| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 155255 | A. BUILDING _____ B. WING _____ | 07/16/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| WOODVIEW A WATERS COMMUNITY | 3420 EAST STATE BLVD FORT WAYNE, IN 46805 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) |
|---|---|
| F 0552<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that residents are fully informed and understand their health status, care and treatments.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure the resident representative was notified of a change in treatment for 1 of 3 residents reviewed. (Resident C) Findings include: The record review for Resident C began on 7-14-2020 at 1:45 p.m. [DIAGNOSES REDACTED]. The 5 day admission MDS (Minimum Data Set) assessment completed on 5-8-2020 indicated Resident C had a BIMS (Brief Interview for Mental Status) of 6/15. The BIMS of 6 indicated Resident C had severe cognitive impairment. Resident C required an extensive assist of 1 staff for bed mobility, transfers, walking in room/corridor, locomotion on/off unit, toileting and personal hygiene. The resident required supervision with set up help for eating. Resident C had no impairment on her upper extremities and impairment on one side of her lower extremities. The resident used a walker or wheelchair and had severe pain. The resident had a fall in last six months prior to admission with a fracture and had 2 or more falls without injury since admission to the facility. The resident was 61 inches tall, weighed 147 pounds and was prescribed antianxiety medications. A review of Resident C's physician orders [REDACTED]. The DON (Director of Nursing) provided an order note on 7-16-2020 at 9:51 a.m., which indicated Resident C, with a BIMS of 6, was informed of the new order for the [MEDICATION NAME] for anxiety. There was no documentation the resident representative was notified of the new prescription for [MEDICATION NAME]. A review of Resident C's physician orders [REDACTED]. There was no documentation in the nurse progress notes the resident representative was notified. A confidential interview with Resident C's family on 7-14-2020, indicated there was a concern that the facility just did not communicate what they were doing with changing the resident's medications. An interview with the DON on 7-16-2020 at 9:51 a.m., indicated there was no documentation to support the notification of the resident's representative regarding the [MEDICATION NAME] order. An interview with the DON on 7-16-2020 at 1:52 p.m., indicated the facility did not have a policy on reporting changes to the resident representative. An interview with the DON on 7-16-2020 at 4:00 p.m., indicated the staff nurse should report significant changes for residents as soon as possible to the resident representative. Medication changes be communicated to the resident representative within a day. This Federal tag relates to Complaint IN 047. 3.1-3(n)(2)(3) |
| F 0609<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure a resident fall resulting in a fracture was reported to the State Agency within the timeframe required for 1 of 2 residents reviewed. (Resident D) Findings include: During the initial tour on 7-14-2020 which began at 9:25 a.m., the ADON (Assistant Director of Nursing) indicated Resident D had a recent fall with a [MEDICAL CONDITION]. The record review for Resident D began on 7-15-2020 at 2:42 p.m. [DIAGNOSES REDACTED]. The most recent quarterly MDS (Minimum Data Set) assessment for Resident D was completed on 4-17-2020. The resident's BIMS (Brief Interview for Mental Status) score was 3/15, which indicated the resident was severely cognitively impaired. The resident required an extensive assist of one person for bed mobility and transfers, and walking in the room or corridor did not occur. The resident did not have any impairment of his upper and lower extremity. The most recent MDS significant change assessment for Resident D was completed on 5-15-2020. The resident's BIMS score was 4/15. This indicated the resident was severely cognitively impaired. The resident required an extensive assist of two staff for bed mobility and transfers, and walking in the room and corridor did not occur. The resident had impairment on one side of his lower extremity. The most recent fall risk assessment was completed on 6-28-2020.The assessment indicated a score of 12 (the assessment did not define the level of fall risk based on the score). A nore on the assessment indicated Resident D was at risk for falls. The note indicated the resident needed assistance with bed mobility, transfers and toileting. The resident was noted to use a wheelchair, had unsteady gait, balance, and muscle weakness. A review of the nurse progress notes dated 5-4-2020 at 8:05 a.m., indicated Resident D walked out of his room into the hallway pushing his bedside table and huis breakfast on it. A CNA (Certified Nurse Aide) and the nurse quickly went to the resident to assist him. The resident lost his balance before they could reach him and slowly fell to the floor on his left side. The nurse performed a full skin assessment. The resident had skin tear to his left forearm and complained of lower left extremity pain. The resident stated his pain was a 10 on a scale of 1-10. There were no open areas noted on his left lower extemity. There was no bruising noted. The resident gaurded hisleft lower extremity when the nurse raised his leg and the pain was less tolerable as the nurse stretched out his leg. The resident was lifted from the floor using a gait belt and was assisted to bed. As needed (PRN) Tylenol 650 mg (milligrams) was administered as ordered. The resident's left forearm was cleansed and covered with a dry dressing. The resident's legs were elevated on a pillow as tolerated. The res ident's son, the NP (Nurse Practitioner), DON (Director of Nursing), and Administrator were all notified of the incident. A new order for an x-ray from the NP was put into place. A review of the nurse progress note dated 5-4-2020 at 9:49 a.m., indicated Resident D's son requested the resident stay at the facility for treatment rather than going to the emergency room . A review of the nurse progress note dated 5-4-2020 at 2:11 p.m., indicated Resident D's xray results had been received and a referral to was made to Orthopedics. The nurse made the appointment for 5-5-2020 at 1:45 p.m. A review of the nurse progress note dated 5-5-2020 at 3:01 p.m., indicated the Orthopedic clinic called and indicated Resident D had a fractured left hip and would be sent to the hospital for surgical repair. The Incident Report number 170 for Resident D was provided by the DON on 7-15-2020 at 12:38 p.m. The report, dated 5-7-2020, indicated on 5-4-2020 at 8:00 a.m., Resident D was ambulating in his room towards his door while pushing his bedside table. It was observed by the nurse that his left leg started to give out and he rolled down onto the floor. Resident D complained of left hip pain, xrays were ordered, and the resident was diagnosed with [REDACTED]. Resident D was seen by orthopedics on 5-5-2020 and transferred to the hospital directly from orthopedic office to repair his left femur. The resident had left hip pinning surgery on 5-6-2020 with no known complications. An interview with the DON on 7-16-2020 at 10:13 a.m., indicated after reviewing the incident, the report had been sent to the state on 5-7-2020. The incident occurred on 5-4-2020. The DON indicated she thought she had reported this on 5-4-2020 An interview with the DON on 7-16-2020 at 10:18 a.m., indicated the facility reported the fall with fracture for for Resident D on 5-7-2020. The DON indicated the fall incident occurred on 5-4-2020 and the facility was between DON staff at that time. An interview with the DON on 7-16-2020 at 1:52 p.m., indicated the facility did not have a policy on reporting incidents to the State. An interview with the DON on 7-16-2020 at 4:00 p.m., indicated a fall with a major injury should be reported to the State within 24 hours from the occurrence. This Federal tag relates to Complaint IN 204. 3.1-28(c) |
| F 0689<br><br>**Level of harm** - Actual harm<br><br>**Residents Affected** - Few | **Ensure that a nursing home area is free from accident hazards and provides adequate** |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0689<br><br>**Level of harm -** Actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>**supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on interview and record review, the facility failed to ensure the mechanical lift policy was followed by trained staff during a transfer of 1 of 1 resident reviewed for a fall. This resulted in a major injury and hospitalization .<br>(Resident B) Findings include: During the initial tour on 7-14-2020 at 9:25 a.m., the ADON (Assistant Director of Nursing) indicated Resident B was in the hospital related to a fall. The record review for Resident B began on 7-14-2020 at 2:39 p.m. [DIAGNOSES REDACTED]. The most recent MDS (Minimum Data Set) quarterly assessment was completed on 5-19-2020 for<br>Resident B. The resident had a BIMS (Brief Interview for Mental Status) score of 10 of 15, which indicated the resident was moderately cognitively impaired. The resident required an extensive assistance of two staff for bed mobility and transfers. The resident was dependent on two persons for toilet use. The resident's current weight was 318 pounds. A review of the physician current orders indicated Resident B should use a Hoyer lift for transfers. The order date was 10-26-2018 and the order was currently active. A review of the Fall Risk assessment dated [DATE] indicated Resident B's fall risk score was 17. The meaning of the score was not identified, but a written entry indicated the resident had the need to use a hoyer lift for traansfers. A review of the Fall Risk assessment dated [DATE] indicated Resident B's fall risk score was 14. The meaning of the score was not identified, but a written entry indicated the resident had a recent fall noted with pain to the lower left extremity and was sent to the emergency room for an evaluation. A current care plan titled risk for falls, indicated the need for assistance with transfers was initiated for Resident B on 10-14-2018. The fall risk care plan was revised on 7-8-2020 with an entry regarding a fall with a major injury on 7-7-2020. The interventions were updated on 7-8-2020, to ensure the resident was being transferred using appropriate equipment by trained personnel. A review of the nurse progress notes for Resident B on 7-7-2020 at 10:09 a.m., indicated a CNA (Certified Nurse Aide) notified the nurse that Resident B had slipped out of hoyer lift while being transferred to wheelchair from bed. The resident was noted to be laying on her back on the floor. The hoyer pad was noted to still be connected to lift. The resident was able to perform active range of motion to both upper extremities and the right lower extremity with discomfort. The resident complained of pain to the left lower extremity. The resident was alert and talking, the NP was made aware, and a new order was received to send the resident to ER for evaluation and treatment. The resident was transported to the hospital at 9:50 a.m. A nurse progress note for Resident B dated 7-7-2020 at 2:35 p.m., indicated the hospital called the facility and notified the nurse the resident had a displaced fracture of left femoral proximal shaft, and the resident would be having surgery the next morning. The DON (Director of Nursing) provided a fall investigation for Resident B on 7-14-2020 at 2:20 p.m. A review of the fall investigation indicated the fall happened on 7-7-2020 at 9:40 a.m. and was witnessed by staff members Housekeeper 1 and CNA 2. The investigation indicated the nurse entered the room, it was observed the hoyer sling was attached to the lift with 3 of 4 loops hooked onto the lift. One loop was off the hook. Statements were obtained from both staff members present during the fall. CNA 2 indicated the resident was positioned properly in the sling, the resident moved her leg while she was moving the hoyer away from the bed causing one of the loops on the hoyer sling to come off the hook. She indicated the resident then slid out of the sling suddenly and landed on her bottom. Housekeeper 1 stated he was asked to hold the wheelchair during the transfer, and it appeared the sling was fully attached to the lift when they began to transfer the resident. He indicated he noticed the resident started slipping suddenly and fell out of the sling. He indicated it was possible that one of the hooks may not have been on the lift properly. CNA 2 indicated that she asked Housekeeper 1 to assist her because she did not see any nursing staff available at the time that she was ready to transfer the resident. CNA 2 and Housekeeper 1 were re-educated regarding only trained staff would assist with any type of transfer including the use of mechanical lifts. The NP was notified at 1:45 p.m. the resident had a fracture to the left hip and would receive surgery. The DON provided a copy of CNA 2's education at orientation. The CNA checklist for CNA 2 indicated she was trained on 2-21-2019regarding transfer of a resident with a mechanical lift. No further education for CNA 2 on mechanical lifts was provided. A copy of CNA 2 and Houeskeepr 1's education was provided by the DON on 7-15-2020 at 12:44 p.m. the training indicated all staff members not trained on transfers would not assist with any resident transfers including any mechanical lift transfers. An interview with CNA 3 on 7-14-2020 at 3:30 p.m., indicated the mechanical lifts were stored in the shower room. The CNA indicated she had been trained on the hoyer lift and indicated two persons were needed to use a hoyer lift with a resident. CNA 3 indicated when the resident was over 300 pounds, the staff had been instructed to use three trained persons. CNA 3 demonstrated how to use the hoyer lift. She was observed to place the hoyer pad loops on the metal circle loops on the hoyer lift. CNA 3 indicated the loops had to be double checked all four loops were secured, so that teh loops would not slip off before the lift was raised to transfer a resident. She indicated once the loops were secured, the legs of the lifts were opened, the resident moved to the bed or wheelchair and then the legs of the lift were closed and the resident lowered. An interview with Housekeeper 1 on 7-15-2020 at 9:57 a.m., indicated he had not been trained on the use of a hoyer lift. He indicated he was just educated that he was not to assist a CNA on any duties, including hoyer lift transfers. He indicated if he was asked, he was to go get a nurse for assistance. An interview with the DON on 7-15-2020 at 10:15 a.m., indicated two CNAs were required for transfers with the hoyer lift, she was not certain when the resident's weight was over a certain amount, if that would require an additional CNA for assistance. A current, undated Safety Policy was provided by the DON on 7-14-2020 at 2:20 p.m. This policy was for orientation and annual review for .Gait Belts .Hoyer Lift .all nurses aides and nurses involved in the transfer of a resident requiring the use of a Hoyer Lift, failing to use such Hoyer Lift as specified, will be found guilty of willful intent to endanger a resident .Two to Three-Person Transfers .all nurses aides and nurses involved in the transfer or transport of a resident requiring assistance of more than one staff will be required to follow facility guidelines, and failure to do so will cause the nurse aide or nurse to be found of willful intent to endanger a resident At the bottom of the form, there were three signature lines for staff to sign regarding the policy and procedures for lifting, transferring and gait belt use for the facility.<br>An current, undated policy, Residents Transfers was provided by the DON on 7-15-2020 at 3:55 p.m. The policy indicated, .In order to protect the safety and well-being of staff and residents, and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents .4. Resident transfers requiring mechanical lifts will be completed by two persons .6. Staff will be observed for competency in using mechanical lifts and observed periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques .9. Safe lifting and movement of residents is part of an overall facility employee health and safety program, which .c. Provides training on safety, ergonomics and proper use of equipment The DON provided the User Instruction Manual for the hoyer lift on 7-16-2020 at 10:18 a.m. On page 4 under Warning a statement indicated .Do not lift a patient unless you are trained and competent to do so This Federal tag relates to Complaint IN 204. 3.1-45(a) |