STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155349	A. Building B. Wing	10/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Saint Anne Home	1900 Randallia Dr 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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on interview and record review the facility failed to ensure staffing followed competent skills during a mechanical lift transfer for 1 of 3 residents reviewed (Resident B).Findings include:A facility reported incident, dated 9/8/25, indicated during Resident B's transfer, the staff member heard a pop noise. Resident B was assessed, and an x-ray indicated the resident had a left humerus fracture.Resident B's record was reviewed on 10/1/25 at 10:34 AM. Diagnoses included anemia, obesity, hyperglycemia and chronic kidney disease.An order, dated 4/16/25, indicated Resident B should be transferred via Sara lift with 2 staff assistance.An interdisciplinary disciplinary team (IDT) noted, dated 9/16/25, indicated during Resident B's transfer on 9/8/25, Qualified Medication Aide (QMA) 2 heard a pop noise. The note indicated QMA 2 transferred Resident B via a Sara lift (sit to stand mechanical lift) onto her bed. The note indicated after the transfer, QMA 2 repositioned Resident B into a lying position on her bed by placing her arm behind Resident B's right shoulder and her other arm under Resident B's legs. The note indicated that after the noise was heard, the nurse assessed, and an x-ray was completed.A signed validation checklist for mechanical lifts, including sit to stand lifts, dated 8/6/25, was provided by the Administrator on 10/1/25 at 11 AM. The checklist indicated QMA 2 received education and was checked off on all mechanical lifts, including sit to stand lifts. The checklist indicated functions of the lift and requirements of 2 staff present for transfers were discussed with QMA 2.In an interview, on 10/1/25 at 10:12 AM, Resident B indicated on 9/8/25, QMA 2 transferred her alone in the Sara lift to her bed. After the transfer, QMA 2 grabbed the back of Resident B's right arm and under her legs to reposition her flat in bed. Resident B indicated she then felt a pop in her left arm and her left arm went numb. In an interview, on 10/1/25 at 10:43 AM, the Administrator indicated QMA 2 performed the Sara lift transfer and repositioned Resident B alone without additional staff present. The Administrator indicated 2 staff were required to be present during Sara lift transfers.In an interview, on 10/1/25 at 11 AM, Certified Nurse Assistant (CNA) 3 indicated all mechanical lifts, including Sara lifts required a 2 person assist with transferring. CNA 3 indicated even after the transfer was completed, 2 staff were required to reposition a resident from sitting to lying position in bed.In an interview, on 10/1/25 at 11:07 AM, QMA 2 indicated she transferred Resident B via sit to stand Sara lift alone on 9/8/25. After transferring Resident B, she placed her one arm behind Resident B's right shoulder and the other arm under Resident B's legs and laid Resident B flat in bed. QMA 2 indicated no other staff were present during the transfer nor repositioning. QMA 2 indicated 2 staff were required to be present during all mechanical lift transfers, including Sara lifts. QMA 2 indicated she had never been trained or educated on Sara lift transfer requirements.A policy, dated 1/2025, titled Safe Resident Handling/Transfers, was provided by the Administrator on 10/1/25, indicated 2 staff are required to assist with all mechanical lifts.This citation relates to Intake 2613062.

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