STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155816	A. BUILDING 00 B. WING	05/24/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ARLINGTON PLACE HEALTH CAMPUS	1635 N ARLINGTON AVE INDIANAPOLIS, IN 46218

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00408462, IN00408598, and IN00408256. Complaint IN00408462 - Federal/State deficiencies related to the allegations are cited at F550 and F684. Complaint IN00408256 - Federal/State deficiencies related to the allegations are cited at F684. Complaint IN00408598 - No deficiencies related to the allegations are cited. Survey dates: May 23 and 24, 2023 Facility number: 013005 Provider number: 155816 AIM number: 201256400 Census bed type: SNF: 17 SNF/NF: 30 Residential: 10 Total: 57 Census payor type: Medicare: 11 Medicaid: 24 Other: 12 Total: 47 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on May 26, 2023	F 0000	**PLAN OF CORRECTION FOR ARLINGTON PLACE HEALTH CAMPUS** **F000 INITIAL COMMENTS** 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 complaint survey conducted on May 23, 2023 through May 24, 2023. Please accept this Plan of Correction as the provider's credible allegation of compliance as of June 5, 2023. The provider respectfully requests desk review with paper compliance to be considered in establishing that the provider is in substantial compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Janet Worley	RN, DHS	06/02/2023

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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F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his			

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	or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on observation, interview, or record review, the facility failed to ensure a resident was treated with respect and dignity for 1 of 3 residents reviewed for abuse. (Resident K) Findings include: The clinical record for Resident K was reviewed on 5/24/23 at 12:00 p.m. Her diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, heart failure, anxiety, depression, and chronic kidney disease. A care plan, last reviewed/revised 5/18/23, indicated she had impaired functional status in regards to bed mobility, transfers, toileting, and eating. She required assistance with bed mobility, transfers, eating, and toilet use. An interview was conducted with Resident K on 5/24/23 at 12:04 p.m. She indicated she was verbally abused by CNA (Certified Nursing Assistant) 5. CNA 5 had an attitude with her when she was in her room earlier this month to provide care. CNA 5 informed Resident K of her (CNA 5's) age and that she was a "grown a** woman," just like her. Resident K was trying to inform CNA 5 what she needed, when CNA 5 informed her she knew how to do her job. "I said okay and shut up." Resident K found it "very disrespectful," and it made her feel threatened. This wasn't the first time CNA 5 was disrespectful to her. CNA 5 was unavailable for interview. The employee file for CNA 5 was provided by the DVP (Divisional Vice President) on 5/23/23 at 4:31	F 0550	Resident K assessed and has no concerns with staff treatment. All residents have the potential to be affected. DHS and designee will educate nursing staff on Resident Rights policy. As a measure of ongoing compliance, the SSD or designee will complete 5 resident interviews to ensure staff is following resident rights policy.. Audit will be conducted five times weekly for 4 weeks, then three times weekly for 4 weeks, then twice weekly for 4 weeks, then weekly for 4 weeks, then twice monthly for 3 months, then monthly until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. For quality assurance, the ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6	06/05/2023

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	p.m. The file include a personnel action form. The form indicated the change type was termination with a termination date of 5/12/23. The termination action reason was misconduct. The comment section of the form read, "...On 5/5/23 resident was caring for a resident who previously expressed concerns with this caregiver, during that care employee proceeded to tell the resident that although she didn't like what she said and complained to corporate about that she would provide her care, she then proceeded to tell the resident that she was a grown a** woman and didn't need to be told what to do and that she knew how to provide her care. That was corroborated by witness statement as the employee repeated the story to a coworker after completion of care....Employee terminated at this time for misconduct related to inappropriate conversation with resident during care regarding a previously reported concern..." The 5/9/23 to 5/12/23 Statement of Witness form for the 5/5/23 incident involving Resident K was provided by the CS (Clinical Support) on 5/24/23 at 2:08 p.m. It read, "...Resident reported that on Friday 5/5/23 she was on the phone with family, a newer CNA was on her assignment and he did not know it was ok to interrupt her (which she stated was okay and that has been resolved), the night shift started after shift change and resident put her call light on to get help with HS [bedtime] routine and [name of CNA 5] answered her light. She told the resident 'if I was on evenings and didn't do you, you would complain on me, I don't like what you reported to corporate and state but I'm going to help you momma....'[CNA 5 then got staff member [name of CNA 7] to assist her with transfer and bed mobility, they assisted her into bed at that time. [Name of CNA 7] went back to her assignment and when [name of CNA 5] was		months if warranted until 100% compliance is met.	

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	finished with care she then came over to tell [name of CNA 7] 'I told her about herself that I don't appreciate what she said about me and I know how to care for them and I'm a grown woman....'[Name of CNA 5] was interviewed by DHS/ED [Director of Health Services/Executive Director,] she did share that she had that conversation with the resident....When [name of CNA 7] was interviewed, she did mirror the statement provided by [name of CNA 5] and assistance she provided and did confirm that [name of CNA 5] did tell her their conversation." The Resident Rights Guidelines was provided by the CS on 5/24/23 at 1:44 p.m. It read, "Our residents have a right to...a. Be treated with dignity and respect...e. Freedom to talk with staff and express concerns/grievances without fear of reprisal. f. Be treated fairly, courteously and with respect by all staff." This Federal tag relates to Complaint IN00408462. 3.1-3(t)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on observation, interview, and record review, the facility failed to provide care in a manner that promoted a residents' physical,	F 0684	Resident G is discharged. Resident B and D assessed, no additional impairments. or	06/05/2023

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	mental, and psychosocial well being for a resident who experienced pain during dressing and a resident who suffered a hematoma during care, and to thoroughly investigate and determine the root-cause of a resident's hematoma as to prevent such an injury/trauma from further occurrences for 1 of 3 residents reviewed for safe transportation to and from dialysis and 2 of 3 residents reviewed for abuse. (Residents B, D, and G) Findings include: 1. The clinical record for Resident B was reviewed on 5/23/23 at 11:00 a.m. Her diagnoses included, but were not limited to: morbid obesity, atrial fibrillation, rheumatoid arthritis, gout, hypertension, glaucoma, and end stage renal disease. The 3/23/23 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 12, indicating she was moderately cognitively impaired. She required extensive assistance of 2 persons for bed mobility, transfers, toileting, and personal hygiene. A care plan, last reviewed/revised 5/4/23, indicated she had impaired functional status. An intervention was for required staff to provide assistance with bed mobility, transfers, eating, and toilet use. An observation and interview was conducted with Resident B on 5/23/23 at 1:09 p.m. in her room. She indicated staff helped her with getting dressed, in and out of bed, and with toileting. She went to dialysis 3 times a week. She pointed to an area on her lower right leg and indicated at first she had a small bump on that area of her leg, but		concerns identified. **All like** Residents have the potential to be affected by the alleged deficient practice. DHS or designee to educate nursing staff on Pain Observation and Management. As well as utilization of mechanical lift and skin impairment policies. - DHS or designee will be responsible for auditing residents who require assistance with dressing and have a diagnosis of hemiparesis and/or hemiplegia for pain during dressing. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. - DHS or designee will be responsible for auditing residents who require transportation to and from dialysis to verify care plan and current transfer status are accurate and up to date. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is	

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	then it turned into a much larger bump and now there was a hole there. She remembered being in bed in her room "doing something" and hit her leg on the wooden footboard of her bed. Resident B's bed had a wooden footboard that stuck out on the sides further than the edge of the mattress. The 4/17/23, 11:53 a.m. nurse's note, written by LPN (Licensed Practical Nurse) 2, read, "Resident noted to have hematoma 5.5 x 7.5 cm on RLE [right lower extremity.] Purple and blue in color. Assisted resident into bed and elevated extremity. Applied wrapped ice pack. Resident requested PRN (as needed) pain medication with pain of 5/10. Notified DHS [Director of Health Services] and POA [Power of Attorney.] Will cont. [continue] to monitor." An interview was conducted with LPN 2 on 5/24/23 at 11:20 a.m. She indicated when she came into work at 6:00 a.m. on 4/17/23, Resident B was already at dialysis. When a dialysis staff member brought Resident B back to the unit later that morning, and they collaborated care, the staff member informed her that Resident B was complaining of leg pain after her dialysis treatment, when transferred from the dialysis chair into her wheel chair. Resident B didn't usually like to lie down after dialysis, but that day, she did, because her leg hurt. LPN 2 assessed her leg and there was a hematoma, "looked bruised." She put ice on it and asked Resident B what happened. Resident B informed her that earlier that morning, CNA 5 lifted her legs out and it hurt. LPN 2 informed the oncoming nurse, LPN 3, of the area and to monitor it. The next time LPN 2 came into work, Resident B was in the hospital. LPN 2's understanding was that Resident B's leg injury occurred when CNA 5 assisted Resident B with getting up and ready for dialysis the morning of		maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. - DHS or designee will be responsible for auditing dialysis residents with newly identified non-pressure related skin impairments to ensure the root cause of impairment has been identified. An audit of 5 residents will be conducted 3 times a week times 4 weeks, 2 times a week times 4 weeks, 1 time a week x4 weeks, every 2 weeks times 3 months, monthly times 3 months and until continued compliance is maintained for 2 consecutive quarters (six months). The results of these audits will be reviewed by the QAPI committee overseen by the ED. For quality assurance, the ED and/or Designee will review any findings, and subsequent corrective actions at least quarterly in the campus quarterly quality assurance meeting. The plan will be revised, as warranted. The QA team will review audits at least quarterly and increase frequency of audits if increased concerns noted and will decrease the frequency of audits if no concerns are noted. Ongoing monitoring will continue past 6 months if warranted until 100% compliance met. ="" p="">	

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	4/17/23. The 4/17/23, 4:39 p.m. nurse's note, written by LPN 3, read, "resident noted yelling in extreme pain r/t [related to] hematoma on right inner calf. Hematoma has enlarged since first noted site remains dark purple/black...sent to [name of local hospital] for eval [evaluation] and tx [treatment.]" An interview was conducted with LPN 3 on 5/23/23 at 2:37 p.m. She indicated Resident B had a small area on her leg, but by the end of the shift, it was the size of a golf ball, so they sent her to the hospital. LPN 2 informed her of the area during shift report on 4/17/23 and that CNA (Certified Nursing Assistant) 5 was rough with Resident B during care. CNA 5's employment had since been terminated from the facility. An interview was conducted with the DON (Director of Nursing) on 5/24/23 at 10:39 a.m. She indicated after speaking with LPN 2, it was her understanding CNA 5 was getting Resident B out of bed and it hurt her leg, that Resident B didn't swing her legs like she usually did and it hit the side of the bed. She wrote an IDT (Interdisciplinary Team) note about it. The 4/19/23 IDT note, written by the DON, read, "Resident with hematoma presenting to RLE in a.m., area increased in size with reports of pain/discomfort as day went on, resident without recent history of fall or trauma, unable to identify cause other than noting area after staff assisted with bilateral leg mobility from lying to sitting per usual routine. Resident on anticoagulant history with recent complicated hospitalizations and repeat HD [hemodialysis] access revision procedures. Resident to ER [emergency room] for eval and treat as indicated, will update plan of care			

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	with additional needs upon return." The 4/17/23 to 4/21/23 hospital notes indicated Resident B was admitted to the emergency department on 4/17/23 with a hematoma of the right lower leg. The discharge summary read, "Hospital Course: ...presented with complaints of leg pain and was admitted with a principal diagnosis of hematoma of right lower leg. CTA [computed tomography angiography] runoff noted evolving hematoma right lateral leg. 6.5 x 4.1 x 7.4 cm. Hemoglobin on admission 11.9. Noted history of frequent falls. All anticoagulation home Eliquis held...Patient will need to continue hold Eliquis for 4 more days and have it restarted in outpatient setting." The 4/17/23 skin integrity event, closed by the DON on 4/19/23, described the bruise to Resident B's right lower extremity as purple-black, ecchymosis-large irregularly formed hemorrhagic area with swelling and moderate pain. New interventions to be taken to aide in healing and prevent reoccurrence included "turn with care interventions." 2. The clinical record for Resident D was reviewed on 5/23/23 at 11:21 a.m. Her diagnoses included, but were not limited to: hemiplegia and hemiparesis, following cerebral infarction affecting left non-dominant side, Alzheimer's disease, dementia, morbid obesity, and chronic kidney disease. The 3/17/23 Quarterly MDS (Minimum Data Set) assessment indicated she had a BIMS (brief interview for mental status score) of 12, indicating she was moderately cognitively impaired. She required extensive assistance of 1 person for dressing.			

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A care plan, last reviewed/revised 5/4/23, indicated she had impaired functional status.

An interview was conducted with Resident D on 5/23/23 at 2:05 p.m. She indicated she'd lived at the facility for the past 3 years. She'd been physically abused in the facility by CNA (Certified Nursing Assistant) 4, who pulled on her arm when providing her care, as recently as 3 weeks ago. She had a bruise on her left arm from CNA 4 pulling on it and wanted the bruise to be observed. She hadn't told anyone about CNA 4 pulling on her arm.

An observation of Resident D's arm and interview was conducted with Resident D and the DON (Director of Nursing) on 5/23/23 at 2:16 p.m. The DON assisted Resident D with getting her left arm out of her shirt sleeve to observe her bare arm. There was a dark, raised area on the upper part of her left arm. The DON indicated it always looked like that. A family member, present in the facility, joined in on the observation and indicated her arm always looked like that, and that Resident D would tell her if something was wrong. Resident D indicated CNA 4 pulled on her arm and she didn't like it. Resident D indicated other staff were more "easy" with her when providing care.

An interview was conducted with CNA 4 by telephone on 5/23/23 at 3:33 p.m. She indicated she'd worked at the facility for 7 years. Resident D required staff assistance for all of her activities of daily living. Resident D always complained to her of her arm hurting. "I tell her I have to lift it a little to get her bra on." CNA 4 put Resident D's bra and shirt on at the same time, so she didn't have to do it twice. Resident D complained of her arm hurting as recently as last week or this week. CNA

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	4 informed the nurse on duty of Resident D's arm pain, but was unsure which nurse. No one had ever shown CNA 4 a new technique for how to put on Resident D's bra without it causing her pain. "She's been saying this for 2 or 3 years." CNA 4 had previously offered for Resident D to not wear a bra. Resident D wore bras that pulled over her head, not ones that snapped in the back or front. "It's not a problem when the snap is in the back." CNA 4 never spoke with anyone about Resident D getting bras with snaps instead of pullovers. Resident D's clothes were already picked out by family on a hanger in her cabinet, so she just put those on her, instead of further discussing it with family or nurse management. An interview was conducted with LPN (Licensed Practical Nurse) 2 on 5/24/23 at 11:20 a.m. She indicated Resident D sometimes informed her that her left arm hurt and would ask for a pain pill. After getting dressed in her room, she would come out to the nurse's station and inform her that her left foot or arm hurt. LPN 2 would regularly ask about the location and intensity of the pain, but not what happened to cause the pain. "I would say once a week either her arm or foot hurts right after getting dressed." An interview was conducted with the DON (Director of Nursing) on 5/24/23 at 9:28 a.m. She indicated she spoke with Resident D and family about Resident D's bras. They were going to try to get her a sports bra that closed in the front. CNA 4 should be informing someone if Resident D is complaining of pain in her arm every time she gets her dressed, but she has never said anything about it. The Abuse and Neglect Procedural Guidelines was provided by the Clinical Support on 5/24/23 at			

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	144 p.m. It read, "Prevention i. Assure that prevention techniques are implemented in the campus. Identify, correct, and intervene in situations where abuse and/or neglect are more likely to occur. These may include but are not limited to, an analysis of: ...2. Assigned staff demonstrate knowledge of individual resident needs." 3. The clinical record for Resident G was reviewed on 5/23/23 at 11:48 a.m. Resident G's diagnoses included, but not limited to, chronic kidney disease/end stage renal disease, diabetes type II, congestive heart failure, anemia, and hemiplegia (difficulty or inability to move half of body) affecting the left side. Resident G admitted to the facility on 4/7/23 with two pressure ulcers (one on the coccyx and the other on the right heel) Resident G's admission MDS (Minimum Data Set) dated 4/14/23 indicated, she was cognitively intact, required extensive assistance of two persons for bed mobility and transfers; and was totally dependent on one person for locomotion off the unit. A facility Lift Evaluation dated 4/10/23 indicated, Resident G was not: ambulatory, able to be transferred with limited assistance, able to reliably stand and pivot, or able to maintain a sitting position without assistance. Per the evaluation, Resident G required the use of the total mechanical lift. A nursing note dated 4/16/23 at 2:35 p.m. indicated, "During patient care large hematoma/blister[sic, hematoma, a collection of blood within a body of tissue, worse than a bruise) noted to interior right calf approx [sic, approximate] size of a baseball". The nurse placed an abdominal pad over the site and wrapped it in			

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	155816	A. BUILDING 00 B. WING	05/24/2023

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	kerlix. The note indicated, Resident G denied pain, discomfort, unable to recall hitting her leg on anything, or was aware of the hematoma. An IDT (Interdisciplinary Team) note dated 4/18/23 at 10:13 a.m. indicated, Resident G had a hematoma noted to her posterior right leg and required a total mechanical lift for transfers. The note indicated, "although no recent trauma noted, resident states legs rest at location of pole coinciding with bruise/hematoma, thin fragile skin with history of new and recurrent impairments, on HD[sic, hemodialysis] and also receives eliquis[sic, a blood clotting inhibitor]..." The IDT note did not indicate any staff interviews had been conducted to investigate the cause of the hematoma. A wound care note dated 4/18/23 at 10:46 a.m. indicated, on Resident G's right lower extremity a hematoma currently measured 14 cm(centimeters) by 15 cm and extended out from the leg by 3.5 cm. They noted a thin layer of epithelial tissue covering the hematoma which moved when palpated. The underlying hematoma was dark purple and firm. The dressing that was present had a moderate amount of serosanginous(sic, blood mixed with clear fluid) drainage. The area around the hematoma was lighter blue with possible hemosiderin staining (darkly colored reside visible through skin caused by leaked blood from capillaries and the breaking down of blood cells). The resident denied pain in the hematoma. A Nurse Practitioner's (NP) note recorded as a late entry on 4/21/23 at 10:50 a.m. and dated as 4/20/23 at 10:50 a.m. indicated, Resident G's comorbidities were all stable and well managed at that time. Additionally, "Nursing reports resident has large			

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	hematoma to right shin, found on Tuesday from an unknown source, fluid filled previously, now has burst, draining serosang[sic, serosanginous] fluid, patient reports area painful. BLE[sic, bilateral lower extremity] unchanged from previous assessments. Unable to get US [sic, ultrasound] imaging today, will sent to ED[sic, emergency department] for eval[sic, evaluation]." A Statement of Witness Form was provided on 5/24/23 by Clinical Support (CS). The form was dated 4/18/23 and indicated, the interviewee was Resident G. When asked if any trauma, falls, issues with foot pedals had occurred over the weekend the resident could not recall. The form was not signed by Resident G nor the witness to the statement. It was only signed by the DON (Director of Nursing), but not dated. The Witness Form stated, "All Statement of Witness Forms must be signed by the Interviewee, Witness and the Interviewer/Preparer prior to submission". An Anonymous interview indicated, when Resident G was asked about what happened to her right lower leg, she indicated, when at the facility, they used a mechanical lift for transfers and a male CNA (Certified Nursing Assistant) had crushed her leg using the lift causing the hematoma. Resident G's son indicated, he (the male who was utilizing the lift when the trauma occurred) was "recklessly swinging" her while in the mechanical lift. An interview with Resident G was conducted on 5/23/23 at 3:53 p.m. Resident G indicated, the hematoma on her right leg was caused by the gentleman who was operating the mechanical lift. She stated, "he had got me into it and was trying to get me into a specialty chair in dialysis room. All I know is my leg got slammed into a piece of			

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	equipment. I said, Ouch and told him it hurt." She indicated, no one looked at it. She was unsure if the person worked for the dialysis center or the facility. Additionally, she indicated, she was now fearful of the total mechanical lifts and will not go in one again. An interview with the Dialysis Center Manager (DCM) within the facility where Resident G received her dialysis was conducted on 5/24/23 at 10:29 a.m. indicated, usually the staff from the facility do not enter the dialysis center except when they needed assistance with their total mechanical lift or to assist in pulling a resident up in the chair. Resident G was on the dialysis schedule for Tuesday, Thursday, and Saturday runs. The last time she had received dialysis prior to the hematoma being identified was 4/15/23 and a male dialysis employee worked on that day and time. An interview with DON was conducted on 5/24/23 at 1:19 p.m. DON indicated, she had not spoke with the dialysis center concerning Resident G's hematoma. She indicated, there was nothing on her run sheets and no interviews had been conducted with the dialysis center concerning Resident G's hematoma. An interview with DON conducted on 5/24/23 at 2:18 p.m. indicated, when asked about how she had identified that Resident G's hematoma location matched up with the pole on the overhead lift when allegedly Resident G was unable to recall the incident per the nursing notes, DON indicated, it was a likely scenario based on her requiring a total mechanical lift, dialysis, and was on Eliquis. When asked if she had provided additional education to the staff regarding safety/care needed when lifting residents with			

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such comorbities, she indicated, "no". When asked if Resident G had other hematoma's on her as a result of the usual operation of the overhead lift, DON indicated, "no, but she had other skin issues".

Resident G's wound management in the clinical record only identified the pressure wounds on her coccyx and heel.

Resident G's clinical record did not contain any further evaluations of the hematoma nor were there any additional measurements.

A Guidelines for Resident utilizing a Lift policy was provided on 5/23/23 at 4:14 p.m. from Clinical Support (CS). The policy indicated, "Purpose To ensure the safety of residents and staff when performing lift transfer tasks...All devices are safe to be used by one staff member per manufactures guidelines. Staff should see the assistance of a second person for those resident's care planned for assistance of two with the lifting device or as needed for safe handling."

A Bruise, Rash, Lesion, Skin Tear, Laceration Assessment Guidelines policy was received on 5/24/23 at 1:44 p.m. from CS. The policy indicated, "May complete Bruise event in EHR (electronic health record) by an RN/LPN [sic, registered nurse/licensed practical nurse] if the bruise warrants documentation due to extent and/or location."

This Federal tag relates to Complaints IN00408462 and IN00408256.

3.1-37(a)