STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155493	A. BUILDING 00 B. WING	06/16/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCENIC HILLS CARE CENTER	311 E FIRST ST FERDINAND, IN 47532

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (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 a Recertification and State Licensure Survey. Survey dates: June 10, 11, 12, 15, and 16, 2015 Facility number: 000534 Provider number: 155493 AIM number: 100267220 Census bed type: SNF: 7 SNF/NF: 68 Total: 75 Census payor type: Medicare: 12 Medicaid: 36 Other: 27 Total: 75 These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2-3.1.	F 0000	Preparation or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged, or conclusions set forth on the statement of deficiencies. This plan of correction is prepared and executed solely because it is required by Federal and State law. This plan of correction is submitted in order to respond to the allegations of noncompliance cited during annual survey review concluding on 6-16-2015 Please accept this plan of correction as the provider's credible aggregation of compliance effective on or before 7-9-2015	
F 0241 SS=D Bldg. 00	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that			

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

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	maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation, interview, and record review, the facility failed to ensure care was provided in a manner that promoted dignity and well being, in that, a resident was addressed during care in a tone of voice which was perceived by the resident as sassy and unkind, resulting in the resident ruminating for nights about the incident. (Resident #97) Findings included: During an interview and observation on 6/11/15 at 8:45 A.M., Resident #97 indicated LPN #2 was working the evening shift a few days ago and LPN #2 had been very rude to her. Resident #97 indicated her bandage had fallen off and, when LPN #2 saw it, LPN #2 asked Resident #97 in a very sassy and unkind tone of voice, "Why did you take that off?" Resident #97 said, "I told her I didn't take it off. LPN #2 always thinks everything is my fault." Resident #97 said, "I lay awake at nights thinking about what she said and I know she is the boss. I don't mind when people tell me what to do, but I don't like it when they accuse me of things I didn't do." Resident #97 said, "LPN #2 would be so ugly to me, and then she would come and	F 0241	F 241 Residents #97 suffered no ill effects from the alleged deficient practice and through corrective action and in servicing will ensure the campus promotes care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Upon being informed of incident by the state surveyor an investigation was initiated and nurse suspended. The incident was reported to the ISDH. The investigation was completed and the nurse was counseled and completed mandatory training. The nurse identified will no longer be caring for this resident. **Completion Date 7-9-2015** All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will promote care for the residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Each alert and oriented residents on the hall where the nurse worked have been interviewed to assure dignity of the residents maintained. **Completion Date 7-9-2015** All staff have been in serviced regarding resident's dignity. Systemic change is the SS	07/09/2015

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	say, 'good night honey.' There is no sense in someone being that unkind." The clinical record of Resident #97 was reviewed on 6/12/15 at 8:30 A.M. The record indicated the diagnoses of Resident #97 included, but were not limited to, heart disease, congestive heart failure, and chronic kidney disease. A Care Plan for "COGNITION" dated 6/9/15 included, but was not limited to, "I am alert and oriented to person, place, time and situation. I can make my wants/needs known without issue." A "CHANGE IN CONDITION FORM" dated 6/3/15 read as follows: "...Resident has skin tear to top of left forearm ...by removing band-aid per self..." The Admission MDS (Minimum Data Set) assessment dated 5/9/15 indicated Resident #97 experienced no cognitive impairment. During an interview on 07/21/15 at 10:30 A.M., the Nurse Consultant indicated LPN #2 had been suspended but would receive Customer Service Training before returning and providing care for residents residing at the facility. The Nurse Consultant further indicated that Resident #97 would be moved to 100 hall and		director will complete questionnaire on 5 residents weekly to assure resident's dignity maintained. **Completion Date 7-9-2015** ED/Designee will interview 3 random residents to assure dignity and respect of the individual 5 x a week for a month then 3 x week for a month then weekly with results forwarded to QA Committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Comple tion Date 7-9-2015**	

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	would not be provided cared by LPN #2 again. The Customer Service Training was provided by the Assistant Director of Nursing on 6/16/15 at 11:29 A.M., and it read as follows: "2. CONTACT...Present yourself as a professional...Use a pleasant tone of voice..." A copy of the "Resident Rights" was provided by the Assistant Director of Nursing on 6/16/15 at 11:29 A.M., and it read as follows: "...1. The facility provides services in a manner that will assist you in maintaining your...dignity and well being..." 3.1-3(t)			
F 0279 SS=D Bldg. 00	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain			

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	the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on observation, interview, and record review, the facility failed to ensure a care plan was developed, in that, a resident identified as being at risk to experience falls did not have a care plan with effective interventions to prevent falls for 1 of 2 residents who met the criteria for review of accidents. (Resident #105) Findings include: On 6/11/15 at 12:13 P.M., Resident #105 was observed in a common lounge area of the 300 unit, sitting in a wheel chair waving with the right hand and stated, "come here". During an interview, at that time, Resident #105 was observed to pull up the shirt sleeve on the left arm and stated, "...it hurts so bad...I fell out of bed last night..." The left wrist and lower forearm of Resident #105 was then observed, to have black and/or purple areas of discoloration, swelling, and deformity.	F 0279	F 279 Resident #105 was admitted to the campus on 6/2/15 an admission assessment was completed at that time and a temporary care plan for safety was completed as stated on 2567 by the surveyor "Safety Plan of Care " with the following interventions:Assess fall risk at admission, quarterly and PRN{as needed} Ensure glasses clean and in place, refer to Therapy, ensure call light with in reach, observe elopement attempts and wandering, redirect resident, instruct on use of call light." The above interventions remain appropriate and in effect on the residents plan of care. The plan of care is updated daily for any changes resident may experience. The incident that occurred on 6-11-2015 between the hours of 2:30am and 4pm when the resident fractured her arm was an injury of unknown origin. It could not be established that the resident did fall. The care plan was updated at that time from the investigation to include a scoop mattress and revised toileting plan. Resident 105 continues with therapy and therapist continue to recommend	07/09/2015

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	The clinical record of Resident #105 was reviewed on 6/11/15 at 12:30 P.M. The record indicated Resident #105 was admitted to the facility on 6/3/15 with diagnoses including, but not limited to, Alzheimer's disease. During an interview on 6/12/15 at 11:15 A.M. the ADHS (Assistant director of Nursing) indicated the Admission MDS (Minimum Data Set) assessment was in process, but the initial evaluation tools indicated Resident #105 experienced severe cognitive impairment. The Admission Physician's Orders dated 6/3/15 included, but were not limited to, orders for, "...May be up ad lib [at liberty]...PT [Physical Therapy]/OT [Occupational Therapy] to eval [evaluation]..." A Nursing Admission Assessment dated 6/3/2015 indicated Resident #105 was able to transfer and ambulate independently, experienced, "...cognitive impairment that effects safety/judgment... Did the resident have a fall in the last month prior to admission...unable to assess...Did the resident have a fall in the last 2-6 months prior to admission...unable to assess..." and/or was at risk to experience a fall due to cognitive impairment. The assessment		resident be up ad lib in campus and during therapy treatments when the resident is challenged she may need SBA for therapy treatments only. **Completion Date 7-9-2015** All residents have the potential to be affected and therefore through alterations in provision of care and in servicing the campus will assure the campus continues to use the results of the assessments to develop, review and revise the resident's comprehensive plan of care. All residents safety plans of care have been reviewed. **Completion Date 7-9-2015** An in-service has been completed with nurses covering the federal regulation of development of a care plan. Systemic change is each resident status will be reviewed during CCM on admission and the temporary care plan will be reviewed with the IDT during the assessment and review process to assure care plans initiated as appropriate from the initial assessment and thereafter care plans will be updated daily with changes in the resident. **Completion Date 7-9-2015** DHS or designee will audit 3 random residents care plans to ensure the campus developed a comprehensive care plan for each resident that includes measureable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the	

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	included a "Safety Plan of Care" with the following interventions: "Assess fall risk at admission, quarterly, and PRN [as needed], Ensure glasses are clean and in place, Refer to therapy, Ensure call light is within reach, observe elopement attempts and wandering, Redirect resident, Instruct resident on use of call light." An untimed Physician's Telephone Order dated 6/4/15 indicated, "OT services 5X [times]/wk [week] X45 days. Tx [treatment] may include ADL [Activities of Daily Living] training, cognitive...pt [patient]/caregiver education..." An untimed Physician's Telephone Order dated 6/4/15 indicated, "PT eval completed. Tx 5X/wk X45 days. Tx to include gait training...pt [patient]/caregiver education..." An untimed PT Initial Assessment dated 6/4/15 indicated Resident #105 required supervision during ambulation on level surfaces and/or hand held assistance for ambulation on unlevel surfaces and/or was at risk to experience a fall. An untimed OT Initial Assessment dated 6/4/15 indicated Resident #105 required stand by assistance (close enough to reach patient if assist needed) for		comprehensive assessment 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments. **Completion Date 7-9-2015**	

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	"functional transfers, toilet...bed mobility, supine to sit...bed mobility, sit to stand.." An Assessment Review and Considerations form dated 6/5/15 indicated, "Fall Risk...cognitive impairment...Medications...An individualized care plan has been initiated to address the above risk factors and minimize the risk of falling and/or reduce the likelihood of injury..." The form lacked any additional interventions to ensure the safety of Resident #105. A Resident First Conference note dated 6/8/15 indicated Resident #105 experienced no safety issues. An Individual Plan Report dated 6/9/15 indicated Resident #105, "...toileting assist as needed...Transfers up ad lib...Ambulation up ad lib..." The plan lacked any documentation related to Resident #105's risk to experience a fall and/or decreased safety awareness. A CNA Assignment Sheet provided by LPN #10 on 6/11/15 at 11:10 A.M. indicated Resident #105 was independent with ambulation. The assignment sheet lacked any documentation of safety concerns. During an interview on 6/16/15 at 12:15			

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	P.M. OT #2 indicated Resident #105 required stand by assistance for transfers. During an interview on 6/16/15 at 12:16 P.M. PT #1 indicated Resident #105 required stand by assistance for transfers. During an interview on 6/16/15 at 2:15 P.M., the ADHS indicated a care plan had not been developed to address a safety risk, because Resident #105 had an order to be up ad lib and PT/OT had indicated Resident #105 ambulated independently. During an interview on 6/16/15 at 3:00 P.M., the HFA (Health Facilities Administrator] and the ADHS indicated no documentation could be provided to indicate interventions had been implemented and/or supervision had been provided to ensure the safety of Resident #105. 3.1-35(a)			
F 0323 SS=G Bldg. 00	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.			

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	Based on observation, interview, and record review, the facility failed to ensure services were provided to prevent accidents, in that, a cognitively impaired resident (Resident #105) and a dependent resident (Resident #44) identified as being at risk to experience accidents, were not provided supervision, and/or necessary assistance, and experienced accidents for 2 of 2 residents who met the criteria for review of accidents. This deficient practice resulted in Resident #105 experiencing a left wrist fracture. Findings include: 1. During an interview on 6/11/15 at 9:30 A.M., LPN #10 indicated Resident #105 had not experienced a fall and/or a fracture in the last 30 days. On 6/11/5 at 10:00 A.M. Resident #105 was observed in a common lounge area of the 300 Unit sitting in a stationary chair, leaning on the left arm of the chair with closed eyes. Resident #105 was observed, at that time, holding the left wrist across the chest with the right hand. On 6/11/15 at 12:13 P.M., Resident #105 was observed in a common lounge area of the 300 unit, sitting in a wheel chair waving with the right hand and stated,	F 0323	F 323 Campus is respectfully requesting an IDR for this tag as we would like the opportunity to appeal the citation of F323. We would like to request a face to face review of this citation. We do not believe the contents as cited meets the criteria for the citation as well as we believe it does not meet the level of scope and severity as cited. 1.) Resident #105 was admitted to the campus on 6-3-2015 an admission assessment was completed and a safety plan of care was initiated. On 6-3-2015 an order was received for the resident to be up ad lib. On the morning of 6-11-2015 at 4am resident #105 presented in her room sitting in her chair c/o of wrist pain stating she hit her arm. Later in the morning of 6-11-2015 resident 105 stated she fell causing the injury. Resident 105 is cognitively impaired and the campus reported the injury of unknown origin and began an investigation. Resident 105 had been checked on throughout the night at 12:45am, 2:00am, and 4am as noted above per the documented nurses notes. Resident 105 continues to follow up with the orthopedic who casted her wrist. Therapy continues to treat resident 105 and recommendations continue to be resident up ad lib in the campus and when resident is receiving therapy sessions she will have a therapist stand by with	07/09/2015

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	"come here". During an interview, at that time, Resident #105 was observed to pull up the shirt sleeve on the left arm and stated, "...it hurts so bad...I fell out of bed last night..." The left wrist and lower forearm of Resident #105 was then observed, to have black and/or purple areas of discoloration, swelling, and deformity. During an interview, at that time, LPN #10 stated, "...that's what she told us, too. I am waiting on the x-ray report to come back..." The clinical record of Resident #105 was reviewed on 6/11/15 at 12:30 P.M. The record indicated Resident #105 was admitted to the facility on 6/3/15 with diagnoses including, but not limited to, Alzheimer's disease. A [name of hospital] History and Physical Examination report dated 5/27/15 indicated, "...increased confusion...has had a digression in her functioning over the past 4 to 5 days...has had a gradual decline in her memory...it has become worse...patient has been making irrational decisions, has endangered herself..." A [name of hospital] Behavioral Health Services report dated 5/28/15 indicated, "...has been experiencing significant memory loss...illogical thoughts..."		therapy treatment. 2.) Resident #44 was reviewed by therapy on 6-12-2015 for transfer needs. Resident #44 stated he understood the risk of using the SARA lift but stated he wanted to continue utilizing the SARA lift as he wants to be able to use the commode. Therapy wrote an order for the resident to be a Hoyer lift with 2 assist for transfers from w/c to bed and 3 staff to assist for stand aid lift transfers in the spa bathroom. An in service with nursing staff on this new plan of care was initiated at this time. **Completion Date 7-9-2015** All other residents are at risk to be affected by the alleged deficiency and through alterations in processes and in servicing the campus will ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. All resident's plan of care for safety/transfer needs have been reviewed and updated if necessary. **Completion Date 7-9-2015** Nursing staff have been in serviced by DHS/ADHS concerning the transfer/ ambulation assist needed for residents in the campus, location of safety care plans, and lift recommendations. Systemic change is C.N.A/nurses will complete competency of using SARA lift and complete annually	

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	During an interview on 6/11/15 at 3:15 P.M., LPN #10 indicated the X-ray results had been received and Resident #105 had experienced a fracture to the left wrist. During an interview on 6/12/15 at 9:14 A.M. the ADHS (Assistant Director of Health Services) indicated the injury to the left wrist of Resident #105 was of unknown origin. During an interview on 6/12/15 at 11:15 A.M. the ADHS indicated the Admission MDS (Minimum Data Set) assessment was in process, but the initial evaluation tools indicated Resident #105 experienced severe cognitive impairment. The Admission Physician's Orders dated 6/3/15 included, but were not limited to, orders for, "...May be up ad lib [at liberty]...PT [Physical Therapy]/OT [Occupational Therapy] to eval [evaluation]..." A Nursing Admission Assessment dated 6/3/2015 indicated Resident #105 was able to transfer and ambulate independently, experienced, "...cognitive impairment that effects safety/judgment... Did the resident have a fall in the last month prior to admission...unable to		thereafter monitored by DHS/ADHS Care plans will state resident transfer/ambulation assist. **Completion Date 7-9-2015** DHS /designee will monitor 3 random resident at risk for accidents/incidents to assure safety interventions in place and interventions effective 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x 6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 7-9-2015**	

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	assess...Did the resident have a fall in the last 2-6 months prior to admission...unable to assess..." and/or was at risk to experience a fall due to cognitive impairment. The assessment included a "Safety Plan of Care" with the following interventions: "Assess fall risk at admission, quarterly, and PRN [as needed], Ensure glasses are clean and in place, Refer to therapy, Ensure call light is within reach, observe elopement attempts and wandering, Redirect resident, Instruct resident on use of call light." An untimed Physician's Telephone Order dated 6/4/15 indicated, "OT services 5X [times]/wk [week] X45 days. Tx [treatment] may include ADL [Activities of Daily Living] training, cognitive...pt [patient]/caregiver education..." An untimed Physician's Telephone Order dated 6/4/15 indicated, "PT eval completed. Tx [treatment] 5X/wk X45 days. Tx to include gait training...pt [patient]/caregiver education..." An untimed PT Initial Assessment dated 6/4/15 indicated Resident #105 required supervision during ambulation on level surfaces and/or hand held assistance for ambulation on unlevel surfaces and/or was at risk to experience a fall.			

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	155493	A. BUILDING 00 B. WING	06/16/2015

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	An untimed OT Initial Assessment dated 6/4/15 indicated Resident #105 required stand by assistance (close enough to reach patient if assist needed) for "functional transfers, toilet...bed mobility, supine to sit...bed mobility, sit to stand.." An untimed OT daily progress note dated 6/9/15 indicated, "Pt ambulated around obstacles while holding 3 pound bag with 1 LOB (Loss of Balance)..." An Assessment Review and Considerations form dated 6/5/15 indicated, "Fall Risk...cognitive impairment...Medications...An individualized care plan has been initiated to address the above risk factors and minimize the risk of falling and/or reduce the likelihood of injury..." The form lacked any additional interventions to ensure the safety of Resident #105. A Resident First Conference note dated 6/8/15 indicated Resident #105 experienced no safety issues. An Individual Plan Report dated 6/9/15 indicated Resident #105, "...toileting assist as needed...Transfers up ad lib...Ambulation up ad lib..." The Nursing notes from 6/9/15 at 9:30			

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	A.M. through 6/11/15 at 7:15 A.M., were reviewed and lacked any documentation Resident #105 had experienced an adverse event. A Nursing note dated 6/11/15 at 7:15 A.M. indicated, "Noted res [resident] rubbing L [left] wrist. Examined et noted raised area 0 [no] bruising. Res c/o [complaint of] pain [with] range of motion..." A Nursing note 6/11/15 at 8:00 A.M. indicated, "FNP [Family Nurse Practitioner] examined L wrist et [and] ordered 2 view X ray." A Nursing note dated 6/11/15 at 12:40 P.M. indicated, "...Noted res rubbing her L wrist. Visitor standing in area res stated 'Come here' res showed visitor her wrist. She stated 'I fell last night when I was getting up to go to the bathroom'..." An untimed Fall Circumstance Report dated 6/11/15 indicated Resident #105 experienced an unwitnessed fall in the resident's room on 6/11/15 at an unknown time. The report further indicated Resident #105 experienced a swollen area on the left wrist and included a handwritten notation of, "Res has changed stories from hitting on on table, thinks she may have bumped it et			

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	that she had to use toilet et fell out of bed..." A Nursing note dated 6/11/15 at 5:00 P.M. indicated, "Late Entry for 6/11/15 at 0415 [4:15 A.M.] CNA notified this nurse of Resident c/o pain to L hand, [sic] Resident sitting in bedside chair...Res stated '...bumped my hand on my bed + [and] it hurts bad," "[sic] I really whacked it" During an interview on 6/16/15 at 12:15 P.M. OT #2 indicated Resident #105 required stand by assistance for transfers. During an interview on 6/16/15 at 12:16 P.M. PT #1 indicated Resident #105 required stand by assistance for transfers. During an interview on 6/16/15 at 2:15 P.M., the ADHS indicated the event during night shift on 6/11/15 was not considered a fall because the event was not witnessed. During an interview on 6/16/15 at 3:00 P.M., the HFA (Health Facilities Administrator] and the ADHS indicated no documentation could be provided to indicate interventions had been implemented and/or supervision had been provided to ensure the safety of Resident #105.			

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A Radiology report dated 06/11/15 indicated, "...Conclusion: Transverse distal radial fracture with mild dorsal angulation..."

A Policy and Procedure for Fall management Program Guidelines provided by the HFA on 6/16/15 at 3:15 P.M. indicated, "Purpose:...mitigate fall risk factors and implement preventative measures..."

2. Resident #44 had been admitted to the facility on 11/23/11. His diagnoses included but were not limited to, chronic obstructive pulmonary disease, chronic kidney disease stage 4, depression, and diabetes. His current Minimum Data Set assessment (MDS) dated 6/2/15 and his previous MDS dated 02/25/15 indicated, extensive assistance of 2 or more staff for bed mobility, transfers, and a total cognition score of 14 (cognition intact).

Nursing notes dated 5/21/15 at 6:00 P.M., indicated, "CRCA [Certified Registered Care Aide] [Certified Nursing Assistant] reported to this nurse that resident has skin tear to right elbow measuring 4 cm x 4 cm x .1 cm and bruise to left back measuring 3.5 cm x 2 cm resident having difficulty standing while using SARA lift [mechanical stand aid lift] - resident not

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	standing appropriately with the use of the lift and resident hit right elbow and bruise to left side of back - all safety precautions are taken while SARA is in use-Dr. [physician's name]-[first name of Power of Attorney POA] notified ADHS [Assistant Director of Health Services] also notified - New orders received and noted to apply steri-strips to skin tear-Monitor Q [every] Shift x 14 days then re- eval [re evaluate]-Monitor bruise to left side of back Q shift x 14 days then re-eval- Will continue to monitor..." Nursing note dated 5/23/15 at 3:55 P.M., indicated, "CRCA was taking resident out of bathroom using SARA [mechanical stand aid lift] Lift-resident not standing appropriately and his feet came off the SARA lift even with the straps around his legs-this nurse was summoned to help assist resident to floor-has skin tear measuring 2 cm C-shape to Right ring finger steri-strips applied. ADHS notified...Will continue to monitor..." Nursing note dated 5/23/15 at 6:10 P.M., indicated "...apply steri-strips to Right ring finger monitor Q [every] Shift x 14 days and Use Hoyer [mechanical] lift for transfers." The physician's current order before the			

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	observed resident transfer on 6/12/15 at 11:45 A.M., indicated, "6/11/15 Clarification: Use stand-aid for transfer. May use Maxi-move [hoyer lift] PRN [when needed]." On 6/12/15 at 11:45 A.M., CNA #8 indicated she was going to transfer Resident #44 from his bed to his wheelchair by herself using a stand aid [Sara] lift. CNA # 8 indicated her CNA assignment sheet indicated to utilize the assistance of 1 staff and a mechanical lift for transfers. CNA #8 at that time was made aware of the safety concern in regard to only 1 staff utilizing the stand aid lift to transfer the resident. On 6/12/15 at 11:50 A.M., the Administrator was made aware of the concern of Resident #44 being transferred with a stand aid lift and the assistance of one staff. The Administrator indicated the facility's policy indicated the newer lifts such as the stand aid can be used by one staff but more staff could be utilized if needed. Observation on 6/12/15 at 11:53 A.M., resumed of CNA #8 assisting Resident #44 to sit on the edge of the bed. CNA #8 then applied his shoes, and positioned his feet on the lift. She fastened a strap around each leg and straps around his			

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	back area. At that time, CNA #7 entered Resident #44's room . CNA #8 proceeded with the transfer utilizing the control unit of the lift. Resident #44 stood and his left foot slipped. CNA #8 then repositioned Resident #44's left foot on the lift and continued with the lift transfer. The transfer ended with the lift not positioned close enough to the resident's wheelchair. CNA #7 then had to grab the resident's wheelchair and position it behind the resident on the lift so the resident could be seated in his wheelchair. On 6/12/15 at 11:55 A.M., CNA #7 was interviewed regarding Resident #44's transfer with the stand aid lift. CNA #7 indicated she was used to using 2 staff when using lifts such as the stand aid and the hoyer lift. On 6/12/15 at 12:05 P.M., CNA # 8 was interviewed regarding the transfer of Resident #44. She indicated the resident's foot had slipped and there had been a problem with the turning of the lift during the transfer. CNA #8 indicated that 2 staff had been needed for the transfer of Resident #44 . On 6/12/15 at 12:15 P.M., during an interview, the Administrator, was made aware that the resident's foot had slipped			

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	during the transfer and of the problem with the turning of the lift during the transfer. The Administrator was also made aware of another CNA had entered the resident's room and assisted CNA #8 by bringing the wheelchair to where the resident had been transferred. The Administrator was made aware that 2 staff had been needed for the transfer. The Administrator indicated she would have therapy do an evaluation in regard to transferring Resident #44. On 6/12/15 at 2:30 P.M., the ADHS provided documentation that she indicated was the facility policy from the stand aide and hoyer lift manufactory's instructions that was entitled, "General Information [undated]." The policy included, but was not limited to, "... Policy on Number of Staff Members Required for Patient Transfer: ArjoHuntleigh's [name of manufacture] passive and active series of lifts are designed for safe usage with one caregiver. There are circumstances, such as combativeness, obesity, contracture etc. of the individual that may dictate the need for a two-person transfer. It is the responsibility of each facility or medical professional to determine if a one or two person transfer is more appropriate, based on the task, resident load, environment, capability, and skill level of the staff			

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	members..." On 6/15/15 at 11:26 A.M., during an interview with the ADHS she indicated the therapy department had written a physician's order dated 6/9/15 for use of a stand aid lift or SARA left. The ADHS also indicated therapy had written an order on 6/11/15 for use of a stand aid lift for transfer and may use maxi move lift prn (when needed). The ADHS indicated Resident #44 had an order for therapy received on 5/28/15, for 10 Occupational Therapy (OT) visits which would include transfers. The ADHS explained typically if the resident was standing well staff were to use the stand aid lift but, the order had an option to use the maxi move (hoyer lift) if needed. The ADHS indicated Resident #44's current transfer order was a clarification order dated 6/12/15 and indicated 2 staff were to assist for hoyer lift in room transfers and 3 staff to assist for stand aid lift transfers in the Spa bathroom. On 6/15/15 at 1:43 P.M., Occupational Therapists #1 and #2 were interviewed regarding Resident #44's transfers. OT therapist #1 explained that Resident #44 had been inconsistent with his mobility during therapy. OT #1 indicated if Resident #44 was able to bear weight then he would be ok for the use of the			

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	stand aid lift. The therapists indicated Resident #44 had been evaluated on 5/27/15. The evaluation had been after nursing progress notes on 5/21/15 and 5/23/15 had indicated that Resident #44 had not been standing appropriately during transfers with the stand aide lift. OT staff #2 indicated she had worked with CNAs doing transfers during therapy but had not provided specific inservice training for CNAs in regard to transfers. She indicated, at that time, that the CNAs at the facility felt more comfortable using 2 staff with the lift transfers of Resident #44. OT #2 indicated at times, Resident #44 was moody with staff and unable to focus on a task. The therapists indicated Resident #44 had been inconsistent in following cues and with his performances during therapy. On 6/16/15 at 8:29 A.M., a facility policy entitled, "Guidelines for 'SWAT-We've got Your Back' Program [undated]" was reviewed. The policy included, but was not limited to, "Purpose: to ensure the safety of residents and staff when performing mobility/transfer tasks. Procedure: ...6. All devices are safe to be used by one staff member per manufactures guidelines. Staff should seek the assistance of a second person for those			

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	residents' care planned for assistance of two with the lifting device or as needed for safe handling..." 3.1-45(a)(2)			
F 0465 SS=D Bldg. 00	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFOR TABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. Based on observation, interview, and record review, the facility failed to ensure housekeeping services were provided, in that, the carpeted common areas of Unit 300 had a strong, pervasive odor of urine and/or furniture in the common areas of Unit 300 had wet and/or dry urine stains for 1 of 4 units on 5 of 5 survey days. (Unit 300). Finding include: 1. During an observation on 6/11/15 at 9:13 A.M. the carpeted resident lounge area, the carpeted TV area, and the carpeted hallway were observed to have a strong urine odor. Stains observed throughout carpeted areas. 2. During an observation on 6/11/15 at 11:43 A.M., the carpeted resident lounge	F 0465	F 465 The 300 unit carpets and furniture were cleaned on 6-16-2015. **Completion Date 6-16-2105** All residents have the potential to be affected by the alleged deficient practice and through alterations in processes and in servicing will ensure the campus provides a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. **Completion Date 7-9-2015**	07/09/2015

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	area, the carpeted TV area, and the carpeted hallway were observed to have a strong, pervasive urine odor. A wet area 6 inches by 3 inches was observed in the center of one of the 2 upholstered chairs located in the TV area. White stains were observed on the couch cushion in the TV room. 3. During an observation on 6/12/15 at 9:13 A.M. the lounge area, TV area, and/or hallway on Unit 300 were observed to have a pervasive odor of stale urine and/or multiple dried stains on the carpet. 4. During an observation on 6/12/15 at 10:43 A.M., the carpeted resident lounge area, the carpeted TV area, and the carpeted hallway were observed to have a strong, pervasive urine odor. Stains were observed throughout carpeted areas. The couch and chairs located in the lounge area were observed to have multiple stains. 5. During an observation on 6/15/15 at 8:23 A.M., the carpeted resident lounge area, the carpeted TV area, and the carpeted hallway were observed to have a strong, pervasive urine odor. Stains were observed throughout carpeted areas. The couch and chairs located in the lounge area were observed to have multiple		All items identified on the 2567 have been cleaned. All housekeeping employees have been in serviced on cleaning the floors properly and observing the need of when to clean the furniture. Systemic change is Housekeeping supervisor is to round at the beginning and end of her shift and review all furniture and carpets in the campus to assure clean and sanitary. **Completion Date 7-9-2015** ED/designee will complete environmental rounds to ensure carpets and furniture clean and sanitary 5x a week for a month then 3x a week for a month then weekly with results forwarded to QA committee monthly x6 months and quarterly thereafter for review and further suggestions/comments **Completion Date 7-9-2015**	

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	stains. 6. During an observation on 6/16/15 at 8:10 A.M., the lounge area, the TV area, and/or hallway on Unit 300 were observed to have a pervasive odor of stale urine and/or multiple dried stains on the carpet. 7. During an observation on 6/16/15 at 9:18 A.M., the carpeted resident lounge area, the carpeted TV area, and the carpeted hallway were observed to have a strong, pervasive urine odor. Stains were observed throughout carpeted areas. The couch and chairs located in the lounge area were observed to have multiple stains. 8. During a tour of the 300 unit on 6/16/15 at 9:25 A.M., the House Keeping Supervisor (HKS) indicated she could smell urine odor and had smelled urine odor in the past, especially when it was humid outside. The HKS further indicated that the chairs were cleaned at the end of the month and the cushions on the couch were exchanged when necessary. The HKS indicated the carpets had been cleaned, but the HKS was unsure of the exact date and/or was not able to provide documentation the carpets had been cleaned.			

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	The "Furniture Maintenance" policy was provided by the HKS on 6/16/15 at 9:32A.M., and read as follows: "...it is imperative for us to constantly monitor the condition of the furniture daily...Cleanliness is also very important to provide a quality appearance and minimize spread of bacteria...2, Clean all noticeable spots immediately..." The "Floor Care" was provided by the HKS on 6/16/15 at 9:32A.M., and read as follows: "...The individual assigned to the vacuuming duties should be carrying spot cleaner to address spots as noticed. WE do not want to wait for carpet cleaning schedules to address." 3.1-19(f)			