### Statement of Deficiencies and Plan of Correction

**Identification Number:** MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING 155810

**Date Survey Completed:** 11/25/2015

**Name of Provider or Supplier:** VERNON MANOR CHILDRENS HOME

**Street Address, City, State, Zip Code:** 1955 S VERNON ST WABASH, IN 46992

**ID Prefix Tag**

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<tr>
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**Summary Statement of Deficiencies**

This visit was for the Investigation of Complaint IN00187401.

Complaint IN00187401 - Substantiated. Federal/State deficiency related to the allegations is cited at F323.

Survey dates: November 24 and 25, 2015

Facility number: 000274
Provider number: 155810
AIM number: 100271660

Census bed type:
- SNF/NF: 77
- Total: 77

Census payor type:
- Medicare: 1
- Medicaid: 75
- Other: 1
- Total: 77

Sample: 3

This deficiency reflects State findings cited in accordance with 410 IAC 16.2-3.1.

QR completed by 11474 on November

**Plan of Correction**

This plan of correction constitutes my written allegation of compliance for the alleged deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This plan is submitted to meet requirements established by state and federal law.

Plan of Compliance is effective: December 14, 2015

**Laboratory Director's or Provider/Supplier Representative's Signature**

_____________________________________________________________________________________________________

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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 disclosable 14 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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<th>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION</th>
<th>X2) MULTIPLE CONSTRUCTION</th>
<th>X3) DATE SURVEY COMPLETED</th>
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<td>F 0323</td>
<td>SS=D</td>
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### SUMMARY STATEMENT OF DEFICIENCIES

**F 0323**

**Corrective action for residents identified:**

| F323 Free of Accident Hazards |
| Lower extremity injuries |
| Liftand transfer observations with return demonstration audits completed by the Director of Nursing (DON) or designee for therapy and nursing staff using mechanical-hoyer type lifts for resident C and other residents who require mechanical-hoyer type lift transfers |

**Identification of others at risk:**

Residents transferred with mechanical-hoyer type lifts have the potential to be injured.

**Findings include:**

- The clinical record for Resident C was reviewed on 11/24/15 at 11:40 a.m.
- Resident C’s diagnoses included, but were not limited to, diabetes type II, morbid obesity, major depressive disorder, delusional disorder and dementia.
- Review of the nursing notes, dated 11/17/15 at 10:50 a.m., indicated Resident C sustained a 2.0 cm x 0.8 cm x <0.1 cm abrasion to the bridge of the nose due to the mechanical lift coming into contact with Resident C's nose during a transfer.
During an interview on 11/24/15 at 10:40 a.m., Resident C indicated the mechanical lift had tipped during a transfer and hit her in the nose.

During an interview on 11/24/15 at 12:04 p.m., COTA (Certified Occupational Therapy Assistant) #6 indicated, on 11/17/15, she and PTA #7 were transferring Resident C from the bed to the wheelchair to take Resident C to therapy. COTA #6 indicated during the transfer, the mechanical lift tipped and Resident C landed in the wheelchair and the hoyer hit Resident C in the nose.

During an interview on 11/24/15 at 12:10 p.m., PTA (Physical Therapy Assistant) #7 indicated on 11/17/15 he was assisting COTA #6 with Resident C’s transfer from bed to chair using the mechanical lift. PTA #6 indicated the legs of the mechanical lift were separated and started to shift once Resident C was being lowered into the wheelchair, causing the mechanical lift to tip and hit Resident C in the nose.

During an interview on 11/24/15 at 11:56 a.m., the Maintenance Director indicated all work orders were put into the computer unless it was an emergency in which he would be called immediately.
The Maintenance Director also indicated equipment needing repair should be removed from the floor until he had a chance to examine it. The Maintenance Director stated he had looked at the mechanical lift in question after being notified by nursing. "I checked the lift completely. I tightened everything up that could be tightened. Nothing felt out of place and nothing was missing." The Maintenance Director indicated there had been no missing bolts on the mechanical lift.

On 11/25/15 at 9:00 a.m., the Maintenance Director provided the following written statement: "Therapy paged me with a concern with one of our lifts on 11/17/15. I immediately inspected the lift following the incident when they explained the legs closed while lowering [Resident C's name] into her chair. After thoroughly inspecting the lift, I found the legs would stay open if locked properly. For good practice and extra precaution, I tightened up ALL [sic] nuts and bolts on this lift and inspected All [sic] other lifts in the building. No further problems at this time. All lifts passed inspection on 11/17/15." The Maintenance Director indicated the legs on the lift would move if they were not locked properly.
Review on 11/25/15 at 9:27 a.m., of the "Incident & Accident Report and Investigation" dated 11/18/15, indicated one Interdisciplinary Team (IDT) documented the cause of the incident was a missing bolt. The Director of Nursing summary indicated "1. Maint. immediately serviced lift. 2. All lifts checked 0 [zero] issues noted."

Review on 11/25/15 at 9:50 a.m., of the maintenance repair log from 1/21/15 through 11/17/15 indicated all mechanical lifts were checked and provided maintenance on a routine basis. The Maintenance Director indicated since the incident on 11/17/15 was an emergency and he was called immediately. The nursing staff did to put in a work order.

During an interview on 11/25/15 at 9:30 a.m., the Director of Nursing indicated the IDT team had not reviewed the inspection of the lift by the Maintenance Director and had miscommunication as to the cause of the incident. The Director of Nursing indicated the mechanical lift was in good repair at the time of transfer and the cause of the incident was due to the legs not being properly locked in place. The DON indicated the therapist involved in the incident were not part of the nursing staff. The DON was unsure
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**Summary Statement of Deficiencies**  
(Each deficiency must be preceded by full regulatory or LSC identifying information)

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<td>if the therapist had documented competencies on using the mechanical lifts. No further information was provided. During an interview on 11/25/15 at 10:00 a.m., the Administrator indicated therapy did not routinely get residents up. This federal tag relates to Complaint IN00187401. 3.1-45(a)(1)</td>
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**Provider's Plan of Correction**  
(Each corrective action should be cross-referenced to the appropriate deficiency)

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Event ID: CIFD11  
Facility ID: 000274  
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