

DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2023	
NAME OF PROVIDER OR SUPPLIER INDEPENDENCE VILLAGE OF AVON		STREET ADDRESS, CITY, STATE, ZIP CODE 182 S COUNTY ROAD 550 E, AVON, , 46123					
(X4) ID PREFIX TAG R 0000	SUMMARY STATEMENT OF DEFICIENCIES...		ID PREFIX TAG R 0000	PROVIDER'S PLAN OF CORRECTION...		(X5) COMPLETION DATE	
	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00415606. Complaint IN00415606 - State Residential Findings related to the allegations are cited at R0117. Survey dates: August 22, 2023 Facility Number: 003902 Residential Census: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 31, 2023.			ATT: Brenda Buroker Director of Division Long Term Care2 North Meridian StreetIndianapolis, Indiana 46204Re: Complaint Survey Independence Village of Avon 182 S County Road 550 E Avon, IN 46123Dear Ms. Buroker, On August 22, 2023, a Complaint survey with complaint no. (IN00415606)and Survey Event ID 1CEB11was conducted by the Indiana State Department of Health. Enclosed please find the Statement of Deficiencies with our facilities Plan of Correction for the alleged deficiency.Please consider this letter and Plan of Correction to be the facility's credible allegation of compliance.We respectfully request a desk review to ensure that the facility has achieved substantial compliance with the applicable requirements as of the date set forth in the Plan of Correction of Sept 21, 2023.Please feel free to call me with any further questions at 317-745-2766 Respectfully submitted,Romeo Behl			

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			Independence Village of Avon 182 S County Road 550 E Avon, IN 46123	
R 0117	Personnel - Deficiency 410 IAC 16.2-5-1.4(b) (b) Staff shall be sufficient in number, qualifications, and training in accordance with applicable state laws and rules to meet the twenty-four (24) hour scheduled and unscheduled needs of the residents and services provided. The number, qualifications, and training of staff shall depend on skills required to provide for the specific needs of the residents. A minimum of one (1) awake staff person, with current CPR and first aid certificates, shall be on site at all times. If fifty (50) or more residents of the facility regularly receive residential nursing services or administration of medication, or both, at least one (1) nursing staff person shall be on site at all times. Residential facilities with over one hundred (100) residents regularly receiving residential nursing services or administration of medication, or both, shall have at least one (1) additional nursing staff person awake and on duty at all times for every additional fifty (50) residents. Personnel shall be assigned only those duties for which they are trained to perform. Employee duties shall conform with written job descriptions. Based on observation,	R 0117	R0117 Personal Deficiency The facility requests paper compliance for this citation. <i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies.</i> <i>The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> <i>1)Immediate actions taken for those residents identified:</i>	09/21/2023

interview, and record review, the facility failed to ensure personnel were trained and demonstrated competency in the use of a mechanical lift prior to providing care to 1 of 1 residents reviewed for mechanical lifts (Resident B)

Findings include:

On 8/22/23 at 11:00 a.m., the resident's family member arrived to visit the resident. She indicated the staff turnover was high and they did not pay attention to how to get him up in the chair. They had never dropped him, but he had felt like he would fall out of the mechanical lift pad. When staff had first started using the lift pad, they often had it on wrong and they did not know how to use it. She had to leave notes posted on the walls regarding how to use the lift for the staff. The resident indicated he did not believe the staff had been trained to use the lift by the way they transferred him.

During an observation of Resident B in his room on 8/22/23 at 10:54 a.m., the Resident had a sit to stand mechanical lift in his room and a mechanical lift in his bathroom. He was alert and oriented, and up in an electric wheelchair. He had just completed his shower and had finished dressing. The hospice aides were present.

Resident B was reassessed for the mechanical lift by Wellness Director/Designee.

In-service and education provided to all nursing direct care staff on use of Hoyer lift and mechanical lift.

2)How the facility identified other residents:

Any resident residing in the facility had the potential to be affected.

Audit completed on residents with change in condition to identify if resident will need to use mechanical lift for transfer.

3)Measures put into place/ System changes:

WD will In-service all new nursing staff members on mechanical lift upon hire and annually. WD will review/audit 2 nursing staff members' file once a week for 1 month and then 1 nursing staff member x 1 for 3 months to ensure In-service on mechanical lift and skills checklist has been completed.

The hospice aide indicated the staff at the facility got the resident up with the mechanical lift and the hospice agency staff provided his personal care when they are there. The aide was not sure if the hospice agency provided education on using the mechanical lift or if the education was provided by the facility staff. She indicated the hospice company did provide a lot of education to the staff regarding care for the hospice patient. The resident was directing care needs as the hospice staff was preparing him for the day. The resident indicated he had some CNA's who got him up and did not know how to use the lift properly. He was unable to recall the names of the staff. He indicated due to constant change in staff he could not remember who everyone was.

On 8/22/23 at 11:33 a.m., review of medical record indicated the resident had a diagnosis of but not limited to, functional quadriplegia dated 1/5/2021. He began hospice services on 7/11/23. A service plan, dated 6/11/2020, indicated the use of a lift for transfers to transfer safely with assistance of 2 persons. Staff were to report any changes in ability to transfer to the nurse. The resident was unable to get in and out of bed, chair, car etc., without total physical assistance

4)How the corrective actions will be monitored:

WD/Designee will be responsible for this plan of correction and Audit findings will be presented to the QAA Committee monthly x 6 months. The results of these audits will be reviewed in Quality Assurance Meeting monthly for 6 months or until 100% compliance is achieved x3 consecutive months. The QA Committee will identify any trends or patterns and make recommendations to revise the plan of correction as indicated.

5)Date of compliance: 9/21/2023

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from staff.

On 8/22/23 a confidential interview indicated the only resident at the facility who required total assist was Resident B and the staff used a mechanical lift to transfer him.

On 8/22/23 a confidential interview indicated there was one resident who required maximum assist to transfer, and some maximum assistance with care was provided to Resident B. A mechanical lift was used to transfer him as needed. When they started with the facility they had not been provided any training or skills evaluation to use the lift.

On 8/22/23 a confidential interview indicated there was only one resident whom they used the mechanical lift, Resident B. They knew how to use the lift due to previous experience as a CNA, but training or skills evaluation to use the lift was not provided when hired or in orientation at the facility.

On 8/22/23 at 10:05 a.m., the Wellness Director indicated they had a few residents who required max assist of one person with care. There was one resident, Resident B, who required transfer assistance with a mechanical lift. She indicated he was a hospice resident, and

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the hospice company provided the mechanical lift. All training and competency of the facility staff was completed by the hospice agency for any staff who utilize the mechanical lift. Residents were allowed to stay in assisted living even when they required total care if they received hospice care services. The facility did not train the staff on use of mechanical lifts because hospice provided it.

On 8/22/23 at 12:15 pm the Wellness Coordinator provided a document titled, "Training," and a handwritten title at the top indicated "Hoyer Lift 4/7/23. The document was signed by care staff. In addition, she provided a document titled, "Step Program: Full Body Mechanical Lift (Hoyer) and indicated this was part of the in-service education material provided to the care staff. Attached was a document titled, "Competency Check: Total Mechanical Lift (Hoyer) and indicated this was the competency evaluation for the care staff. The document was undated and unsigned by care staff.

On 8/22/23 at 12:15 p.m., the Wellness Coordinator provided a Training Requirements Policy, dated 2/21/23, and indicated the policy was the one currently being used by the facility. Policy "...Standard Operating Procedure ...Initial orientation

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must include...2. Prior to working independently, each employee must be given an orientation to the community by the supervisor (of his or her designee) of the department in which the employee will work. This orientation must include...f. All staff must have orientation to their specific job skills. Annual training must include ...3. The frequency and content of in-service education and training programs must be in accordance with the skills and knowledge of the facility personnel"

On 8/22/23 at 12:15 p.m., the Wellness Coordinator provided a Safety Based Transfer and Movement Ergonomic Program (STEP), dated 2/21/23, and indicated the policy was the one currently being used by the facility. Policy indicated, "...Standard Operating Procedure ...1. Purpose. The purpose of the safety-based Transfer and Movement Ergonomic Program (STEP) is to promote safety and reduce injuries for both residents and care staff during transfers, when providing assistance, using mechanical lifts and helping with repositioning ...Training ...1. All care staff shall receive training on resident transfers and repositioning during initial orientation and at least annually thereafter. Additional training shall be provided as needed to

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reinforce proper use/understanding for resident transfers and repositioning and use of mechanical assistive devices. 2. Care staff members shall successfully complete a proper return demonstration for resident transfers and repositioning. 3. Documentation of training and successful return demonstration of transfers and repositioning shall be kept in the care staff's employee file"

This State tag relates to Complaint IN00415606.

Based on observation, interview, and record review, the facility failed to ensure personnel were trained and demonstrated competency in the use of a mechanical lift prior to providing care to 1 of 1 residents reviewed for mechanical lifts (Resident B)

Findings include:

On 8/22/23 at 11:00 a.m., the resident's family member arrived to visit the resident. She indicated the staff turnover was high and they did not pay attention to how to get him up in the chair. They had never dropped him, but he had felt like he would fall out of the mechanical lift pad. When staff had first started using the lift pad, they often had it on wrong and they did not know how to use it. She had to leave notes

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This State tag relates to Complaint IN00415606.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting provided it is determined that other safeguards provide sufficient protection to the patients. (See instructions.)

LABORATORY DIRECTOR'S OR
PROVIDER/SUPPLIER REPRESENTATIVE'S
SIGNATURE

TITLE

(X6) DATE