

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155152	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 03/17/2014
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NAME OF PROVIDER OR SUPPLIER MONTICELLO HEALTHCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 N MAIN ST MONTICELLO, IN 47960
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F000000	<p>This visit was for the Investigation of Complaint IN00145208.</p> <p>Complaint IN00145208-Substantiated. Federal/State deficiencies related to the allegations are cited at F205, F282, and F323.</p> <p>Survey Dates: March 17, 2014</p> <p>Facility number: 000072 Provider number: 155152 AIM number: 100287440</p> <p>Survey team: Regina Sanders, RN, TC Julie Ferguson, RN</p> <p>Census bed type: SNF: 9 SNF/NF: 81 Total: 90</p> <p>Census Payor type: Medicare: 16 Medicaid: 16 Other: 58 Total: 90</p> <p>Sample: 4</p> <p>These deficiencies reflect State</p>	F000000	<p>The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.</p> <p>This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation and requests a Desk Review in lieu of a post survey revisit on or after April 7, 2014.</p>	

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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F000205 SS=A	<p>findings cited in accordance with 410 IAC 16.2.</p> <p>Quality review completed on March 20, 2014, by Janelyn Kulik, RN.</p> <p>483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return.</p> <p>At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>Based on record review and interview, the facility failed to ensure</p>	F000205	F205 Notice of Bed-hold policy before/upon transfer	04/07/2014

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	<p>a resident and a family member were given an opportunity to pay privately for a bed hold for days of absence in excess of the State's bed-hold limit, related to a resident transferred to a hospital who could not return to the facility due to a bed not being available, for 1 of 3 residents reviewed for transfers in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's record was reviewed on 03/17/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and end stage renal disease. The resident was discharged from the hospital on 02/18/14. The resident did not have a Power of Attorney or Responsible Party and made her own decisions.</p> <p>The Admission MDS (Minimum Data Set) Assessment, dated 01/16/14, indicated the resident had no cognition impairment.</p> <p>A Physician's Order, dated 02/18/14, indicated to transfer the resident to the hospital related to a high creatinine (kidney function test).</p> <p>The record indicated a, "Notice of</p>		<p>It is the practice of this provider to ensure that each resident receives the opportunity to pay privately for a bed hold for days of absence in excess of the State's bed-hold limit.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident #B no longer resides in the facility.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents that are out of the facility at the hospital have the potential to be affected by the alleged deficient practice.</p> <p>Residents that are out of the facility at the hospital will be contacted by a facility representative to give them the opportunity to pay privately for a bed hold for days of absence in excess of the State's bed hold limit. The Interdisciplinary Team will be re-educated by April 7, 2014 related to contacting residents at the hospital and giving them an opportunity to pay privately for a bed hold for days of absence in excess of the State's bed hold limit.</p> <p>What measures will be put into place or what systemic changes</p>		

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	<p>Transfer or Discharge" form was sent with the resident to the hospital, which included the facility's Bed Hold Policy.</p> <p>The facility's Bed Hold Policy, dated 01/11, and received from the Administrator as current, indicated, "...the resident or resident's responsible party may request the facility to hold open the residents bed during their absence by paying the full daily rate. A facility representative will contact the responsible party and/or POA (Power of Attorney) to obtain their wishes on whether they prefer to have the resident discharged or whether they would like to pay the daily rate during their absence to hold the bed..."</p> <p>During an interview on 03/17/14 at 3:45 p.m., the Administrator indicated no one had contacted the resident or the resident's family to give them a choice for the bed to be held. She indicated the resident had not come back to the facility after her hospitalization because there were no female beds available. She indicated the facility boxed up the resident's belongings and kept them in a safe place for her.</p>		<p>you will make to ensure that the deficient practice does not recur?</p> <p>The facility activity report will be run every morning by a member of the Interdisciplinary Team except for the weekends and holidays. Any resident that is transferred to the hospital or their designee will be contacted by a member of the Interdisciplinary team and given the opportunity to pay privately for a bed hold for days of absence in excess of the State's bed hold limit. During weekends and holidays, the Manager on call will be contacted regarding any transfers or discharges. The Manager on call or their designee will be responsible to contact the resident or a family member to give them the opportunity to pay privately for a bed hold for days of absence in excess of the State's bed hold limit. Notification will be documented in the resident's medical record.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · The CQI tool titled "Bed Hold" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance. · The CQI committee reviews 				

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F000282 SS=D	<p>This Federal tag relates to Compliant 145208</p> <p>3.1-12(a)(25)(B)</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 record review and interview, the facility failed to follow residents' care plans, related to fall risk interventions for 3 of 3 residents reviewed for falls in a total sample of 4. (Residents #B, #C, and #D)</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 03/17/14 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia.</p> <p>The Quarterly Minimum Data Set Assessment (MDS), dated 12/21/13, indicated the resident was</p>	F000282	<p>the audits monthly and action plans are developed as a threshold of 100% is not met to ensure continual compliance.</p> <p>The Director of Nursing Services or her designee is responsible to monitor for compliance.</p> <p>Compliance Date: April 7, 2014</p> <p>F 282 Services by Qualified Persons/per care plan</p> <p>It is the practice of this provider to follow residents' care plans related to fall risk interventions.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Based on the information provided, residents B & C no longer reside in the facility.</p> <p>We have reviewed the care plan and the fall risk interventions of resident #D and notified staff of the interventions. Fall interventions are in place per plan of care.</p> <p>How will you identify other</p>	04/07/2014	

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	<p>cognitively impaired, required extensive assistance of one for transfers, and was unable to steady self with standing and transfers without the help of staff.</p> <p>The Care Plan, dated 10/23/13, indicated the resident was a risk for falls, required assistance with transfers, and had poor decision making skills. The interventions included, (07/30/13) pressure alarm to the chair to alert staff of attempts to transfer without assistance and do not leave the resident unattended while toileting.</p> <p>The Nurses' Progress Notes indicated:</p> <p>02/24/14 at 7:58 a.m.-"Resdinet (sic) was assisted to the restroom with 1 staff, staff memembr (sic) went to her wardrobe to get her clothes for the day, resdinet (sic) stood from toilet and fell on the floor, hitting her head on the toilet...send residnet (sic) to ER..."</p> <p>During an interview on 03/17/14 at 2:20 p.m., the Director of Nursing (DoN) indicated the resident should not have been left alone in the bathroom.</p>		<p>residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents with fall risk interventions on their care plans have the potential to be affected by the alleged deficient practice.</p> <p>All residents with fall risk have been audited to ensure their care plans related to fall risk interventions are up to date.</p> <p>The aide assignment sheets have been updated to reflect appropriate fall risk interventions.</p> <p>Nursing staff will be re-educated on care plans related to fall risk intervention by April 7, 2014 by the Clinical Education Coordinator or her designee.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Nursing staff will be re-educated on care plans related to fall risk interventions by April 7, 2014 by the Clinical Education Coordinator or her designee.</p> <p>A Post Test will be administered.</p> <p>Aide Assignment sheets are updated to reflect changes in the residents' needs.</p> <p>Each resident's care plan is reviewed and updated quarterly and as needed to reflect the residents' needs.</p> <p>The Charge Nurse will ensure that resident's fall risk interventions are in</p>		

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	<p>2. Resident #D's record was reviewed on 03/17/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to, hypertension and dementia with senile with delusions.</p> <p>The care plan dated 05/03/13 indicated Resident #D was at risk for falls. The interventions included not to leave the resident in the bathroom unattended while being toileted.</p> <p>The 03/14/14 Nurse's Note at 2:46 p.m. indicated Resident #D was assisted to the toilet by a CNA. The resident then attempted to transfer herself, unassisted, and fell trying to get back into wheelchair. The resident received multiple abrasions to the face, a cut with noted blood to the forehead, and the resident was transferred to the Emergency Room.</p> <p>During an interview on 03/14/14 at 3:04 p.m., the DoN indicated the resident was left unattended in the bathroom. She indicated staff should have stayed with the resident.</p> <p>3. Resident #B's record was reviewed on 03/17/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and end stage renal</p>		<p>place and ensuring CNA assignment sheets are followed. each shift per the care plan by conducting rounds.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> · The CQI tool titled "Fall Management" will be utilized by the Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance. · The CQI committee reviews the audits monthly and action plans are developed as a threshold of 95% is not met to ensure continual compliance. · The Director of Nursing Services or her designee is responsible to monitor for compliance. <p>Compliance Date: April 7, 2014</p>		

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	<p>disease.</p> <p>The Admission MDS Assessment, dated 01/16/14, indicated the resident had no cognition impairment, required extensive assistance of 2 or more for transfers, was unable to balance self with standing without help, and had a history of falls prior to being admitted into the facility.</p> <p>A Care Plan, dated 01/10/14, indicated the resident was at risk for falls due to general weakness and expressed a fear of falling. The interventions included to use two assistants for transfers.</p> <p>A Physical Therapy Plan of Care, dated 01/10/14 to 02/08/14, indicated the resident required maximum assistance of two (two people) for transfers from bed to chair.</p> <p>An Event Report, dated 02/01/14 at 2:31 p.m., indicated, "...CNA was transferring res. (resident) to recliner, her legs became weak, she leaned on CNA, and CNA lowered her to the floor..."</p> <p>A fall investigation, dated 02/04/14, indicated one CNA had placed a gait</p>				

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F000323 SS=G	<p>belt on the resident and had attempted to transfer the resident with only one assistant. The investigation indicated the CNA had attempted to get the resident to sit back in the wheelchair when the resident leaned on the CNA, pushing the CNA and the CNA then lowered the resident to the floor.</p> <p>During an interview on 03/17/14, the DoN indicated there were not two CNA's used to transfer the resident, only one CNA attempted the transfer and she had used the gait belt.</p> <p>This Federal Tag relates to complaint IN00145208.</p> <p>3.1-35(g)(20</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.</p>			
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	<p>Based on record review, observation and interview, the facility failed to ensure residents received supervision and assistance to prevent accidents, related to leaving residents who were at risk for falls in the bathroom without supervision and the residents fell, which resulted in a fractured left hip for one resident and a fractured arm and bruising of the face for one resident (Residents #C and #D) and transferring a resident, who required 2 assistants for transfers with only 1 assistant, (Resident #B) for 3 of 3 residents reviewed for falls in a total sample of 4.</p> <p>Findings include:</p> <p>1. Resident #C's record was reviewed on 03/17/14 at 12:30 p.m. The resident's diagnoses included, but were not limited to, hypertension and dementia.</p> <p>The Quarterly Minimum Data Set Assessment (MDS), dated 12/21/13, indicated the resident was cognitively impaired, required extensive assistance of one for transfers, and was unable to steady self with standing and transfers without the help of staff.</p>	F000323	<p>F323 Free of Accident hazards/supervision/devices</p> <p>It is the practice of this provider to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Based on the information provided, residents B & C no longer reside in the facility.</p> <p>We have reviewed the care plan and the fall risk interventions of resident #D and notified staff of the interventions. Fall risk interventions are in place per plan of care.</p> <p>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?</p> <p>Residents with fall risk interventions on their care plans have the potential to be affected by the alleged deficient practice.</p> <p>All residents with fall risk have been audited to ensure their care plans related to fall risk interventions are up to date.</p>	04/07/2014			

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	<p>The Care Plan, dated 10/23/13, indicated the resident was a risk for falls, required assistance with transfers, and had poor decision making skills. The interventions included, (07/30/13) pressure alarm to the chair to alert staff of attempts to transfer without assistance and do not leave the resident unattended while toileting.</p> <p>A Physician's Order, dated 07/30/13, indicated an order for a chair alarm to alert staff of unassisted transfers.</p> <p>The Nurses' Progress Notes indicated: 02/12/14 at 6:40 a.m.-"staff assisted resident to the bathroom and then back to bed. Gait is extremely unsteady..."</p> <p>02/12/14 at 10:09 a.m.-"Gait continued to be unsteady this morning..."</p> <p>02/13/14 at 5 a.m.-"Resident's bed pressure alarm sounded and CNA entered resident's room. Resident was standing with her walker and fell back onto her buttocks onto her roommate's blue mat. CNA could not get to her in time of fall...Resident was wanting to go to the bathroom...Denies pain..."</p>		<p>The aide assignment sheets have been updated to reflect appropriate fall risk interventions. Nursing staff will be re-educated on care plans related to fall risk intervention by April 7, 2014 by the Clinical Education Coordinator or her designee.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>Nursing staff will be re-educated on care plans related to fall risk interventions by April 7, 2014 by the Clinical Education Coordinator or her designee. A Post Test will be administered. Aide Assignment sheets are updated to reflect changes in the residents' needs. Each resident's care plan is reviewed and updated quarterly and as needed to reflect the residents' needs. The Charge Nurse will ensure that resident's risk fall interventions are in place and ensuring CNA assignment sheets are followed each shift per the care plan by conducting rounds .</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>The CQI tool titled "Fall Management" will be utilized by the</p>				

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	<p>02/24/14 at 7:58 a.m.-"Resdinet (sic) was assisted to the restroom with 1 staff, staff memembr (sic) went to her wardrobe to get her clothes for the day, resdinet (sic) stood from toilet and fell on the floor, hitting her head on the toilet...send residnet (sic) to ER..."</p> <p>02/27/14 at 7:17 p.m.-"Resident arrived to facility (return from hospital)...Edema noted to (l) (left) leg...3 bandages to L hip/leg from surgery...Numerous bruising noted throughout body..."</p> <p>03/01/14 at 2 a.m.- "Ten staples noted to left hip area. Seven staples to left mid thigh area. Three staples noted to area above the left knee. Bruising to left hip and left thigh..."</p> <p>An Admission Note from the hospital, dated 02/24/14, indicated the resident had comminuted intertrochanteric fracture of the left proximal femur (hip fracture).</p> <p>A fall investigation, dated 02/24/14, indicated the resident was in the bathroom and had attempted to transfer herself off the toilet without assistance, was not able to transfer self and fell. The investigation</p>		<p>Interdisciplinary team weekly times four, monthly times three and quarterly thereafter for at least six months to ensure compliance.</p> <ul style="list-style-type: none"> The CQI committee reviews the audits monthly and action plans are developed as a threshold of 95% is not met to ensure continual compliance. The Director of Nursing Services or her designee is responsible to monitor for compliance. <p>Compliance Date: April 7, 2014</p>				

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(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			
	<p>indicated the environment was checked for safety hazards and none were found.</p> <p>During an interview on 03/17/14 at 2:20 p.m., the Director of Nursing (DoN) indicated the resident should not have been left alone in the bathroom.</p> <p>2. Resident #D's record was reviewed on 03/17/14 at 10:45 a.m. The resident's diagnoses included, but were not limited to, hypertension and dementia with senile with delusions.,</p> <p>The Quarterly MDS Assessment dated 12/15/13, indicated the resident had moderately impaired cognition, required extensive assistance of two or more for transfers and toileting, and was unsteady without staff assistance while standing.</p> <p>The Fall Risk assessment dated 07/31/13 at 11:49 a.m., indicated Resident #D was at risk for falls.</p> <p>The care plan dated 05/03/13 indicated Resident #D was at risk for falls. The interventions included, not to leave the resident in the bathroom unattended while being toileted.</p>						

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	<p>The 03/14/14 Nurse's Note at 2:46 p.m. indicated Resident #D was assisted to the toilet by a CNA. The resident then attempted to transfer herself, unassisted, and fell trying to get back into wheelchair. The resident received multiple abrasions to the face, a cut with noted blood to the forehead, and the resident was transferred to the Emergency Room.</p> <p>On 03/14/14, the hospital "After Visit Summary" indicated, Resident #D had a right humerus closed fracture and was treated with immobilization. Discharge instructions also indicated the resident had a concussion or a closed head injury.</p> <p>A fall investigation, dated 03/14/14, indicated the staff heard Resident #D yelling for help. Resident #D was found on the bathroom floor injured and was transferred to the Emergency Room.</p> <p>On 03/17/14 at 1:30 p.m. Resident #D was observed sitting in wheelchair, with her right arm in sling and multiple dark green, red and purple brushing to resident's face.</p>						

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	<p>During an interview on 03/14/14 at 3:04 p.m., the DoN indicated the resident was left unattended in the bathroom. She indicated staff should have stayed with the resident.</p> <p>3. Resident #B's record was reviewed on 03/17/14 at 10:30 a.m. The resident's diagnoses included, but were not limited to, diabetes mellitus and end stage renal disease.</p> <p>The Admission MDS Assessment, dated 01/16/14, indicated the resident had no cognition impairment, required extensive assistance of 2 or more for transfers, was unable to balance self with standing without help, and had a history of falls prior to being admitted into the facility.</p> <p>A Care Plan, dated 01/10/14, indicated the resident was at risk for falls due to general weakness and expressed a fear of falling. The interventions included to use two assistants for transfers.</p> <p>A Physical Therapy Plan of Care, dated 01/10/14 to 02/08/14, indicated the resident required maximum assistance of two (two people) for transfers from bed to</p>			

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	<p>chair.</p> <p>An Event Report, dated 02/01/14 at 2:31 p.m., indicated, "...CMA was transferring res. (resident) to recliner, her legs became weak, she leaned on CNA, and CNA lowered her to the floor..."</p> <p>A Nurses' Progress Note, dated 02/03/14 at 10:08 a.m., the resident complained of severe pain in the left leg, bilateral shoulders, and back. The note stated the resident requested to go to the hospital and the Physician was notified and an order was received to transfer the resident to the Emergency Room.</p> <p>A fall investigation, dated 02/04/14, indicated one CNA had placed a gait belt on the resident and had attempted to transfer the resident with only one assistant. The investigation indicated the CNA had attempted to get the resident to sit back in the wheelchair when the resident leaned on the CNA, pushing the CNA and the CNA then lowered the resident to the floor. The resident sat on the floor with the left leg tucked under her right leg. The CNA then went to get the nurse. The resident then attempted to get herself towards the bed and</p>						

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	<p>indicated she could get herself into the bed. Two nurses and one CNA attempted to get the resident off the floor and could not. Three nurses and three CNA's were able to lift the resident back into her wheelchair. No concerns were voiced from the resident.</p> <p>The Emergency Room Physician Progress Note, dated 02/03/14, indicated the resident complained of left hip pain, right shoulder pain and back pain, which began after the resident had fallen. The note indicated the resident had informed the Physician that when the nurses attempted to get her off the floor they had dropped her, causing the pain to increase.</p> <p>The hospital Discharge Summary, dated 02/07/14, indicated the resident had a large left knee effusion and partial quadriceps muscle tear and would require a left knee immobilize.</p> <p>During an interview on 03/17/14, the DoN indicated there were not two CNA's used to transfer the resident, only one CNA attempted the transfer and she had used the gait belt.</p> <p>This Federal Tag relates to</p>						

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	complaint IN00145208. 3.1-45(a)(1) 3.1-45(a)(2)			