STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155153	A. Building B. Wing	09/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthwin	20531 Darden Rd South Bend, IN 46637

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31719 Based on interview and record review, the facility failed to ensure a Hoyer Lift (a mechanical lift device) was used safely, by staff, for 1 of 3 residents reviewed for accidents. (Resident D) Finding includes: On 9/20/24 at 11:04 A.M., a review of the clinical record for Resident D was conducted. The resident's diagnoses included, but were not limited to: non-traumatic brain injury, insulin dependent diabetic, seizure disorder and aphasia. A Fall Risk assessment, dated 7/9/24, indicated the resident was a high risk for falls. A Quarterly MDS (Minimum Data Set) assessment, dated 7/11/24, indicated the resident was non-verbal, dependent (helper does all of effort) with all transfers, had no falls and weighed 155 pounds. A Fall Care Plan, initiated on 6/7/23 and revised on 2/2/24, indicated the resident was at risk for an injury related to seizure activity, immobility and increased tone due to a brain injury. The interventions included, but were not limited to: obtain labs as ordered, keep physician informed of results, inform physician of seizure activity and resident dependent on staff and transferred using a mechanical lift with two (2) persons. A Nursing Progress Note, dated 8/28/24 at 7:19 P.M., indicated at 7:00 P.M., the nurse was called into Resident D's room. The CNA's indicated they were transporting the resident when she slipped from the Hoyer sling towards the floor. One of the CNAs indicated she caught the resident and lowered her to the floor. Resident D was lifted from the floor via the Hoyer lift with the RNs present. The resident had been assessed and did not appear to be in any pain or distress. At 7:35 P.M., the medical doctor and Resident D;s sister/power of attorney (POA) were notified of the incident. (continued on next page)

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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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Nurse Practitioner (NP) Note, dated 8/29/24 at 10:50 A.M., indicated the NP had been asked to observe/evaluate the resident due to the resident being lowered to the floor, during a transfer the previous night. The assessment indicated the resident had no bruising, no edema or redness reported or observed. During the evaluation, the resident was resting quietly, making bubbles with her saliva, which was her normal. She exhibited no fever or chills. Her vital signs were as follows: blood pressure 122/61, pulse 97, temperature 97.7 and oxygen level was 99% on room air. The progress note indicated the staff were to monitor the resident for bruising, fever, chills, elevated blood sugars or agitation. A new order for blood work was received due to the resident's low grade fever and elevated blood sugar levels. A Nursing Progress Note, dated 8/29/24 at 7:25 P.M., indicated the physician was notified of the resident having seizure activity which lasted for 30 seconds, with grunting and left upper arm movements. A NP Progress Note, dated 8/30/24 at 12:36 P.M., indicated the resident was experiencing a low grade fever and elevated blood sugars.Sister and POA is at bedside and monitoring how resident's BS [blood sugar] is being monitored, she has been on the phone with medtronic to trouble shoot her insulin pump. Nursing reports that she had a seizure activity last night, and a low grade fever, in house labs were done and showed WBC [white blood cell] of 16, this morning nursing reports no fever. Resident is comfortably lying down in bed, she is having her period, also presents redness around PEG tube insertion. Sister informs that her brother was just diagnosed with food sensibility, and she would like to know if [name of resident] also has it for eggs, will hold her egg feeding for 3 days and reintroduce it The NP Note indicated the resident's oxygen level was 88% on room air, she had unlabored breathing, and he breath sounds were diminished bilaterally. As a result, supplemental oxygen was ordered to keep Resident D's oxygen level above 90%. A Nursing Progress Note, dated 8/31/24 at 7:01 A.M., indicated .Patient appears ill. Straight catheterization for Urine specimen, cloudy amber with milky pus appearance. Large green bile return from gastric tube, 0500 feeding held A Nursing Progress Note, dated 8/31/2024 8:45 A.M., indicated the physician had been notified of the urine test results and the concern of resident's antibiotic allergies. New orders were received from the physician to transfer Resident D to a local hospital for an evaluation. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An emergency room Report, dated 8/31/24 at 1:43 P.M., indicated Resident D presented to ED (Emergency Department) at 9:53 A.M. for an evaluation of shortness of breath and hyperglycemia. The resident's family reported the resident had been dropped, from a Hoyer lift, 3 days ago and it had been reported to the family the resident had not hit the ground. The family reported to the ED physician the resident's oxygen level was at 88% on room air and she had been placed on oxygen, then referred to the emergency room (ER). The resident's family was concerned about some left lower knee swelling. The report indicated during the exam the resident appeared in no acute distress, her airway was patent with moist mucous membranes. The resident's breath sounds indicated diffuse crackles in all lung fields with respirations non labored. The resident's extremities had normal ROM (range of motion) with no edema with her contractures noted in all extremities. There was some edema and apparent tenderness to the left knee over the tibial plateau area. No pressure ulcers were noted. Per the family the resident appeared to be slightly agitated and uncomfortable compared to her baseline. The ER lab results indicated a high [NAME] Blood Count (WBC) at 13.29, a high glucose level at 315, with a urinalysis having trace blood, WBC and mucous. The ER Report indicated x-rays were obtained of the left tibia and fibula which revealed fractures. The resident's family had requested further x-rays be completed. An x-ray of both hands indicated .osseous demineralization with degenerative changes. Left thumb soft tissue swelling-left proximal phalanx fx [fracture] of left thumb An x-ray of left tibia/fibula indicated .There is acute comminuted mildly displaced fracture of the proximal tibial metaphusis, with likely extension into tibial plateaus .Mildly displaced fracture of the proximal fibula. Diffuse osseous demineralization Healthline at www.healthline.com defined bone demineralization .is when you lose bone minerals quicker than you can replace them. Bone demineralization can lead to brittle bones that put you at risk of fracture A Facility, self reported, Incident #399, dated 9/3/24 at 10:30 A.M. indicated during hospital record review the Director of Nursing (DON) found out Residet D had fractures noted. The incident indicated .Resident had an incident on 8/28/24 when during a Hoyer transfer the resident began to slide out of the sling. Staff responded and lowered resident to the floor. Resident was assessed and found to have no obvious signs of injury. Resident was sent toER on [DATE] for other acute symptoms, and there is where the fractures were found There was no explanation in the investigation regarding how the resident slipped out of the Hoyer sling if it was proprerly attached to the machine. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 9/19/24 at 4:34 P.M., CNA 3 indicated she was assisting with the transfer of Resident D with CNA 2. She had taken the yellow sling, which was already underneath the resident, and placed the loops onto the Hoyer, while CNA 2 was at the controls of the mechanical lift (Hoyer) . They were transferring the resident from a recliner to her bed. The resident was lifted from the recliner and started to slip out of the sling, when the Hoyer lift was between the bed and the chair. CNA 3 indicated she caught the resident in her arms so she would not hit the floor, lowering the resident to the floor. She indicated the resident did not hit her head nor any limbs on the bed, recliner or Hoyer bars. She indicated all 4 corners straps were still connected to the Hoyer lift device. She stated the resident was not making any extra movements/flailing during the transfer and she was not sure why the resident fell out of the sling. After the resident was lowered to the ground in the Hoyer lift, she placed a pillow under the resident and went and got a nurse to assess the resident. She indicated the resident did not cry out, was normally nonverbal, just her eyes looked like they were saying what just happened. During an interview, on 9/20/24 at 2:27 P.M., CNA 2 indicated the sling was in the recliner and she assumed it was crossed (the lower straps were criss crossed between the resident's legs prior to being attached to the Hoyer lift machine to prevent the resident from slipping out of the end of the sling) from previous use and tt was yellow in color. She was at the controls and CNA 3 was with the resident. She indicated when they started to raise the resident, with the Hoyer lift, she told CNA 3 something doesn't look right so she stopped the transfer and held the resident over the recliner for a few minutes. She then decided to go ahead and proceed with the transfer towards the resident's bed as the resident had been in the chair and did not want to put her back in the chair. As she went to turn the Hoyer lift toward the bed, something happened and she saw CNA 3 holding onto the resident in her arms. CNA 2 indicated the resident was still in the sling with her feet touching the floor and CNA 3 holding her in her arms, so she lowered the Hoyer with resident in it to the floor. She indicated the resident did not hit any part of her body onto the Hoyer lift. During an interview, on 9/20/24 at 2:45 P.M., RN 4 indicated when she entered Resident D's room RN 5, CNA 2 and CNA 3 were in the room and the resident was on the ground. RN 4 indicated the sling was no where near the resident when she entered the room. The CNAs reported to her the resident had slid from the bottom of the sling and CNA 3 had held onto the resident until she was lowered to the floor. Both CNA's indicated the resident did not hit the floor, only the resident's feet were touching the floor after she slid from the sling. RN 4 assessed the resident and the resident had no visible signs of pain, as Resident D was unable to verbalize pain. During an interview, on 9/20/24 at 3:22 P.M., RN 5 indicated she arrived to Resident D's room after she had been lowered to the floor. She indicated she observed a yellow sling underneath the resident but it was no longer hooked up to Hoyer lift. The CNAs indicated they were transferring the resident when she slid out of the bottom of the sling and CNA 3 caught her and then the resident was lowered to the floor. She indicated the resident was not moaning or grimacing or showing signs of pain or discomfort. She assisted RN 4 with lifting the resident off the floor and onto the bed using the Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/24/24 at 10:32 A.M., the DON provided a policy titled, Low Lift Program, dated 5/10/23 and indicated the policy was the one currently used by the facility. The policy indicated .The program is to ensure safety from injury of both residents and staff members and to preserve the dignity of the residents by using the most effective means for moving a resident with diminished lower body sensation, weakness, instability, amputation or injury. To safely lift a resident who is unable to assist in transfer by pivoting out of bed into a chair, Geri-chair or wheelchair .Total Lift - is used for residents who are unable to bear their own weight and/or are too heavy to move themselves or are severely disabled On 9/24/24 at 10:33 A.M., the DON provided a policy titled, Fall Management Program, dated 5/10/23 and indicated the policy was the one currently used by the facility. The policy indicated .Each resident will be assessed for the risks of falling using the Fall Risk Assessment and will receive care and services in accordance with the level of risk to minimize the likelihood of falls .A near miss also considered a fall, is when a resident would have fallen if someone else had not caught the resident from doing so This citation related to Complaints IN00442717 and IN00442926. 3.1-45(a)(1) 3.1-45(a)(2)