

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155565	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/04/2014
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NAME OF PROVIDER OR SUPPLIER HICKORY CREEK AT SUNSET	STREET ADDRESS, CITY, STATE, ZIP CODE 1109 S INDIANA ST GREENCASTLE, IN 46135
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F000000	<p>This visit was for the Investigation of Complaint IN00143330.</p> <p>Complaint IN00143330 Substantiated. Federal/state deficiencies related to the allegations are cited at F323.</p> <p>Survey dates: February 2 & 3, 2014</p> <p>Facility number: 000418 Provider number: 155565 AIM number: 100274870</p> <p>Survey team: Joyce Hofmann, RN</p> <p>Census bed type: SNF/NF: 53 Total: 53</p> <p>Census payor type: Medicare: 8 Medicaid: 39 Other: 6 Total: 53</p> <p>Sample: 4</p> <p>This deficiency also reflects state findings in accordance with 410 IAC 16.2.</p>	F000000	<p>This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by the state and federal law. Hickory Creek at Sunset desires this Plan of Correction to be the facilities Allegation of Compliance. Compliance is effective 2/21/2014. The facility is at this time requesting a desk review for this plan of correction.</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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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 record review and interview, the facility failed ensure 1 of 4 sampled residents reviewed for falls and Hoyer lift transfers, received adequate supervision to prevent a fall from a Hoyer lift which caused hospitalization with injuries to the head and bruising to neck, shoulder and leg (Resident B).</p> <p>Findings include:</p> <p>Resident B's closed clinical record was reviewed on 02/03/14 at 12:00 p.m. and indicated the resident had diagnoses which included, but were not limited to, Fered progressive muscular dystrophy, quadriplegia, seizure disorder, Friedreich's ataxia, developmental delay, peripheral neuropathy, uterine fibroids, and depression.</p> <p>Resident B's quarterly Minimum Data Set (MDS) assessment, dated 11/09/13, indicated Resident B was a total assist of 2 persons for bed</p>	F000323	<p>It is the practice of this facility to ensure that theresidents' environment remains as free of accidents and hazards as possible;and that each resident receives adequate supervision and assistance to preventaccidents. Describe what the facility did to correct the deficient practice foreach client cited in the deficiency. Resident B was sent to the ER immediatlyas indicated in the statement of deficiencies- she has not returned to thisfacility as of this date. An investigation was immediately initiated. Diagramsof the room were completed including placement of the resident, Hoyer Lift,wheel chair and sling. Staff was interviewed and statements obtained.Reenactments of the incident were completed to discover the cause of theresidents fall. One on One check offs on mechanical lifts was initiated on1/23/2014 with no C.N.A.'s being allowed to work until completed. C.N.A. #2contacted D.O.N. on 1/26/14 and confessed that she was not in the room at thetime of the transfer and both C.N.A.'s were</p>	02/21/2014	

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	<p>mobility and transfers. The assessment indicated a 2 person assist for transfers with a Hoyer lift.</p> <p>Resident B's Fall Risk Assessment with last assessment, dated 10/31/14, indicated a total score of "7" with 10 or above being high risk.</p> <p>Resident B's care plan for "I am at risk for falls. I can not use my legs. I have muscular dystrophy and I am dependent on a Hoyer lift for all transfers", dated 08/24/12, indicated interventions which included, but were not limited to, "... * All transfers via hoyer lift and 2 staff members *Staff to make sure hoyer slings are not frayed or ripped * Staff to have 2 staff members present for all transfers...."</p> <p>Nurse's Notes, dated 01/23/14 at 11:40 a.m., indicated the writer was alerted to grab supplies for vital signs and upon entering resident's room there was the maintenance man, DON, and 2 CNAs. The record indicated, Res (Resident) face down with towel under head. Bleed (sic) noted from head. Hoyer next to resident c (with) w/c (wheelchair) @ (at) ft.(feet)." The resident's right arm was behind the back of the resident and the resident</p>		<p>suspended at that time until further interviews could be completed. C.N.A. #1 admitted to not following policy and procedure and was terminated. C.N.A. #2 received a three day suspension for giving a false testimony impeding an investigation. An in service was held for nurses 1/28/2014 in which education on transfers with a focus on monitoring and assisting C.N.A.'s with transfers along with demonstrations of how accident occurred and check offs on mechanical lifts for nurses. Describe how the facility reviewed all clients in the facility that could be affected by the same deficient practice and state what action the facility took to correct the deficient practice the facility identified as being affected. All residents being transferred by mechanical lifts have the potential to be affected by the same deficient practice. However, no other resident has been affected and it is our goal that with education and continued skills check offs that no other resident will be affected. Describe the steps or systemic changes the facility made or will make to ensure the deficient practice does not recur, including any in services, but this should also include any system changes you have made. It is our desire that this kind of accident never recurs. all nursing staff before working the floor will have completed a skills check off</p>		

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	<p>stated she wanted turned over and go to the hospital. The resident's arm was repositioned and resident was log rolled. A 5 centimeter (cm) x 3 cm laceration to right forehead with bruising and swelling noted. The resident complained of lower back pain, hip pain, head pain, and neck pain. Ice was applied to head injury and emergency medical services arrived and applied neck brace and gauze wrap to the head laceration. Resident B was taken to the local hospital and messages were left for family.</p> <p>Nurse's Notes, dated 01/23/14 at 5 p.m., indicated at approximately 3:00 p.m., the hospital called and reported the resident was flown to another hospital and family returned phone calls and were aware of the transfer.</p> <p>Review of the facility's follow-up investigation of the incident, dated 01/28/14, indicated, "Two CNAs were transferring resident using the mechanical lift. As the resident was a few inches above the seat of the wheelchair, one of the CNAs was positioning the resident's legs in preparation for the final stage of the transfer (she was quadriplegia) and the other</p>		<p>on mechanical lifts and annual check offs will continue. Assignment sheets continue to show mode of transfer on all residents and state when 2 staff are needed. Nurses have been in serviced on transfers with a focus on monitoring and assisting C.N.A.'s with transfers along with demonstrations of how accident occurred and check offs on mechanical lifts for nurses. Assignment sheets continue to show mode of transfer on all residents and state when 2 staff are needed. Nurses have been in serviced on transfers with a focus on monitoring and assisting C.N.A.'s with transfers along with demonstrations of how accident occurred and check offs on mechanical lifts for nurses. nurses will continue to monitor and assist C.N.A.s as needed with transfers. C.N.A.s will document on assignment sheets the names of the staff who has assisted with transfers - weekly audits of assignment sheets will be conducted by Staff Development Coordinator. In addition to the charge nurses, the D.O.N. and Staff Development Coordinator will periodically observe staff performance as they are rounding in the facility, including observation of the C.N.A.'s as they are using mechanical lifts. Any identified issues regarding the procedures for using the mechanical lifts will be addressed</p>		

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	<p>CNA was standing behind the wheelchair to assist the resident to sit in the chair as the lift was being lowered. At this time, one of the straps of the sling slipped off the hook and the resident fell from the sling to the floor. The CNAs were unable to stop the resident's slide to the floor, because of her body size and weight."</p> <p>The follow-up investigation indicated, Resident B "received a laceration to the right side forehead and complained of back pain." The physician was notified and the resident transferred to the county hospital. The family was notified. Resident B was transferred from the county hospital to another hospital in Indianapolis.</p> <p>Further investigation revealed only 1 CNA was present at the time of the transfer incident. CNA #2 contacted the Director of Nursing (DON) on 01/26/14 and confessed that she was not in the room at the time of the transfer.</p> <p>Both CNAs were suspended pending further investigation. During interview with CNA #1, reenactment of incident (with DON in the sling) per new statement still did not</p>		<p>at the time of observation -the D.O.N., Staff Development Coordinator, and/or charge nurse will intervene immediately and make sure the resident is safe. Once that is assured, the staff involved will be retrained on the proper procedure and the facility policy focusing the mechanical lift. Progressive disciplinary action, up to, and including termination of employment, will be done for instances of continued non compliance. Describe how the corrective actions will be monitored to ensure the efficient practice does not recur, i.e. what quality assurance program will be put into place. The D.O.N. or Staff Development Coordinator will review the results of the monitoring activities and observations of mechanical lift transfers at monthly Quality Assurance Committee meeting for three months. Any committee recommendations for further process improvement will be followed up by the D.O.N. or Staff Development Coordinator and the results of those recommendations will be brought back to the next monthly QA Committee meeting for further review and discussion. If there has been 100% compliance with the proper use of mechanical lifts in the facility at the end of three months, the QA Committee may decide to stop further review of this process with the committee; however the</p>		

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	<p>produce anticipated outcome. However, placement of left lower strap on top of the swivel bar hook did result in a manner consistent with statement and injuries. "With placement of the strap on top of the swivel hook did result in a manner consistent with statement and injuries. With placement of the strap on top of the swivel bar hook, C.N.A. then elevated feet of D.O.N. and strap slid off. Further more control arm made the same noise as described in earlier interviews. The underneath side of the control arm was noticed at that time to have the same shape as the laceration on the resident's forehead and D.O.N. was lunged forward. _____ [CNA #1] was terminated as a result of not following policy and procedure during a transfer. _____ [CNA #2] received a 3 day suspension for giving a false testimony impeding an investigation." An inservice was held for nurses on 01/28/14 in which education on transfers with a focus on monitoring and assisting CNAs with transfers along with demonstration/check offs. One on one check offs for all CNAs started on 01/23/14 and no CNAs have been allowed to work without completing check offs.</p>		<p>observations of performance and follow up as indicated previously will continue on an ongoing basis.</p>	

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	<p>Interview with CNA #1, on 02/04/14 at 2:11 p.m., indicated the strap to the Hoyer lift came undone and Resident B fell out face first onto the floor. The CNA indicated she yelled for help of another CNA, CNA #2 came to help with the maintenance man, then a nurse and the staff educator. CNA #1 indicated she assumed Resident B hit her head on the swivel bar and caused the laceration to the right side of face. CNA #1 indicated the area was measured by the Director of Nursing (DON) to be 5 centimeters (cm) times 0.5 cm. CNA #1 indicated the resident bled enough to almost make her pass out and made her very nervous. CNA #1 indicated the resident's face started to swell and bruise on the right side of her head. CNA #1 indicated the resident complained of pain in her hip and bottom area. CNA #1 admitted to operating the Hoyer lift by herself and indicated, "We don't ask for help, all the aides transfers via Hoyer lift by themselves. We're short staffed, the nurses are not willing to help or answer call lights.</p> <p>CNA #2 was unavailable for interview.</p> <p>Interview with the DON, on 02/04/14</p>			

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	<p>at 12:13 p.m., indicated they were getting residents up for lunch and she was going to the nurse's station when she heard the maintenance man holler for towels. The DON indicated when she walked into the room, they had towels under her head and Resident B was lying face down on her right side with her right arm twisted towards her back. The DON indicated staff were holding pressure to her head and the nurse was doing the vital signs, and she was checking her hips and leg length. The DON indicated the resident was fighting them and screaming. The resident wanted to roll over on her back and the staff logged rolled her onto her back side. On 02/04/14 at 12:25 p.m., the DON and staff educator re-enacted the transfer as earlier by the aide and the black strap on the resident's left side was on top of the hook instead of being placed down past the curve. When the strap fell off with movement of the feet, the sling lunged the person in the sling forward, thus hitting the bottom of the swivel bar. The DON indicated the laceration was identical to the bottom of the swivel bar.</p> <p>Interview with the staff development educator, on 02/04/14 at 12:30 p.m.,</p>			

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	<p>indicated the DON had hollered at her to get vital sign equipment and she in turn hollered at the nurse and both of them went to the resident's room. The staff educator indicated she saw Resident B face down on the floor with her arm bent toward her back, and blood by her head. The staff educator indicated the resident wanted to be turned over and staff logged rolled her over. Ice was applied to her head wound and vital signs were taken. The staff educator indicated the resident would not calm down and kept wanting to go to the hospital. The staff educator indicated she interviewed CNA #2 who told her there were 2 aides in the room, said the strap came undone, and indicated she was standing in back of the wheelchair. The staff educator indicated the aide made a point to tell her the resident was restless and scooting around in her chair.</p> <p>Interview with LPN #4, on 02/04/13 at 12:45 p.m., indicated he was working at the med cart and was told by the staff educator to bring his vital sign stuff and come with her. LPN #4 indicated he followed the staff educator into the room and the resident was on the floor face down</p>				

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	<p>and leg twisted. LPN #4 indicated the resident wanted to be turned over and towels were already down under her head. LPN #4 indicated he did the vital signs and indicated the resident complained of back, hip, and neck pain. LPN #4 indicated there was bleeding from the head and the resident was hysterical and the resident could not accurately answer questions.</p> <p>Interview with the maintenance man, on 02/04/14 at 12:56 p.m., indicated he was in the hallway talking to housekeeping staff when CNA #1 came to the door and hollered to get some towels and indicated CNA #1 said Resident B fell out of the Hoyer sling. The maintenance man indicated he saw 1 corner of the Hoyer lift sling hanging down. The maintenance man indicated there was only CNA #1 in the room when she hollered for help. The maintenance man indicated the resident was hysterical, crying real bad and hurting.</p> <p>Photos sent with complaint showed large bruising to Resident B's right shoulder, leg, multiple bruising to face, including both eyes, chin, mouth area, and neck area.</p>			

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	<p>Review of the facility's policy on "Hoyer Lift (Mechanical Lift)", with revision dated of June 2006, indicated, "All resident transfers that are done by means of a mechanical lift will be done with 2 nursing staff members (nursing assistants or nurses) in attendance at all times... Purpose: To enable staff member(s) to lift and move a resident safely, with as little effort as possible...."</p> <p>Review of the undated, manufacturer's recommendations for "Lifting The Patient", indicated, "WARNING When 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 place, lower the patient back onto the bed and correct the problem... 1. Pump the lift handle or press the UP button to raise the patient above the bed. The patient should be elevated high enough to clear the bed with their weight fully supported by the lift. 2. When the patient is lifted from the bed (with the patient's head supported by the sling and/or an assistant), he/she will be raised to a sitting position. 3. When patient is</p>			

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	<p>clear of the bed surface, swing their feet off the bed. 4. Using the steering handles, move the lift away from the bed. 5. When moving the patient lift away from the bed, turn patient so that he/she faces assistant operating the patient lift. 6. Press the DOWN button (electric) or open control valve (manual/hydraulic) lowering patient so that his feet rest on the base of the lift, straddling the mast. Close control valve. 7. Pull the patient lift away from the bed and push from behind with both hands firmly on the push handle."</p> <p>This federal finding is related to Complaint IN00143330.</p> <p>3.1-45(a)(2)</p>			