

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155029	X2) MULTIPLE CONSTRUCTION A. BUILDING <u>00</u> B. WING _____	X3) DATE SURVEY COMPLETED 09/02/2015
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NAME OF PROVIDER OR SUPPLIER COMMUNITY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5600 E 16TH ST INDIANAPOLIS, IN 46218
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F 0000 Bldg. 00	<p>This visit was for the Investigation of Complaint IN00180604.</p> <p>Complaint IN00180604 -- Substantiated. Federal/State deficiencies related to the allegations are cited at F323, F498 and F9999.</p> <p>Survey dates: September 1 and 2, 2015</p> <p>Facility number: 000012 Provider number: 155029 AIM number: 100274900</p> <p>Census bed type: SNF/NF: 100 Total: 100</p> <p>Census payor type: Medicare: 12 Medicaid: 69 Other: 19 Total: 100</p> <p>Sample: 3</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1.</p> <p>QR completed by 30576 on September 9,</p>	F 0000	<p>F000 The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that this Plan of Correction be considered the Letter of Credible Allegation of Compliance and requests a desk review in lieu of a post survey on or after 9/23/15.</p> <p>The facility respectfully requests a face-to-face IDR for F323 and F999 as the facility disagrees with the scope and severity of the deficiencies.</p>	

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=D Bldg. 00	<p>2015</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. Based on interview and record review, the facility failed to ensure a staff member followed the facility's policy regarding the use of a mechanical lift, which resulted in a fall for 1 of 3 residents reviewed for falls. This same staff member failed to follow the facility's policy regarding the immediate notification of her supervisor and/or licensed nurse to provide an immediate physical assessment to the resident. These deficient practices resulted in the resident having delayed assessment, evaluation and treatment and resulted in the resident being psychologically harmed with anxiety when requiring the assistance of the mechanical lifts since the fall. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 9-1-15 at 11:15 a.m. His</p>	F 0323	<p>F323 The facility respectively requests a face-to-face IDR for F323 and F999 as the facility disagrees with the scope and severity of the deficiencies. The facility failed to ensure a staff member followed the facility's policy regarding the use of a mechanical lift, which resulted in a fall for 1 of 3 residents reviewed for falls. The same staff member failed to follow the facility's policy regarding the immediate notification of her Supervisor and/or licensed nurse to provide an immediate physical assessment to the resident(Resident #B). These deficient practices resulted in the resident having delayed assessment, evaluation and treatment and resulted in the resident being psychologically harmed with anxiety when requiring the assistance of the mechanical lift since the fall.</p> <p>What corrective action(s) will be accomplished for those residents found to have been</p>	09/23/2015

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	<p>diagnoses included, but were not limited to, paraplegia, schizophrenia, diabetes, epilepsy and a history of urinary tract infection.</p> <p>Review of his admission Minimum Data Set assessment, dated, 6-21-15, indicated he required extensive assistance of 2 or more persons for bed mobility and transfers, is unable to walk and used a wheelchair for mobility. It indicated he is moderately cognitively impaired. It indicated he had no falls in the 6 months prior to admission and none since admission.</p> <p>Review of the September, 2015 recapitulation orders indicated he had been physician ordered to use a mechanical lift with two assists (persons) for transfers since admission to the facility.</p> <p>Review of a "Fall Event" report, dated, 8-12-15 at 3:05 p.m., indicated Resident #B reported to facility staff that on 8-11-15, during the evening shift, he had "slid out of w/c [wheelchair] during a transfer, landing on his bottom." Associated documentation indicated the report by the resident to the staff member occurred at 11:26 a.m. A physical assessment shortly thereafter indicated no injuries. The attending physician was</p>		<p>affected by the deficientpractice?</p> <ul style="list-style-type: none"> ·Resident #B no longer resides at this facility. ·CNA #1, was terminated and no longer works at facility. · CNA #2, who came to assist, was provided with additional training on and corrective action. The facility Clinical Education Coordinator (CEC) re-educated CNA #2 on how to conduct hoyer lift transfers properly that included skills validation/return demonstration. Skills validation for CNA#2 was completed on 8/19/2015. <p>How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All residents have the potential to be affected by the alleged deficient practice ·All staff will be in serviced by the CEC/Designee by 9/23/15 on the fall management program, mechanical lift procedure and falling/fainting procedure including immediate notification of resident falling or being lowered to the ground. ·All residents with hoyer lifts have been reviewed by the ADNS/Designee to ensure that they've had a physical assessment conducted by a licensed nurse post fall for the past 60 days 	

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	<p>notified of the fall and ordered xrays on-site "stat," or immediately of the lower back, bilateral hips and lower extremities. Due to the quality of the xrays, the attending physician requested the resident be sent to the local emergency room for evaluation and treatment. Resident #B returned to the facility within 3 hours and was found to have a contusion (bruise) to the right hip with no identified fractures.</p> <p>In an interview with the Director of Nursing (DON) on 9-1-15 at 1:05 p.m., she indicated the CNA who was working with Resident #B on the evening shift of 8-11-15 was a new CNA who had been working at the facility for a week or so. She indicated she had completed her skills orientation. She indicated, upon interview with CNA #1, after the fall, she was told that the resident was up in his w/c with the sling of the mechanical lift under him. She attached the sling straps on one side of the mechanical lift "and as she was walking around the w/c, he began to slip out. She said she lowered him to the floor. Then she got another CNA to help her get him back into his chair and to bed." She indicated the other CNA assumed the (licensed) nurse had already been notified and checked him out (assessed the resident for injuries). "However, the new CNA hadn't notified</p>		<ul style="list-style-type: none"> · All nursing staff will be skills validated on mechanical lifts and falling/fainting procedure by the CEC/Designee by 9/23/15 What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur? ·All staff will be in serviced by the CEC/Designee by 9/23/15 on the fall management program, mechanical lift procedure and falling/fainting procedure including immediate notification of resident falling or being lowered to the ground. ·All nursing staff will be skills validated on mechanical lifts and falling/fainting procedure by the CEC/Designee by 9/23/15 ·The ADNS/designee will review the facility activity report daily to ensure that all falls were reported, physical assessment was conducted by a licensed nurse immediately, and resident is assessed daily for 72 hours post fall to assessfor harm and/or injury. ·CEC/designee will conduct rounds, by 9/23/15, on all shifts using nurse rounds audit tool to ensure that mechanical lifts are operated per facility policy and to ensure that all staff are aware of the need to immediately report all falls and residents being lowered to the ground to a Licensed Nurse. How the corrective 		

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	<p>the nurse. She said she was new and just kind of got confused." She indicated CNA #1 was terminated "due to the fact the fall occurred, the new CNA failed to report it and failed to follow our policy on two assists [persons] with [name brand of the mechanical lift]." She indicated CNA #2 was counseled on reporting of unusual occurrences, including falls, to the immediate supervisor.</p> <p>In a telephone interview with CNA #2 on 9-1-15 at 3:00 p.m., she indicated CNA #1 had asked her to assist in getting Resident #B back into bed as he had slipped out of the w/c on the pad and CNA #1 then lowered him to the floor. She indicated, "He is a 2 person assist with the [name brand of the mechanical lift]. We always use 2 people with [name brand of the mechanical lift] and I know that's how she was trained [at the facility]." She indicated CNA #1 had been employed approximately one to two weeks at the facility. She indicated she and CNA #1 used the mechanical lift to get the resident placed into bed. "She kind of indicated to me that she was going to report this to the nurse after we got him back to bed. We kept asking him if he was okay or hurt and he said he was fine. Didn't see any redness or swelling." She indicated, "Normally, if I would have</p>		<p>action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <ul style="list-style-type: none"> ·A Fall Management and Mechanical Lift CQI tool will be completed weekly times 4 weeks, monthly times 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up. ·If threshold of 95% is not achieved an action plan will be developed to ensure compliance. <p>By what date will systematic changes be completed?</p> <ul style="list-style-type: none"> ·All systematic changes will be completed by 9/23/15. 	

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	<p>lowered somebody to the floor, I would tell the nurse as soon as possible. I was surprised the new CNA hadn't done this."</p> <p>In an interview with Resident #B on 9-2-15 at 9:20 a.m., he indicated he recently had a fall which involved a new CNA, CNA #1. "She tried to put me to bed with the [name brand of the mechanical lift] by herself. At the time, I didn't know they [the facility] always uses two people [to assist] with [name brand of the mechanical lift]. I just assumed she knew what she was doing." He indicated CNA #1 connected the sling incorrectly to the mechanical lift. "As she started the [mechanical] lift up in the air, I fell to the floor." He indicated CNA #1 then went to seek the assistance of someone else. He indicated CNA #2 came to provide assistance. He indicated both CNA's lifted him off the floor by placing their arms under his armpits and raised him off of the floor and onto the bed. He indicated he overheard the two CNA's talking. He indicated, "I heard them say they wasn't going to bother with filing the paperwork or filing a report because it was just extra paperwork."</p> <p>Resident #B indicated he has no sensation/feeling from approximately his diaphragm and below, due to the paraplegia. He indicated he typically has</p>			

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	<p>back pain, but has experienced it more since the fall, requiring the use of "as needed" or "PRN" pain medications several times. He indicated "I've never had any problems with the [name brand of the mechanical lift], but now I get pretty nervous about using the [name brand of the mechanical lift]."</p> <p>On 9-1-15 at 3:30 p.m., the DON provided a copy of CNA #1's personnel file. It contained a copy of the following items:</p> <ul style="list-style-type: none"> - A job description, signed and dated by CNA #1 on 7-23-15. The job description indicated, "...Transfer...Obtains assistance of another staff member if needed before starting to transfer a resident...Observes and immediately reports to Charge Nurse, unusual occurrences, significant changes in resident's physical or behavioral condition...Immediately reports fall/injury of a resident or self to Charge Nurse...Ensures that each Nursing Assistant has been given report regarding his/her residents at the beginning of each shift..." -A skills procedure for "Falling/Fainting." The procedure indicated, "1. Call for nurse and stay with resident...3. Do NOT move resident..." It indicated CNA #1 successfully completed this procedure, 			

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	<p>but was undated.</p> <p>-A skills procedure for "Mechanical Lift." The procedure indicated, in bold print and at the beginning of the procedure, "NOTE: Two (2) staff is [sic] required at all times when using a mechanical lift." It indicated CNA #1 successfully completed this procedure on 8-3-15.</p> <p>On 9-2-15 at 1:05 p.m., the DON provided a copy of CNA #2's personnel file. It contained a copy of the following items:</p> <p>- A job description, signed and dated by CNA #2 on 3-11-15. The job description indicated, "...Transfer...Obtains assistance of another staff member if needed before starting to transfer a resident...Observes and immediately reports to Charge Nurse, unusual occurrences, significant changes in resident's physical or behavioral condition...Immediately reports fall/injury of a resident or self to Charge Nurse...Ensures that each Nursing Assistant has been given report regarding his/her residents at the beginning of each shift..."</p> <p>-A skills procedure for "Falling/Fainting." The procedure indicated, "1. Call for nurse and stay with resident...3. Do NOT move resident..." It indicated CNA #2 successfully completed this procedure</p>			

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F 0498 SS=D Bldg. 00	<p>4-11-15.</p> <p>-A skills procedure for "Mechanical Lift." The procedure indicated, in bold print and at the beginning of the procedure, "NOTE: Two (2) staff is [sic] required at all times when using a mechanical lift." It indicated CNA #2 successfully completed this procedure on 4-11-15.</p> <p>This Federal tag relates to Complaint IN00180604.</p> <p>3.1-45(a)(2)</p> <p>483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.</p> <p>Based on interview and record review, the facility failed to ensure a staff member followed facility policies and procedures for the use of a mechanical lift and failed to follow facility procedures for prompt reporting of a fall to supervisory staff. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 9-1-15 at 11:15 a.m. His</p>	F 0498	<p>F498 The facility failed to ensure a staff member followed facility policies and procedures for the use of a mechanical lift and failed to follow facility procedures for prompt reporting of a fall to supervisory staff. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</p> <ul style="list-style-type: none"> ·Resident #B no longer resides at this facility. ·CNA #1, was terminated and 	09/23/2015

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	<p>diagnoses included, but were not limited to, paraplegia, schizophrenia, diabetes, epilepsy and a history of urinary tract infection.</p> <p>Review of his admission Minimum Data Set assessment, dated, 6-21-15, indicated he required extensive assistance of 2 or more persons for bed mobility and transfers, is unable to walk and used a wheelchair for mobility. It indicated he is moderately cognitively impaired. It indicated he had no falls in the 6 months prior to admission and none since admission.</p> <p>Review of the September, 2015 recapitulation orders indicated he had been physician ordered to use a mechanical lift with two assists (persons) for transfers since admission to the facility.</p> <p>Review of a "Fall Event" report, dated, 8-12-15 at 3:05 p.m., indicated Resident #B reported to facility staff that on 8-11-15, during the evening shift, he had "slid out of w/c [wheelchair] during a transfer, landing on his bottom." Associated documentation indicated the report by the resident to the staff member occurred at 11:26 a.m. A physical assessment shortly thereafter indicated no injuries. The attending physician was</p>		<p>no longer works at the facility.</p> <ul style="list-style-type: none"> · CNA #2, who came to assist, was provided with additional training and corrective action. The facility Clinical Education Coordinator (CEC) re-educated CNA #2 on how to conduct hooyer lift transfers properly that included skills validation/return demonstration. <p>How will you identify otherresidents having the potential to be affected by the same deficient practiceand what corrective action will be taken?</p> <ul style="list-style-type: none"> ·All resident have the potential to be affected by the alleged deficient practice ·All staff will be in serviced by the CEC/Designee by 9/23/15 on the fall management program, mechanical lift procedure and falling/fainting procedure including immediate notification. ·All residents with hooyer lifts have been reviewed by the ADNS/Designee to ensure that they've had a physical assessment conducted by a licensed nurse post fall for the past 60 days · All nursing staff will be skills validated on mechanical lifts and falling/fainting procedure by the CEC/Designee by 9/23/15 <p>What measures will be put intoplace or what systemic changes you will make to ensure that the deficientpractice does not recur?</p>	

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	<p>notified of the fall and ordered xrays on-site "stat," or immediately of the lower back, bilateral hips and lower extremities. Due to the quality of the xrays, the attending physician requested the resident be sent to the local emergency room for evaluation and treatment. Resident #B returned to the facility within 3 hours and was found to have a contusion (bruise) to the right hip with no identified fractures.</p> <p>In an interview with the Director of Nursing (DON) on 9-1-15 at 1:05 p.m., she indicated the CNA who was working with Resident #B on the evening shift of 8-11-15 was a new CNA who had been working at the facility for a week or so. She indicated she had completed her skills orientation. She indicated, upon interview with CNA #1, after the fall, she was told that the resident was up in his w/c with the sling of the mechanical lift under him. She attached the sling straps on one side of the mechanical lift "and as she was walking around the w/c, he began to slip out. She said she lowered him to the floor. Then she got another CNA to help her get him back into his chair and to bed." She indicated the other CNA assumed the (licensed) nurse had already been notified and checked him out (assessed the resident for injuries). "However, the new CNA hadn't notified</p>		<p>·All staff will be in serviced by the CEC/Designee by 9/23/15 on the fall management program, mechanical lift procedure and falling/fainting procedure including immediate notification.</p> <p>·All nursing staff will be skills validated on mechanical lifts and falling/fainting procedure by the CEC/Designee by 9/23/15</p> <p>·TheADNS/designee will review the facility activity report daily to ensure that allfalls were reported, physical assessment was conducted by a licensed nurseimmediately, and resident is assessed daily for 72 hours post fall to assessfor harm and/or injury.</p> <p>·CEC/designeewill conduct rounds on all shifts using nurse rounds audit tool to ensure that mechanical lifts are operated per facility policy.</p> <p>How the corrective action(s) willbe monitored to ensure the deficient practice will not recur, i.e., whatquality assurance program will be put into place?</p> <p>·A Fall Management and Mechanical Lift CQI tool will be completed weekly times 4 weeks, monthly times 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</p> <p>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>By what date will systematicchanges be completed?</p>	

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	<p>the nurse. She said she was new and just kind of got confused." She indicated CNA #1 was terminated "due to the fact the fall occurred, the new CNA failed to report it and failed to follow our policy on two assists [persons] with [name brand of the mechanical lift]." She indicated CNA #2 was counseled on reporting of unusual occurrences, including falls, to the immediate supervisor.</p> <p>In a telephone interview with CNA #2 on 9-1-15 at 3:00 p.m., she indicated CNA #1 had asked her to assist in getting Resident #B back into bed as he had slipped out of the w/c on the pad and CNA #1 then lowered him to the floor. She indicated, "He is a 2 person assist with the [name brand of the mechanical lift]. We always use 2 people with [name brand of the mechanical lift] and I know that's how she was trained [at the facility]." She indicated CNA #1 had been employed approximately one to two weeks at the facility. She indicated she and CNA #1 used the mechanical lift to get the resident placed into bed. "She kind of indicated to me that she was going to report this to the nurse after we got him back to bed. We kept asking him if he was okay or hurt and he said he was fine. Didn't see any redness or swelling." She indicated, "Normally, if I would have</p>		<p>All systematic changes will be completed by 9/23/15.</p>		

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	<p>lowered somebody to the floor, I would tell the nurse as soon as possible. I was surprised the new CNA hadn't done this."</p> <p>In an interview with Resident #B on 9-2-15 at 9:20 a.m., he indicated he recently had a fall which involved a new CNA, CNA #1. "She tried to put me to bed with the [name brand of the mechanical lift] by herself. At the time, I didn't know they [the facility] always uses two people [to assist] with [name brand of the mechanical lift]. I just assumed she knew what she was doing." He indicated CNA #1 connected the sling incorrectly to the mechanical lift. "As she started the [mechanical] lift up in the air, I fell to the floor." He indicated CNA #1 then went to seek the assistance of someone else. He indicated CNA #2 came to provide assistance. He indicated both CNA's lifted him off the floor by placing their arms under his armpits and raised him off of the floor and onto the bed. He indicated he overheard the two CNA's talking. He indicated, "I heard them say they wasn't going to bother with filing the paperwork or filing a report because it was just extra paperwork."</p> <p>Resident #B indicated he has no sensation/feeling from approximately his diaphragm and below, due to the paraplegia. He indicated he typically has</p>			

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	<p>back pain, but has experienced it more since the fall, requiring the use of "as needed" or "PRN" pain medications several times. He indicated "I've never had any problems with the [name brand of the mechanical lift], but now I get pretty nervous about using the [name brand of the mechanical lift]."</p> <p>On 9-1-15 at 3:30 p.m., the DON provided a copy of CNA #1's personnel file. It contained a copy of the following items:</p> <ul style="list-style-type: none"> - A job description, signed and dated by CNA #1 on 7-23-15. The job description indicated, "...Transfer...Obtains assistance of another staff member if needed before starting to transfer a resident...Observes and immediately reports to Charge Nurse, unusual occurrences, significant changes in resident's physical or behavioral condition...Immediately reports fall/injury of a resident or self to Charge Nurse...Ensures that each Nursing Assistant has been given report regarding his/her residents at the beginning of each shift..." -A skills procedure for "Falling/Fainting." The procedure indicated, "1. Call for nurse and stay with resident...3. Do NOT move resident..." It indicated CNA #1 successfully completed this procedure, 			

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	<p>but was undated.</p> <p>-A skills procedure for "Mechanical Lift." The procedure indicated, in bold print and at the beginning of the procedure, "NOTE: Two (2) staff is [sic] required at all times when using a mechanical lift." It indicated CNA #1 successfully completed this procedure on 8-3-15.</p> <p>On 9-2-15 at 1:05 p.m., the DON provided a copy of CNA #2's personnel file. It contained a copy of the following items:</p> <p>- A job description, signed and dated by CNA #2 on 3-11-15. The job description indicated, "...Transfer...Obtains assistance of another staff member if needed before starting to transfer a resident...Observes and immediately reports to Charge Nurse, unusual occurrences, significant changes in resident's physical or behavioral condition...Immediately reports fall/injury of a resident or self to Charge Nurse...Ensures that each Nursing Assistant has been given report regarding his/her residents at the beginning of each shift..."</p> <p>-A skills procedure for "Falling/Fainting." The procedure indicated, "1. Call for nurse and stay with resident...3. Do NOT move resident..." It indicated CNA #2 successfully completed this procedure</p>			

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F 9999 Bldg. 00	<p>4-11-15. -A skills procedure for "Mechanical Lift." The procedure indicated, in bold print and at the beginning of the procedure, "NOTE: Two (2) staff is [sic] required at all times when using a mechanical lift." It indicated CNA #2 successfully completed this procedure on 4-11-15.</p> <p>This Federal tag relates to Complaint IN00180604.</p> <p>3.1-14(i)</p> <p>3.1-13 ADMINISTRATION AND MANAGEMENT</p> <p>(g)(1) Immediately informing the division by telephone, followed by written notice within twenty-four (24) hours of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents.</p> <p>This state rule was not met as evidenced by:</p> <p>Based on interview and record review, the facility failed to report a resident fall from a wheelchair or from a mechanical lift for 1 of 3 residents reviewed for falls</p>	F 9999	<p>F 9999 FINAL OBSERVATIONS The facility respectfully requests a face-to-face IDR for F323 and F999 as the facility disagrees with the scope and severity of the deficiencies. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? ·Resident B no longer resides in this facility How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? ·All residents have the potential to be effected by the alleged deficient practice.</p>	09/23/2015			

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	<p>of a resident diagnosed with paraplegia to the Indiana State Department of Health (ISDH) as an unusual occurrence. This deficient practice has the potential to adversely affect the physical and mental health and well-being of a resident dependent on facility staff for transfers. (Resident #B)</p> <p>Findings include:</p> <p>Resident #B's clinical record was reviewed on 9-1-15 at 11:15 a.m. His diagnoses included, but were not limited to, paraplegia, schizophrenia, diabetes, epilepsy and a history of urinary tract infection.</p> <p>Review of his admission Minimum Data Set assessment, dated, 6-21-15, indicated he required extensive assistance of 2 or more persons for bed mobility and transfers, is unable to walk and used a wheelchair for mobility. It indicated he is moderately cognitively impaired. It indicated he had no falls in the 6 months prior to admission and none since admission.</p> <p>Review of the September, 2015 recapitulation orders indicated he had been physician ordered to use a mechanical lift with two assists (persons) for transfers since admission to the</p>		<p>·All staff will be in-serviced on the Incident Reporting Policy Certified Facilities by the CEC/designee by 9/23/15.</p> <p>·Corporate Consultant in-serviced the ED on the Incident Reporting Policy on 9-16-15.</p> <p>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?</p> <p>·All staff with be in-serviced on the Incident Reporting Policy Certified Facilities by the CEC/designee by 9/23/15.</p> <p>·DNS/designee will review the Facility Activity Report daily including fall events to identify any occurrence that may be considered a reportable incident and consult with the Executive Director to determine if the event is reportable to ISDH and if applicable to local law enforcement per CMS and ISDH guidelines.</p> <p>·Corporate Consultant will in-serviced the ED on the Incident Reporting Policy on 9-16-15.</p> <p>·CEC/designee will in-service all new employees on the Incident Reporting Policy upon hire and then yearly thereafter.</p> <p>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?</p> <p>·A Fall Management CQI tool will be completed weekly times 4</p>		

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	<p>facility.</p> <p>Review of a "Fall Event" report, dated, 8-12-15 at 3:05 p.m., indicated Resident #B reported to facility staff that on 8-11-15, during the evening shift, he had "slid out of w/c [wheelchair] during a transfer, landing on his bottom." Associated documentation indicated the report by the resident to the staff member occurred at 11:26 a.m. A physical assessment shortly thereafter indicated no injuries. The attending physician was notified of the fall and ordered xrays on-site "stat," or immediately of the lower back, bilateral hips and lower extremities. Due to the quality of the xrays, the attending physician requested the resident be sent to the local emergency room for evaluation and treatment. Resident #B returned to the facility within 3 hours and was found to have a contusion (bruise) to the right hip with no identified fractures.</p> <p>In an interview with the Director of Nursing (DON) on 9-1-15 at 1:05 p.m., she indicated the CNA who was working with Resident #B on the evening shift of 8-11-15 was a new CNA who had been working at the facility for a week or so. She indicated she had completed her skills orientation. She indicated, upon interview with CNA #1, after the fall, she</p>		<p>weeks, monthly times 6, and quarterly thereafter for one year. Data will be submitted to the CQI committee for follow up.</p> <p>·If threshold of 95% is not achieved an action plan will be developed to ensure compliance.</p> <p>By what date will systematic changes be completed?</p> <p>·All systematic changes will be completed by 9/23/15.</p>	

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	<p>was told that the resident was up in his w/c with the sling of the mechanical lift under him. She attached the sling straps on one side of the mechanical lift "and as she was walking around the w/c, he began to slip out. She said she lowered him to the floor. Then she got another CNA to help her get him back into his chair and to bed." She indicated the other CNA assumed the (licensed) nurse had already been notified and checked him out (assessed the resident for injuries). "However, the new CNA hadn't notified the nurse. She said she was new and just kind of got confused." She indicated CNA #1 was terminated "due to the fact the fall occurred, the new CNA failed to report it and failed to follow our policy on two assists [persons] with [name brand of the mechanical lift]." She indicated CNA #2 was counseled on reporting of unusual occurrences, including falls, to the immediate supervisor. On 9-1-15 at 2:45 p.m., the DON indicated this situation had not been reported to the ISDH as an unusual occurrence due to the lack of injury to Resident #B.</p> <p>In a telephone interview with CNA #2 on 9-1-15 at 3:00 p.m., she indicated CNA #1 had asked her to assist in getting Resident #B back into bed as he had slipped out of the w/c on the pad and</p>			

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	<p>CNA #1 then lowered him to the floor. She indicated, "He is a 2 person assist with the [name brand of the mechanical lift]. We always use 2 people with [name brand of the mechanical lift] and I know that's how she was trained [at the facility]." She indicated CNA #1 had been employed approximately one to two weeks at the facility. She indicated she and CNA #1 used the mechanical lift to get the resident placed into bed. "She kind of indicated to me that she was going to report this to the nurse after we got him back to bed. We kept asking him if he was okay or hurt and he said he was fine. Didn't see any redness or swelling." She indicated, "Normally, if I would have lowered somebody to the floor, I would tell the nurse as soon as possible. I was surprised the new CNA hadn't done this."</p> <p>In an interview with Resident #B on 9-2-15 at 9:20 a.m., he indicated he recently had a fall which involved a new CNA, CNA #1. "She tried to put me to bed with the [name brand of the mechanical lift] by herself. At the time, I didn't know they [the facility] always uses two people [to assist] with [name brand of the mechanical lift]. I just assumed she knew what she was doing." He indicated CNA #1 connected the sling incorrectly to the mechanical lift. "As she started the [mechanical] lift up in the</p>			

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	<p>air, I fell to the floor." He indicated CNA #1 then went to seek the assistance of someone else. He indicated CNA #2 came to provide assistance. He indicated both CNA's lifted him off the floor by placing their arms under his armpits and raised him off of the floor and onto the bed. He indicated he overheard the two CNA's talking. He indicated, "I heard them say they wasn't going to bother with filing the paperwork or filing a report because it was just extra paperwork."</p> <p>Resident #B indicated he has no sensation/feeling from approximately his diaphragm and below, due to the paraplegia. He indicated he typically has back pain, but has experienced it more since the fall, requiring the use of "as needed" or "PRN" pain medications several times. He indicated "I've never had any problems with the [name brand of the mechanical lift], but now I get pretty nervous about using the [name brand of the mechanical lift]."</p> <p>In an interview on 9-2-15 at 1:05 p.m., the DON indicated it is not a common occurrence for the facility to have a staff member to operate a mechanical lift without a second staff person, to have a fall associated with a mechanical lift, or for a fall not to be reported to the facility's supervisory staff or</p>			

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	<p>administration promptly.</p> <p>On 9-1-15 at 10:25 a.m., the DON provided a copy of a policy entitled, "Reportable Incidents Policy." It was dated August, 2014, and was indicated to be the current policy utilized by the facility. This policy indicated, "All reportable incidents which occur against a resident will be reported to ISDH and if applicable to local law enforcement per CMS and ISDH guidelines. Reportable incidents: A reportable incident is defined as any happening not consistent with the routine operation of the nursing facility, which may have caused or may have the potential for causing injury to residents...All reportable incidents are to be viewed as serious for purposes of investigation and follow-up. Each facility must weigh all relevant facts when determining if the event is reportable. When a reasonable doubt exists in determining if an event is reportable, the event should be reported..."</p> <p>This Federal tag relates to Complaint IN00180604.</p> <p>3.1-13(g)(1)</p>						

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

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