

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155230	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/15/2024
NAME OF PROVIDER OR SUPPLIER Rosebud Village		STREET ADDRESS, CITY, STATE, ZIP CODE 2050 Chester Blvd Richmond, IN 47374	

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 - 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** 28309</p> <p>Based on interview and record review, the facility failed to ensure a fall from a mechanical lift did not occur during a transfer from the bed to the chair, resulting in cervical and thoracic fractures of the spine, for 1 of 3 residents reviewed for falls. (Resident B)</p> <p>The deficient practice was corrected on 1-10-24, prior to the start of the survey, and was therefore past noncompliance. The facility had completed assessments of the resident who had experienced a fall, conduct neurological checks, and audits related to fall events.</p> <p>Findings include:</p> <p>The clinical record of Resident B was reviewed on 2-13-24 at 5:40 p.m. His diagnoses included, but were not limited to, Alzheimer's disease, dementia, anxiety, depression, insomnia, aphasia and, nondisplaced fracture of the 7th cerebral vertebra and fracture of the 1st and 2nd thoracic vertebrae (neck area and upper spine area), sustained on 12-30-23.</p> <p>In an interview with CNA 3 on 2-13-24 at 4:26 p.m., she indicated she and CNA 4, were working on the secured memory care unit (MCU) and had entered Resident B's room to provide incontinence care, prior to getting him up from bed and into his chair. CNA 3 indicated she connected the hook of the sling to the mechanical lift of the bottom left hook and CNA 4 connected all the other hooks. Once they had the sling connected to the mechanical lift, they raised him up off the bed. As [name of CNA 4] was starting to move him towards the [tradenname of the chair], more of turning his body in the sling toward the [tradenname of the chair], not really moving the actual mechanical lift and he was kind of between the bed and the chair, the hook on the top left, came undone. He literally did a flip in midair backwards and landed on his head. He let out some kind of a scream and I saw blood. I wouldn't call it a ton of blood, but some blood and I ran out to get the nurse at the desk on the unit while [name of CNA 4] stayed with him. It was [staff name], I think she is a QMA. The next thing I know a nurse and aide from A Hall came to help and check him out. The nurse was holding pressure to his head where he was bleeding. He got sent out to the hospital pretty quick. The EMS [emergency medical services] people were here pretty quick. I am [age under 18] .There seems to be some conflicting information as to if I'm allowed to help with the mechanical lifts or just not even touch them. So, that evening, I did hook up the one bottom hook. After I did that, I did tell [name of CNA 4] she should be the one to hook up the rest of the hooks on the mechanical and she did. From what I was told after this, we aren't allowed to operate the mechanical lifts until we are 18 now. Indicated she has worked at the facility for about 5 months.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>In an interview on 2-14-24 at 11:45 a.m., with CNA 4, she recalled Resident B's fall. She could not recall the exact date, but indicated the fall occurred at approximately 4:30 p.m. to 5:00 p.m., prior to dinner. She indicated Resident B's normal routine is to be assisted up into a chair for every meal and then returns to bed. She explained she and CNA 3 provided incontinence care prior to assisting him up via the mechanical lift. I did all the mechanical lift operation because the other aide is [under 18]. If you are under 18, you can't operate the lifts, but you can be the helper. We got the sling hooked up to the lift like we normally would do. Then one of the upper hooks on the sling came undone .We had him between the bed and chair with the chair closer to the bathroom and he fell on to the floor near the dresser. He was about 4 to 5 feet in the air when it happened. He fell from sling. I cannot recall if he flipped in the air or fell straight to the ground. He usually makes a 'shhhew' noise and he immediately stopped. I don't remember him yelling after the fall, but he might have. I was pretty upset and traumatized by the whole thing. He doesn't really keep his eyes open most of the time and I don't remember him opening his eyes. Plus, he is pretty much non-verbal except for the 'shhew' sound he makes. When he landed on the floor, he was in the fetal position and bleeding from his head. The other aide immediately ran to get the QMA at the desk on the MCU and then the A Hall nurse came and checked him out. We left him in the same position he landed and didn't try to move him. Somebody, not sure who, got a washcloth to cover his head where it was bleeding and to put pressure on it. Don't know who called for an ambulance, but the EMT's were there pretty quick. They didn't move him until they were ready to put him on their cart and transport him to the hospital. I remember one of the EMT's did ask what happened and I remember we told them that he fell about 4 or 5 feet from the [mechanical lift] when we were in the middle of moving him from the bed to his chair.</p> <p>Feedback from hospital was he had some type of broken back and the place on his head did not get any stitches to his head. The laceration looked really bad at the beginning because he seemed to be bleeding a lot. It looked much better after they cleaned it up at the hospital.</p> <p>After all of this, I spoke with Administrator and Director of Nursing. I had to write out a statement and got training for the mechanical lift. I think they did do some type of inspection of the mechanical lifts and tried to do a re-enaction of what happened. I don't know what they found out about any problems with the [mechanical lifts]. She indicated she has been employed at the facility for less than a year. Never happened to me before.</p> <p>In an interview on 2-14-24 at 10:40 a.m., with the Assistant Director of Nursing (ADON) and the Corporate Staff, they indicated they wished to clarify a statement of the policy and procedure related to mechanical lifts. They indicated for the statement of staff under [AGE] years of age, not being able to operate the mechanical lifts, staff under 18, may assist with the use of the mechanical lift, such as connecting the straps to the the lift, but cannot operate the machine itself.</p> <p>A document entitled, Fall Reviews-Event 1-2-24, indicated on 12-30-23 at 5:00 p.m., Resident B had a fall from a mechanical lift while being transferred from his bed and into his chair while being assisted by two staff members. He did strike his head during the event and landed on his left side. Immediate care was provided of pressure held to a sustained laceration to his head, contacting emergency transport services and notification to the medical director and the family. Initial neurochecks indicated he were within normal limits for this resident. At the emergency room visit, a CT scan detected moderate age-indeterminate compression of T3 [third thoracic vertebra] and nondisplaced fractures of the posterior transverse processes of the C7 [seventh cervical vertebra], T1 [first thoracic vertebra], T2 [second thoracic vertebra].'</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On 2-14-24 at 9:14 a.m., the ADON provided a copy of an undated document entitled, Mechanical Lift/Hoyer Lift Safety, and it was identified as a training document. This document indicated, I understand that all mechanical lifts .require the use of 2 trained people to operate safely .I understand that I must inspect the sling for any defects or wear and tear prior to applying the sling on a resident .I understand that if I am under the age of 18, I am not able to operate a mechanical lift but may be the second person assisting for safety.</p> <p>This Federal tag relates to Complaint IN00427546.</p> <p>3.1-45(a)(1)</p> <p>3.1-45(a)(2)</p>		