STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155836	A. BUILDING _____ B. WING _____	C 08/26/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CUMBERLAND TRACE HEALTH & LIVING COMMUNITY	1925 REEVES ROAD PLAINFIELD, IN 46168

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F 000	INITIAL COMMENTS This visit was for the Investigation of Complaint IN00388163. Complaint IN00388163 - Substantiated. Federal/state deficiencies related to the allegations are cited at F689. Survey dates: August 25, and 26, 2022 Facility number: 013455 Provider number: 155836 AIM number: 201293440 Census Bed Type: SNF/NF: 68 SNF: 30 Residential: 62 Total: 160 Census Payor Type: Medicare: 17 Medicaid: 45 Other: 36 Total: 98 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on September 7, 2022.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §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	F 689		

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

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F 689	Continued From page 1 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure a resident was mechanically transferred using proper technique for 1 of 3 residents reviewed for falls with injury resulting in actual harm when a resident fell during a Hoyer lift transfer and obtained multiple right leg fractures and a displaced fracture of the spine in lumbar 4 (L4) (Resident B). Findings include: On 8/25/22 at 2:08 p.m., Resident B was observed, at a different skilled nursing home facility, lying in bed with her personal blanket covering her, bunched around her waist. The resident was restless with continuous movements to include moving her hand back and forth over her abdomen and rolling her head side to side. The resident opened her eyes occasionally without focusing and did not respond to verbal stimuli. Family at bedside indicated, Resident B had recently been dropped from a Hoyer (mechanical lift) for the second time on 8/13/22 after having been dropped from the Hoyer previously in February of 2022. The family was furious and in total shock at the condition the resident was currently in. In February, the resident received a gash on her head and broke her femur (long bone in the top of the leg), and this time the resident had broken bones in her knee in three places and fractured her hip. The resident was visited prior to the current incident and was alert, talkative, and fed herself.	F 689	Past noncompliance: no plan of correction required.	

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An Indiana State Reportable incident form, dated 8/12/22 at 8:01 a.m., indicated the resident had a witnessed fall. After notification to the physician, the resident was sent to the hospital for treatment and was admitted to the hospital with diagnoses to include fractures to the spine, right tibia, and right fibula. Certified Nursing Assistant (CNA) 18 was suspended pending investigation and was terminated.

Resident B's record was reviewed on 8/25/22 at 12:00 p.m. Diagnoses on Resident B's profile included, but were not limited to osteoporosis, pain in right and left knees, dementia without behavioral disturbance, lack of coordination, abnormal posture, cognitive communication deficit, periprosthetic fracture around internal prosthetic right hip joint on 2/3/22, transient cerebral ischemic attack, and difficulty in walking.

A care plan, dated 8/3/18, indicated the resident was at risk for falling and fall related injuries related to weakness and impaired mobility. The goal was to minimize risk for injuries. Approaches included resident to be transferred by Hoyer lift dated 1/23/19, staff education dated 2/3/22, and cue/remind resident to utilize call light to seek assist as needed and keep personal items and frequently used items within reach dated 8/3/18.

A Physician's order for Resident B, dated 7/18/18, indicated Hoyer (mechanical) lift for transfers.

A quarterly Minimum Data Set (MDS) assessment, completed on 7/21/22, assessed Resident B as having the ability to make herself understood and to understand others. A Brief Interview for Mental Status (BIMS) score of 9 indicated the resident had moderately impaired

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cognition. The resident was a total dependence of 2 or more persons physical assist for bed mobility, transfers, locomotion off the unit, toileting, and personal hygiene. She did not walk in the room or corridor. Extensive assistance of 2 or more persons physical assist for locomotion on the unit. Mobility devices included a wheelchair.

An Event note, dated 8/13/22 at 7:45 a.m., indicated Licensed Practical Nurse (LPN) 19 was called to the room by CNA 18 and Resident B was found on the floor. The resident reported acute back pain and right hip pain. 911 was notified and the resident was transported to a local hospital.

A weekly progress note for Resident B, dated 8/11/22 at 1:45 p.m., indicated the resident was an extensive assist of 2 persons for toileting and transfers via Hoyer lift with body sling, and an extensive assist of 1 person for bed mobility.

An emergency room History and Physical report, dated 8/13/22, indicated Resident B presented to the hospital as a transfer from another local hospital status post fall from a Hoyer lift at the nursing home. "Per EMS [Emergency Medical Services] patient fell 4 feet out of a Hoyer lift, landing on her back onto metal machinery. Was found by EMS coughing and slightly gagging on the ground. SNF [Skilled Nursing Facility] denied LOC [loss of consciousness], but patient thinks she had LOC." In February 2022, Resident B had a fall from a Hoyer lift at the same SNF facility and sustained a right periprosthetic femur fracture (fracture close to a knee transplant). On 8/13/22, a computed tomography (CT) scan of the spine showed probable acute mildly displaced fracture of right transverse process of L4 (break

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in the wing-like bone on the 4th lumbar vertebra in the spine) and "suspected nondisplaced fracture verses artifact in bilateral transverse processes of L2" which were new compared to an abdomen CT from 2/2/22. The assessment section of the report indicated Resident B had a periprosthetic fracture of shaft of femur (thigh bone), fracture of right proximal fibula (just below the knee), fracture of proximal end of right tibia (upper part of shin bone close to the knee), and osteoporosis (loss of bone tissue causing the bones to become weak and brittle).

A typed witness statement, dated and signed by the Administrator on 8/13/22, indicated on 8/13/22 the Administrator had called CNA 18 to get a statement from her pertaining to what had happened with Resident B. CNA 18 said she was using the Hoyer by herself. She had just gotten Resident B dressed and was trying to get her weighed with the Hoyer. She asked Resident B to cross her arms and when she moved a "little bit," she slid out of the Hoyer to the floor.

A typed witness statement, dated 8/13/22 and signed by LPN 19, indicated on 8/13/22 at 7:45 a.m., LPN 19 was called to Resident B's room. "The other nurse and I immediately went to the room. Upon entering I saw [Resident B] on the floor lying on the legs of the Hoyer lift. Her mid-back was directly on one of the legs of the Hoyer lift. I asked the CNA if she fell from the Hoyer and she said yes. I asked her why she didn't come and get one of us to assist and she said nothing. [Resident B] was immediately complaining of back pain when I started to assess her lower extremities. I told the other nurse and CNA not to move her and that I was calling 911. Paperwork and vital signs were given

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to the 911 staff when they arrived."

State of Indiana license information indicated CNA 18 had been licensed as a Certified Nursing Assistant since 10/20/12.

A Job Specific Orientation - Certified Nursing Assistant checklist, signed by CNA 18 and the department head, indicated the employee had initialed as having received nursing equipment training to include operating the lift and using a gait belt on 7/28/22.

On 8/25/22 at 10:18 a.m., Registered Nurse (RN) 8 and LPN 5 were observed looking at the CNA daily assignment sheets when asked for a list of residents on the unit that required mechanical transfers. The assignment sheets listed information on specifics of resident care and assistance needed for transfers to include the mechanical lifts.

On 8/25/22 at 10:52 a.m. RN 9 indicated it was a requirement for 2 staff to be used for all mechanical lift transfers of residents. They had to put safety first.

On 8/25/22 at 10:55 a.m., CNA 10 indicated when using the mechanical lift to transfer a resident, she would first put a Hoyer pad under the resident, then call the nurse to assist with the transfer. One person operated the Hoyer and the other stood behind the resident and guided her into the chair. Staff were to always use 2 staff for both Hoyer and stand up lift transfers.

On 8/26/22 at 10:05 a.m., QMA (Qualified Medication Aide) 15 indicated, Resident B required total assist with activities of daily living

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(ADLs), and she did not ambulate. The resident required total assist with transfers and use of the Hoyer lift. Two staff members were required when transferring residents with a Hoyer.

A confidential interview during the survey indicated Resident B had declined and required care with ADLs to include total assistance of 2 for transfers with the Hoyer lift. Hearsay from others was that Resident B had 2 falls related to falling from the Hoyer lift, but they were not sure if 1 or 2 staff members had been present at the time of the falls.

On 8/26/22 at 1:56 p.m., the Administrator indicated Resident B required assistance with her ADLs, she did not ambulate, and was a total assistance for transfers with the mechanical Hoyer lift. On 8/13/22 CNA 18 was transferring Resident B with the Hoyer lift by herself. CNA 18 indicated she had just gotten the resident dressed and was weighing her when the resident moved and fell from the Hoyer. LPN 19 assessed the resident and determined she needed sent out 911. To his knowledge the resident had received injuries to include fractures to the tibia, fibula, and spine. CNA 18 had been a full-time employee for approximately a month and had been trained on proper Hoyer use during the orientation process. When LPN 19 asked CNA 18 why she did not get them for help the CNA just shrugged her shoulders and really had no response. A mass text was immediately sent to all staff members with a reminder that 2 persons were required for all Hoyer transfers. Staff were trained on use of mechanical lifts during initial orientation. This was the 2nd fall for Resident B this year involving the use of the Hoyer and only 1 staff member.

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On 8/26/22 at 2:54 p.m., Resident B's son indicated, the resident was currently in poor health, receiving hospice services, and had the expectation of 1 to 7 days to live. The son indicated the granddaughter had recorded the resident as saying the mechanical lift had fallen on her, and that was what happened to her spine.

On 8/26/22 at 3:00 p.m., the daughter-in-law indicated, prior to the fall the resident had been alert, talkative, feeding herself, playing bingo, and planning her life with minimal issues. On Saturday, the nursing home called and said the resident had been dropped and sent to the hospital. Resident B had 3 broken bones below the knee, a fractured hip, and fractures in her back. A hospital physician had told the family the big picture was the resident was shutting down due to such a big traumatic stress to the body and she would not recover. It was "unreal" the difference in the resident's health before and after the fall, she went from planning her life to actively dying. The family was told the CNA was using the Hoyer lift by herself, the resident in the sling, and the resident just tipped over. The facility had told family after the first incident in February the staff had been trained and re-trained on the Hoyer use and still this happened again.

On 8/26/22 at 2:52 p.m., the Regional Clinical Specialist provided a Fall Prevention Policy and Procedure, dated May 2016, and indicated the policy was the one currently being used by the facility. The policy indicated, "Strategies for interventions to prevent falls will be individual for each resident...Care Plans are a vital part of the nursing process and serve as an individualized pathway used by all caregivers ...Individualized interventions on the fall care plan will be

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duplicated onto the care sheets to ensure care plan strategies are integrated into the health system ...Fall prevention and fall intervention educational materials will be made available to all direct associates on an ongoing basis..."

On 8/26/22 at 2:52 p.m., the Regional Clinical Specialist provided a Transferring A Resident With A Hoyer Lift Skills Validation form, undated, and indicated the facility had no specific mechanical lift policy but used the validation checklist as the training expectations for use of the lifts. The validation list indicated, "Obtain a lift and the appropriate resident's sling and take to resident's room ...Two staff members are required for a mechanical lift ...One staff member will man the lift while the other staff member stabilizes the resident's head and feet during the transfer ...Have a staff member support resident's legs while the other monitors movement of the lift. The resident should be monitored for verbal or non-verbal signs of pain or discomfort. If noted, the transfer should be stopped. One staff member is to stay with the resident while the other staff member gets the nurse ...One staff member moves the lift in position and lines the lift up to the chair, while the other staff member supports the legs and feet during the move ..."

The deficient practice was corrected on 8/15/22 prior to the start of the survey when the facility implemented a systemic plan that included terminating CNA 18, staff re-education on mechanical lifts, staff mechanical lift skill check offs, mechanical lift audits, and ongoing monitoring. Therefore, the deficient practice was Past Noncompliance.

This Federal tag relates to Complaint

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