STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	366114	A. BUILDING ______ B. WING _____	**05/12/2015**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KINDRED TRANSITIONAL CARE AND REHAB-THE GREENS	**1575 BRAINARD RD LYNDHURST, OH 44124**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0323 **Level of harm -** Actual harm **Residents Affected -** Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure a resident was safely turned in bed. Harm occurred when Resident #96, who was totally dependent on staff for care, fell out of bed while staff was providing care and sustained a left knee fracture. The facility also failed to provide adequate supervision to prevent a fall for Resident #61. The deficient practice affected two residents (Resident #96 and Resident #61) of four residents reviewed for falls. The facility census was 168. Findings include: 1. Review of the medical record revealed Resident #96 was admitted on [DATE] and re-admitted on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident required extensive assistance of two persons for bed mobility. Review of a late entry progress note dated 03/12/15 at 10:30 A.M., revealed Resident #96 was receiving care from two State-tested Nurse Aides (STNA #1 and #2) and while the STNAs were turning the resident, the resident continued to roll until she rolled out of bed and onto her bilateral knees. The physician was notified and x-rays of both knees were ordered. Review of the progress note dated 03/12/15 at 10:32 P.M. revealed Resident #96 sustained a left knee fracture from the fall. The physician ordered the resident be sent to the hospital for evaluation and treatment. The resident was admitted to the hospital and returned to the facility on [DATE]. Review of a Patient Nursing Evaluation (part two) dated 03/12/15 at 4:15 P.M. revealed Resident #96's bed safety assessment was completed and indicated the resident was non-ambulatory, unable to get out of bed without assistance, and was totally immobile in bed. The resident was assessed as a medium fall risk and was unaware of her position in bed in proximity to the edge of the bed. Review of a Performance Improvement Form dated 03/16/15 revealed STNA #1 received counseling and a final written warning due to a resident under her care rolled out of bed which resulted in an injury. The director of nursing (DON) documented a corrective action plan indicating STNA #1 was educated on the importance of having the orientee be actively engaged in the care of dependent residents. Review of the personnel file for STNA #2 revealed she resigned without notice on 03/15/15. Interview with the DON on 05/11/15 at 4:30 P.M. revealed an investigation of the fall was conducted but the DON would not permit the surveyor to read the investigation. The DON read the results of the fall investigation as follows: Two STNAs (STNA #1 and STNA #2) were in the room. STNA #1 turned Resident #96 on her side to provide incontinence care and stated the resident just kept rolling. The DON stated STNA #2 was a new employee on orientation. STNA #2 was standing on the opposite side of the bed at the foot of the bed. STNA #2 stated the resident's foot slid off the bed, causing her whole body to go down. STNA #2 stated STNA #1 came around the bed and when the nurse (unidentified) entered the room, the three of them returned Resident #96 to bed. The DON revealed STNA #1 was suspended and received a corrective action. The DON stated STNA #2 did not receive a corrective action, but she was verbally educated on the need to be actively involved in the care of dependent residents. Interview on 05/12/15 at 12:27 P.M. with Registered Nurse (RN) #4, revealed she had conducted the post-fall investigation. RN #4 verified STNA #2 was standing at the foot of bed observing, but not assisting in the resident's care. RN #4 verified she did not document the height of the bed at the time of the fall and verified the resident was not mobile in bed and did not resist care. The Administrator was present during the interview and stated she did not understand what the deficient practice was, and that the STNA had a lapse in judgment and this was an isolated incident. Observation of Resident #96 on 05/11/15 at 12:20 P.M. with STNA #5 revealed the resident was lying on her back and did not voluntarily move. An interview with STNA #5 at this time revealed the resident would grimace to show pain sometimes when moved; the resident was on a turn schedule and required two hour checks for bowel incontinence. STNA #5 stated Resident #96 had no fall precautions. Observation on 05/12/15 at 1:20 P.M. revealed Resident #96 lying on her left side and mucus was drooling from her mouth. RN #4, who was present in the room, cleansed the resident's mouth. The resident did not move during the care. 2. Review of the medical record for Resident #61 revealed an admission on 11/01/12 with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed the resident had severe cognitive deficits, was totally dependent on two staff for bed mobility, transfers, dressing, toileting and hygiene. Resident #61 required a mechanical lift for transfers. Record review of progress notes dated 05/04/15 at 9:24 A.M. revealed Resident #61 was on her side and rolled out of bed onto the floor. The resident hit her head and right shoulder. Resident #61 complained of head pain and right shoulder pain. The note also revealed the resident was non-ambulatory. The physician was notified and the resident was transferred to the hospital for testing. The resident was not admitted to the hospital, the X-rays were normal and the resident had no injury. Interview with the DON and the corporate nurse (RN #6) on 05/11/15 at 3:40 P.M. revealed on 05/04/15 at approximately 8:45 A.M., STNA #3 was providing incontinence care to Resident #61 and found a small open area on the resident's coccyx. STNA #3 left the resident and went to the door to tell the nurse who was in the hallway. The DON stated when the STNA and the nurse entered the room, the resident was found with her knees on the floor and her head and hands on the side rail. Resident #61 had some noted swelling on her forehead. Interview with RN #4 on 05/12/15 at 1:15 P.M. revealed she documented the fall in the computer and did note the resident hit her head on the floor. RN #4 stated that was not really true, and that after she had investigated, she determined the resident hit her head on the side rail as she was sliding out of the bed. RN #4 revealed Resident #61 was assessed as a one person assist for bed mobility and verified the MDS indicated the resident was a two person assist, but that was not always true. RN #4 revealed she educated STNA #3 to make sure beds were lowered and residents were the middle of the bed before leaving their bedside. On 05/12/15 at 3:15 P.M. an interview with the DON verified Resident #61 was totally dependent and two staff should have been present when turning her. This deficiency substantiates allegations contained in Complaint Number OH 879.

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.