STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155061	A. BUILDING 00 B. WING	08/10/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ENVIVE OF LAWRENCEBURG	403 BIELBY RD LAWRENCEBURG, IN 47025

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00414379 and IN00413989. Complaint IN00414379 - Federal/State deficiency related to the allegation is cited at F689. Complaint IN00413989 - Federal/State deficiency related to the allegation is cited at F689. Survey dates: August 9 and 10, 2023 Facility number: 000022 Provider number: 155061 AIM number: 100274510 Census Bed Type: SNF/NF: 46 Total: 46 Census Payor Type: Medicare: 4 Medicaid: 34 Other: 8 Total: 46 This deficiency reflects State Finding cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 15, 2023.	F 0000	**Plan of Correction FOR Envive Healthcare of lawrenceburg Complaint Survey** Preparation or execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts alleged or conclusions set forth on the Statement of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted to respond to the allegation of noncompliance cited during the Complaint Survey conducted Aug. 9-10, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of August 31, 2023. The provider respectfully requests desk review with paper compliance be considered in establishing that the provider is in substantial compliance.	
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			

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

Shelley Miller | Chief Nursing Officer | 09/02/2023

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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	possible; and §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 transfer a resident, that required a full body mechanical lift, safely using the appropriate lift resulting in a fracture for 1 of 3 residents reviewed for accidents. (Resident C) Findings include: On 8/9/23 at 11:08 a.m., the Director of Nursing (DON) indicated on 7/27/23 Resident C was being assisted into bed with a lift. The resident yelled out in pain and was sent out to the Emergency Room (ER). The resident had a fractured left fibula and a follow up appointment with Orthopedics. During an observation and interview on 8/9/23 at 1:57 p.m., Resident C was lying in her bed, her left leg was wrapped and elevated on a pillow. She indicated she required a full body mechanical lift for transfers. On 7/27/23, the day of the incident, she was in the wheelchair for a long time and had asked to be put to bed. The full body mechanical lift had quit working. The staff couldn't find a cord to charge it, so they use a standing aid transfer system (required partial weight bearing) to transfer her to the bed. The resident had asked them not to use the standing aid unit. The staff indicated she had to use it or she could not get back to bed. The Certified Nursing Aides (CNAs) held the back of her pants and had an arm under each of her arms as they assisted her to stand up. She told them to set her back in the chair, but they wouldn't. They rolled her over to the bed, then swung her legs onto the bed.	F 0689	**F689– Free of Accident Hazards/Supervision/Devices SS - G** *"Based on observation, interview, and record review, the facility failed to transfer a resident, that required a full body mechanical lift, safely using the appropriate lift resulting in a fracture for 1 of 3 residents reviewed for accidents. (Resident C)"* **1: What corrective action(s) will be accomplished for those residents found** ·Resident C received treatment and follow up with orthopedics. ·DNS and Maintenance verified full body mechanical lift is in working order. **2: How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken.** ·All residents requiring transfer with a full body mechanical lift have the potential to be affected by the alleged deficient practice. ·No additional resident issues were found related to the alleged deficient practice. **3: What measures will be put into place or what systemic**	08/31/2023

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	The clinical record for Resident C was reviewed on 8/9/23 at 12:48 p.m. A Quarterly MDS (Minimum Data Set) assessment, dated 6/30/23, indicated the resident was cognitively intact. She required extensive assistance of two or more staff members for mobility, transfers, and toilet use. She was 67 inches tall and weighed 263. The resident's diagnoses included, but were not limit to, cirrhosis of the liver, chronic kidney disease Stage 3, weakness, and anxiety. A Care Plan, with a revision date of 12/18/22, indicated the resident had an Activities of Daily Living (ADL) self-care performance deficit, related to immobility. The interventions indicated the resident required a mechanical lift with two staff assistance for transfers. The resident's record lacked documentation related to the transfer on 7/27/23 at 6:15 p.m. A Progress Note, dated 7/27/23 at 10:34 p.m., indicated Resident C started to complain of chest pain and right foot pain. The right foot was unremarkable. The resident stated that the chest pain was like when she had an MI (Myocardial Infarction). The staff called 911 and the local ER was notified. A Progress Note, dated 7/28/23 at 5:13 a.m., indicated the resident would be returning to the facility with a fracture of the left fibula. An Orthopedic Report, dated 8/1/23, indicated the resident was non-ambulatory at baseline. An x-ray of the left ankle indicated a nondisplaced distal fibula fracture. During an interview on 8/10/23 at 11:17 a.m., CNA		**changes will be made to ensure that the deficient practice does not recur?** ·All clinical staff were in-serviced on: ·*"Resident Transfers" policy including alternative plan for how residents who need a full body lift should be transferred if the lift is not in working service.* ·*"Accidents, Incidents & Investigations" policy* **4: How the corrective action will be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?** ·DNS/designee will monitor five transfers with residents requiring full body mechanical lifts three times a week x4 weeks, twice a week x4 weeks, weekly x4 weeks then monthly x3months to ensure residents are transferred safely using the appropriate lift or, in the event the appropriate lift is out of service that the alternative lift plan is followed per policy. The results of these audits will be reviewed by the QAPI committee overseen by the Executive Director for no less than six months. The results will be reviewed for patterns, trends and continued recommendations for process monitoring and improvement until 100% compliance is achieved.	

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	3 indicated on 7/27/23 Resident C had been up since that morning because she had an appointment. The full body mechanical lift (non-weight bearing) was how they got her up that morning, and she was insisting that she had to lay down. Her family member was in the room at the time. They went to get the full body mechanical lift and it was not operating correctly. There was concern for the resident's safety. The nurse was notified, and the care plan only stated, "mechanical lift with two assists." It was explained we could use the standing aid transfer system and the resident agreed. Because she was a large person, for safety, a third CNA assisted with the transfer. The standing aid transfer system was placed in front of her, with one staff on each side, one behind her, and her family member in front. She was assisted to a somewhat standing position and the lift pad used with the full body mechanical lift was attached to the standing aid transfer system. During the pivot of the standing aid transfer system the resident cried out indicating she was in pain. She was lowered to her bed, laid down, placed in a comfortable position, and the nurse was notified. During an interview on 8/10/23 at 10:56 a.m., Licensed Practical Nurse (LPN) 2 indicated on the day of the incident (7/27/23) she was the day shift nurse. The incident occurred during the nursing shift change (6:15 p.m.). Resident C had been up since the 1:00 p.m. smoke break and was insisting she wanted to lay down. The CNAs went to get the full body mechanical lift and it was not working. They notified the nurse and the only plausible solution for immediate transfer was by using the standing aid transfer system. The resident was agreeable to the standing aid transfer system, because she insisted, she was not going to sit up all night. They normally used the full		**5. Date of completion:** 8/31/2023	

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	body mechanical lift for her transfers, but her care plan only indicated a mechanical lift with two-assist. To ensure her safety a third CNA was sent into the room to assist with the other two staff doing the transfer. She had not contact maintenance about the full body lift since the girls had already posted in the notification that the full body lift was down (not working) twice. During an interview on 8/10/23 at 10:12 a.m., the DON indicated when the facility rented the full body mechanical lift, and it was not working the decision was made to use the standing aid transfer system to put the resident in bed. The resident's requested to go to bed. The resident was agreeable to use the standing aid transfer system. She just wanted to get to bed. A third CNA was sent in to assist the other two CNAs for safety. The resident's family member was also present in the room during the transfer. The CNAs had indicated that as they were turning the standing aid transfer system, the resident stated, "oh my leg," and they immediately sat her on the edge of the bed with the unit. A Physical Therapy Discharge Summary, dated 12/28/22 through 1/31/23, provided by the PT (Physical Therapy) Manager on 8/10/23 at 1:47 p.m., indicated Resident C was non-ambulatory. During an interview on 8/10/23 at 1:48 p.m., the PT Manager indicated the standing aid transfer system was a mobility frame sit to stand unit. It was primarily used by the therapy department. There were only two nurses who had been trained to use the mobility frame and it had never been used with Resident C. A Physical Therapy Evaluation and Plan of Treatment, dated 12/28/22, indicated Resident C			

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	required assistance for transfers using a full body mechanical lift. During an interview on 8/10/23 at 1:57 p.m., the DON indicated the Fire Department was not contacted for assistance with a transfer for Resident C on 7/27/23. During an interview and observation on 8/10/23 at 2:03 p.m., CNA 4 demonstrated to the DON how the standing aid transfer system was to be used. The DON indicated she was not aware the unit was not a mechanical lift. During an interview on 8/10/23 at 3:06 p.m., the DON indicated there were 14 residents that resided in the facility that required a full body mechanical lift for transfers. The full body mechanical lift was fixed on 7/28/23. The current facility policy, titled "Resident Transfers" , with a revision date of 9/2022, was provided by the DON on 8/10/23 at 1:45 p.m. The policy indicated, " ...to ensure the safety of residents and staff when performing mobility/transfer task ...SOP DETAILS ...1. Shall determine the type of transfer device, amount of assistance required to assist with safe mobility ...b. weight bearing status ...3. Determine the amount of assistance required for transfers and record this on the ...Resident Care Plan ..." The current facility policy, titled "Accidents/Incidents/Investigation", with a revision date of 10/2022, was provided by the DON on 8/10/23 at 1:45 p.m. The policy indicated, " ...3. In compliance with current rules and regulations governing accidents and or incidents involving a medical device ..."			

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	This Federal tag relates to Complaints IN00414379 and IN00413989. 3.1-45(a)			