

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
--	--

(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	<p>This visit was for the Investigation of Complaints IN00179703 and IN00181119.</p> <p>Complaint IN00179703- Substantiated. No deficiencies related to the allegations are cited.</p> <p>Complaint IN00181119- Substantiated. A deficiency related to the allegations is cite at F309.</p> <p>Survey date: September 2, 3, and 4, 2015.</p> <p>Facility number: 000273 Provider number: 15A011 AIM number: 100267870</p> <p>Census bed type: NF: 122 Total: 122</p> <p>Census payor type: Medicaid: 121 Other: 1 Total: 122</p> <p>Sample: 4</p> <p>This deficiency reflects State findings cited in accordance with 410 IAC</p>	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under and state and federal law. Please accept this plan of correction as our credible allegation of compliance. Should additional information be necessary to confirm said compliance, feel free to contact me.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 09/04/2015
NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176		
(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	
	16.2-3.1 QR was completed by 30576 on September 8, 2015.				
F 0309 SS=G Bldg. 00	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Based on record review and interview, the facility failed to provide adequate supervision and training to ensure a resident was protected from harm. Resident C suffered a fracture of the right tibia during a transfer when a staff member (CNA #1) failed to follow facility policy and the resident's assessment requiring 2 person transfers and attempted to transfer Resident C without assistance. 1 resident of 3 reviewed for harm in a sample of 4. (Resident #C)	F 0309	F309 Requires the facility to provide adequate supervision and training to ensure a resident was protected from harm. 1. Resident C was treat for . 2. All residents have the potential to be affected. The CNA assignment sheets were reviewed ensuring the transfer order matched the plan of care for each resident. No concerns were noted. See below for corrective measures. 3. The Transfer: Two Person Lift policy and procedure was reviewed with no changes made. (See attachment A) The staff was inserviced on the on the above	09/08/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2015
--	---	---	---

NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
--	--

(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>Findings include:</p> <p>An annual Minimum Data Set assessment dated 6/25/2015 indicated Resident C was severely cognitively impaired, was totally dependent on staff for all activities of daily living, and was totally dependent and required 2 staff for transfers.</p> <p>A care plan for Resident C initiated 12/23/2014 and updated 7/01/2015 indicated "Problem: Resident requires total care secondary to developmental delay...Interventions...2 person to transfer."</p> <p>Daily CNA assignment sheets indicated Resident C was a 2 person transfer.</p> <p>Nurse's progress notes indicated: 8/15/15 11:00 P.M. "CNA notified nurse resident right involving the distal ankle swollen et (and) pale purple upon nurse assessment HR (heart rate) 144 resident not moving right leg as normal resident guarding right ankle (symbol for "with") left leg S/S (signs and symptoms) pain PRN (as needed) tyl adm (Tylenol administered) MD notified N.O. (new order) received for x-ray of right ankle... (name of x-ray company) out to do x-ray pending results..."</p> <p>8/16/15 1:30 A.M. "x-ray results received</p>		<p>procedure. 4. The DON or his designee will monitor four transfers a day ensuring the staff is following the resident's plan of care on how to transfer as well as following the policy correctly. The DON or his designee will utilize the nursing monitoring tool daily times for weeks, then weekly times four weeks, then every two weeks times two months, then quarterly thereafter until 100% compliance is obtained and maintained.(See attachment B) The audits will be reviewed during the facility's quarterly quality assurance meetings and the plan of correction will be adjusted accordingly if warranted. 5. The above corrective measures will be completed on or before September 8, 2015.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
--	--

(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>resident has spiral fracture involving the distal (away) third of the right tibial shaft MD paged pending reply..."</p> <p>8/16/15 2:00 A.M. "MD replied N.O. (new order for narcotic pain medication) PRN for pain et refer to orthopaedic surgeon..."</p> <p>A "Report of Concern" form dated 8/16/15 completed and signed by the Director of Nursing indicated "Nature of concern: Resident weighs 60.1 (symbol for "pounds") (CNA #1) lifted him by herself 4 times on her shift without assistance. (The) 4th time resident suffered a RLL (right lower leg) spiral fracture D/T (due to) foot was caught in W/C (wheel chair)...Follow up action: D.O.N. (Director of Nursing) spoke with (CNA #1) 8/16/15 P.M. Explained she was not following the care plan and facility will re-inservice lifting policy."</p> <p>An "Accident and Incident Report and Investigation" form for Resident C indicated: "Date of Incident: 08/15/15, Time: 9:30 P.M., Location: resident in bed. Thorough description of incident: CNA notified nurse resident right ankle swollen et (and) pale purple resident not moving foot as normal S/S (signs and symptoms) pain HR (heart rate, symbol for "up") 144 (beats per minute) guarding</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 09/04/2015
--	---	--	---

NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176
--	--

(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>right ankle (symbol for "with") left leg et foot..."</p> <p>A hospital Admission H and P (history and physical) note dated 8/17/15 indicated "History of present illness: Leg: Broke leg on Friday/Saturday. Happened when taking him out of his chair. His leg became stuck and he was lifted and his right leg broke. X-rays performed Saturday (sic) night and revealed right tibia fracture."</p> <p>The Director of Nursing was interviewed on 9/03/15 at 1:10 P.M. He indicated it was facility policy that all residents weighing over 50 pounds were designated to be 2 person transfers, that CNA #1 was aware Resident C was a 2 person transfer, and that she had acted in conflict with facility policy in transferring resident C resulting in a fracture of Resident C's right lower leg. He also indicated there was staff available in the immediate area who could have assisted CNA #1 with the transfer, but she did not seek help. He indicated CNA #1 was removed from patient care duty until she had completed re-training on resident transfers.</p> <p>A facility policy dated 10/2014 titled "Transfer: Two Person Lift" indicated: "Purpose: To safely lift resident for</p>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15A011	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____		X3) DATE SURVEY COMPLETED 09/04/2015
NAME OF PROVIDER OR SUPPLIER ESPECIALLY KIDZ HEALTH & REHAB			STREET ADDRESS, CITY, STATE, ZIP CODE 2325 S MILLER ST SHELBYVILLE, IN 46176		
(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>transfers. Policy: Apply basic principles when transferring a resident. 1. Plan and organize what you are going to do before you begin. 2. Remember safety first for both the resident and yourself..."</p> <p>This Federal tag relates to Complaint IN00181119.</p> <p>3.1-37(a)</p>				