STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155330	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 06/26/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALEM CROSSING	200 CONNIE AVE SALEM, IN 47167

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED 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
F0000	This visit was for the Investigation of Complaint IN00109601. Complaint IN00109601 - Substantiated. Federal/state deficiencies related to the allegations are cited at F323. Survey dates: June 25 and 26, 2012 Facility number: 000223 Provider number: 155330 AIM number: 100267680 Survey team: Jennie Bartelt RN Census bed type: SNF/NF: 85 Total: 85 Census payor type: Medicare: 5 Medicaid: 58 Other: 22 Total: 85 Sample: 4 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 6/29/12 by Suzanne	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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	Williams, RN			

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F0323 SS=D	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 observation, interview, and record review, the facility failed to ensure residents were transferred safely with the use of a gait belt for 2 of 3 residents reviewed related to transfers in a sample of 4. (Residents A and C) Findings include: 1. On 6/25/12 at 6:20 p.m., Resident A was observed in her wheel chair using her feet to move the wheel chair down the hallway. The resident attempted to arise from the wheel chair, and a safety alarm used to alert staff to the resident arising unassisted sounded. During observation of care completed on 6/25/12 at 6:55 p.m., CNAs #24 and #16 assisted Resident A to retire for the night. Resident A was rolled in her wheel chair into her room, assisted to dress in night clothes while seated in the wheel chair, and rolled into the bathroom. Without using a gait belt, the CNAs each reached under one arm of the resident, lifted the resident, pivoted her, and seated her on	F0323	F323 1. Because all residents have the potential to be affected by the alleged deficient practices, the CNA assignement sheets were updated to the use of the gait belt for residents requiring assistnace with transfers. All CNA and nursing staff were inserviced by the therapy department on gait belt use on 7/3/12. AS of 7/3/12 the therapy department conducted gait belt skills validation testing for 100% of the CNA and nursing staff. 2. The charge nurse will conduct rounds on each shift to ensure each CNA wears a gait belt to ensure the gait belt is part of the CNA uniform. The charge nurses will conduct rounds on all shifts to ensure the CNAs use the gait belt when transferring a residents. 3. To ensure compliance, the DNS/Designee is responsible for the completion of the gait bet CQI tool weekly times 4 weeks, bi monthy times 2 months, and then quarterly until continued compliance is maintained for 2 consecutive quarters. The results of these audits will be reviewed by the CQI committee overseen by the Executive Director. If thershold of	07/09/2012

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	the toilet. The resident did not fully straighten her knees to stand during the transfer. When the resident was finished on the toilet, the CNAs again reached under the resident's arms and lifted to assist her to stand. During interview at this time, CNA #24 indicated Resident A could walk, and the resident walked with slow, wobbly, shuffling steps toward the bed with the CNAs standing by and lightly touching the resident's elbow. A gait belt was not used. The CNA Assignment Sheet for Resident A was provided by the Director of Nursing on 6/25/12 at 7:00 p.m. The assignment indicated the resident required the assistance of two for transfers. The clinical record for Resident A was reviewed on 6/25/12 at 8:00 p.m. The Minimum Data Set (MDS) assessment, dated 4/24/12, indicated the resident required the extensive assistance of two persons for transfers. During interview on 6/26/12 at 2:55 p.m., the Director of Nursing indicated if a resident requires the assistance of two for transfers, a gait belt should be used for the transfer. 2. On 6/25/12 at 7:40 p.m., Resident C was observed seated in her wheel chair in		95% is not achieved an action plan will be developed to ensure compliance. The systemic changes will be completed by 7/13/12	

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	the hallway near the nurse's station. Her head was drooped forward, and her eyes were closed. CNAs #16 and #18 told the resident they would put her to bed, and rolled her wheel chair to her bedroom. The resident's eyes remained closed and head down. CNA #18 asked the resident if she needed to use the restroom and encouraged her to do so. The resident was rolled to the restroom. CNA #18 asked Resident C if she was awake enough to stand up. The resident eyes remained closed. CNA #18 indicated if Resident C is more awake, she can be transferred with the assistance of one, but at this time needed the assistance of two. Without using a gait belt, CNA #18 and CNA #16 each reached under one of the resident's arms and lifted her from the wheel chair. The resident was stooped over, and CNA #16 appeared to manually lift the resident to pivot her onto the toilet. As the resident sat on the toilet, the staff removed her day clothes and dressed her in pajamas. The resident continued to have her head drooped down and eyes closed as she sat on the toilet. After care was completed, the CNAs again reached under the resident's arms, and pivoted her into her wheel chair, and rolled her wheel chair next to her bed. The CNAs again reached under the resident's arms and lifted her to pivot to the bed. The resident's knees were bent			

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	during the transfer, and CNA #18 held the waistband of her pajama pants. CNA #18 indicated the resident usually bears weight "but not tonight." The resident's eyes remained closed as she was laid into bed and bed clothes were arranged. The clinical record for Resident C was reviewed on 6/25/12 at 8:40 p.m. The admission MDS assessment, dated 5/22/12, indicated the resident required the extensive assistance of two for transfers. The Care Plan, dated 5/16/12, indicated, "Fall risk related to history of and diagnosis of dementia. Goal: Resident will have no injury related to falls." Interventions included, but were not limited to, "Provide assistance as needed." On 6/26/12 at 10:30 a.m., Resident C was observed in her wheel chair at the nurse's station with her head down and eyes closed. A visitor was at the resident's side, asked the resident if she felt bad and wanted to lie down, and summoned staff for assistance. CNA #8 and LPN #15 rolled Resident C's wheel chair into her room. The CNA and LPN both indicated the resident slept well last night, and CNA #8 indicated this was the resident's second nap of the morning. Without using a gait belt, CNA #8 and LPN #15			

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	reached under the resident's arms and lifted to assist the resident to stand. The resident stepped with wobbly steps as she was assisted to pivot onto the bed. The resident's eyes remained closed during the transfer, and her eyes were closed as CNA #8 turned her and positioned her in bed. On 6/26/12 at 3:15 p.m., the Director of Nursing provided the facility's policy for "Back Support Program and Gait Belt Policy." Review of the policy indicated, "...It is the policy of ASC [American Senior Communities] that all nursing staff utilizes gait belts when transporting residents. The purpose of this program is to reduce and/or eliminate...injuries to our residents....Gait belts are to be used at all times for transfers or mobility...." This federal tag relates to Complaint IN00109601. 3.1-45(a)(2)			