

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155488	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/25/2014
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NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB-ROLLING HILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 3625 ST JOSEPH RD NEW ALBANY, IN 47150
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F000000	<p>This visit was for Investigation of Complaint IN00150573.</p> <p>Complaint IN00150573 - Substantiated. A Federal/state deficiency related to the allegation is cited at F323.</p> <p>Survey date: 6/25/2014</p> <p>Facility number: 000526 Provider number: 155488 AIM number: 100266970</p> <p>Survey team: W. Christopher Greeney, QIDP</p> <p>Census bed type: SNF: 0 SNF/NF: 94 Residential: 0 Total: 94</p> <p>Census payor type: Medicare: 8 Medicaid: 70 Other: 16 Total: 94</p> <p>Sample: 3</p> <p>This deficiency also reflects state findings cited in accordance with 410</p>	F000000	<p>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. This plan of correction is prepared and submitted because of requirement under state and federal law. Please find enclosed the plan of correction for the survey ending June 25th, 2014. Please accept this plan of correction as our credible allegation of compliance effective on July 16th, 2014. Please find sufficient documentation providing evidence of compliance with the plan of correction. The documentation serves to confirm the facility's allegation of compliance. Thus, the facility respectfully requests the granting of paper compliance. Should additional information be necessary to confirm said compliance, feel free to contact</p>	
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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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F000323 SS=G	<p>IAC 16.2-3.1.</p> <p>Quality Review completed on June 30, 2014, by Brenda Meredith, R.N.</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 record review and interview, the facility failed, for 1 of 3 residents (Resident B) reviewed for prevention of falls, to implement appropriate transfer techniques designed to prevent a resident from falling during transfer.</p> <p>Finding includes:</p> <p>A facility submitted State of Indiana Incident Report, dated 6/8/14, indicated CNA (Certified Nursing Assistant) #1 was involved in transferring Resident B from a bed to a chair in the resident's room. The report indicated "the resident's legs became weak and she was assisted to the floor per CNA." The report further indicated that while no injuries were found during assessment immediately</p>	F000323	<p>F 323 Requires that the facility 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> <p>1. Resident B was immediately transferred to the hospital for evaluation and treatment. No other residents were affected or harmed.</p> <p>2. Any resident who requires assistance with a transfer is at risk. Therapy will assess all residents (to be completed by 7/16/2014) to update the needed level of assistance and assistive device (if indicated) that each resident need(s) (See Attachment 1 and Attachment 1-A). C.N.A care sheets will be</p>	07/16/2014

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	<p>after the fall and the resident verbalized no pain, 4.5 hours later the resident's "left knee was swollen", and "x-rays indicated bilateral knee fractures."</p> <p>Resident B's clinical record was reviewed 6/25/14 at 3:00 P.M. Resident B's Annual Minimum Data Set (MDS) assessment, dated 9/12/13, indicated the resident had "extensive" needs with transfers and required a two person physical assistance with transfers.</p> <p>On 6/25/14 at 3:15 P.M. the facility provided for review an "Interdisciplinary Team Falls Review," dated 6/9/14, which indicated that on 6/8/14 Resident B had a "witnessed fall" which resulted in the resident being discharged to a hospital after x-rays were obtained and indicated "bilat knee fx [bilateral knee fractures]." A "Root Cause Analysis" attached with the IDT Falls Review indicated "CNA states lowered resident to the ground." The analysis also indicated the "CNA transferred resident by herself-resident 2 assist [resident is a two-person assist with transfers], not using gait belt." The analysis further indicated the "CNA needs education about transfers, gait belt, CNA assignment sheet." Interview on 6/25/14 at 3:40 P.M. with the facility's Staff Development Coordinator indicated that policies and procedures regarding</p>		<p>updated to reflect any findings from the assessments (See Attachment 2) to be complete by 7/16/2014). All resident's care plans will be reviewed and updated as appropriate (See Attachment 3) to be completed by 7/16/2014. Nursing staff will complete competency skills check-offs for (See Attachment 4 and Attachment 4-1) gait belt and transfers, by 7/16/2014.</p> <p>3.SDC or designee will in-service nursing staff on proper transfer technique, gait belt (See Attachment 5 and Attachment 6), and care sheets usage (See Attachment 2).</p> <p>4.The DNS or designee will complete CNA transfer audit sheet (See Attachment 7) and observe the proper transfer technique performed 5 times a week for 30 days, then 3 times a week for 30 days, and then 2 times a week for 30 days. All findings will be addressed immediately for correction. Observation results will be reviewed by QI Committee for 3 months and then will determine if 100% compliance has been achieved for on-going monitoring.</p> <p>5.The above corrective measures will be completed on or before July 16, 2014.</p>				

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	<p>CNA assignment sheets are reviewed with employees during orientation. The Staff Development Coordinator provided the attendance rosters and the orientation agendas for 5/21/14 and 5/22/14 indicated CNA #1 attended and participated with orientation training at hiring. CNA #1's name was on the sign in sheet for day of the initial orientation.</p> <p>Interview with the facility's Director of Nursing (DON) on 6/25/14 at 3:45 P.M. indicated CNA #1 was immediately suspended pending investigation following the fall and that the CNA indicated during interview with the DON during the investigation that she didn't refer to the facility's CNA care assignment sheet prior to the transfer. The DON indicated after the investigation, CNA #1 was reinstated, on 6/16/14, following a meeting where corrective action was implemented and an inservice on using CNA care sheets, proper use of transfers and use of gait belts was provided. Review of the corrective action, dated 6/11/14, provided by the DON, indicated CNA "attempted to transfer a 2 person assist by herself." The corrective action, which was signed by CNA #1, indicated the CNA was educated on the above expectations during orientation." The DON indicated CNA #1 returned to work</p>			

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	<p>on 6/16/14, but one week later resigned her position with the facility. CNA #1 was unavailable for interview regarding the above incident.</p> <p>This Federal tag relates to Complaint IN00150573.</p> <p>3.1-45(a)(2)</p>						