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| | 155698 | A. BUILDING 00<br>B. WING | 11/03/2022 |

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| BETHANY POINTE HEALTH CAMPUS | 1707 BETHANY RD<br>ANDERSON, IN 46012 |

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| F 0000<br><br>Bldg. 00 | This visit was for the Investigation of Complaints IN00389479 and IN00392796.<br><br>Complaint IN00389479 - Substantiated. No deficiencies related to the allegations were cited.<br><br>Complaint IN00392796 - Substantiated. Federal/State deficiencies related to the allegations are cited at F689.<br><br>Survey dates: November 2 and 3, 2022.<br><br>Facility number: 011045<br>Provider number: 155698<br>AIM number: 200380790<br><br>Census Bed Type:<br>SNF/NF: 26<br>SNF: 25<br>Total: 51<br><br>Census Payor Type:<br>Medicare: 15<br>Medicaid: 24<br>Other: 12<br>Total: 51<br><br>This deficiency reflects State Findings cited in accordance with 410 IAC 16.2-3.1.<br><br>Quality review completed November 4, 2022 | F 0000 | The submission of this plan of correction does not indicate and admission by Bethany Pointe Health Campus that the findings and allegations contained herein are accurate, true representation of the quality of care provided, and the living environment provided to the residents of Bethany Pointe Health Campus. The facility recognizes its obligation to provide legally and medically necessary care and services to its residents in an economic and efficient manner. The facility hereby maintains it is in substantial compliance with all state and federal requirements governing the management of this facility. It is thus submitted as a matter of statute only. The facility respectfully requests from the department a desk review for substantial compliance. | |
| F 0689<br>SS=D<br>Bldg. 00 | 483.25(d)(1)(2)<br>Free of Accident Hazards/Supervision/Devices<br>§483.25(d) Accidents.<br>The facility must ensure that - | | | |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| Jenny McCurdy | RN, Clinical support nurse | 11/18/2022 |

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| | §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>Based on observation, interview and record review, the facility failed to ensure safe mechanical lift transfers for 1 of 2 residents reviewed. (Resident B)<br><br>Findings include:<br><br>Resident B's clinical record was reviewed on 11/2/22 at 9:33 a.m. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting right non-dominant side, other chronic pain, muscle weakness (generalized), difficulty in walking, not elsewhere classified, other abnormalities of gait and mobility, other lack of coordination, age-related physical debility, and unspecified displaced fracture of surgical neck of right humerus and subsequent encounter for fracture with routine healing.<br><br>His orders included hydrocodone-acetaminophen (narcotic pain reliever) 7.5-325 mg, one tablet twice daily and two tablets at bedtime, 1/2 bedrails for bed mobility and to aid in transfers, quarterly lift assessment on the 27th of every third month and sling to his right arm for four to six weeks.<br><br>An 8/16/22, quarterly, MDS (Minimum Data Set) assessment indicated he was moderately cognitively impaired. He required extensive assistance of two staff members for bed mobility, transfers and toilet use. He had an impairment to one side of his upper and lower extremity. | F 0689 | 1. Resident B was affected by alleged insufficient practice; resident B was assessed for safe mechanical lift transfers. Resident reviewed for care planned transfers and care plan was updated to ensure appropriate interventions are in place. Resident physician is aware.<br>2. All like residents have the potential to be affected by the alleged deficient practice. Nursing staff has been educated on proper use of mechanical stand lift. IDT (interdisciplinary team educated on quarterly lift assessment policy. All like residents assessed for appropriate and timely lift evaluations with appropriate updates. All like resident's care plans reviewed to ensure that appropriate mechanical lift is in place.<br>3. As a measure of ongoing compliance, the DHS and/or designee will audit to ensure mechanical lift assessments are current and appropriate for all applicable residents. Audits will be completed on 5 residents per week for 4 weeks, then 3 times per week for 4 weeks, then 1 time per week for 4 months. | 11/19/2022 |

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| | A quarterly lift assessment, dated 6/2/22, indicated a sit to stand lift was recommended for transfers.<br><br>The clinical record lacked a quarterly lift assessment after 6/2/22.<br><br>A CNA care sheet, updated on 9/29/22 and provided by the ED (Executive Director), on 11/3/22 at 1:42 p.m., indicated the resident transferred with the sit to stand lift and used two staff members for transfers.<br><br>An 8/30/22 revised care plan for ADL's (Activity of Daily Living), indicated that the resident had an impairment in functional status regarding transfers, bed mobility, toileting, related to right hemiplegia. His interventions included may use side rails as an enabler to assist with bed mobility created on 8/21/20. The care plan did not included the use of a sit to stand lift. A new intervention for Hoyer lift with transfers created on 11/2/22.<br><br>An undated and unsigned, Investigation Summary for an incident date of 10/16/22, indicated Resident B experienced increased weakness, resulting in his affected side foot, to slip while in mechanical sit to stand lift. There were no complaints of pain. On 10/16, he complained of pain to his right arm. The NP (Nurse Practitioner) was notified, and new orders were received for an x-ray. Pain medication was administered and effective. The immediate action steps taken were that he was assessed for injuries, staff were interviewed, the physician and the resident representative was notified. He had a BIMS (Brief Interview for Mental Status) of 11(moderately cognitive impaired) and his pain level was moderate. The timeline of event was | | DHS and/or designee will complete care plan audits to ensure appropriate mechanical lift is documented. Audits will be completed on 5 residents per week for 4 weeks, then 3 times per week for 4 weeks, then 1 time per week for 4 months.<br>4. As a quality measure, the Executive Director (ED) or designee will review any findings and corrective action at least quarterly in the campus Quality Assurance Performance Improvement meetings. The plan will be reviewed and updated as warranted and will continue until 100% compliance is maintained. | |

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| | 10/12 - he was transferred via sit to stand lift, right foot slipped off the lift. There were no complaints of pain or discomfort. 10/16 - he complained of pain to his right arm. The NP was notified with new orders received for x-ray. 10/17 - he was sent to ER (Emergency Room) for an evaluation/treatment for right humeral neck fracture. He returned from the hospital with a sling in place, orders to wear it for four to six weeks, and follow up with orthopedics. Pain management was in place and effective. The report indicated critical factors *key points campus defense of situation was he was being transferred per plan of care, equipment was being utilized per manufacturer guidelines. The summary of the investigation was he was being transferred per plan of care when his arm slipped during transfer. He did not complain of pain until 10/16/22. The NP was notified and new orders were received. New interventions for therapy to evaluate and treat as indicated and to utilize hoyer lift for transfers.<br><br>A nurses note, completed by the ADON and recorded as a late entry, on 10/17/22 at 4:48 p.m. and dated for 10/12/22 at 12:46 p.m., indicated nursing was notified the resident's affected arm and leg had slipped off the sit to stand lift. He was placed in bed. A pain assessment was completed and he denied pain. A skin assessment was completed with no new areas noted.<br><br>A NP note, recorded as a late entry on 10/18/22 at 12:17 a.m. and dated for 10/14/22 at 12:17 a.m., indicated the resident was seen 10/18/22 for an acute visit for right arm pain. Nursing had asked the Nurse Practitioner to see the resident due to complaints of right arm pain, his stroke residual arm. He often had pain but reported it had become worse about 24 hours ago. He was being transferred from his chair to his bed with an | | | |

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| | assistive device and his footing slipped a bit. He did not fall or significantly break plane of position. There was no impact anywhere in his body. He had always been very protective of his arm due to exaggerated sensation of skin when moving his arm. He did allow the NP to move his arm up and there was no resistance or pain at the shoulder. His radial and brachial pulses were palpable. His arm was warm and capillary refill was brisk. There was no increased swelling. His arm was moveable at the elbow without resistance. His wrist was stiff and finger flaccid but joints stiff as well. His wrist did not produce pain when moved. He reported that the pain had improved today as compared to yesterday. He did allow the NP to elevate his arm on a pillow. He reported the pain was about a 3/10 and it was mostly in the forearm area. He did report that when he turned over and used his left arm to turn, he was not able to tell if his right arm moved appropriately. He felt that he may had his right arm positioned in a bad spot when he turned but did not realize it due to not having feeling. He currently took one Norco (pain reliever) every a.m. and two Norco at night, he had been on this regimen for years. A midday dose would be added. The NP advised that it would be best to go ahead and x-ray his arm just to be sure there was no pathological type of fracture. He often refused recommended interventions and declined this recommendation as well. This was discussed with nursing who would be with him the whole weekend and advised, if he complained of any increased pain or guarding to reinforce recommendation for x-ray. If necessary, the NP would reach out to his daughter for compliance.<br><br>On 10/15/22 at 8:21 p.m., he was up and participating in his normal routine, he denied any complaints of pain or discomfort thus far. | | | |

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| | On 10/16/22 at 3:23 p.m., he complained of pain to his right arm (shoulder, elbow, forearm, upper arm, and hand) and refused to get out of bed. The NP was made aware and new orders were received to obtain an x-ray to his right arm to include shoulder, elbow, upper arm, forearm, and hand. A mobile x-ray company was made aware and awaiting the arrival of the technician. Routine pain medication was given with some relief.<br><br>A patient report from the mobile x-ray company, dated 10/16/22, indicated the impression of the right arm x-ray was an acute fracture of humerus neck.<br><br>A NP note, recorded as a late entry on 10/18/22 at 12:42 a.m. and dated for 10/17/22 at 12:41 a.m., indicated he was seen for a fracture of the proximal neck of his right humerus. He developed pain and complained about it initially to the NP last Friday. He denied any type of fall, particularly no impact fall and staff confirmed this. He had hemiparesis of the right arm. He declined recommendation for an x-ray at that time. He stated that the pain had improved over the past few days. The NP discussed with nursing who would be present and caring for him over the weekend to notify if pain developed and reinforce the recommendation for an x-ray. If declining an x-ray continued, to reach out to his daughter to encourage him to allow for an x-ray. He did, in fact, develop more pain, particularly with attempts to reposition and did allow for an x-ray that showed a humerus neck fracture. He was sent to the ER for evaluation due to lack of provoking event to warrant fracture. He was seen in the ER and in review of notes appeared to be error in report of events. ER notes stated that he fell while being transferred. Specifically, that he fell due to being transferred with the assistance of one nurse | | | |

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| | when he required two. This was inaccurate. He was never transferred by nursing. He was assisted using a transfer device that was always operated by one nurse/aide. He was never manually transferred, even by two people, due to discomfort in manual transfer and the risk for injury. He reported last week he was being transferred with an assistive device and one nursing assistant trained on the device and his foot slightly slipped. There was no significant brake in plane of position, no impact, no hyper extension occurred. No manual under the arm transfer by one or two staff members has occurred. Transfers only occur with assistance of transfer device with one trained nursing aide per regulations. He did report reduced sensation on the right side. Based on the location of the fracture, it was believed this was secondary to osteoporosis/osteopenia of an aged epiphyseal plate and atrophy of surrounding muscle and tissue. NP would continue with plans to splint the arm and have him follow up with orthopedics and add vitamin D as he did have worsening renal function. Vitals remained stable. His pain was controlled with Norco.<br><br>A hospital x-ray of right humerus minimal two views, dated 10/17/22 at 12:50 p.m., indicated the findings were a humeral neck fracture which was minimally displaced. There was no obvious soft tissue swelling or defect. The impression indicated minimally displaced humeral neck fracture.<br><br>On 10/17/22 at 4:43 p.m., the facility was notified of the x-ray result. The NP, DHS (Director of Health Services), ED and POA (Power of Attorney) was notified. POA requested the resident to be sent to ER, the resident was agreeable. | | | |

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| | On 10/17/22 at 5:00 p.m., the resident returned from the ER evaluation. An x-ray was completed with confirmed proximal humeral neck fracture. His right arm was placed in a sling and new orders were received to repeat imaging in four to six weeks. He was to wear a sling for four to six weeks and to follow-up with the primary care doctor or orthopedic specialist.<br><br>An IDT (Interdisplinary Team) note, dated 10/18/22 at 9:40 a.m., indicated MDS and DHS met to discuss the resident's pain and musculoskeletal event. He previously was transferred with a sit to stand lift and the right affected arm and leg slipped off of the lift. He denied pain at the time, a few days later, he was complained of pain on his right affected side, x-rays were completed, the results returned of right humeral neck fracture. He was sent to the ER and returned with a sling in place. The intervention was that he to be transferred with hoyer lift. Nursing would continue to monitor. The NP and family were aware.<br><br>During an observation of Resident B, on 11/2/22 at 10:45 a. m., he was observed lying in bed with his right arm in a sling.<br><br>During an interview, QMA 5 on 11/2/22 at 1:21 p.m. indicated CNA 9 was getting Resident B up with the sit to stand lift. She saw his call light on. When she went to answer the call light CNA 9 she was coming out of his room to get help and they met at the doorway to his room. She observed Resident B hanging in the sling and she told CNA 9 they had to get him out of the sling. They got the sling off and lowered the resident to the floor. The sling was pulled high up under his underarms. His right side was affected and he | | | |

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| | tried to hang on with his left arm. There should be two staff members. They lowered him to the floor, went to get more help and could got him into his wheelchair. It took four staff members, CNA 9, herself and two other CNAs to get him up. CNA 9 was transferring him from his bed to his recliner. He did not complain of any pain at that time. Her nurse (LPN 12) was not on the unit, so she told her as soon as she could. She told the nurse on the opposite hall and the nurse did not assess him before they got him up off the floor. She normally would have had the nurse assess him before they got him up.<br><br>During an interview with CNA 9, on 11/2/22 at 1:33 p.m., she indicated she was transferring Resident B from his bed to his recliner and as she was moving him from the bed to the recliner his right foot on his affected side slid from the sit to stand lift. She put his right foot back onto the lift. He started to move around because he was afraid he was going to fall, moved his left leg, then it slipped off the lift and then his right leg slipped off the lift again. The sling was up under his armpits. He was hanging by the lift pad, his knees were bent and his feet were touching the ground. She asked the resident's roommate to turn on the call light and no one came. She started to go out of the room to get help, when QMA 5 came to the door. QMA 5 indicated it was better that they lowered him to the floor in the lift. They lowered the lift down as far as it would go and removed the lift pad from around him. A nurse did not assess him before they lifted him from the floor. It took four staff members to lift him off the floor and get the resident into his recliner. He did not complain of any pain. He should have been transferred with two people. She transferred him by herself because he had been asking for about an hour to get up, he was impatient, and no one | | | |

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| | was able to help her so she decided to get him up by herself. He didn't say he was in pain and was telling them to hurry up, so she assumed he was in pain.<br><br>During an interview with LPN 12, on 11/2/22 at 3:42 p.m., she indicated she was not aware of the incident until the next day.<br><br>During an interview on 11/3/22 at 1:24 PM, CNA 7 and CNA 13 indicated it was required for them to use two staff members with the sit to stand lifts and they should always strapped the resident legs to the lift.<br><br>During a follow up interview with QMA 5, on 11/3/22 at 1:52 p.m., she indicated Resident B's feet were off the sit to stand lift when she entered his room, she did not remember unhooking the straps for his legs from the lift and she didn't think he had them on.<br><br>During an interview the ADON on 11/3/22 at 2:04 p.m., indicated Resident B did not start complaining of pain until the weekend. She believed she found out about the incident on Monday, 10/17/22 but couldn't be 100% certain. The resident did have a pain event completed on the 16th. She was aware there was only one CNA who transferred him. According to the manufactures guidelines they could use one staff member for the mechanical lifts. If they chose to use a second person, then it was the facility's preference.<br><br>A review of the User Instruction Manual for the sit to stand lift was provided by the Executive Director, on 11/3/22 at 2:42 p.m. The manual was ambiguous to the specifications related to assistance needed for transfers while using the | | | |

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| | mechanical lift.<br><br>A current policy titled, "Guidelines for Resident Utilizing a Lift," provided by the Executive Director, on 11/3/22 at 1:42 p.m., indicated the following: "Procedures...1. The Lift Evaluation will be completed quarterly by nurse if device is used...3. All devices are safe to be used by one staff member per manufactures guidelines. Staff should seek the assistance of a second staff person for those residents' care planned for assistance of two with the lifting device or as needed for safe handling...."<br><br>This Federal tag relates to complaint IN00392796.<br><br>3.1-45(a)(1) | | | |