

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155214	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/09/2014
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NAME OF PROVIDER OR SUPPLIER ST ANTHONY HOME - CROWN POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 203 FRANCISCAN DR CROWN POINT, IN 46307
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F000000	<p>This visit was for the Investigation of Complaint IN00156538.</p> <p>This visit was in conjunction with the PSR (Post Survey Revisit) to the Investigation of Complaint IN00156004 completed on 09/16/14.</p> <p>Complaint IN00156538-Substantiated. Federal/State deficiency related to the allegation was cited at F323.</p> <p>Survey date: October 9, 2014</p> <p>Facility number: 000120 Provider number: 155214 AIM number: 100274780</p> <p>Survey team: Regina Sanders, RN, TC</p> <p>Census bed type: SNF: 29 SNF/NF: 143 NCC: 2 Total: 174</p> <p>Census payor type: Medicare: 36 Medicaid: 97 Other: 39 Total: 174</p>	F000000	<p>St. Anthony Home ("the provider") submits this Plan of Correction ("POC") in accordance with specific regulatory requirements. It shall not be construed as an admission of any alleged deficiency cited. The Provider submits this POC with the intention that it be inadmissible by any third party in any civil or criminal action against the Provider or any employee, agent, officer, director, or shareholder of the Provider. The Provider hereby reserves the right to challenge the findings of this survey if at any time the Provider determines that the disputed findings: (1) are relied upon to adversely influence or serve as a basis, in any way, for the selection and / or imposition of future remedies, or for any increase in future remedies, whether such remedies are imposed by the Centers for Medicare and Medicaid Services ("CMS"), the state of Indiana or any other entity; or (2) to serve, in any way, to facilitate or promote action by any third party against the Provider. Any changes to Provider policy or procedures should be considered to be subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and should be inadmissible in any proceeding on that basis.</p>	

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>Sample: 3</p> <p>This deficiency reflects state findings cited in accordance with 410 IAC 16.2.-3.1.</p> <p>Quality review completed on October 16, 2014, by Janelyn Kulik, RN.</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 to ensure a resident received adequate assistance to prevent accidents, related to not following the</p>	F000323	1.1 Resident E no longer resides in this facility. CNA #1 was placed on administrative leave. The facility reported this incident to the Indiana State Department	10/24/2014

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	<p>facility's policy for 2 assistance with the use of a mechanical lift, for a resident who required a mechanical lift for transfers. The resident was admitted into the hospital with a laceration to the head and a subdural hematoma (bleeding of the brain), after the incorrect transfer was completed, for 1 of 3 residents reviewed for mechanical lift transfers in a total sample of 3. (Resident #E and CNA #1)</p> <p>Findings include:</p> <p>Resident #E's record was reviewed on 10/09/14 at 10:36 a.m. The resident's diagnoses included, but were not limited to, dementia and stroke.</p> <p>The annual Minimum Data Set assessment, dated 03/21/14, indicated the resident had long and short term memory problems, no behaviors, was dependent on two assistance for transfers, and had no falls.</p> <p>A care plan, dated 03/21/14, indicated the resident was at a risk for falls and the interventions included to use a mechanical lift with two assistance for all transfers.</p> <p>A care card (information to care for the resident), dated 07/11/14, and received from the Director of Nursing (DoN) on</p>		<p>of Health and the Crown Point police department on 7/18/14. A thorough internal investigation was completed with appropriate action taken. 1.2 CNA #1 was placed on administrative leave and did not return to the facility. Director of Staff Development / designee completed re-education with return demonstration on mechanical lift use and transfer protocols for the nursing staff. This re-education was initiated on 7/18/14 at the All Staff meetings and was completed 8/18/14. 1.3 Nurse Managers / designees created a log of residents on each unit who require use of mechanical lifts for transfers and initiated direct observation of transfer via use of mechanical lift for five (5) random transfers per unit weekly (all shifts). These observations started on the second shift of 7/24/14 and continued for four (4) weeks with any improper lift use corrected immediately (re-education maintained in the Staff Development office). The facility then re-initiated that Nurse Managers / designees will perform direct observation of transfer via use of mechanical lift for five (5) random transfers per unit weekly (all shifts) for a period of nine (9) months with any improper lift use corrected immediately and re-education of staff to be completed. 1.4 DON / designee will report random transfer observation findings to</p>				

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	<p>10/09/14 at 3 p.m., indicated the resident required a mechanical lift with the assistance of two for transfers.</p> <p>A clinical note, dated 07/17/14 at 8:32 p.m., indicated, "Staff noticed a skin tear to res. (resident) left thumb, writer into (sic) assess, a skin tear noted to left thumb 1 x .2 cm (centimeter), a small amount of bleeding noted...Unknown how it happened. MD (Medical Doctor) updated...message left on POA machine..."</p> <p>A clinical note, dated 07/18/14 at 9:53 a.m., indicated, "3:40 a.m. writer summoned into residents (sic) room...resident is drulling (sic) and nonresponsive (sic). While doing assessment Resident (sic) open slightly one one (sic) would not move any body parts. Reassessment to hand found left thumb steri strips in place and then noticed further laceration to left thumb and first digit. Vitals taken...Instructed CNA to continue with residents personal care. After a few minutes writers (sic) summoned (sic) back in the room. CNA found small amount of blood underneath residents (sic) head. Writer cleaned area around back of neck and noticed a small of (sic) dried blood no active bleeding. Writer and CNA continued to asses (sic) area then noticed a laceration behind the</p>		<p>the Quality Assurance (QA) Committee monthly for nine (9) months. The QA Committee will monitor data presented for any trends, and determine if further monitoring / action is necessary for continued compliance. 1.5 Correction date is 10/24/14.</p>				

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	<p>right ear area clean no active bleeding...sendin (sic) resident ER (sic)...5:30 am (sic) received called (sic) from ER...Massive Brain Bleed..."</p> <p>The hospital notes, dated 07/18/14, indicated the resident's diagnoses were scalp laceration, hemorrhage of the brain, and skin tear of hand without complication. The notes indicated the resident had five staples used to close the 4.5 cm (centimeter) wound behind the right ear and the CT of the head indicated the resident had a left frontal lobe hemorrhage and the resident did not appear to have excessive bruising or other extremity injuries.</p> <p>An Emergency Room note, dated 07/18/14 at 5:53 a.m., indicated the facility was notified about the CT scan and the facility had stated they did not know if the resident had fallen or not and the CNA had gone in to the resident's room about 3:30 a.m. to turn the resident and discovered the laceration to the back of her right ear.</p> <p>An Emergency Room note, dated 07/18/14 at 6:14 a.m., indicated they had contacted the facility again, and the Nurse for the resident indicated the resident had been in bed all night and upon checking the resident, the resident</p>			

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	<p>was less responsive, and blood was seen on the pillow, and with turning the resident the wound to the head was observed. The Nurse could not recall if the side rails were up and had informed the Emergency Room she had not noticed any objects in the bed, which may have caused the bleeding.</p> <p>The Emergency Room note, dated 07/18/14, indicated the resident was admitted into the facility with the diagnosis of interparenchymal hemorrhage (bleeding in the brain).</p> <p>A Hospital History and Physical, dated 07/18/14, indicated, "...laceration behind the right ear. The staff at the nursing home state that they are unsure how the patient sustained a laceration to the back of her head. She also has a small laceration to the right hand as well. Nursing home staff also states that she she (sic) does not ambulate and they found her laying in bed...the patient has a large 4 cm laceration over the area of the mastoid process (behind the ear)...The patient has a skin tear to the web space between the thumb and index finger on the right hand...CT brain...Hemorrhage measures up to approximately 4.5 cm...x 3.3 cm wide x 3.7 cm high...There is rightward midline shift..."</p>			

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	<p>A facility investigation, dated 07/18/14, indicated the Nurse and the CNA (CNA #1) had found the resident unresponsive and drooling, noted a skin tear to the left thumb and then noticed a small amount of blood on the pillow. The investigation indicated there was no blood found on the clothing or bed sheets. The investigation indicated a CNA had transferred the resident to bed alone using the mechanical lift on the evening of 07/17/14. The investigation indicated the CNA had not followed the facility's lift/transfer protocol and a stain on the mechanical lift pad may have been blood. The investigation indicated the Local Police Department had been notified of the incident and due to the ongoing investigation, the resident's room, mechanical lift, and the lift pads had been secured. The investigation indicated attempts to contact CNA #1 during the continued investigation was unsuccessful and a certified letter had been sent to her for continued investigation of the incident.</p> <p>A typed interview with CNA #1 on 07/18/14 at 10:30 a.m., typed by the DoN, indicated CNA #1 had transferred the resident with a mechanical lift on 07/17/14 a little before 8 p.m. CNA #1 indicated she had transferred the resident by herself. The interview indicated CNA</p>			

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	<p>#1 denied the resident had hit anything or fell during the transfer and the resident had a discoloration of the left hand but the skin had not broke until the resident was placed in bed. CNA #1 indicated she had to change the resident's gown because of the blood from the hand skin tear. CNA #1 indicated she had provided incontinence care due to loose bowel movements 2-3 times and there was no blood noted during any of those times. CNA #1 admitted to using only one assistance for the mechanical lift transfer.</p> <p>A typed note by the DoN, dated 07/18/14 at 3:30 p.m., indicated CNA #2 (also worked the evening of 07/17/14) had fed the resident dinner and denied seeing any type of head injury or blood. CNA #2 indicated CNA #1 had not asked her for help with the residents on 07/17/14.</p> <p>A handwritten note, dated 07/21/14 and written by the DoN, indicated CNA #2 had noticed a spray bottle of disinfectant and Lysol on the bin outside of the resident's room around 8 p.m. on 07/17/14.</p> <p>A hand written note, written and signed by CNA #3, dated 07/18/14, indicated she came in at 10:23 (p.m.) and CNA #1 had given her report and said everything was normal, but (Resident #E) had a skin</p>			

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	<p>tear on her left thumb. CNA #3 indicated she had looked in on the resident and the resident looked, "okay". She indicated she was in and out of Resident #E's room three or four times and the resident looked, "okay". CNA #3 indicated she had gone into the resident's room around 1:00 (a.m.) to check the resident for incontinency, the resident was dry, and the resident acted normal. CNA #3 indicated she then gone into the resident's room at 3:45 a.m. and she noticed she was unresponsive and drooling and she went and reported the change to the Nurse on duty. She indicated after the Nurse assessed the resident, she continued to change the resident's incontinent brief and when she rolled the resident to the side, she noticed blood on the bed and her pillow. CNA #3 then immediately reported this to the Nurse. CNA #3 indicated she moved the resident's hair around and found a gash behind the resident's ear.</p> <p>The Police report, no date listed for date assigned, indicated the incident was reported on 07/18/14 at 3:51 p.m., indicated, "...I noticed that the bed linen sheets were missing as well as any signs of blood stains on the bed. A small amount of what appeared to be blood was on the floor by the bedroom entry door, as well as on the left side of the padded</p>			

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	<p>section of the top hoist used to hoist the patient from the bed to the chair...(DoN Name) advised that the hoist was used during the morning after the above victim was transported to (Hospital Name)..She further advised that the bed sheets were also taken during transport..."</p> <p>During an interview on 10/09/14 at 2:06 p.m., the DoN indicated she and the Administrator at the time of the incident had called CNA #1 and received a statement from her and then had her re-enact the transfer with the mechanical lift. She indicated the area behind the back of the ear was difficult to see and during the night, the lights were not always turned on due to the resident sleeping, so the blood may not have been seen with the earlier checks on the resident. She indicated after CNA #1 came back in to the facility to do the re-enactment, the facility could not get a hold of Terminated CNA #1 again. The DoN indicated she had checked the corners of the room, the bed, the window ledge and the resident's clothes and could not find blood or signs of any possible cause of injury. She indicated the trauma had occurred, but the facility could not say how it occurred. She indicated they could not definitely prove the injury came from the improper transfer with the mechanical lift. She indicated the</p>			

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	<p>resident had no change in behavior or crying out through out the night of 07/17/14-07/18/14.</p> <p>During an interview on 10/09/14 at 3:42 p.m., the DoN indicated the facility had completed the annual competency audits for mechanical lifts and other tasks in June 2014. She indicated the facility started mechanical lift audits and inservices on 07/25/14 and the majority of the staff had been audited and inserviced by 08/18/14. She indicated some staff had been on leave of absence and the last of the staff were inserviced on 09/02/14. The DoN indicated the facility was continuing to audit mechanical lift transfers randomly on all shifts five times a week and if there are concerns, it was discussed daily in the meeting and re-education was given.</p> <p>A facility policy, dated 02/12, titled,"Mechanical Lift (Full Body)" and received from the Administrator as current, indicated, "...It is the policy of the facility that one person is required to maneuver lift and a second person is required to guide the resident during the transfer..."</p> <p>This Federal Tag relates to complaint IN00156538.</p>			

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