

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155586	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 06/30/2015
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NAME OF PROVIDER OR SUPPLIER LUTHERAN LIFE VILLAGES	STREET ADDRESS, CITY, STATE, ZIP CODE 6701 S ANTHONY BLVD FORT WAYNE, IN 46816
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00175454.</p> <p>Complaint IN00175454 – Substantiated. Federal/State deficiency related to the allegations is cited at F323.</p> <p>Survey dates: June 29 and 30, 2015.</p> <p>Facility number: 000283 Provider number: 155586 AIM number: 100275020</p> <p>Census bed type: SNF/NF: 117</p> <p>Total: 173</p> <p>Census payor type: Medicare: 20 Medicaid: 67 Other: 30 Total: 117</p> <p>Sample: 3</p> <p>These deficiencies reflect State findings cited in accordance with 410 IAC 16.2–3.1.</p>	F 0000		

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 0323 SS=G Bldg. 00	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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 interviews, the facility failed to ensure nursing staff properly applied straps on a mechanical lift before transferring a resident, resulting in a fall with a hip fracture. This affected 1 of 3 residents reviewed for falls, Resident B.</p> <p>The facility also failed to ensure a resident was transferred following the nursing care plan with 2 staff members present, and failed to ensure the same resident was toileted in the shower room area as designated on the care plan. This affected 1 of 3 residents reviewed for falls, Resident C.</p> <p>Findings include:</p> <p>1. During initial tour of the facility, on 6/29/15, at 9:53 A.M., LPN #2 indicated Resident B had been moved to the Rehab Unit recently because he had a fall resulting in a hip fracture. During initial tour of the Rehab unit,</p>	F 0323	<p>Please accept this as our credible allegation of compliance to our recent ISDH annual survey. Submission of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of facts alleged or the corrections set forth on the statement of deficiencies. This Plan of Correction is prepared and submitted because of requirements under State & Federal Law. We are also scanning in several attachments as supportive documentation.</p> <p>F323 Corrective Actions to be accomplished for those residents affected: The individual nursing staff that were responsible for the incidents to Resident B and to Resident C had been counseled with corrective action reports (see attached counseling reports) according to policy; following both incidents. The nursing staff were presented with an in-service (see attached agenda and sign in roster) on July 7 & 8, 2015 regarding the updated policies/procedures (see attached -Standing Lift, Mechanical Lift & Safe Resident Handling); this</p>	07/17/2015

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	<p>accompanied by RN #1, on 6/29/15, at 10:30 A.M., Resident B was observed lying in bed and told the RN he had pain in his right hip. The resident then indicated he had slipped out of a mechanical lift during a transfer because staff had not hooked the straps correctly.</p> <p>The electronic record for Resident B was reviewed, on 6/29/15, at 2:00 P.M. A nurse's progress note, dated 6/9/15 at 5:23 P.M., indicated, "while at med cart writer herd (sic) a thud and resident yell out CNA informed writer that resident had fell out of the hoyer lift. upon (sic) entering room resident was laying on the floor, and on a leg of the Hoyer lift ..."</p> <p>The Director of Nursing Services (DNS) provided an investigation of Resident B's fall, on 6/29/15, at 3:00 P.M. The investigation, dated 6/9/15, was reviewed on 6/29/15 at 3:02 P.M., and indicated CNA #6 and BNA(Basic Nursing Assistant) #7 were preparing to transfer Resident B in the mechanical lift per his care plan and CNA assignment sheet. During the transfer, the resident slid out of the sling and fell to the</p>		<p>included a return demonstration from each individual staff (see attached return demonstration checklists). These appear to be isolated incidents. Other residents having thepotential to be affected and the corrective actions: The facility has identified which residents utilize lifts and the specific type of lift / sling along with staff assisted transfers. Each resident's careplan & CNA assignment sheet were updated as necessary with this information on lifts/transfers. To assure the nursing staff are following proper lift techniques/safe transfer policies and that no other residents are affected or will be affected, the nursing staff are being monitored for compliance with daily audits /observations (see attached audit forms). This includes 10 daily audits from Thursday, July 9, 2015 through July15, 2015. The facility will conduct 6 audits per day from Wednesday, July15 through July 22, 2015. The facility will conduct 2 audits per day from Wednesday, July 22 through July 31,2015. For the month of August, 2015, the facility will conduct weekly audits to assure the policy and procedure for proper transfers and proper use of lifts. For the month of September 2015, the facility will conduct monthly audits regarding compliance to our lift and transfer policy and procedures. The</p>				

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	<p>floor landing on the base of the lift on his right hip. The resident was transferred to the hospital for a possible hip fracture. Upon investigation the CNA and BNA reported they hooked the resident up to the mechanical lift but did not cross the sling between his legs according to the manufacturer's instructions. When they went to transfer the resident he slid out of the sling. Both the CNA and BNA were given written warnings immediately due to no previous performance issues. Both were then educated on the proper use of mechanical lifts and where to find the manufacturer's instructions.</p> <p>The DNS was interviewed, on 6/29/15, at 3:25 P.M., and indicated instructions were attached to each Hoyer lift for staff to review. She indicated CNA #6 was new to the facility at the time of the incident, and was still in training. She indicated CNA #6 was supposed to be training with CNA #11.</p> <p>The DNS indicated CNA #6 was still in training and had not been checked off on transfers using the mechanical lifts. She indicated BNA #7 had been checked off on</p>		<p>results from the respective audits will be reviewed @ our weekly resident review meetings and our monthly QA meetings for compliance to policy/procedure.</p> <p>What Measures were put into place to ensure this does not happen again: Facility training protocol has been updated with the revised policy/procedures for mechanical lifts and safe resident handling. This includes an increased emphasis on safe and appropriate transfers with lifts and following careplans through CNA assignment sheets regarding 2-person transfers. Additionally, to assure the nursing staff are following the updated Standing Lift/Mechanical Lift/Safe Resident Handling Policy/Procedures and that no other residents are affected or will be affected, the nursing staff are being monitored for compliance. This includes 10 daily audits from Thursday, July 9, 2015 through July 15, 2015. The facility will conduct 6 audits per day from Wednesday, July 15 through July 22, 2015. The facility will conduct 2 audits per day from Wednesday, July 22 through July 31, 2015. For the month of August, 2015, the facility will conduct weekly audits to assure the policy and procedure for proper transfers and proper use of lifts. For the month of September 2015, the facility will conduct monthly audits regarding compliance to our lift and transfer policy and procedures. The</p>				

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	<p>the skills check list for use of mechanical lifts. The DNS provided a skills checklist for BNA #7, on 6/29/15, at 3:25 P.M., which was reviewed at this time. The checklist was updated 12/16/2014 and indicated BNA #7 had initialed the checklist for positioning/transferring residents using the Sara lift and Maxi lift on 2/26/15.</p> <p>The DNS provided the Performance Reports, for CNA #6 and BNA #7, on 6/29/15 at 3:25 P.M. Both of the Performance Reports were regarding an incident which occurred on 6/9/15, and were dated as issued on 6/10/15. The Performance Reports were reviewed, on 6/29/15, at 3:30 P.M., and indicated CNA #6 and BNA #7 were given a written warning which indicated, "A resident was improperly placed in a sling for transfer using a mechanical lift (full body lift). Improper placement of sling and the wheelchair not being in the proper position to transfer resident resulted in resident falling from the sling and sustaining a hip fracture. "</p> <p>CNA #6 was interviewed, on 6/29/15, at 3:47 P.M., and</p>		<p>results from the respective audits will be reviewed @ our weekly resident review meetings and or monthly QA meetings for compliance to policy/procedure.</p> <p>How the corrective actions will be monitored: The results from our updated Standing Lift/Mechanical Lift/Safe Resident Handling audits will be reviewed at our weekly resident review meetings and our monthly QA meeting for compliance. Nursing Unit Managers will monitor for compliance and Director of Nursing will monitor for ongoing compliance. Please find the following attachments:</p> <ol style="list-style-type: none"> 1. Staff counseling/ corrective action reports (three reports) for the incidents on Resident B and Resident C. 2. Staff posting of inservice for July 7 and 8, 2015; inservice agenda; inservice sign in sheets from staff. 3. Policies regarding Standing lifts; Mechanical Lifts and Safe Resident Handling. 4. Completed return demonstration forms from inservice for proper use of mechanical lifts and appropriate safe handling of residents (transfers), included is only a small percentage sampling of all staff. 5. Nursing Audit forms starting on July 9 for observation of appropriate transfers and mechanical lifts. 		

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	<p>indicated he was in training at the time of the incident, but had worked at another facility as a CNA for almost a year. He indicated he and BNA #7 had gone into Resident B's room, with CNA #11. He indicated CNA #11 then left the room to answer a call light, so he and BNA #7 proceeded to use a Hoyer lift to get the resident up for dinner. CNA #6 indicated when they applied the Hoyer straps to the lift, they failed to cross the straps between the resident's legs. He indicated BNA #7 also had to turn around to reach for the resident's wheelchair as it was not placed properly for the transfer. CNA #6 indicated he had assisted with another resident transfer using the same type of Hoyer lift at this facility, but had not been checked off on the skill's list for transfers using mechanical lifts at this facility.</p> <p>BNA #7 was interviewed, on 6/29/15, at 4:10 P.M. She indicated CNA #6 and CNA #11 had gone into Resident B's room to get him up for dinner, then BNA #7 had gone in to help. She indicated CNA #11 left the room but she was not sure why. She indicated she and CNA #6 hooked up the straps</p>			

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	<p>to the Hoyer lift, but neglected to cross the straps before transferring the resident causing the resident to slide out of the lift. She indicated she had to turn around to reach for the resident's wheelchair, and when she looked back, the resident was sliding out of the lift. She indicated she had received training, and been checked off on Hoyer transfers, and had used the same Hoyer before and was aware the straps had to be crossed when applied.</p> <p>LPN #8 was interviewed, on 6/29/15, at 4:25 P.M., regarding the incident. She indicated she was working the day of the incident, and heard a "big thud." She indicated she entered the resident's room and the resident was laying on the floor on his right side, and his right leg was laying on the base of the Hoyer lift. She indicated she could tell the straps were incorrectly applied as soon as she entered the room. She indicated CNA #6 and BNA #7 were in the room with the resident. She indicated she told them they should not have been in the room alone transferring the resident. She indicated CNA#6 was a new employee and was supposed to</p>			

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	<p>stay with CNA #11 for training, and BNA #7 needed to take her test (for CNA certification.)</p> <p>The DNS provided a current policy for Mechanical Lifts, on 6/30/15, at 9:20 A.M. The policy was dated as revised on 3/15/13.</p> <p>The policy was reviewed on 6/30/15, at 9:30 A.M., and indicated the following: This procedure required 2 staff members, one would operate the lift and the other would guide the resident and sling into the chair. Both staff would communicate with each other through out the procedure to avoid sudden movements.</p> <p>The policy indicated, "always follow manufactures guidelines for use. "</p> <p>The DNS provided a "Lift Operating Instructions" form(undated) for transferring a resident from bed to chair, on 6/30/15, at 10:20 A.M. The policy was reviewed at this time and indicated the following: "Attach sling to lift – Attach the loops by the patient's shoulders to the lift using the shortest loops." The instructions also indicated, "Take the wing that is lying over the left leg and hook it on the right hook on the longest loop. Then</p>			

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	<p>take the wing lying over right leg, cross it over and hook it on the left hook on the longest loop. "</p> <p>2. The clinical record of Resident C was reviewed on 6/29/15 at 10:30 A.M. Diagnoses included, but were not limited to, osteoarthritis, anxiety, and depression.</p> <p>The Progress Note, dated 5/10/15 at 6:39 P.M., indicated Resident C was assisted to the bathroom in her room. The resident indicated she could not stand any longer and staff lowered the resident to the floor. The progress note indicated there was no injury to the resident.</p> <p>The at risk for falls due to decreased mobility and history of falls Care Plan dated 10/24/14 was updated after the resident fell on 5/10/15 with a new intervention to take Resident C to the toilet in the shower room. The at risk for fall care plan also indicated on 10/17/14 an intervention to transfer the resident with assist of 2 staff members.</p> <p>The Progress Note dated 6/20/15 at 6:58 P.M. indicated "...while transferring, res (resident) stated her ankle buckled and fell on her</p>			

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	<p>buttocks. stated she did not hit her head. denies any injuries. assisted to w/c (wheel chair)."</p> <p>On 6/29/15 at 4:00 P.M. the Director of Nursing Service (DNS) was interviewed and indicated on 6/20/15 CNA #9 had transferred Resident C by herself in the resident's bathroom. The DNS indicated Resident C was to be transferred with assist of 2 staff members and was to use the toilet in the shower room.</p> <p>The Progress Note dated 6/24/15 at 12:19 P.M. indicated "Nurse called to residents (sic) room where resident had been placed on the floor during ambulation to toilet. resident noted to be sitting on bathroom floor in front of toilet leaning with her head on bar for standing assistance with both legs facing the doorway. Resident stated her leg buckled so she could not stand any longer causing CNA to lower and place the resident on floor in bathroom...Resident denies any pain/discomfort however she stated she thinks she may have hit her head. Nurse notified (Resident C's Physician's name) office and new orders rec'd (received) just to</p>			

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	<p>monitor resident neuros and call if condition worsens...."</p> <p>On 6/29/15 at 3:30 P.M. interview with the DNS indicated CNA #10 had transferred Resident C to the toilet by herself. The DNS indicated Resident C was a 2 person assist with a transfer.</p> <p>This federal tag relates to complaint IN00175454.</p> <p>3.1-45(a)(2)</p>				