STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY COMPLETED
	155181	A. BUILDING 00 B. WING	05/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
CARMEL HEALTH & LIVING COMMUNITY	118 MEDICAL DR CARMEL, IN 46032

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F 0000 Bldg. 00	This visit was for the Investigation of Complaint IN00407987. Complaint IN00407987 - Federal/State deficiencies related to the allegations are cited at F689. Survey dates: May 8 and 9, 2023 Facility number: 000095 Provider number: 155181 AIM number: 100290490 Census bed type: SNF: 7 SNF/NF: 129 Total: 136 Census payor type: Medicare: 13 Medicaid: 114 Other: 9 Total: 136 This deficiency reflects state findings cited in accordance with 410 IAC 16.2-3.1. Quality review was completed on May 18, 2023.	F 0000	Submission of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or correction set forth on the statement of deficiencies. The plan of correction is prepared and submitted because of requirement under the state and federal law. Please accept this plan of correction as our credible allegation of compliance. Please find enclosed this plan of correction for this survey. Should additional information be necessary to confirm said compliance, feel free to contact me.	
F 0689 SS=D 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 possible; and			

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

Tiffany Tackett | RN | 05/30/2023

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	§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. Based on interview and record review, the facility failed to ensure a staff member followed the Hoyer lift policy and procedure while transferring a resident from her bed into her wheelchair for 1 of 2 residents reviewed for falls from a Hoyer lift. (Resident B) Finding includes: A concern was called into the Indiana Department of Health regarding Resident B being "dropped" from a Hoyer lift. The record for Resident B was reviewed on 5/8/23 at 1:34 p.m. Diagnoses included, but were not limited to, paraplegia, neuralgia and neuritis, acute embolism and thrombosis of left femoral vein, neuromuscular dysfunction of bladder, anxiety disorder, depression, morbid (severe) obesity due to excessive calories, and attention and concentration deficit. A physical therapy note, dated 4/26/23, indicated Resident B was a two person assist for bed mobility and transfers. Precautions were she had complete paraplegia (unable to use the lower half of the body from the waist down), neck and back brace. A progress note, dated as a late entry on 5/1/23 at 1:17 a.m., indicated on 4/30/23 at approximately 8:00 p.m., Resident B requested to get out of bed into her wheelchair. Her request was granted by use of the Hoyer lift. When the CNA was close to sitting her into her wheelchair, the Hoyer sling started to get loose, and the CNA was unable to control it. The CNA decided to lower the Hoyer	F 0689	**F 689 The facility must ensure staff members follow the Hoyer Lift Policy and Procedure to prevent falls or injury from a hoyer lift transfer.** **1. Resident B was treated for a muscle strain per MD order. Resident B's pain is managed by nursing staff and her Physician. Resident B is being transferred by two staff with the Hoyer lift. The resident also continues being treated by therapy.2. All residents have the potential to be affected. No other residents have fallen while being transferred with a Hoyer lift.** **3. The Policy and Procedure on Hoyer lift transfers was reviewed with no changes made to the policy. The C.N.A staff was re-educated on the policies/procedures for the use of a Hoyer Lift and need for two staff for Hoyer Lift transfers. 4. Resident Hoyer lift transfers will be observed by the DON or designee for proper number of staff and technique. If there are noted to be any concerns, or any area that need correction, the appropriate steps will be taken to correct the issue at the time of observation. The DON or designee will observe 3 Hoyer**	05/12/2023

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	lift sling and the resident to the floor. Two hours after the fall, the resident complained of numbness and generalized pain. A document, titled "Post Fall Assessment," dated 5/1/23 at 1:21 a.m., indicated Resident B was observed in the prone position (lying on her stomach) immediately after the fall. Prior to the fall, the resident was lying in bed. The location she was found at was next to her bed. The environmental factors, which contributed to her fall was the "Wrong size hoyer Pad." Resident B indicated the aide was trying to assist her into her wheelchair using the Hoyer lift. The Hoyer pad being used was small and loose. The aide had to lower her onto the floor. A progress note, dated 5/1/23 at 1:05 p.m., indicated the IDT (Interdisciplinary Team) met to review Resident B's fall, which occurred on 4/30/23 at 8:15 p.m. She was lying in bed prior to the fall. The staff indicated she was being lifted in a Hoyer lift and transferred to her wheelchair, the Hoyer pad appeared to be loose, so she was quickly lowered to the floor. The Hoyer pad was repositioned, and she was lifted into her wheelchair. The new intervention was there was to be three staff members assisting with her Hoyer lift transfers. Amended 5/1/23 at 2:00 p.m., the IDT felt the prior intervention was not suitable for the resident's fall, so they changed the intervention to state "Hoyer Pad size and placement verified by 2 staff members." During an interview, on 5/8/23 at 4:21 p.m., Resident B was sitting in her room in her wheelchair. She indicated CNA 1 had transferred her by herself with the Hoyer lift on 4/30/23, and she had to be lowered to the floor. While CNA 1 was attempting to pull her back into her		**Lift transfers per day using an observation tool to document the findings 5 times weekly for four weeks, then three times weekly for four weeks, then 2 times weekly for four weeks, then quarterly thereafter to ensure resident transfers with the Hoyer lift are being done with the appropriate number of staff. The observation tool will be reviewed during the facility Quality Assurance meetings and the plan of correction will be adjusted accordingly. 5. The above corrective measures will be completed on or before 5/12/2023.**	

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	wheelchair seat, she slipped out of the Hoyer sling and started to fall. She was hanging from the "tiny" bars at the top of the Hoyer lift where the Hoyer sling attached. She held onto the bars to keep from hitting the floor. Her feet and legs "hit" the floor first, then the upper part of her body was slowly lowered to the floor. Her feet and legs "hit" first because they had come out of the sling. CNA 1 told her to hold onto the bed, then she told her to ease down onto her stomach, which the CNA helped her to do. The CNA went out of the room to get assistance to get her off the floor and into her chair because there was no one else in the room. RN 3 and QMA 2 came into the room to assist CNA 1 to get her off the floor. Later that evening, she began to have pain from her neck to her waist on the left side from holding onto the "tiny" bars of the Hoyer lift. She went to the ER to get a CT scan done of her neck a couple days later. The ER physician determined she had a pulled muscle and placed her on a muscle relaxer for five days. During an interview, on 5/9/23 at 11:30 a.m., the ED (Executive Director) indicated Resident B was supposed to be cared for as a "Care in Pairs" resident, so she required two staff members to be with her. QMA 2 was standing in the doorway during the Hoyer lift transfer in case CNA 1 needed assistance with the transfer. He should have been inside the room assisting with the transfer. According to their Hoyer lift policy, there was to be two staff members in the room assisting with the Hoyer lift transfers. During an interview, on 5/9/23 at 4:47 p.m., CNA 1 indicated she was doing Resident B's Hoyer lift transfer by herself and there was no one standing at the door during the transfer. She knew she was supposed to have a second person assisting her,			

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	but she was not able to find a second person after two attempts of looking. She had transferred Resident B by herself with the Hoyer lift without any problems one other time. She attempted two times to lift the resident off the bed with the Hoyer lift, but both times CNA 1 felt like the resident was slipping out of the Hoyer sling. Both times she lowered her back onto the bed and checked all the connections of the sling on the bar where it connects and tried again. Finally, the third time she tried to lift her with the Hoyer lift the sling did not feel like it was slipping until she got her over the wheelchair and started to pull her back into the wheelchair. Even though she had the sling crisscrossed at the legs as she was supposed to, the resident began slipping out of the Hoyer sling. She was trying to seat the resident back in the wheelchair, watch where the resident's feet and legs were since she was paralyzed, run the remote control, and move the Hoyer lift by herself. She slowly lowered the resident to the floor; her legs and feet were on the floor first. She instructed the resident to grab the bed and she assisted her onto her stomach, where the resident laid until she went to find RN 1 and QMA 3 to help her get the resident off the floor into her wheelchair. A current policy, titled "Transferring a Resident with a Hoyer/Mechanical Lift Skills Validations," undated and provided by the ED on 5/9/23 at 3:00 p.m., indicated "...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 the movement of the lift...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...."			

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	A current policy, titled "Safe Use of a Mechanical Lift," dated as reviewed on 8/15/22 and provided by the ED on 5/9/23 at 3:00 p.m., indicated "...GENERAL GUIDELINES: 1. At least 2 trained staff members are needed to safely move a resident using a mechanical lift. 2. Mechanical lifts may be used for tasks that require...a. Lifting a resident from the floor b. Transferring a resident from bed to chair and vice versa...1. PROCEDURE FOR A HOYER OR OTHER MECHANICAL LIFT TRANSFER: 1. Obtain the lift and the appropriate sling for the resident and take to the resident's room...Have a minimum of 2 trained staff to compete the transfer using the Hoyer/mechanical lift...One staff member will manage the lift while the other staff member ensures the resident's head and feet are stabilized during the transfer. 13. Politely ask the resident to cross their arms across their chest or ask if you can cross their arms for them. 14. Raise the sling with resident and check to see that the sling is evenly placed with no slipping or pressure against the resident's skin. 15. Have one staff member support the resident's legs while the other monitors the movement of the lift. This Federal tag relates to Complaint IN00407987. 3.1-45(a)(2)			