

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 045203	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/01/2024
NAME OF PROVIDER OR SUPPLIER The Springs Batesville		STREET ADDRESS, CITY, STATE, ZIP CODE 1975 White Drive Batesville, AR 72501	

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)
<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46724</p> <p>Based on observation, interview, and record review, the facility failed to properly transfer a resident using a mechanical lift and failed to investigate and educate to prevent possible injury for one (Resident #2) sampled resident who was transferred via mechanical lift.</p> <p>The findings are:</p> <p>Review of an electronic Medical Diagnosis Chart revealed Resident #2 had a diagnosis of paraplegia.</p> <p>Review of a quarterly Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 08/19/2024 indicated Resident #2 understands and is understood, had a Brief interview of Mental Status (BIMS) score of 14 (13-15 cognitively intact), ambulated via wheelchair, and had no falls since their last assessment.</p> <p>Review of Resident #2's Care Plan showed the resident required a mechanical lift with assistance of 2 staff members for transfers.</p> <p>Review of Resident #2's Electronic Medical Record (EMR) did not document a fall on 06/10/2024.</p> <p>On 10/01/2024 at 8:49 AM, during an interview Resident #2 relayed that on the evening of 06/10/2024, while being transferred from the wheelchair to the bed via mechanical lift, they began to slide out of the lift sling. Resident #2 stated they tried to tell the two Certified Nursing Assistants (CNAs) they were sliding but the CNAs continued with the transfer and the resident slid out of the lift sling onto the floor with the lift sling under their arms holding their upper body up. Resident #2 said the two female CNAs got the assistance of two male CNA's and were able to use a sheet to lift the resident's lower body and position the lift sling under the resident and safely transfer them into the bed. Resident #2 denied any injury.</p> <p>On 10/01/2024 at 8:56 AM, during an interview CNA #1 said they were asked to come to room [ROOM NUMBER] to help with something, and that when they arrived, Resident #2 was sitting on the floor with mechanical lift pad slid up on back and under arms holding them up. They confirmed there was no in-service, retraining. or witness statements taken following this incident.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/01/2024 at 9:44 AM, during an interview LPN #2 stated the incident was not reported to her, but she remembered someone talking the next day about Resident #2 sliding out of the lift pad and onto the floor.</p> <p>On 10/01/2024 at 9:57 AM, during an interview LPN #3 stated she was unaware of an incident involving Resident #2 until the next day at approximately 6:30 AM. She stated she reported the incident to the Treatment nurse (LPN #4) who then reported it to the Director of Nursing (DON) and Assistant Director of Nursing (ADON). LPN #3 stated she questioned Resident #2's CNA (CNA #6), who reported that Resident #2 did not hit the floor. LPN #3 said the treatment nurse went and preformed a body audit and questioned the resident. LPN #3 did not know if a formal in-service was initiated but stated she educated her CNAs on proper transfer with a lift.</p> <p>On 10/01/2024 at 10:04 AM, during a phone interview CNA #7 stated he was not in the room when Resident #2 slid out of lift pad, and the CNA working that hall came and got him to help transfer a resident. He stated when he got the room, he saw Resident #2's lower body had slid out of the lift pad and onto the floor, the resident was sitting with their back to the wheelchair. He stated he and 3 other CNAs got the resident back onto the lift pad using a sheet and then resident #2 was lifted into wheelchair. When asked if he knew what time this was, CNA #7 replied, he was pretty sure it was before lunch.</p> <p>On 10/01/2024 at 10:07 AM, during a phone interview with CNA #5, who is no longer employed at this facility, she stated she had helped CNA #6 transfer Resident #2 from wheelchair to the bed. When they began lifting the resident up with the mechanical lift, the resident began to slide out of lift pad. She stated, Resident #2 never touch the floor. When asked if she reported this event, she replied, she didn't think it needed reporting.</p> <p>On 10/01/2024 at 10:10 AM, CNA #6, who no longer works at this facility, was contacted by phone for an interview. CNA #6 stated she did not remember the event that took place. CNA #6 called back at 10:11 AM and recalled she was transferring Resident #2 from the wheelchair to bed using a mechanical lift, when the resident slipped out of lift pad and slid down to the floor. She went on to say the resident did not touch the floor because they landed on pillows that were on the foot of the wheelchair. CNA#6 stated it was her , a nurse and another CNA in the room. When asked if she reported the incident to anyone stated she did not since the nurse was in the room at the time.</p> <p>On 10/01/2024 at 10:14 AM, during an interview with the Director of Nursing (DON) regarding the events of the evening of 06/10/2024, she stated she knew nothing about the incident, she was in the hospital at the time and does not recall knowing anything about incident. When questioned regarding staff training on operating the mechanical lift, she reported new hires are trained during orientation and staff re-trained yearly. When asked if an in-service had been performed after Resident #2 had slid from the lift seat, she replied not that she was aware of as she was just finding out about it.</p> <p>On 10/01/2024 at 10:33 AM, during an interview the Assistant Director of Nursing (ADON) stated she had also been in the hospital at the time of the incident, but when she found out about it later had questioned CNA #7 who told her the resident had never touched the floor.</p> <p>Review of CNA #1, #5, #6, and #7 employee files indicated training and check off of mechanical lift usage during new hire orientation.</p> <p>(continued on next page)</p>		

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