

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155126	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 04/15/2015
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NAME OF PROVIDER OR SUPPLIER MEDCO HEALTH AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 457 S SR 145 FRENCH LICK, IN 47432
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F 000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00170851.</p> <p>Complaint IN00170851 - Substantiated, Federal/State deficiencies related to the allegations are cited at F157 and F323.</p> <p>Survey dates: April 14 and 15, 2015</p> <p>Facility number: 000054 Provider number: 155126 AIM number: 100287850</p> <p>Census bed type: SNF/NF: 69 Total: 69</p> <p>Census payor type: Medicare: 8 Medicaid: 51 Other: 10 Total: 69</p> <p>Sample: 4</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p>	F 000	<p>"This Plan of Correction constitutes the facility's written allegation of compliance for the deficiencies cited. This submission of this plan of correction is not an admission of or agreement with the deficiencies or conclusion contained in the Department's inspection report."Please find attached additional information to support the submitted Plan of Correction, including the re-education completed in the preparation and implementation of the Plan of correction. We are requesting a desk review. Please feel free to contact Stacy Burton, HFA, should you need any additional information to support the desk review @ 812-936-9991. Thank You for your consideration to this request.</p>	
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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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F 157 SS=D Bldg. 00	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).			

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	<p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>Based on observation, interview, and record review, the facility failed to notify the physician and family member in a timely manner of a resident's fall, for 1 of 3 residents reviewed for notification, in a sample of 4. Resident A</p> <p>Findings include:</p> <p>On 4/14/15 at 10:45 A.M., during the initial tour, the Administrator indicated Resident A had recently fallen.</p> <p>On 4/14/15 at 11:25 A.M., Resident A was observed sitting in a wheelchair, by the nursing station. Her left arm was observed to be in a soft cast, wrapped with an ace bandage. Her left arm was in a sling. RN # 1 indicated at that time that Resident A "fell and shattered her elbow." RN # 1 indicated the resident had cerebral palsy, but could communicate with sounds and gestures.</p>	F 157	<p>The IDT completed a re-assessment of Resident A and Care Plans were updated to reflect the current status of the Resident. A one time review of the current Resident population over the last 45 days has been completed to identify any issue with the resident changing level of planes and was not reported to the Nurse immediately, including a resident lowered to the floor, and and to ensure MD/Family Notification was completed as per expectation. Licensed Supervisory Nurses have been re-educated on MD/Family Notification following a fall, completing assessments in their entirety, and fall prevention policy and procedure. It is the responsibility of any employee to immediately report an accident/incident to the Licensed Supervisory Nurse. The Licensed Supervisory Nurse is responsible to assess Resident and notify the MD/Family. Monitoring was</p>	04/30/2015
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	<p>The clinical record of Resident A was reviewed on 4/14/15 at 11:35 A.M. Diagnoses included, but were not limited to, cerebral palsy, muscle weakness, and fractured left humerus.</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 3/3/15, indicated Resident A scored a 15/15 for cognition, indicating no memory impairment. The resident required extensive assistance of two+ staff for transfer, and extensive assistance of one staff for toileting. A test for "Balance During Transitions and Walking" indicated the resident was "Not steady, only able to stabilize with staff assistance" while moving on and off of the toilet and surface-to-surface transfer. The MDS assessment indicated the resident had fallen once within the last 90 days.</p> <p>Nursing Progress Notes included the following notations:</p> <p>3/25/15 at 9:00 P.M., written by RN # 2: "[CNA # 1] called for this nurse to assess resident [left] elbow. This nurse assessed did not note any warmth, redness, or swelling @ this time. Muscular pain reliever analgesic balm rubbed onto elbow @ this time. Resident tolerated well. CNA stated, 'Resident was being</p>		<p>initiated on 3-26-15 and included Licensed Supervisory Nurses to observe 2 Certified Nursing Assistants per shift, 1 on each unit, for transfer techniques; use of gait belts and or mechanical lift. Observations will be continued until each Certified Nursing Assistant has been observed by a Licensed Supervisory Nurse. This plan was completed on 4-1-15. Observations will continue daily across shifts for 4 weeks, 3 times accross shifts weekly for 4 weeks and then weekly across shifts for 10 weeks, monthly for 3 months and then quarterly for 2 quarters. Any further non compliance will result in 1:1 re-education, disciplinary action as deemed necessary, up and including termination. The HFA/Designee will be responsible to review the results of auditing as per the schedule identified above. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 6 months and then quarterly for 2 quarters. Any further action will be as determined by the QAPI Committee.</p>	

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	<p>transferred to commode. Asked resident to give bear hug and when transferring resident twisted opposite direction of expected and CNA noticed resident was going to fall so lowered resident to floor. The incident occurred around 7:30 pm. Resident was placed into bed and around 9:00 pm Resident turned call light on and reported pain in her elbow. After initial assessment, there were [no] further complaints this evening."</p> <p>3/26/15 at 10:00 A.M.: "Noted Res [resident] [with] swelling and bruising to [left] elbow. [Name of Nurse Practitioner] notified and STAT x-ray of elbow and shoulder ordered. [X-ray company] called and x-ray ordered. Elbow immobilized and ice applied @ this x [time]. DON [Director of Nursing] notified of [left] elbow."</p> <p>A Radiology report, dated 3/26/15, indicated: "...Conclusion: Limited study due to patient positioning. Findings raise suspicion for fracture...."</p> <p>Nursing Notes continued:</p> <p>3/26/15 at 2:00 P.M.: "X-ray results rec [received] and [Nurse Practitioner] notified. N.O. [new order] to [increase] Tylenol # 4 to TID [three times daily]...Place arm in sling until appt</p>			

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	<p>[appointment] [with] Ortho...."</p> <p>3/26/15 at 4:00 P.M.: "Res remains with sling in place [with] ice pack...Grandma at bedside. Call placed to [name of guardian] to update on condition and new orders and message left."</p> <p>On 4/14/15 at 3:20 P.M., the Administrator provided an incident report regarding Resident A, dated 3/26/15. The report included: "Type, Fall, Location, Bathroom - Resident, Activity, Transferring...Physician called 3/26/15 10:00, POA [power of attorney] called [Name] 3/26/15 10:15...."</p> <p>On 4/14/15 at 4:00 P.M., during an interview with RN # 2, she indicated she was working on the evening of 3/25/15. She indicated she was notified at 9:00 P.M. that Resident A was complaining of left elbow pain. She indicated Resident A was lying in bed at that time. She indicated CNA # 1 informed her at that time that the resident had been lowered to the floor at approximately 7:00 P.M. that night. She indicated that the resident had put on her light at 9:00 P.M., because she had to go to the bathroom, and then complained of pain. RN # 2 indicated she assessed the resident's elbow, and did not notice any warmth or redness. She indicated that CNA # 1 informed her that</p>			

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	<p>the resident had gotten out of bed by herself at approximately 9:00 P.M. RN # 2 indicated she did not see the resident on the floor. RN # 2 indicated she did not call the physician nor the family that night.</p> <p>On 4/14/15 at 4:10 P.M., CNA # 1 was interviewed. CNA # 1 indicated she was working on 3/25/15, and cared for Resident A. She indicated she was transferring Resident A to the commode, and Resident A "arched her back" so she lowered her to the floor. She indicated she did not have a gait belt around Resident A. She indicated she did not recall the resident hitting her elbow on anything. She indicated she did not inform the nurse at that time, "but now I know I should have." CNA # 1 indicated the resident did not complain of pain at that time. CNA # 1 indicated the resident put her call light on at approximately 9:00 P.M., and had "put herself on the floor." CNA # 1 indicated she assisted the resident back to bed, and then the resident complained of elbow pain, so she notified her nurse.</p> <p>On 4/15/15 at 10:35 A.M., during an interview with the DON and Administrator, the Administrator indicated that staff were to report falls to the physician and family "in a timely</p>			

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F 323 SS=G Bldg. 00	<p>manner," and that RN # 2 did not call either "because it was too late."</p> <p>On 4/15/15 at 9:10 A.M., the Assistant Director of Nursing provided the current facility policy on "Fall/Injury Management - Post Fall or Injury," revised November 2013. The policy included: "[The corporation] recognized proper action following a fall includes:...Communicating the fall to the physician and the responsible party in a timely manner...."</p> <p>This Federal tag relates to Complaint IN00170851.</p> <p>3.1-5(a)(1)</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.</p> <p>Based on observation, interview, and record review, the facility failed to safely transfer a resident, resulting in a fall and</p>	F 323	The IDT completed a re-assessment of Residents A and C and Care Plan updated to reflect the current status of the Residents.A one time review of	04/30/2015

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	<p>fractured elbow; failed to notify the nurse to perform an assessment immediately following the fall; failed to notify the family and/or physician timely following the fall; failed to document completely and accurately the events of the fall; and failed to properly secure a resident during a hoier transfer, resulting in a fall, for 2 of 3 residents reviewed for falls, in a sample of 4. Resident A, Resident C</p> <p>Findings include:</p> <p>1. On 4/14/15 at 10:45 A.M., during the initial tour, the Administrator indicated Resident A had recently fallen.</p> <p>On 4/14/15 at 11:25 A.M., Resident A was observed sitting in a wheelchair, by the nursing station. Her left arm was observed to be in a soft cast, wrapped with an ace bandage. Her left arm was in a sling. RN # 1 indicated at that time that Resident A "fell and shattered her elbow." RN # 1 indicated the resident had cerebral palsy, but could communicate with sounds and gestures.</p> <p>On 4/14/15 at 11:30 A.M., the Administrator provided a list of residents, highlighting those considered "interviewable." Resident A was marked as interviewable.</p>		<p>the current Resident population over the last 45 days has been completed to identify any issue with the resident changing level of planes and was not reported to the Nurse immediately, lowered to the floor, fall from mechanical lift, and MD/Family Notification. Licensed Supervisory Nurses have been re-educated on MD/Family Notification following a fall, completing assessments in their entirety and fall prevention policy and procedure. It is the responsibility of any employee to immediately report an accident/incident to the Licensed Supervisory Nurse. The Licensed Supervisory Nurse is responsible to assess the Resident and notify the MD/Family. Monitoring was initiated on 3-26-15 and included Licensed Supervisory Nurses to observe 2 Certified Nursing Assistants per shift, 1 on each unit, for transfer techniques; use of gait belts and or mechanical lift. Observations will be continued until each Certified Nursing Assistant has been observed by a Licensed Supervisory Nurse. This plan was completed on 4-1-15. Observations will continue daily across shifts for 4 weeks, 3 times across shifts weekly for 4 weeks and then weekly across shifts for 10 weeks, monthly for 3 months and then quarterly for 2 quarters. Any further non compliance will result in 1:1 re-education,</p>	

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	<p>The clinical record of Resident A was reviewed on 4/14/15 at 11:35 A.M. Diagnoses included, but were not limited to, cerebral palsy, muscle weakness, and fractured left humerus.</p> <p>A Physician's order, initially dated 4/12/13 and on the March 2015 orders, indicated, "Activity Level: Up as tolerated to wheelchair/electric scooter."</p> <p>A "Resident Lifting, Transferring and Repositioning Data Collection," initially dated 2/22/14 and last dated 9/4/14, indicated, "Resident's level of assistance: Extensive Assistance, Weight Bearing Capabilities: [left blank], Bilateral Upper Extremity Strength present? No...Check all that apply when determining lifting...C.P. [cerebral palsy], poor wt. bearing. Based on data collection findings, the Interdisciplinary Team (IDT) recommendation for transferring and repositioning techniques are: Transferring: [one] assist, Repositioning: [one] assist...." Documentation, dated 9/4/14, indicated, "[No] change." Documentation following the 9/14/14 date, undated, indicated: "Quarterly, [No] [changes] noted @ this time."</p> <p>A quarterly Minimum Data Set (MDS) assessment, dated 3/3/15, indicated Resident A scored a 15/15 for cognition,</p>		<p>disciplinary action as deemed necessary up and including termination. The HFA/Designee will be responsible to review the results of auditing as per the schedule identified above. Results of the reviews will be forwarded to the Quality Assurance Performance Improvement Committee monthly for 6 months and then quarterly for 2 quarters. Any further action will be as determined by the QAPI Committee.</p>	

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	<p>indicating no memory impairment. The resident required extensive assistance of two+ staff for transfer, and extensive assistance of one staff for toileting. A test for "Balance During Transitions and Walking" indicated the resident was "Not steady, only able to stabilize with staff assistance" while moving on and off of the toilet and surface-to-surface transfer. The MDS assessment indicated the resident had fallen once within the last 90 days.</p> <p>A resident care plan, initially dated 12/5/14 and updated 3/3/15, indicated: "Problem: Potential or Actual ADL [activities of daily living]/Mobility deficit...r/t [related to] Cerebral Palsy, Muscle spasm, profound M.R. [mental retardation], Cervical spondylosis, As evidenced by: Generalized weakness...Interventions: Provide assistive device as needed for transfer: [one] assist...."</p> <p>An additional resident care plan, initially dated 12/5/14 and updated 3/27/15, indicated: "Fall/Injury Risk related to: History of Falls, stiffness, unsteady, pain, shuffled gait, leaning, cervical spondylosis...cerebral palsy...3/27/15 [left] elbow bruising/edema...fall (assisted) in bathroom...Interventions: Ambulation: 2A [assist of two], Transfer:</p>			

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	<p>2A, 3/27/15 Rsd [resident] prefers bear hug transfer...Rug to floor - plays on floor...2/25 Dycem to w/c [wheelchair]...."</p> <p>Nursing Progress Notes included the following notations:</p> <p>3/25/15 at 9:00 P.M., written by RN # 2: "[CNA # 1] called for this nurse to assess resident [left] elbow. This nurse assessed did not note any warmth, redness, or swelling @ this time. Muscular pain reliever analgesic balm rubbed onto elbow @ this time. Resident tolerated well. CNA stated, 'Resident was being transferred to commode. Asked resident to give bear hug and when transferring resident twisted opposite direction of expected and CNA noticed resident was going to fall so lowered resident to floor. The incident occurred around 7:30 pm. Resident was placed into bed and around 9:00 pm Resident turned call light on and reported pain in her elbow. After initial assessment, there were [no] further complaints this evening."</p> <p>3/26/15 at 10:00 A.M.: "Noted Res [resident] [with] swelling and bruising to [left] elbow. [Name of Nurse Practitioner] notified and STAT x-ray of elbow and shoulder ordered. [X-ray company] called and x-ray ordered.</p>			

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	<p>Elbow immobilized and ice applied @ this x [time]. DON [Director of Nursing] notified of [left] elbow."</p> <p>A Radiology report, dated 3/26/15, indicated: "...Conclusion: Limited study due to patient positioning. Findings raise suspicion for fracture...."</p> <p>Nursing Notes continued:</p> <p>3/26/15 at 2:00 P.M.: "X-ray results rec [received] and [Nurse Practitioner] notified. N.O. [new order] to [increase] Tylenol # 4 to TID [three times daily]...Place arm in sling until appt [appointment] [with] Ortho...."</p> <p>A hospital radiology report, dated 3/31/15, indicated, "Impression:...Comminuted and complex intra-articular fracture at the distal humerus...."</p> <p>An Orthopedic Physician's note, dated 3/31/15, indicated, "[Resident A]...apparently last week Wednesday on March 25, 2015 fell from standing height while a healthcare provider was helping her off the commode. She landed apparently onto her left upper extremity. Pain was noted. She has noted dramatic bruising over the last week...Left elbow: Appearance: Dramatic ecchymosis</p>			

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	<p>[bruising] and swelling noted over the elbow...Anticipate performing surgery this coming Friday at hospital...."</p> <p>On 4/14/15 at 2:15 P.M., CNA # 3 and CNA # 4 were observed to transfer Resident A from her wheelchair to the commode. They utilized a gait belt during the transfer. At that time, they each indicated that they always utilized a gait belt during transfers. CNA # 3 indicated prior to Resident A's fall, the resident required the assist of "1 or 2 staff." CNA # 4 indicated that she transferred the resident herself by having the resident wrap her arms around her neck, but that she "always used a gait belt."</p> <p>At that time, Resident A was interviewed. CNA # 3 was present during the interview. Resident A indicated "yes" or "no" by shaking and nodding her head. She nodded "Yes" when asked if [CNA # 1] was the person who transferred her when she hurt her elbow. She nodded "No" when asked if CNA # 1 was wearing a gait belt to assist her.</p> <p>On 4/14/15 at 3:20 P.M., the Administrator provided an incident report regarding Resident A, dated 3/26/15. The report included: "Type, Fall, Location, Bathroom - Resident, Activity, Transferring...Physician called 3/26/15</p>			

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	<p>10:00, POA [power of attorney] called [Name] 3/26/15 10:15...Cognition Prior to Occ. [sic], Oriented to Person/Place/Time...Injuries Left Elbow...Nurse's Note of what happened: [CNA # 1] came to find [RN # 2] because resident reported pain in Left elbow. This nurse assessed resident's elbow. Resident was in bed when this nurse assessed elbow...Resident points to elbow. Answers with simple yes or no answers. Witness statement...Staff was assisting resident to restroom per care plan. Resident was instructed to give a big bear hug for transfer. While transferring toward commode, resident twisted opposite direction from expected direction and was lowered to floor by staff..." A "Follow up Report," dated 4/14/15 and written by the DON, indicated, "Resident was lowered to the floor by a CNA approx. 7:30 pm on 3/25/15...CNA slid resident down her leg and stated resident ended up sitting on her bottom on the bathroom floor...CNA stated around approx 9pm resident's light was on. CNA entered room to find resident on the floor next to her bed. Resident c/o [complained of] elbow pain at this time by pointing to her elbow...Staff assisted resident back to bed. Resident will often intentionally get down on the floor from her bed or wheelchair...it is believed that resident fx</p>			

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	<p>[fractured] her elbow while getting out of bed...Recommendation, Staff to educate resident to not get out of bed or wheelchair to go to rug on her floor alone. Staff to educate resident to ask for assistance."</p> <p>On 4/14/15 at 4:00 P.M., during an interview with RN # 2, she indicated she was working on the evening of 3/25/15. She indicated she was notified at 9:00 P.M. that Resident A was complaining of left elbow pain. She indicated Resident A was lying in bed at that time. She indicated CNA # 1 informed her at that time that the resident had been lowered to the floor at approximately 7:00 P.M. that night. She indicated that the resident had put on her light at 9:00 P.M., because she had to go to the bathroom, and then complained of pain. RN # 2 indicated she assessed the resident's elbow, and did not notice any warmth or redness. She indicated that CNA # 1 informed her that the resident had gotten out of bed by herself at approximately 9:00 P.M. RN # 2 indicated she did not see the resident on the floor. RN # 2 indicated she did not call the physician nor the family that night.</p> <p>On 4/14/15 at 4:10 P.M., CNA # 1 was interviewed. CNA # 1 indicated she was working on 3/25/15, and cared for</p>			

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	<p>Resident A. She indicated she was transferring Resident A to the commode, and Resident A "arched her back" so she lowered her to the floor. She indicated she did not have a gait belt around Resident A. She indicated she did not recall the resident hitting her elbow on anything. She indicated she did not inform the nurse at that time, "but now I know I should have." CNA # 1 indicated the resident did not complain of pain at that time. CNA # 1 indicated the resident put her call light on at approximately 9:00 P.M., and had "put herself on the floor." CNA # 1 indicated she assisted the resident back to bed, and then the resident complained of elbow pain, so she notified her nurse.</p> <p>On 4/15/15 at 10:35 A.M., during an interview with the DON and Administrator, the DON indicated that nursing staff are informed in orientation to always use gait belts during transfers. The DON indicated following this incident, all nursing staff were inserviced to report any fall to the nurse immediately. The Administrator indicated that staff were to report falls to the physician and family "in a timely manner," and that RN # 2 did not call either "because it was too late."</p> <p>On 4/15/15 at 9:10 A.M., the Assistant</p>			

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	<p>Director of Nursing provided the current facility policy on "Fall/Injury Management - Post Fall or Injury," revised November 2013. The policy included: "[The corporation] recognized proper action following a fall includes: Ascertaining if there were injuries and providing treatment as necessary...Communicating the fall to the physician and the responsible party in a timely manner...."</p> <p>2. The clinical record of Resident C was reviewed on 4/14/15 at 2:40 P.M. Diagnoses included, but were not limited to, closed head injury and persistent vegetative state.</p> <p>An annual MDS assessment, dated 12/18/14, indicated the resident was unable to be assessed for cognition, and required total dependence of two+ staff for transfer.</p> <p>A Physician's order, initial date 5/2/05 and on the January 2015 orders, indicated, "Persistent Vegetative State: Transfer w[with] assist of 2 and mechanical lift."</p> <p>A Physician Communication form, dated 1/28/15 at 4:45 A.M., indicated, "The resident appears to have slid out of hoyer lift to have hard nodule/area on buttock.</p>			

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	<p>0430 [4:30 A.M.] This nurse heard a scream. This nurse ran towards the scream et [and] arrived @ [room number]. This nurse entered room to see 2 CNAs in room et Rsd head laying on back on floor [with] head facing bed et legs et feet laying over the legs of the hoyer lift. 0445 [4:45 A.M.] [Name of physician] notified et made aware of the situation and made aware of hard nodule/area on buttocks et asked for x-ray of pelvis/coccyx. Physician replied...Just continue to monitor...."</p> <p>A "Multi-Disciplinary Therapy Screening Tool," dated 1/28/15, indicated: "Fall during hoyer transfer - Nursing to provide staff education re: appropriate hoyer pad placement/securing hoyer straps."</p> <p>A Physician's note, dated 2/6/15, indicated: "Fell off hoyer lift while transporting. Landed on buttock. Has been asymptomatic. X-ray showing questionable pelvic fx. Re-read not seen fx [sic]."</p> <p>On 4/14/15 at 3:45 P.M., the Medical Records staff provided an incident report. The report, dated 1/28/15, indicated: "Type: Fall...Activity: Transferring, Witnesses, CNA # 5 and CNA # 6...Cognition Prior to Occ. Comatose, Injuries, Abrasion Lower Right Back,</p>						

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	<p>Lower Right Back...Immediate Actions Taken, Lift taken out of use until inspection. CNAs re-educated on appropriate use of lift and safety checks while operating lift...." A "General Follow up," written by the DON and dated 2/6/15, indicated, "...Root Cause, CNA did not ensure all straps were secure before lift was used...."</p> <p>On 4/15/15 at 10:35 A.M., during an interview with the DON and Administrator, the DON indicated all staff were inserviced on the correct use of the hoyer lift following this incident. The DON indicated the education director observed each CNA using the lift. The Administrator indicated CNA # 5 did not work at the facility anymore.</p> <p>On 4/15/15 at 2:55 P.M., the Medical Records staff provided "General Guidelines" regarding the hoyer lift. The guidelines included: "...The patient should be approximately centered on the sling section...CAUTION When using either the chains or straps to connect the sling to the patient lift, the shortest of the two sections of the chains or straps MUST be attached to the back section of the sling...."</p> <p>This Federal tag relates to Complaint IN00170851.</p>			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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