STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155333	A. BUILDING 00 B. WING	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00449522 and IN 00450157. This visit resulted in a Partially Extended Survey-Substandard Quality of Care - Immediate Jeopardy. Complaint IN00449522: Federal / state deficiencies related to the allegation(s) are cited at F600 and F609. Complaint IN00450157: Federal/State deficiencies cited at F689. Survey Date: January 21, 22, 23, & 24, 2025 Facility number: 000226 Provider number: 155333 AIM number: 100267730 Census bed type: SNF: 10 SNF/NF: 81 Total: 91 Census payor type: Medicare: 11 Medicaid: 63 Other: 17 Total: 91 These deficiencies reflect State findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on January 31, 2025.	F 0000	This plan of correction is to serve as Paoli Health and Living's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Paoli Health and Living or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this provision constitute an agreement or admission of the survey allegations. ="" span submission="" does="" not="" constitute="" an="" admission="" by="" or="" its="" management="" company="" that="" the="" allegations="" contained="" in="" survey="" report="" a="" true="" accurate="" portrayal="" provision="" nursing="" care="" other="" services="" facility.="" nor="" agreement="" allegations.<="" p="">
="" p="">	
F 0600 SS=J	483.12(a)(1) Free from Abuse and Neglect			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Lyndie McGraw	HFA	02/20/2025

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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Bldg. 00	Based on observation, interview, and record review, the facility failed to protect a resident's right to be free from sexual abuse by staff for 1 of 3 residents reviewed for abuse allegations. (Resident C) This deficient practice resulted in an alert and oriented female resident alleging staff to resident sexual abuse on 12/28/24 when Resident C indicated that Certified Nurse Aide (CNA) 13 lifted her gown during care and licked or sucked on her breast a week prior. CNA 13 indicated to a police detective on 12/21/24 that, "she asked me to do it, so I done it, to shut her up." This Immediate Jeopardy began on 12/18/24 at approximately 4:00 P.M. when Resident C alleged that CNA 13 had lifted her gown and placed his mouth on her breasts. Resident C was tearful during staff interviews and indicated that she did not want the staff member to place his mouth on her breasts. On 12/21/24 local law enforcement placed CNA 13 under arrest after admitting the allegation. CNA 13 indicated to the police detective that he was assisting Resident C and she "was flirting with him so he did it for like two seconds." The Facility Administrator 2 was notified of Immediate Jeopardy on 1/22/25 at 1:05 P.M. The Immediate Jeopardy was removed, on 1/24/25 at 1:44 P.M., and the deficient practice was corrected on 12/21/24, prior to the start of the survey and was therefore Past Noncompliance. Finding includes: An Indiana Department of Health (IDOH) Facility Reportable Incident (FRI) form, dated 12/18/24 at 4:15 P.M., indicated Resident C reported, "a CNA made contact with her chest area during care ..." CNA 13 was suspended during the investigation.	F 0600	On 12/17/24 an action plan was developed for a different facility allegation that was made. Immediate action and in-servicing of all staff members PRIOR to their next shift worked was initiated on 12/17/24 and was ongoing into 12/18/24 when it was deemed completed. This education content was applicable for both allegations. The same is applicable for the staff and resident interviews that were completed on 12/17/24 into 12/18/24, the interviews covered both allegations. 12/18/24 The facility failed to ensure that staff member did not engage in inappropriate actions with resident per res allegation **br="">** **="" spanthe="" corrective="" actions="" to="" be="" accomplished="" for="" those="" residents="" found="" have="" been="" affected="" by="" the="" practice.<="" span="">** ="" span="">** **="" span="">** a="" name="_Hlk25142462">Current resident's with a BIMS 10 or higher were interviewed to ensure they feel safe and to identify any inappropriate staff interactions. Residents with BIMS under 10, a head to toe assessment was	01/25/2025

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	The facility's investigation of Resident C's allegation included an untimed, typed note, signed by the Social Service Director (SSD), dated 12/18/24. The note indicated when asked if anyone that worked at the facility had ever made her uncomfortable or scared, Resident C began to cry and stated, "yes, [CNA 13]." When asked what CNA 13 had done to make her feel that way, Resident C indicated, "he sucked my boob, and it felt weird." An untimed and unsigned, typed, facility interview summary with CNA 13, dated 12/19/24, indicated CNA 13 assumed the allegation of abuse came from Resident C because Resident C said things like that, rubbed his arm, and tried to hug him. The interview summary indicated CNA 13 identified he was always by himself in the resident's room. An undated local PD investigation report indicated a police officer arrived at the facility, on 12/20/24, and spoke with Facility Administrator 1 and the Social Service Director (SSD). Staff informed the police officer that Resident C had alleged that CNA 13 had, "sucked on her nipples... for a while." CNA 13 had told her not to tell anyone. On 1/21/24, CNA 13 was placed under arrest for an offense of sexual battery after indicating to local PD that, "...she asked me to do it, so I done it..." The follow-up FRI, dated 12/26/24, indicated a police report was made by the facility. The police department started their investigation. The police department did notify the facility that the alleged employee was detained and that their investigation is ongoing.		completed. All current residents were reviewed by DON/Admin for appropriate staff/visitor relationships. An investigation including staff members who may have worked with the alleged employee in the time frame alleged by the resident, or for any known inappropriate interactions between staff/residents. III. The facility policy on Resident Abuse was reviewed with no changes made to the policy. The facility will put into place the following systematic changes to ensure that the practice does not recur. The facility management team was re-educated by the Corporate Educator. Facility staff will receive re-education immediately or upon reporting to work, and will not be able to work until education has been completed regarding Resident Abuse and the facility procedures regarding resident abuse, reporting abuse, appropriate staff/resident relations, types of abuse, examples of abuse with timely suspension, professionalism. Any employee who is hired will receive ongoing education on Abuse Prohibition and procedure and will have screening that will be reviewed. All education with all staff completed by 12/18/24 The results of the weekly interviews will be addressed with the IDT team/Administrator for further interventions. The interview	

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	During an interview, on 1/21/25 at 12:30 P.M., Facility Administrator 2 and Registered Nurse (RN) 4 indicated CNA 13 admitted to sucking Resident C's nipples during a local Police Department (PD) investigation. During record review, on 1/22/25 at 10:45 A.M., Resident C's diagnoses included, but were not limited to cerebrovascular disease, major depressive disorder, anxiety, dysphagia, altered mental status, and chronic pain. The most recent quarterly Minimum Data Set (MDS) assessment, dated 11/13/24, indicated the resident had no cognitive impairment, had occurrences of feeling down, depressed, and/or hopeless, one-sided upper extremity impairment, had lower extremity impairment to both sides, was dependent while toileting, and required substantial to maximum assistance of two staff members to roll left to right in bed. A care plan, revised 1/15/25, included Resident C had specific needs related to their care. An intervention included bed mobility, resident dependent upon two-person assistance. During an observation and interview, on 1/22/25 at 3:00 P.M., Resident C was observed sitting up in bed in her room. She was wearing a gown. The resident spoke coherently but did not answer direct questions. A male entered the resident's room and identified himself as Resident C's boyfriend. The male indicated a staff member had touched Resident C inappropriately. During an interview on 1/24/25 at 2:30 P.M., the SSD indicated that Resident C did require reassurance that CNA 13 would not be returning to the facility.		results will be reviewed at the monthly quality assurance meeting. Changes may be made to the process, based upon the results of the audits until 100% compliance is achieved. An Ad-HOC QAPI meeting was held with the Medical Director on 12/18/24 regarding the allegations made on 12/18/24 and the actions taken for the involved resident, and all residents who have potential to be affected. The Regional Director and Clinical Specialist will review any allegations of abuse for compliance with reporting and investigation weekly for 12 weeks. V. Plan of Correction completion date: 12/21/24	

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	On 1/21/25 at 2:00 P.M., The Facility Administrator 2 supplied a facility policy titled, "Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy", dated 6/4/19. The policy indicated, "It is the policy of [company name] ... to provide each resident with an environment that is free from verbal, sexual, physical, and mental abuse ... b. Examples of Actual Abuse: ...iii. Rape or inappropriate sexual touching or relationship between staff and resident ..." The past noncompliance Immediate Jeopardy began on 12/18/24. The Immediate Jeopardy was removed on 1/24/25 and the deficient practice corrected 12/21/24 after the facility implemented a systemic plan that included the following actions; in-services related to procedures for resident abuse and ongoing monitoring. This citation relates to complaint IN00449522. 3.1-27(a)(1)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations Based on interview and record review, the facility failed to completely and accurately report an allegation of sexual abuse to the state agency for 1 of 3 allegations of abuse reviewed. (Resident C) Finding includes: During a review of facility reported incidents on 1/21/25 at 11:45 A.M., an Indiana Department of Health (IDOH) Reportable Incident form, dated 12/18/24 at 4:15 P.M., indicated, "[Resident C] stated that a Certified Nurses Aide [CNA] made contact with her chest area during care last week.	F 0609	The facility respectfully requests desk review for the following citations. F 609 The facility failed to completely and accurately report an allegation of sexual abuse to state agency. I. The corrective actions to be accomplished for the resident found to have been affected by the practice:	01/25/2025

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	She stated she had not reported to staff until now, but that she had told her roommate. One should note that resident does not have a roommate." A follow up to the incident, dated 12/26/24, indicated, "Resident [C] continues to receive psychosocial monitoring and support as necessary. (Psychiatrist name) continues to follow resident. The facility investigation did not conclude any witnesses to any type of inappropriate actions from the alleged employee or any other employee. The alleged employee remained suspended during the investigation then was terminated. A police report was made by the facility. The police department started their investigation. The police department did notify the facility that the alleged employee was detained and that their investigation is ongoing." During review on 1/21/25 at 2:00 P.M., the facility's investigation of Resident C's allegation included a typed note signed by the Assistant Director of Nursing (ADON). The note indicated on 12/18/24 at approximately 4:00 P.M. the ADON was present in Resident C's room when Resident C indicated CNA 13 "licked my nipples." A review of the local police department investigation report indicated that a police officer arrived at the facility on 12/20/24 and spoke with Facility Administrator 1 and the Social Service Director (SSD). Staff informed the police officer that Resident C had alleged that CNA 13 had "sucked on her nipples... for a while." CNA 13 had told her not to tell anyone. On 1/21/24, CNA 13 was placed under arrest for an offense of sexual battery after indicating to a police detective that, "...she asked me to do it, so I done it..." During an interview on 1/22/25 at 10:25 A.M., RN		The involved resident was assessed, the responsible party notified, MD, Administrator, Local Police Department notified, as well as Indiana Department of Health. An investigation was initiated immediately. The resident was provided psychosocial support. The involved staff member was suspended immediately and terminated form employment. The investigation was turned over to the Paoli Police Department, and the staff member was detained as reported to the IDOH. The involved resident is at baseline and has had no significant change in psychosocial status. II. The facility identified other residents that may potentially by affected by the practice. All residents who were able to be interviewed were interviewed within the facility at the time of the allegation. Any resident who was not able to be interviewed, a head-to-toe assessment was completed at the time of the allegation. There were no other residents with any noted concerns. All reportable incidents within the last 30 days were reviewed for complete and accurate reporting. No concerns were noted. III. The policy on abuse was reviewed, and the procedures for reporting to state agencies was	

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	4 indicated that the facility was notified by the local police department on 1/21/24 that CNA 13 had admitted to Resident C's allegation. On 1/21/25 at 2:00 P.M., Facility Administrator 2 supplied a facility policy titled, Abuse, Neglect, and Misappropriation Prohibition and Prevention Policy, dated 6/4/19. The policy indicated, "...C. Reporting to State Agencies and Local Law Enforcement 1. Allegations of abuse... will be reported immediately to the State licensing/certification agency..." 4. Information reported to the agencies will include, as a minimum: ...c. The type of allegation (abuse...) involved... 5. If a thorough investigation supports a conclusion that an associate of our Community is licensed or registered with the professional licensing agency or nurse aide registry and has abused... or mistreated a resident... the Administrator or designee shall ensure the allegation is reported to the appropriate board, agency or registry..." This citation relates to complaint IN00449522. 3.1-28(b)(2) 3.1-28(c)		reviewed with no changes made. The facility put into place the following systematic changes to ensure that the practice does not recur. The facility Administrator, Director of Nursing, and the RN Clinical Specialist were re-educated on reporting complete, detailed information to state agencies while following the IDOH reporting guidelines. IV. The facility will monitor the corrective action by implementing the following measures. Additional Upper management personnel will review all reportable incidents to state agencies. The review will be done with each report prior to submission to state agency x 6 months. The results of the audits will be reviewed at the monthly quality assurance meeting. Changes may be established to the auditing process, based upon the results of the audits as determined by the Quality Assurance Committee.	
F 0689 SS=J Bldg. 00	483.25(d)(1)(2) Free of Accident Hazards/Supervision/Devices Based on interview and record review, the facility failed to ensure a resident was free from accidents for 1 of 3 residents reviewed for the use of a mechanical lift. A resident was in the process of transferring in a mechanical lift while the lift pad was wrapped under the resident's legs rather than through the resident's legs. The resident did not	F 0689	The facility failed to ensure the residents were free of falls with injury during transfers with the use of a Hoyer lift. I. The corrective actions to be accomplished for those residents found to have been affected by the	01/25/2025

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	possess the required stability to transfer safely with the lift pad wrapped under her legs. The resident slid feet first out of the lift pad which resulted in multiple lower extremity fractures and a laceration to the back of her head. The resident was transferred to a local Emergency Department (ED) where she expired. (Resident D) This Immediate Jeopardy began on 12/25/24 at approximately 7:50 A.M., when Resident D fell 3.5 to 4 feet from a mechanical lift while being transferred by Certified Nurse Aide (CNA) 6 and CNA 7. Resident D's fall resulted in a left femur fracture, left tibial fracture, right femur fracture, right ankle fracture, and a 3-centimeter (cm) laceration to the back of her head. Resident D expired at a local ED on 12/25/24 at 10:42 A.M. While Resident C was being transferred in the mechanical lift, CNA 6 and CNA 7 wrapped a lift pad under the resident's legs, rather than through her legs, due to the resident's rigidity in her lower extremity. The resident lacked the required "good torso stability" to use the under-leg method, as stated in the mechanical lift operator's instructions, and no assessment had been completed that indicated the resident was appropriate for the use of that method. Facility Administrator 2 was notified of Immediate Jeopardy on 1/23/25 at 3:10 P.M. The Immediate Jeopardy was removed on 1/24/25 at 4:48 P.M, and the deficient practice corrected, on 12/27/24, prior to the start of the survey and was therefore Past Noncompliance. Finding includes: An Indiana Department of Health (IDOH) Facility Reportable Incident (FRI) form dated 12/25/24 at 7:50 A.M., indicated that Resident D had a witnessed fall during a transfer using a lift with		practice: The involved resident was assessed, the responsible party notified, MD, Administrator, and resident was sent to the Emergency Room for evaluation and treatment. Investigation was initiated immediately. The involved hoyer lift and sling were removed from use. The two aides involved in her hoyer lift transfer were suspended pending investigation. Employee education file was reviewed for staff involved to verify previous skills validation competency was completed. The resident husband and family were given support. II. The facility will identify other residents that may potentially be affected by the practice. All residents who utilize a hoyer lift were determined. These residents were reviewed, and their plan of care reviewed and updated. Other hoyer slings and hoyer lifts in the facility were removed from the unit until Maintenance could do an inspection of the lifts. Nursing did inspection of all lift slings in the facility. The Manufacturer's guidelines were reviewed. For the remainder of 12/25/24 into day shift of 12/26/24, the facility nurses observed all hoyer lift transfers. III. The Mechanical Lift policy was	

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	two staff present. The resident sustained a laceration to her head and complained of pain. Resident D was sent to Emergency Department (ED) for evaluation. An IDOH FRI follow up report dated 12/26/24, indicated the resident was found to have sustained a left distal femur fracture, left tibial fracture, a right distal femur fracture, and a right ankle fracture. Resident D passed while in the hospital. The facility's investigation report of Resident D's fall, on 12/25/24, included a typed note signed by CNA 6, dated 12/25/24. CNA 6 indicated she and CNA 7 entered Resident D's room while Resident D was lying in bed. Following care and dressing the resident, a lift pad was placed under the resident. The bottom of the lift pad was crossed under Resident D's legs. The lift pad straps were hooked to the mechanical lift so that Resident D would be sitting up in a sitting position and due to the condition of the resident's legs. One of the resident's legs is stiff while the left leg hangs due to the resident having no use of her left side. CNA 6 was operating the mechanical lift. CNA 6 lifted Resident D up high enough that her legs were off the bed. CNA 7 was on the left side of the bed toward the bottom of the bed. CNA 6 pulled the lift out from her bed to place the resident in her chair when she began to fall feet first from the lift pad. As the resident's feet hit the floor, CNA 6 was trying to catch her head. Resident D's head came back and hit the battery box on the mechanical lift. The mechanical lift did not tip. Nursing was immediately notified. An untimed, typed interview conducted, dated 12/25/24, indicated CNA 6 did not know what went wrong during the transfer of Resident D. The		reviewed, and the procedures were reviewed. The facility will put into place the following systematic changes to ensure that the practice does not recur. The facility incorporated additional new employee training in addition to the facility orientation, and specific lift information provided by the manufacturer. The facility nursing and therapy staff received re-education on hoyer lift transfers, as well as the Manufacturer's Guidelines for use of the hoyer and sling. Education included a lift competency checklist specific to the EZ Way Lift utilized in the facility, as well as the criteria for the use of the hoyer lift sling under the legs per the Manufactuer's Guidelines, and a skills validation completed by 12/27/24. Any additional nursing and therapy staff completed the education prior to reporting for any further shifts worked. IV. The facility will monitor the corrective action by implementing the following measures: DON/Designee will observe 3 residents 5 days per week for hoyer lift transfers with staff x 4 weeks, then 3 residents weekly for 8 weeks, then 3 residents monthly for a total of 12 months. The results of the audit will be reviewed at the monthly quality assurance meeting. Changes may be	

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	report indicated CNA 6 placed the lower lift pad straps under the resident's legs, but did not place the excess sling legs over the thighs because one leg was kind of stiff and the other leg was flaccid. The report indicated CNA 6 reported the resident fell from the lift pad feet first and the pad remained attached to the mechanical lift. An untimed, typed interview with CNA 7, dated 12/25/24, included the question, "What do you think went wrong?" CNA 7 indicated, "...If we would have put the pad in between (Resident D's) legs, it may have helped keep her in the pad..." On 1/22/25 at 9:30 A.M., the mechanical lift, EZ Way Smart Lift 500, 600, & 1,000 pound (lb) Capacities Operator's Instructions, dated 6/14/23, was reviewed. The instructions indicated, "Step 1 Position sling under resident... 6) Lift patient's left thigh and pull the left sling leg of the sling under patients' thigh. Then place excess sling leg over the top of the patient's left thigh. 7) Repeat the above step for right thigh. NOTE: If the patient's legs are extremely rigid, it may work better to bring the left sling leg under the right thigh and the right sling leg under the left thigh instead of threading between the patient's legs. The patient must have good torso stability to use this method..." Assistant Director of Nursing (ADON) indicated during an interview, on 1/21/25 at 1:40 P.M., the facility used the EZ Way Smart Lift 600 mechanical lifts. The ADON indicated during an interview, on 1/22/25 at 12:30 P.M., she came to the facility on 12/25/24 following Resident D's fall from the mechanical lift. The ADON indicated, in an effort to understand what happened during the transfer, staff reenacted the transfer of Resident D, by		established to the auditing process, based upon the results of the audits as determined by the Quality Assurance Committee. Ad-HOC QAPI meeting was held with the facility Medical Director regarding the concern and the corrective action plan. V. Plan of Correction completion date: 12/27/24	

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PAOLI HEALTH AND LIVING COMMUNITY	559 W LONGEST ST PAOLI, IN 47454

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	transferring the ADON using the same lift and using same method . The ADON indicated that there were no issues during the reenactment, but that she possessed better body control than Resident D. A record review, on 1/23/25 at 11:00 A.M., indicated Resident D's diagnoses included, but were not limited to, hemiplegia (paralysis or weakness of one side of the body) and hemiparesis (paralysis or weakness on side of body) following nontraumatic intracerebral hemorrhage affecting the left non-dominant side, age-related physical debility, lack of coordination, weakness, and pain. Resident D's the most recent quarterly Minimum Data Set (MDS) assessment, dated 11/1/24, indicated a cognitive function assessment could not be completed due to the resident being rarely to never understood. Resident D had functional limitations to both right and left upper and lower extremities, was dependent for all transfers and mobility use of mech lift with two assistants, and utilized a wheelchair. Resident D's physician orders included, but were not limited to, physical therapy evaluation and treatment (started 11/20/24). PT Evaluation & Plan of Treatment, dated 11/20/24, was reviewed. The evaluation indicated prior equipment used included a Broda chair (specialized chair), hospital bed, and mechanical lift. Prior level of function indicated resident was dependent for mobility and for all care. Resident D's mobility function was assessed with score of 0 out of 12 with 12 being highest or poor and 0 being the lowest. Resident D's balance assessment indicated the resident could not sit unsupported for 30 seconds, resident was unable to sit at the edge of bed, and resident was unable			

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	to stand without upper extremity support. Resident D's care plan included, but was not limited to, Resident has specific needs related to their care. Interventions included, the resident is a two person assist with mechanical lift for transfers (started 11/17/22), use assistive device wheelchair (started 11/17/22). Resident has self-care deficits related to left side hemiplegia/hemiparesis. An intervention included, follow guidelines of physical therapy (PT) (started 7/21/21. Most recent review of plan was November 2024. Resident D's nurse's progress notes included, but were not limited to: 11/25/2024 at 11:03 A.M. - Resident has left lower extremity edema. Extremity elevated on pillow when in bed and when up in Broda chair. 12/25/24 at 8:30 A.M. - During a transfer, the resident fell onto floor while two staff were assisting with transfer. A 3 cm laceration was noted to the back of head. Bilateral legs were bent underneath resident. Resident complaining of pain all over. Ambulance at facility at 8:15 A.M. 12/25/24 at 11:30 A.M. - ED notified the facility that Resident D had passed away at hospital. Resident D's ED nursing progress note, dated 12/25/24 at 9:53 A.M., indicated Resident D was dropped from a lift operated by two CNA's and fell approximately 3.5 - 4 feet. The resident struck the back of her head on the lift. Emergency Medical Services (EMS) reported that Resident D was found in her room, on the floor, under the lift pad when they arrived at the facility. Hospital records included: Resident D's ED physician's progress note, dated 12/25/24 at 11:09 A.M., indicated Resident D fell			

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	out of a mechanical lift that morning. The resident hit the back of her head and her legs were bent under her. Resident D's physical examination indicated obvious deformity at left upper leg with bruising to the left knee. Resident D presented with trauma from fall with a concern of multiple injuries. At 10:35 A.M., Resident with extensive orthopedic trauma that included bilateral femur fractures and a right ankle fracture. At 10:45 A.M., Resident became apneic (temporary loss of breathing) and asystole(cardiac arrest). No heart sounds were heard. Resident D's time of death was 10:42 A.M. Final radiology results included a left femur fracture, left tibial fracture, right femur fracture, and a right ankle fracture. The Physical Therapy (PT) Director indicated during an interview, on 1/23/25 at 11:40 A.M., there was not a specific assessment to be completed for residents who required transfer with a mechanical lift using the under-leg method with the lift pad. The PT Director indicated that a balance test would be a good indicator of a resident's torso stability or if the resident was able to sit up at their bedside. The PT Director indicated during an interview, on 1/23/25 at 12:15 P.M., Resident D's balance assessment likely was not fully completed due to the resident being unable to perform any of the needed exercises to assess her balance. The PT Director indicated the resident had been using a Broda chair and that Broda chairs were generally used for residents who are unable support themselves in a regular wheelchair. The facility mechanical lift training documentation, dated 8/27/24, indicated CNA 6 completed a mechanical lift skills checklist, but did not include documentation to indicate CNA 6 was trained and competent to perform transfer with the			

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	EZ Way Smart Lift prior to 12/25/24. During an interview, on 1/23/25 at 11:55 A.M., the ADON indicated that all staff completed the facility validations skills checklist for mechanical lifts. The facility had not initially provided the EZ Way Smart Lift competency checklist for new hires but did provide the training and ensure competency to all nursing staff immediately following the incident on 12/25/24. On 1/24/25 at 3:30 P.M., Facility Administrator 2 and RN 4 indicated prior to Resident D's fall, on 12/25/24, no specific assessments were in place to determine which transfer methods were best suited for each resident that required a mechanical lift. Resident C had fallen as CNA 6 was pulling the mechanical lift out from under Resident D's bed. CNA 7 was at the foot of the bed and could not reach the resident as she slid from the sling until her feet hit the floor. CNA 7 could not support the resident as she continued to fall next to the bed. On 1/24/25 at 3:50 P.M., CNA 16 indicated that she had received training regarding the use of mechanical lifts for transfers following Resident D's fall on 12/25/24. CNA 16 indicated that she was initially trained to place the mechanical lift pad straps through a resident's legs when transferring but had seen other staff use the under-leg method when using the mechanical lift. CNA 16 indicated that prior to recent in-services and trainings, CNA's that who provided assistance with mechanical lift transfers were able to determine which method to use and different staff used different methods. The EZ Way Smart lift Operator's Instructions provided by Facility Administrator on 1/22/24 at			

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	9:30 A.M. indicated, "For safe operation of the EZ Way Smart Lift, operators should watch the training video, read through this manual, complete the competency checklist, and practice on fellow staff members before use with patients." On 1/22/24 at 10:00 A.M., the Facility Administrator supplied a current facility policy titled, Safe Use of a Mechanical Lift, dated 8/15/22. The policy indicated, "[Company name]... are committed to taking steps to ensure the resident environment remains free of accident hazards as is possible and that each resident receives adequate supervision and assistive devices to prevent accidents... if facility training and instructions shall always be reviewed and followed... At least 2 [two] trained staff members are needed to safely move a resident using a mechanical lift... Lift design and operation varies across manufactures. Staff will be trained and demonstrate competencies using the lifts utilized in their community." Attached to the facility policy was a copy of the Transferring a Resident with a Hoyer/Mechanical Lift Skills Validations checklist. The checklist indicated, " ...9. One staff member will man the lift while the other staff member stabilizes the resident's head and feet during the transfer ... 11. Raise sling/resident ... 12. Have a staff member support the resident's legs while the other monitors the movement of the lift ... 13. Raise the lift high enough to clear the bed and unlock the wheels of the lift ... 14. 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 past noncompliance Immediate Jeopardy began on 12/25/24. The Immediate Jeopardy was removed and the deficient practice corrected by			

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	12/27/24 after the facility implemented a systemic plan which included the following actions: in-services related to procedures for the use of mechanical lifts and ongoing monitoring. This citation relates to complaint IN00450157. 3.1-45(a)(1) 3.1-45(a)(2)			