

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155690	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 10/21/2013
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NAME OF PROVIDER OR SUPPLIER MEADOW BROOK REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 1821 LINDBERG RD ANDERSON, IN 46012
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F000000	<p>This visit was for the Investigation of Complaint IN00136642.</p> <p>Complaint IN00136642 - Substantiated. Federal/State deficiency related to the allegation is cited at F323.</p> <p>Survey date: October 21, 2013</p> <p>Facility number: 000027 Provider number: 155690 AIM number: 100266180</p> <p>Surveyor: Betty Retherford RN, TC</p> <p>Census bed type: SNF/NF: 48 SNF: 6 Total: 54</p> <p>Census payor type: Medicare: 6 Medicaid: 42 Other: 6 Total: 54</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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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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	Quality Review completed by Debora Barth, RN.			

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F000323 SS=D	<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 observation, record review, and interview, the facility failed to ensure a hooyer lift sling was correctly attached to the lift bar resulting in the resident sliding out during a transfer and being lowered to the floor, sustaining a fractured left hip requiring surgical repair and treatment for pain for 1 of 3 residents reviewed for safety during transfers in a sample of 4. (Resident #B)</p> <p>Findings include:</p> <p>The clinical record for Resident #B was reviewed on 10/21/13 at 10 a.m.</p> <p>Diagnoses for the resident included, but were not limited to, history of motor vehicle accident with spinal cord injury and paraplegia, chronic pain syndrome, and degenerative joint disease.</p> <p>An annual minimum data set assessment, dated 9/6/13, indicated the resident was totally dependent on two staff members for transfers and</p>	F000323	Resident #B sustained a fracture to her left hip. No other residents who require transfer via the hooyer lift were affected. All residents who require the use of the hooyer lift for transfer have the potential to be affected. The policy and procedure for hooyer lift transfers has been reviewed and no revisions were made. (See Attachment #1). The facility has re-educated all nursing staff members on the policy and procedure related to hooyer lift transfers. (See Attachment #2). The DON or her designee will observe one hooyer lift transfer daily on scheduled days of for two weeks, three times a week for 2 weeks and then weekly to ensure hooyer lift transfers are completed as per policy and procedure until compliance is maintained for 6 consecutive months. (See Attachment #3). Should concerns be observed, re-education shall be provided. The results of said observations and any re-education and/or corrective action taken will be reviewed during the facility's quarterly QA meetings and the plan adjusted accordingly, if warranted.	11/01/2013			

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	<p>bed mobility.</p> <p>A health care plan problem, dated 6/11/13, indicated the resident was at risk for falls due to multiple risk factors including paraplegia, chronic pain, and spinal cord injury. One of the approaches for this problem was to use a Hoyer lift for all transfers.</p> <p>A nursing note, dated 9/15/13 at 8 p.m., indicated "Transferring resident to bed from powered w/c [wheelchair] to bed by Hoyer lift , Res [resident] pad slid/strap slipped, Res began to slide to floor. Nurse/aide lowered Res to floor, and transferred her to bed."</p> <p>A nursing note, dated 9/15/13 at 8:10 p.m., indicated physician orders were received for multiple x-rays including bilateral knees and hips and the right shoulder, arm, wrist, and hand. An order was also received for an extra Dilaudid (a narcotic pain medication) 4 milligrams to be given times one if pain became present. The clinical record indicated this medication was given at 11 p.m. during the x-ray process.</p> <p>A nursing note, dated 9/16/13 at 2 a.m., indicated the x-ray results were received. An intertrochanteric</p>			

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	<p>fracture of the left hip was noted. The other x-rays were negative for additional fractures. The physician was contacted and the resident was transferred to the hospital for admission on 9/16/13 at 2:40 a.m. The resident required surgical repair of the left hip fracture during the hospital admission.</p> <p>During an observation on 10/21/13 at 8:40 a.m., the Corporate Compliance Nurse obtained the lift sling used during the 9/15/13 transfer of Resident #B. The sling had four sets of different colored loops to be used for attachment of the sling to the lift bar. There were two sets on each side of the sling, one at the top and one at the bottom. Each set of loops contained a yellow, red, and green tightly stitched loop.</p> <p>During an interview on 10/21/13 at 9:30 a.m., the Corporate Compliance Nurse indicated she had completed the investigation related to the resident's fall from the lift sling. She indicated LPN #1 and CNA #2 had prepared the resident for transfer from the wheelchair to the bed. The investigation determined CNA #2 had attached the red loops on his side of the sling onto the lift bar and LPN #1 had attached the yellow loops on the</p>						

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	<p>other side of the sling onto the lift bar. This led to uneven pressure on the loops during the transfer and one loop was allowed to come off of the hook allowing the resident to slide out of the sling. The Corporate Compliance Nurse indicated both sides of the sling should have been attached to the lift bar by the yellow loops. The red loops should not have been used. She indicated it was "human error."</p> <p>This federal tag relates to Complaint IN00136642.</p> <p>3.1-45(a)(2)</p>			