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

FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155763	A. BUILDING 00 B. WING	03/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
NORTH RIDGE VILLAGE NURSING & REHABILITATION CENTE	600 TRAIL RIDGE RD ALBION, IN 46701

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00348172. Complaint IN00348172- Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey dates: March 18 and 19, 2021 Facility number: 011296 Provider number: 155763 AIM number: 200827620 Census Bed Type: SNF/NF: 30 Total: 30 Census Payor Type: Medicare: 3 Medicaid: 20 Other: 7 Total: 30 This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed March 22, 2021	F 0000	This plan of correction is to serve as North Ridge Village Nursing and Rehab's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by North Ridge Village Nursing and Rehab or its management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in the facility, nor does this submission constitute an agreement or admission of the survey allegations.	
F 0689 SS=G Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 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 disclo 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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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure adequate care, supervision and safety measures were in place to prevent accidents during transfers for 2 of 3 residents (Resident B and Resident C) reviewed for accidents. This resulted in the residents experiencing falls with injuries including fracture. Findings include: 1. The clinical record for Resident B was reviewed on 3/18/21 at 10:30 A.M. Diagnoses included, but were not limited to, morbid obesity, fusion of spine, and hemiplegia and hemiparesis. A Minimum Data Set (MDS) assessment from 1/25/21, indicated Resident B had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). A care plan problem initiated on 10/18/19, indicated Resident B had impaired physical mobility related to hemiplegia/hemiparesis, discitis, and spinal fusion. Interventions included, but were not limited to, required 2 person assistance with the Hoyer lift for transfers. A nurse's progress note dated 2/21/21 at 10:45 A.M., indicated Resident B had fallen and had a laceration that was 3.3 centimeters by 0.1 centimeters on the left side of her head. Resident B was alert and orientated at the time. The nurse practitioner was notified, and a new order was received to send Resident B to the emergency room for evaluation and treatment. A nurse's progress note dated 2/21/21 at 12:02	F 0689	**1. CORRECTIVE ACTIONS FOR AFFECTED RESIDENTS:** *Identified, affected residents using lifts and/or trapeze devises will have care plans updated. Additionally, all nursing staff (nurses, C.N.A.'s, QMA's) will be educated regarding proper use of lifts & trapeze assistive devices (see attached Mechanical Lift policy [3/22/21, 4/12/21, 4/13/21] & Trapeze Use Procedure [3/20/21, 4/12/21, 4/13/21]). All current residents using lifts or trapeze will be educated on proper use.* **2. METHODS FOR IDENTIFICATION OF OTHER POTENTIALLY AFFECTED RESIDENTS:** *All current residents using lifts and/or trapeze devises will have care plans updated. Additionally, all nursing staff (nurses, C.N.A.'S, QMA'S) will be educated regarding proper use of lifts & trapeze assistive devices (see attached Mechanical Lift policy [3/22/21, 4/12/21, 4/13/21] & Trapeze Use Procedure [3/20/21, 4/12/21, 4/13/21). All current residents using lifts or trapeze will be*	04/18/2021

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	P.M., indicated the emergency room called the facility, indicated Resident B had a cervical fracture. A CT (Computerized Tomography Scan) of the resident's Cervical Spine dated 2/21/21, provided by Medical Records on 3/19/21 at 2:36 P.M., indicated Resident B had an acute appearing type 2 odontoid fracture (a break in the second cervical vertebra C2). During an observation on 3/18/21 at 11:21 A.M., Resident B was sitting in a wheelchair and she had a brace on her neck. Resident B was interviewed on 3/18/21 at 11:21 A.M. During the interview Resident B indicated when she fell out of the lift on 2/21/21 there was only one staff member present transferring her. Prior to that day there had always been two staff members present when she was transferred with the lift. Resident B indicated the straps were stiff and she thought one had come up over the metal holder while she was being transferred. Resident B indicated she was paralyzed and always used the mechanical lift for transfers. Certified Nursing Assistant (CNA) 2 was interviewed on 3/18/21 at 12:18 P.M. During the interview CNA 2 indicated she was with Resident B when she fell out of the lift on 2/21/21. CNA 2 indicated she had been working at the facility since January and she had been trained on how to use the lift during orientation. She indicated she knew 2 staff were supposed to be present when using the lift. On the day she transferred Resident B by herself, she was unable to find another staff member to help her, so she decided to transfer the resident by herself. She indicated all of the loops were on the mechanical lift correctly. When she		*educated on proper use.* **3. MEASURES TO PREVENT RECURRANCE:** *During nursing department orientation, new nursing employees (nurses, C.N.A.'S, QMA'S) will be educated regarding the proper use of lifts and trapeze assistive devices (see attached Mechanical Lift Policy & Trapeze Use Procedure). All future residents using a lift or trapeze assistive device will be educated on proper use, based on their cognitive status.* **4. CORRECTIVE ACTIONS MONITORING:** *The DON or designee will monitor at least 3 hoyer lift transfers and the use of 3 trapeze assistive devices per week and provide a monthly report, reflecting 1) monitoring of proper use of lifts and trapeze 2) Education of new nursing employees (nurses, C.N.A.'s, QMA's) during orientation (see attached Mechanical Lift Policy & Trapeze Use Procedure) 3) resident education, based on cognitive status, for those using lifts and/or trapeze assistive devices to the QAPI Committee on an on-going monthly basis with a goal to achieve 100% compliance monthly*	

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	started transferring Resident B she thinks a loop came out of the metal holder. Resident B fell forward and hit her head on the desk and then fell to the floor. CNA 2 indicated she knew she should have waited for another staff member to help transfer Resident B. The Director of Nursing (DON) was interviewed on 3/18/21 at 1:55 P.M. During the interview the DON indicated 2 staff members should be present when transferring residents with the mechanical lift. She indicated when Resident B fell out of the lift only CNA 2 was present. The DON indicated CNA 2 was in a hurry and she should have waited for another staff member to help her transfer Resident B with the mechanical lift. A Bariatric Patient Lift User Manual, provided by the DON on 3/19/21 at 2:56 P.M., indicated "SAFETY PRECAUTIONS IMPORTANT: Before using patient lift, please read and adhere to the following safety precautions and warnings. Failure to do so could result in serious personal injury or damage to your patient lift ...WARNING: [Manufacturer] strongly recommends that two caregivers take part in the lifting process." A policy, dated 10/2014, was provided by the DON on 3/18/21 at 12:05 P.M., titled "Mechanical Lift." The policy indicated " ...A mechanical lift is to be utilized for residents who are too heavy to be moved by one person, or who are disabled to the point of inability to assist with transfers. Two (2) personnel members must be present when a mechanical lift is utilized." 2. The clinical record for Resident C was reviewed on 3/18/21 at 11:30 A.M. Diagnoses included, but were not limited to, severe morbid obesity, pain in left and right knee, muscle weakness, history of		*for all new nursing employee (nurses, C.N.A's, QMA's) orientations and residents using lifts and trapeze devices are provided proper use education consistently. The QAPI committee will review monthly and compare the actual percentage compliance with the percentage compliance goal of 100% and make any further necessary recommendations to ensure future incidents are prevented based on achieved compliance percentage if less than the 100% compliance goal.*	

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	falling, and difficulty walking. A Minimum Data Set (MDS) assessment from 12/3/20, indicated Resident C had a Brief Interview for Mental Status (BIMS) score of 15 (cognitively intact). A physician's order dated 2/5/21, indicated Resident C was to have a trapeze over bed to assist with bed mobility. A nurse's progress note dated 2/8/21 at 12:31 P.M., indicated Resident C could not stand any longer and slowly fell to the floor. Resident C had complaints of ankle pain and was sent to the emergency room for evaluation and treatment. A nurse's progress note dated 2/17/21 at 4:33 P.M., indicated Resident C returned to the facility with an intact dressing to his left lateral knee and an ace wrap to his left lower extremity. Hospital notes dated 2/8/21 provided by the DON on 3/19/21 at 2:43 P.M., indicated Resident C was at the hospital due to a fall, and had a closed fracture of the left fibula and tibia. During an observation on 3/19/21 at 12:06 P.M., Resident C was lying in bed. An overbed trapeze triangle was in the middle of the bed and was about 3 feet above the bed.just put with interview below Resident C was interviewed on 3/19/21 at 12:06 P.M. During the interview Resident C indicated that an overhead trapeze had been installed and 2 days later he fell while using it. Resident C indicated the facility put the trapeze in the room, but noone trained him on what it was for or how to use it. He indicated that on the day he fell, there			

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	were 2 CNAs in the room helping him stand up from his wheelchair. He indicated the CNAs told him to use the trapeze to help him stand up from the wheelchair. He indicated that when he was standing holding on to the trapeze it didn't feel right and he was in an awkward position. His grip loosened on the trapeze and he fell. He indicated that a wheelchair was usually close so if he fell back he would have the wheelchair to sit in. He indicated the wheelchair was placed further away than usual and when he asked for the wheelchair it did not get behind him in time and he fell. Resident C indicated he ended up breaking his leg due to the fall. A signed statement by CNA 4 dated 2/10/21 indicated CNA 4 and another CNA were in Resident C's room providing care on 2/8/21. Resident C was unable to stand using his walker with assistance from CNA 4 and co-worker. Resident C wanted to use the trapeze to help him stand. Resident C had been educated that the trapeze was not to be used for transfers and he used it anyway. Resident C pulled himself to a standing position. Resident C said he had to sit down. CNA 4 and co-worker started to move the wheelchair under him and at the same time he fell to the ground. Nurse Aide 3 was interviewed on 3/19/21 at 1:17 P.M. During the interview Nurse Aide 3 indicated she was one of the aides helping Resident C transfer on 2/8/21 when he fell. Nurse Aide 3 indicated Resident C suggested he use the overhead trapeze to help him stand up from the wheelchair. Nurse Aide 3 indicated her and the other CNA in the room told Resident C sure he could try the overbed trapeze bar to help him stand up. Nurse Aide 3 indicated they did not say anything to the resident at that time about not			

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using the trapeze or that it was not to be used for transfers. Nurse Aide 3 indicated that using the overhead trapeze put Resident C in an awkward position which may have contributed to his fall. Nurse Aide 3 also indicated the wheelchair was not as close as it usually was, and it took longer to pull around which also may have contributed to the fall. Nurse Aide 3 indicated she had not been trained on how to use the trapeze prior to the fall. Nurse Aide 3 indicated she did not know that the trapeze was used for bed mobility and was not supposed to be used for transfers. Nurse Aide 3 indicated she was educated on the purpose of the trapeze after the fall occurred.

CNA 4 was interviewed on 3/19/21 at 2:18 P.M. During the interview CNA 4 indicated she was one of the aides helping Resident C transfer on 2/8/21 when he fell. CNA 4 indicated they put Resident C's wheelchair close to the bed so he could use the trapeze to assist him to stand. The trapeze was hanging over his bed and they figured he could use it to help stand. CNA 4 indicated they did not say anything to the resident at that time about not using the trapeze or that it was not to be used for transfers. CNA 4 indicated she did not know the trapeze was only to be used for bed mobility and not for transfers. CNA 4 indicated she was trained on use of the trapeze after Resident C fell.

Therapy Assistant 5 was interviewed on 3/19/21 at 12:22 P.M. During the interview Therapy Assistant 5 indicated there was no documented recommendation for a trapeze for Resident C from therapy. She also indicated if therapy recommended a trapeze for a patient, patient education would occur, and it would be documented their notes.

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	The DON was interviewed on 3/19/21 at 12:29 P.M. During the interview the DON indicated she had talked with Therapy Assistant 5 about a trapeze for Resident C before they put it in his room. The DON indicated a resident would receive education regarding the trapeze before using it and would be documented in therapy notes. The DON indicated a trapeze is used for bed mobility and should not be used for transfers. The DON indicated when a resident received a new device like the trapeze, staff would be trained on how to use it. The DON indicated there was no documentation to indicate Nurse Aide 3 and CNA 4 were trained on how to use the trapeze prior to Resident C's fall. The DON indicated she had spoken with a different person from therapy about the trapeze not Therapy Assistant 5. The DON indicated she and another staff member trained Resident C on how to use the trapeze. She indicated she could not remember the other staff member that was with her at the time he was educated. The DON indicated the education was documented on a 24 Hour paper note. A 24 Hour/Change of Condition Report dated 2/5/21 was provided by the DON on 3/19/21 at 2:10 P.M. The 24 Hour/Change of Condition Report indicated Resident C would receive a trapeze with education to resident. No further information about the education was documented. Bariatric Trapeze Assembly and Operation Instructions provided by the Maintenance Director on 3/19/21 at 3:08 P.M., indicated " ...SAFETY GUIDELINES- PLEASE READ BEFORE USE ...INTENDED USE The [Bariatric Trapeze] is intended to assist in repositioning oneself in bed. WARNING: The trapeze is intended to be used ONLY as an assistive device- that is, to enable patients to more easily and safely reposition			

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	themselves. It is not intended to bear entire body weight." This Federal citation is related to Complaint IN00348172. 3.1-45(a)(2)			