STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(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
F000000	This visit was for the Investigation of Complaint IN00131687. Complaint IN00131687 Substantiated, federal/state deficiencies related to the allegations are cited at F309. Survey dates: July 31 & August 1, 2013 Facility number: 010666 Provider number: 155664 AIM number: 200229930 Survey team: Joyce Hofmann, RN Census bed type: SNF/NF: 96 Total: 96 Census payor type: Medicare: 31 Medicaid: 38 Other: 27 Total: 96 Sample: 3 This deficiency also reflect state findings in accordance with 410 IAC 16.2.	F000000	Ms. Kim RhoadesIndiana State Department of Health Long Term Care Division 2 North Meridian Street, Section 4BIndianapolis, Indiana 46204 August 15, 2013 RE: Survey Event ID: WTOJ11 Dear Ms. Rhoades: Attached you will find the completed Plan of Correction and attachments for our Complaint Survey dated August 1, 2013. We request that our plan of correction, be considered for a paper compliance desk review. Should you have any questions, please feel free to contact me at (317) 347-9051. Sincerely, Margaret Moore EDExecutive Director	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(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
F000309 SS=D	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 interview and record review, the facility failed to utilize foot rests/leg support during transport of a resident who recently had a total knee replacement resulting in an accident with injury that required additional surgery for 1 of 3 sampled residents reviewed for accidents (Resident B). Findings include: Resident B's closed clinical record was reviewed on 07/31/13 at 1:55 p.m. and indicated the resident had diagnoses which included, but were not limited to, right total knee replacement completed on 05/28/13, degenerative joint disease right knee, thrombocytopenia, osteoarthritis, anemia, diabetes, overweight, and chronic kidney insufficiency. The record indicated Resident B was 61 inches tall and weighed 294 pounds. Review of the hospital's Patient Transfer / Order Form, dated 05/31/13, indicated the resident was	F000309	1. Resident B discharged home after surgery on 6/5/2013. 2. All residents needing special precautions such as positioning devices, assistive devices or seating devices for mobility or transfers are at risk for an accident. The DNS and IDT completed an audit of all residents for validation that any resident needing an assistive device for mobility had the proper equipment. 3. Education and In-servicing has been completed with all nursing employees, therapist, and department managers on Orthopedic Precaution: Total Knee Replacement, Accidents and Supervision to Prevent Accidents, and Patient Admission Process. 4. The DNS and IDT will review all admissions prior to resident arrival for available transfer and inquiry information to determine the appropriate assistance with transfer that will be required based on the patient's individual need. As an ongoing practice for admissions, a Nurse and CNA will complete the transport of any resident into the	08/31/2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	stable, transported, accompanied by family, and documentation had been faxed. The form's RN Assessment indicated the resident was low to moderate fall risk, mental status was alert and oriented times 3, had right knee staples, assistive device was a walker, and physical/sensory impairment was a walker. Resident B's Discharge Summary from the hospital, dated 05/31/13, indicated status post right total knee replacement due to osteoarthritis and end-stage tri-compartmental degenerative joint disease. Instructions included, but were not limited to, "... Use your walker or cane as instructed in the hospital and gradually wean off of it over the next few weeks. It is for your safety and balance only...." Resident B's Progress Notes, dated 05/31/13 at 4:00 p.m., indicated Resident B arrived at the facility via a private (friend's) vehicle. Resident B's Progress Notes, dated 05/31/13, at 5:00 p.m., indicated, "Writer in med room to pull pain pills from EDK (emergency drug kit), heard a long, loud, blood-curdling scream, writer came out of med room as other nurse was coming across to assist as		facility that is not transported via stretcher, ensuring the Nurse assesses the reisdent for proper DME needs and safety. This will be an on going process of the facility and any findings will be reported to the PI committee and Safety Committee Monthly for the PI and Safety committee to determine on going monitoring.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK	4102 SHORE DR INDIANAPOLIS, IN 46254

(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
	well. Resident was noted to be in w/c (wheelchair), with neighbor lady beside her, CNA was transporting resident to obtain admission weight, resident had been holding her leg up off floor, when she let leg drop to the floor, which then initiated the screaming. Resident taken back to room, surgical incision had starting have some bloody drainage. Dressing changed, incision verified to be intact, all staples intact, with some bloody drainage at bottom of incision. Pressure applied, bleeding subsided, no dehiscence to incision line noted. Dressings replaced. Resident now up in w/c, administered prn pain medication and sitting in room to continue with admission process." Skin assessments, dated 06/01/13, 06/02/13, and 06/03/13 with first observation on 05/31/13, indicated a right knee front surgical incision 21 centimeters (cm) long and 0.1 cm wide. The surgical incision indicated full thickness skin loss, color red, epithelialization occurring, with blood tinged exudate, no odor, and no signs/symptoms of infection. Pain assessment, dated 05/31/13, indicated the right knee surgical site had 36 staples. Progress Notes, dated 06/01/13 at			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	8:40 a.m., indicated, "Resident a&o x3 (alert and oriented times 3), able to make needs known, ... LRE (Lower Right Extremity) pain secondary to right TKA (total knee athrotomy) well controlled with current management measures, per resident. ...locomotion witt (sic) walker, gait unsteady, PT (Physical Therapy) to eval and treat as necessary,...." Physical Therapy Evaluation, dated 06/01/13, indicated the resident presented with decreased strength, decreased right knee range of motion, decreased standing balance, decreased endurance, and decreased functional mobility. Resident B's Progress Notes, dated 06/02/13 at 10:36 a.m., indicated the Director of Nursing (DON) visited the resident at bedside to see how she was doing, to see how her knee was and see how her stay was going. The notes indicated, "On the day of admission the neighbor came to visit her and staff was pushing her wheelchair. She stated she was in her wheelchair being pushed by staff, her leg became weak and she unexpectedly dropped it. Staff was still pushing her wheelchair and it jerked her right knee. Her incision was still draining, but that it was draining in the hospital as well...."			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	Resident B's Progress Notes, dated 06/02/13 at 3:47 p.m., indicated, "Dry drsg (dressing) continues to R (right) knee surgical incision-small amount of bright red bloody drainage on old drsg. No increased edema, bruising or increased c/o (complaint of) pain to knee-incision edges well approximated-staples intact. Pt (Patient) has new c/o pain today in lower R leg-below surgical incision. No edema, redness or visible trauma noted. ADON (Assistant Director of Nursing) and pt nurse made aware-R leg xray ordered." Progress Notes, dated 06/02/13 at 10:22 p.m., indicated, "Radiology reports received, no fractures or dislocations noted. Called to MD (Medical Doctor)... will have NP follow up with resident in a.m." Progress Notes, dated 06/04/13 at 11:37 a.m., indicated, "...Res (Resident) surgical site is well approximated, with staples.no (sic) drainage from site.Res (sic) has swelling to R kneethat (sic) extends to the thigh.res (sic) c/o of (sic) pain to R shin below the suurgical (sic) site states that it is painful to touch.surgeon (sic) notified of this .waiting (sic) for return call. Res (sic)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	declines pain meds at this time.will (sic) continue to monitor." Progress Notes, dated 06/04/13 at 12:49 p.m., indicated a call from MD office with recommendations to elevate extremity and apply ice for 15 minutes frequently. Progress Notes, dated 06/04/13 at 1:42 p.m., indicated, "Consulted with NP (Nurse Practitioner) about residents (sic) leg stated he assessed it yesterday and did not notice anything significant stated he did notice some edema but no more than to be expected." Late entry, Progress Notes, dated 06/04/13 at 8:45 p.m., indicated the resident's appointment to the surgeon was moved up to 06/05/13. Progress Notes, dated 06/05/13 at 12:49 p.m., indicated Resident B was admitted to the hospital due to hematoma evacuation. Hospital records, dated 06/05/13, indicated surgery date of 06/06/13. Procedures performed were evacuation of hematoma of the right knee, radical debridement of the right knee, patellar tendon repair, and wound vac applied. Postoperative			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	diagnoses indicated, "Hematoma of right total knee replacement" and "Avulsion of the tibial insertion of the medial aspect of the patellar tendon." Review of Resident B's History & Physical from the hospital, dated 06/05/13, indicated Resident B "...had an acute flexion injury to that knee, and has had significant swelling and exquisite pain since that event. On physical examination of the right knee, she has a large-articular hematoma. Xrays of the right knee are normal. ... has developed a hematoma, 1 week s/p (status post) TKA (Total Knee Athrotomy)...." Interview with Resident B, on 07/31/13 at 11:03 a.m., the resident indicated she was transported from the car into the facility via a wheel chair without foot pedals or leg rests. Resident B indicated she was being pushed down the hall to obtain an admission weight while holding her leg up off the floor to prevent dragging. Interview with CNA #1, on 07/31/13 at 3:38 p.m., indicated she got a call for a new admission, and used the wheelchair from the front lobby of facility to assist Resident B from friend's car to her room. CNA #1			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	indicated she pushed Resident B in the wheelchair without foot pedals or leg supports to the shower room to obtain an admission weight. She indicated when transporting from the resident's room to shower room Resident B held her leg that had a total knee replacement up off the floor. She indicated Resident B put her leg down and hollered. She indicated the resident was returned to her room. The nurse removed the ted hose which blood had soaked through and an ace bandage. The nurse cleaned the area which was bleeding at the knee incision. Interview with LPN #2, on 07/31/13 at 9:15 p.m., indicated she was in the med room on 05/31/13 and heard Resident B cry out. LPN #2 indicated Resident B was taken back to her room and she assessed her incision site. LPN #2 indicated Resident B's incision started above the knee and ended 2-3 inches below the knee. LPN #2 indicated she removed the old dressing and the incision was bleeding. She applied pressure to the incision and the bleeding stopped. LPN #2 explained the surgical wound site was cleansed and redressed, and the area had no redness, warmth, or swelling.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	Interview with CNA #1, on 08/01/13 at 2:02 p.m., she was not given a report of Resident B prior to going to the lobby to help get her out of the car. Interview with the Director of Nursing (DON), on 08/01/13 at 3:52 p.m. indicated as a courtesy, the facility used a wheelchair to transport residents from cars to inside the facility. The DON indicated mobility/transport orders were obtained from verbal reports from releasing facility (hospital) and by asking the resident about his/her mobility status. The DON indicated the facility had no policy on using a wheelchair for transporting residents from car to room without being evaluated by therapy. Interview with the Physical Therapist (PT), on 08/01/13 at 4:40 p.m., indicated the therapy department had not assessed the resident prior to the incident. The DON presented, on 08/01/13 at 9:33 a.m., protocol used by the facility, entitled, "Orthopedic Precaution: Total Knee Replacement" which was dated 04/28/11. The information was the same for aides and nurses. The protocol indicated, "This competency			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	pertains to orthopedic precautions for conditions affecting the musculoskeletal system. It is not an all inclusive list. Physician orders supersede the recommended precautions indicated below." The procedure included, but was not limited to, "1. Communicates with the Interdisciplinary Team, as appropriate. 2. Reviews plan of care prior to care or positioning, transfer or ambulation for special precautions such as positioning devices, weight bearing status, assistive devices or seating devices...." Review of the facility's policy for "Accidents and Supervision to Prevent Accidents", dated 04/28/11, indicated, "...Center assess patient to determine the patient's degree of mobility and physical impairment and the proper transfer method. ... Center provides appropriate assistive devices to reduce the risk and/or prevent accidents...." Review of the facility's policy for "Patient Admission Process" policy, dated 08/31/11, indicated, "Prior to Patient Arrival... Review available transfer and inquiry information...." Review of the facility's policy on "Patient Transfers/Mobility", dated			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155664	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING	(X3) DATE SURVEY COMPLETED 08/01/2013
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHAB- EAGLE CREEK		STREET ADDRESS, CITY, STATE, ZIP CODE 4102 SHORE DR INDIANAPOLIS, IN 46254	

(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
	04/28/13, indicated, "... Patients are provided services to maintain or improve transfer and mobility skills to his/her highest realistic level of function or prevent decline, unless unavoidable. ...The interdisciplinary team determines the appropriate assistance with bed mobility, repositioning and transfer is required based on the patient's individual need. ...Patients' are assessed upon admission for transfer and ambulation needs...." This federal tag is related to Complaint IN00131687. 3.1-37(a)			