above incident. The Administrator indicated she did not interview any other CNAs related to the resident's transfer. The Administrator indicated the transfer status of residents is listed on the CNA assignment sheet, and during her investigation, she reviewed one of the CNA assignment sheets that was at the Nurses' station. The CNA assignment			

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	sheet listed the residents transfer status as "A x 2" (assist of two staff members) with "Hoyer" (a mechanical lift device) listed on the line below. The Administrator indicated the CNA assignment sheets are kept on each unit, and the unit managers were responsible for updating the sheets on each unit. When interviewed on 9/28/11 at 1:50 p.m., CNA #3 and CNA #4 both indicated they are to use the CNA assignment sheet to check how each resident is transferred and by how many staff members. This Federal tag relates to Complaint IN00097219. 3.1-45(a)(2)			