

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155753	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/10/2013
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NAME OF PROVIDER OR SUPPLIER HAMPTON OAKS HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 966 N WILSON RD SCOTTSBURG, IN 47170
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F000000	<p>This visit was for Investigation of Complaint IN00129562.</p> <p>Complaint IN00129562 - Substantiated. A federal/state deficiency related to the allegations is cited at F323.</p> <p>Survey date: 6/10/2013</p> <p>Facility number: 004902 Provider number: 155753 AIM number: 200813130</p> <p>Survey team: W. Christopher Greeney, QIDP</p> <p>Census bed type: SNF: 23 SNF/NF: 46 Residential: 23 Total: 92</p> <p>Census payor type: Medicare: 24 Medicaid: 40 Other: 28 Total: 92</p> <p>Sample: 3</p> <p>This deficiency also reflects a state finding cited in accordance with 410</p>	F000000		

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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	IAC 16.2. Quality review 6/13/13 by Suzanne Williams, RN				

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F000323 SS=G	<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 staff followed manufacturer's instructions designed to ensure a sling for a mechanical lift to transfer dependent residents was securely in place prior to transferring residents, from bed to wheelchair, which resulted in one dependent resident falling out of the lifted sling to the floor and sustaining a fracture, for 2 of 3 residents (Residents "B" and "C") reviewed who required the use of a mechanical lift for transfers in the sample of 3.</p> <p>Finding includes:</p> <p>1. The record of Resident "B" was reviewed on 6/10/13 at 11:45 a.m. Resident "B" was originally admitted to the facility on 04/16/2010. A 5/23/13 "Diagnosis List" in the resident record indicated diagnoses including, but not limited to, congestive heart failure, s/p (status post) femur fracture, history of urinary tract infection, cerebral palsy,</p>	F000323	<p>The submission of this Plan of Correction does not indicate an admission by Hampton Oaks Health Campus that the findings contained herein are accurate and true representations of the quality of care and services provided to the residents of Hampton Oaks. This facility recognized it's obligation to provide legally and medically necessary care and services to it residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with the requirements of participation for comprehensive health care facilities (Title 18/19 programs.) to this end; this plan of correction shall serve as the credible allegation of compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statue only.</p> <p>1. Resident B was assessed by the nurse and orders received by physician to transport to the hospital for evaluation and treatment. Resident B returned to the facility within 24 hours of the fall. She was diagnosed with a left humerus fracture with treatment of</p>	06/25/2013

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	<p>hypertension, dehydration, hypolipidemia, cerebrovascular accident with right hemiparesis, seizure disorder, convulsions, pneumonia, edema, sepsis and humerus fracture.</p> <p>Review of Resident B's 1/23/12 Care Plan indicated the resident had osteoporosis and staff were to provide assistance with all transfers using a mechanical lift. A 3/13/13 Fall Risk Care plan (updated 5/22/13 and 5/29/13) indicated the resident was at risk for falls/injury and required the use of a mechanical lift for transfers.</p> <p>A nurse's note dated 5/22/13 at 6:15 p.m. indicated the nurse answered a Certified Nurse Assistant (CNA) verbal call for a nurse. The nurse entered Resident B's room and found Resident B on the floor laying across the mechanical lift's legs with the resident on her right side and head against the wall. The nurse's note indicated, "CNAs told this nurse that res (resident) fell out of the [mechanical lift]." The note further indicated the nurse assessed the resident and found "red place on [right] side of head. Looks like [resident] hit head on [mechanical lift] leg, bruising on the [right] side of</p>		<p>a sling and swath. Staff, resident and family member present during transfer were interviewed. The mechanical lift was taken out of service and inspected along with the slings by ED and DHS with no concerns found.</p> <p>2. All residents with potential to be affected were assessed and no negative outcomes noted.</p> <p>3. Inspection of the mechanical lift was performed on 5/24/13 by an Invacare vendor with no concerns noted. All nursing staff was educated on 5/22-5/24 on proper mechanical lift procedure. Nursing staff were re educated on 6/12 on rechecking the sling after elevating a few inches off the surface of the bed and before moving the patient ensuring the sling is properly connected to the hooks. During new hire orientation all nursing staff will be educated on using the mechanical lift per manufacturer's instructions.</p> <p>4. DHS/ADHS will randomly audit the use of the mechanical lift ensuring staff compliance with manufacturer's guidelines 3 times/week x 4 weeks, 1 time/week x 4 weeks then 1 time/month x 4 weeks or until 100% compliance. Results will be monitored and reviewed monthly in Quality Assurance meeting. Noncompliance will result in requirement of action plan to be implemented until compliance achieved. Proper use of</p>				

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	<p>stomach, [right] hip [and] when asked to move [extremities] [resident] couldn't move [left] shoulder. [Resident] stated [left] arm hurts so bad. Upon inspection there was a knot on [resident's] arm and it looked twisted...called MD [Medical Doctor] to send [resident] to [hospital] for [evaluation] and [treatment]. Family present during fall and assessment. Family also request [resident] be sent to [hospital]. Called 911."</p> <p>A 5/22/13 Fall Circumstance, Assessment and Intervention report, provided by the facility on 6/10/2013 at 11:50 am, indicated the resident fell out of the mechanical lift during transfer. The report further indicated the root cause was "Cloth hook was not on metal securely when sling elevated. Resident fell from sling." The facility incident report summary, provided with the above Fall Intervention report indicated "resident had fallen during a routine transfer...a strap on the upper left corner of lift pad slipped from the metal hook unexpectedly, resulting in the fall... [resident family] states that post fall, she noticed the left strap 'not attached' to the upper left hook." The summary further indicated that CNA #1 stated "they had hooked all four of the straps on to the lift. The resident</p>		<p>lifts will also be reviewed quarterly by Home Office Clinical Support as part of Clinical Assessment tool. 5. Compliance Date: 6/25/2013</p>				

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	<p>was almost all of the way up in the lift when [CNA #1] heard a popping noise and resident fell." The summary further indicated the lift sling pad was inspected and "showed no signs of weakness." The mechanical lift was inspected "per manufacturer and was functioning properly. Caregivers placed the straps on the hooks, but not securely." An incident intervention summary indicated "All staff were educated with proper [mechanical lift] procedure. Staff were able to demonstrate correct procedure with [mechanical lift] transfer...before lifting resident, staff always checks hooks of sling for proper placement and body alignment." Staff lists with signatures were attached with the summary and included manufacturer's instructions for proper use of the lift.</p> <p>Review of the manufacturer's training material attached to the training documentation, on 6/10/2013 at 12:15 pm, indicated the same "warning" on pages which were numbered 30, 32, 35, and 36. That warning stated "When the sling is elevated a few inches off the surface of the bed and before moving the patient, check again to make sure that the sling is properly connected to the hooks of the swivel bar. If any attachments are NOT properly in</p>			

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	<p>place, lower the patient back onto the stationary surface and correct the problem-otherwise injury or damage could occur."</p> <p>Interview with CNA #1 on 6/10/2013 at 2:25 pm, who was present during the transfer on 5/22/13, could not confirm that the above check occurred, or that the CNA had been trained specifically on that step. The CNA indicated she had been trained in her "CNA clinicals" on use of the lift and had watched her facility orientation trainer use the lift prior to her using the lift. "She didn't instruct me; I just knew from clinicals." When asked to describe the steps when using a mechanical lift, the CNA stated "make sure the loops are pulled all the way down before we start." She did not indicate the straps were to be inspected for proper connection to the hooks once the resident had been slightly lifted. When asked to describe what occurred on 5/22/2013 the CNA stated "I hooked the right side. CNA #2 did the left (side), we started to lift her up. I was behind her to grab (the sling) from the back to move her to the bed." The CNA indicated she heard a pop and the resident fell.</p> <p>Interview with CNA #2 on 6/10/2013</p>						

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	<p>at 2:10 pm indicated she had assisted with securing the straps during the transfer of Resident B on 5/22/13. CNA #2 indicated she then began operating the lift's remote and began lifting Resident B while CNA #1 was behind the resident's wheelchair assisting with the lift. CNA #2 did not indicate during the interview that they checked to make sure that the sling was properly connected to the hooks of the swivel bar once the resident had been slightly raised off of the surface. CNA #2 indicated they were trained to check the straps before operating the remote "but now I check more frequently and watch the hook and straps" during operation.</p> <p>Interview with Resident B's family member/guardian on 5/22/13 at 3:57 pm indicated the guardian was present in the room when the lift was being operated. The guardian stated the lift's strap "let loose and my sister fell forward to the side out of the sling." The guardian indicated two CNA's were present and operating the lift when the incident occurred. The guardian stated the two CNA's "were conversing with each other as they were hooking the lift up. They started lifting and they were still talking with each other when the strap let loose." The family member did not</p>						

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	<p>indicate that she observed the CNA's specifically check the connection of the straps to the bar once the resident was slightly off the surface.</p> <p>2. During observation on 6/10/13 at 1:57 pm CNA's #4 and #5 were observed using a mechanical lift to transfer Resident C from a wheelchair to bed. During this time, staff were not observed to check the sling after it was slightly elevated a few inches off the surface of the bed and before moving the resident, to make sure that the sling was properly connected to the hooks of the swivel bar.</p> <p>Interview with the Director of Health Services (DHS) on 6/10/13 at 2:50 pm indicated she responded to the facility after the accident and inspected the lift. The DHS stated the sling "had all the straps intact and there was no wear or tear." The DHS demonstrated with a lift that when the straps are properly hooked, the weight being lifted prevents the strap from moving up the hook, remaining securely on the lift until the weight is released. The DHS visually demonstrated if the strap is only partially over the hook, applied weight could cause it to pull free of the hook. The DHS described the procedures to be followed when transferring</p>						

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	<p>residents with the lift and she did not indicate that there was to be a recheck of the straps connected securely once the resident is slightly lifted off the surface.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 6/10/13 at 3:00 pm indicated she provided training to staff as part of her job duties. When interviewed regarding the procedures for transferring a resident using a mechanical lift, the ADON did not indicate that checking to ensure connections were secure once the resident was slightly lifted off of the surface was a step involved in using the lift.</p> <p>This Federal tag relates to Complaint IN00129562.</p> <p>3.1-45(a)(2)</p>				