

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 365344	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2026
NAME OF PROVIDER OR SUPPLIER Luxe Rehabilitation and Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 957 Becks Knob Road Lancaster, OH 43130	
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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, medical record review, policy review and interview, the facility failed to maintain resident dignity for Resident #15. This affected one resident (#15) of three sampled residents. The facility census was 142. Findings include: Medical record review revealed Resident #15 was admitted to the facility on [DATE] with diagnoses including dementia need for assistance with personal care, reduced mobility, epilepsy, and anxiety disorder. Review of the most recent Annual Minimum Data Set (MDS) 3.0 assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) of 0 indicating severe cognitive impairment. The resident was assessed to require substantial/maximal assist for showering/bathing, personal hygiene, and transfers. Observation on 06/15/26 at 9:51 A.M. revealed Resident #15 being assisted out of her room in a shower chair by Certified Nursing Assistant (CNA) #172. The resident was wearing a nightgown exposing her body from her waist down. Interview on 06/15/26 at 9:51 A.M. with CNA #172 verified Resident #15 hips and lower body was exposed in the hallway in front of other residents and stated she was going to cover the resident up with a sheet since her lower body was exposed. Review of facility policy titled Dignity, dated August 2024 revealed each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. Staff promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures. This deficiency represent non-compliance investigated under Complaint Number 3039180.		

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, resident interviews, staff interviews, work orders, and facility policy review, the facility failed to ensure temperatures in the facility were at a comfortable level. This affected twenty-five residents (#13, #22, #30, #31, #35, #36, #41, #47, #48, #51, #54, #56, #57, #58, #61, #62, #63, #64, #66, #67, #81, #105, #106, #140 and #145) of 142 residents. Facility census was 142. Findings include: Interview and observation on 06/11/26 from 11:55 A.M. to 12:45 P.M. with Maintenance Director #182 of all occupied rooms, common areas and hall temperatures. Maintenance Director #182 stated there are two air conditioning units (AC) out and have been for a couple of weeks. It was going to be repaired in the next few days. During the observations on 06/11/26 temperatures ranged from 68 degrees to 80.4 degrees in resident rooms. The temperatures for resident rooms at 80 degrees did not have window AC units. Review of invoices dated 06/05/26 from (named supplier) for the purchase of two commercial AC units, invoices dated 06/05/26 from for the purchase of seven window AC units, and an invoice dated 06/08/26 from (named supplier) for the purchase of two window AC units. Review of daily facility temperature logs from 06/01/26 to 06/11/26 revealed unit hallway temperatures from 71 degrees to 78 degrees. No room temperatures were taken by Maintenance. Verified with Maintenance Director #182. Review of the maintenance logs from April 2026 through June 2026 revealed no concerns with the air conditioning. Observations and interviews on 06/11/26 from 11:55 A.M. to 12:45 P.M. with Residents #13, #22, #30, #31, #35, #36, #41, #47, #48, #51, #54, #56, #57, #58, #61, #62, #63, #64, #66, #67, #81, #105, #106, #140 and #145 stated it was hot in their rooms. On 06/11/26 room temperatures were conducted with Maintenance Director #182 revealed the following temperatures and interviews revealed: At 12:00 P.M. Resident #22's room was 74.5 degrees, and the resident stated it was too warm. At 12:03 P.M. Resident #13's room was 80.4 degrees, and he stated it was too hot. At 12:05 P.M. Resident #30's room was 74.8 degrees, and the resident stated it was too hot. At 12:05 P.M. Resident #31's room was 74.8 degrees, and the resident stated it was too hot. At 12:10 P.M. Resident #35's room was 72.7 degrees, and the resident stated it was too hot in the evenings. At 12:10 P.M. Resident #36's room was 72.7 degrees, stated it was too hot in the evenings. At 12:13 P.M. Resident #41's room was 76.3 degrees, stated it was hot as hell, had a fan on and was told the air was broken. At 12:15 P.M. Resident #47's room was 76.8 degrees, stated it was too warm. At 12:15 P.M. Resident #48's room was 76.8 degrees, stated it was too warm. At 12:18 P.M. Resident #51's room was 75.8 degrees, stated it was pretty hot in the room. At 12:20 P.M. Resident #56's room was 76.1 degrees, stated it is too warm, has a fan on, in the evenings it gets even hotter, has to go in the hallway to get cooled off. At 12:20 P.M. Resident #57's room was 76.1 degrees, stated it is too warm. At 12:23 P.M. Resident #58's room was 75.2 degrees, stated it is too warm. At 12:24 P.M. Resident #61's room was 79.1 degrees, had a fan on and stated it was too hot. At 12:24 P.M. Resident #62's room was 79.1 degrees, stated it was too hot. At 12:25 P.M. Resident #63's room was 78.7 degrees, stated it was too warm. At 12:25 P.M. Resident #64's room was 78.7 degrees, stated it was too warm. At 12:26 P.M. Resident #66's room was 80.1 degrees, stated it was too warm and had a fan turned on. At 12:26 P.M. Resident #67's room was 80.1 degrees, stated it was too warm and had a fan turned on. At 12:30 P.M. Resident #81's room was 79.3 degrees, stated it was too hot, had a fan on and windows open. At 12:30 P.M. Resident #54's room was 79.3 degrees, stated it was too hot. At 12:35 P.M. Resident #105's room was 73.8 degrees, stated it was too hot. At 12:35 P.M. Resident #106's room was 73.8 degrees, stated it was too hot. At 12:40 P.M. Resident #140's room was 76.6 degrees, stated it was too warm and the windows were open. At 12:43 P.M. Resident #145's room was 75.9 degrees, stated it was too hot. Interview on 06/15/26 at 2:32 PM with Licensed Practical Nurse (LPN) #203 revealed the air conditioning has been an ongoing issue, it went out last year also. It has been very hot and the staff is complaining. Interview on 06/15/26 at 4:43 P.M. with Certified Nursing Assistant (CNA) #133 revealed the resident's assigned to her did (continued on next page)		

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	complain about the heat, but they had fans in their rooms. she did not think it was exceedingly hot in their rooms. I did not notice the temperature in the resident rooms to be 81 degrees. Interview on 06/15/26 at 2:45 P.M. with CNA #252 revealed the residents have complained about the heat. It has been very hot in the facility, worse in the evenings. The air conditioning has been broke for a few weeks. Review of facility policy titled Homelike Environment revised February 2021 revealed residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible. The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include: comfortable and safe temperatures (71 degrees Fahrenheit (F) and 81 degrees F). This deficiency represents non-compliance investigated under Complaint Number 3039180 and 3040812.		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** THE FOLLOWING DEFICIENCY REPRESENTS AN INCIDENT OF PAST NON-COMPLIANCE THAT WAS SUBSEQUENTLY CORRECTED PRIOR TO THIS SURVEY. Based on record review, interview, self-reported incident (SRI) review, hospital record review, death certificate review, and policy review, the facility failed to ensure residents were transferred safely and appropriately to prevent significant injury. This resulted in Immediate Jeopardy on [DATE] at approximately 6:00 P.M. when Resident #17, who was dependent of two staff members and the use of a mechanical sling lift for safety and the inability to bear weight, was transferred from her bed to her wheelchair by Certified Nursing Assistant (CNA) #400 and #402 without the use of a mechanical sling lift. Resident #17's legs became entangled in her wheelchair; however, this was not reported to additional staff or medical providers. Resident #17 had continued complaints of pain, and an X-ray was completed on the right knee on [DATE]. The X-ray showed a right femur fracture. Resident #17 was transferred to the emergency room and diagnosed with two additional fractures, one to the right shin and one to the left tibial plateau (knee). On [DATE], due to a condition decline related to the multiple fractures, Resident #17 was transferred to an in-patient hospice provider and subsequently died on [DATE] due to complications from the fractures. This affected one (Resident #17) of four residents reviewed who required a mechanical lift for transfers. The facility census was 142. On [DATE] at 3:37 P.M. the Administrator, Director of Nursing (DON), and Regional Director of Clinical Operations #403 were notified Immediate Jeopardy began on [DATE] when staff failed to properly transfer Resident #17 using appropriate mechanical equipment resulting in pain, swelling and an identified fracture to the right distal femur. The resident was sent to the emergency room on [DATE] and additional fractures were identified. Resident #17 was not a surgical candidate and expired on [DATE] due to complications from the fractures. The immediate Jeopardy was removed and corrected on [DATE] when the facility implemented the following corrective actions: On [DATE] at 10:00 A.M. a Quality Assurance Performance Improvement (QAPI) meeting was held at the facility, with some participants via phone. This meeting included a root cause analysis and developed a plan of correction. Participants included the Medical Director (via phone), Regional Director of Operations #404 (via phone), Director of Nursing, Assistant Director of Nursing, Unit Manager, Minimum Data Set (MDS) Nurse #129, Regional Nurse #411 (via phone), and the Regional Director of Clinical Services #403 (via phone). The root cause of the resident's injuries was related to an improper transfer, a breakdown in communication, including lack of Point Click Care (PCC) (the software used by the facility to maintain the electronic medical record) access, and inadequate accountability and supervision by Licensed Practical Nurse (LPN) #300. The facility Administrator and DON were educated by the Regional Director of Clinical Services #403 on ensuring staff are knowledgeable and have access to medical records to provide care, ensuring all incidents and changes in condition are reported timely to the provider, and ensuring residents are transferred safely per the plan of care. The plan was approved by the Facility Medical Director and Interdisciplinary Team (IDT) at 11:00 A.M. on [DATE]. On [DATE] at 11:00 A.M. Resident #17 was transferred to the emergency room and returned to the facility on [DATE] at 6:09 P.M. Orders were given for an elastic wrap to the left leg and an immobilizer on the right leg. The resident was monitored for pain, and circulation checks to lower extremities were completed daily by the nurses. Tylenol was given as needed for pain. On [DATE] at 11:15 A.M. the DON, ADON, UM #203, and the Director of Rehabilitation evaluated the following 41 residents #11, #78, #55, #181, #35, #18, #123, #199, #129, #3, #178, #24, #131, #71, #59, #45, #47, #46, #152, #161, #143, #65, #84, #95, #186, #177, #175, #146, #50, #37, #162, #200, #23, #168, #197, #88, #151, #163, #134, #19, and #16 for injuries such as skin alterations and range of motion (ROM) concerns. The identified residents either required a mechanical lift transfer or resided on the same hall as Resident #17. The (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	audit/evaluation was completed at 3:30 P.M. and no injuries were noted. Immediate education began on [DATE] at 2:00 P.M. for all facility Registered Nurses (RN) (12), LPNs (24), and CNAs (51) by the DON in person and via phone. Education included transfers using a mechanical sling lift, orthostatic vitals, skin integrity, pain management , following the care plan, following the Kardex, mechanical sling lift protocols, staff responsibilities for reviewing the care plan and Kardex, following transfer and care instructions, reporting changes or concerns, immediately reporting changes to the appropriate medical providers, and ensuring resident/ family concerns are addressed, who to notify if you are unable to log into PCC, communicating changes in residents to RN's and LPN's , monitoring compliance with transfers and safety orders, falls and incidents, neuro checks, the new shift to shift report sheet to assist the nurse as a quick reference guide with who is a mechanical sling lift , and nurses supervision of CNA's. On [DATE] at 4:30 P.M. the Assistant DON placed the same education into a binder for the agency staff to review. When agency call the DON/designee for their PCC access (every shift worked requires a new PCC log in for agency staff) the education will be provided verbally, and they will be reminded to review the binder as well. The DON/designees will monitor the agency staff to ensure they are receiving the education prior to their shift. On [DATE] at approximately 6:00 P.M. the DON contacted Agency CNA #306 and provided education regarding safe resident transfers utilizing a mechanical sling lift and protocols, staff responsibilities for reviewing and following the resident's care plan and Kardex, adherence to transfer instructions, prompt reporting of changes in resident condition or concerns, appropriate notification procedures when unable to access PCC, communication of resident changes to licensed nursing staff and ensuring resident and family concerns are addressed in a timely manner. The DON placed the Agency CNA on suspension pending outcome of the investigation. On [DATE] at approximately 6:10 P.M. the DON contacted LPN #300 and CNA #302 by telephone regarding safe mechanical sling lift transfers, orthostatic vital signs, skin integrity monitoring, pain assessment and management, compliance with the resident's care plan and Kardex, mechanical sling lift protocols, staff responsibilities for reviewing and following transfer instructions, prompt reporting of changes in condition to appropriate medical providers, addressing resident and family concerns, procedures for reporting inability to access PCC, effective communication with licensed nursing staff, monitoring compliance with transfer and safety orders, fall and incident reporting, neurological checks, and utilization of the newly implemented shift-to-shift report sheet identifying residents requiring mechanical sling lift transfers. Education also included the licensed nurse's responsibility to supervise nursing assistants and ensure care is provided in accordance with the resident's plan of care and physician orders. The DON also placed them on suspension pending outcome of the facility investigation. Beginning [DATE] the shift-to-shift report was implemented for quick access to resident transfer status. This form is updated/reviewed daily (Monday through Friday) by the DON/designee to ensure accuracy. Ongoing, education will be provided by the DON/designee on the above topics for newly hired staff. The DON/designee performed weekly audits beginning the week of [DATE] for four weeks, the audits ended [DATE]. The audits included observation and review of five residents per week for four weeks with observation of residents being transferred, observation of the correct number of staff in assistance, validation the staff having access to PCC, and the medical record reviewed for a mechanical sling lift order and care plan to Kardex. Also, an audit for change of condition, pain and residents' concerns being addressed with a physician was started the week of [DATE] and completed [DATE]. Ad hoc education will be provided by the DON/ designee to any person who is not correctly implementing the plan of correction. On [DATE] at 2:00 P.M. Resident #17 was transported to a follow-up appointment with the orthopedic provider. The resident remained a non-surgical candidate and was to return for another follow-up on [DATE]. On [DATE] at 12:40 P.M. Resident #17 was discharged to a Hospice facility due to decline in her over-all condition since the fractures. The QAPI committee will review the results of these audits weekly x 4 weeks, ending on [DATE]. Findings include:Review of the closed medical record for Resident #17 revealed an admission date of (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	[DATE]. Diagnoses included chronic obstructive pulmonary disease, hypocalcemia, dementia, pain, osteochondrodysplasias (a vast, heterogeneous group of over 450 rare genetic disorders that disrupt the normal development and growth of bone and cartilage), reduced mobility, Parkinson's Disease without dyskinesia, osteoarthritis, and unstageable pressure ulcer of sacral region. Review of the Activities of Daily Living (ADL) care plan dated [DATE] revealed Resident #17 had a performance deficit related to decline in health, decreased mobility, shortness of breath, bilateral lower extremity swelling with hematemesis and increased confusion. Interventions include but are not limited to mechanical sling lift for all transfers with two assists, initiated [DATE]. Review of the Physician's orders dated [DATE] revealed an order for a mechanical sling lift for all transfers with two assists. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #17 was dependent on care and walking was not attempted due to medical condition or safety concern, no impairment to the upper or lower extremities and the resident had severely impaired cognition. The use of a mechanical lift was not answered on the assessment. Record review for Resident #17 revealed an e-Interact change in condition evaluation dated [DATE] at 3:15 A.M., authored by LPN #139, identifying edema/swelling and new or worsening pain to Resident #17's bilateral lower extremities and the change of condition was not reported to the primary care clinician and ice was applied per family request. Record review revealed a progress note dated [DATE] at 3:15 P.M. authored by LPN #139 documented Resident #17's daughter reported the resident's leg was hurting when touched. LPN #139 assessed and mild swelling was observed to the knee, ice pack was applied for comfort and the provider was notified. Review of the progress notes dated [DATE] at 5:59 P.M. authored by LPN #160 revealed Resident #17's daughter asked LPN #160 to assess the resident and increased swelling and warmth was found to the knee. Resident #17's daughter declined to have a physician notified and requested ice to be applied. Record review for Resident #17 revealed an e-Interact change in condition evaluation dated [DATE] at 10:30 P.M. authored by LPN #153 identifying new or worsening pain and the change of condition was not reported to the primary care clinician. Review of progress notes revealed the results of the obtained X-ray were received on [DATE] at 9:45 A.M. identifying a right femur fracture and Nurse Practitioner (NP) #415 was notified and the resident was sent to the emergency room (ER) for further evaluation and treatment. Review of the facility investigation dated [DATE] at 9:45 A.M. revealed staff did not transfer Resident #17 according to the plan of care. During the transfer, the resident's right leg became positioned under the wheelchair, and a CNA gently removed the leg from under the chair. Review of the hospital records dated [DATE] revealed a computed tomography (CT) scan of the right lower extremity with findings of an impacted fracture of the distal femur and the left lower extremity revealed an impacted fracture of the lateral tibial plateau/metaphysis. Review of the hospital care coordination summary revealed a progress note documenting Resident #17's family was advised of injury including right distal femur fracture, right shinbone and left tibial plateau fracture which is concerning considering the non-ambulatory status. The resident was not a surgical candidate. Review of the SRI initiated [DATE] at 7:00 P.M. revealed due to continued concerns, an X-ray was ordered for Resident #17's right leg. The resident's family voiced concerns regarding the resident's care and used the word neglect. Facility Administration notified and an investigation was initiated. On [DATE] at approximately 6:00 P.M. Resident #17 required the replacement of the air mattress on her bed and LPN # 401 and CNA #400 entered Resident #17's room to assist with getting the resident out of bed. She was assisted into a seated position and then CNA #402 entered the room. LPN #401 exited the room and CNAs #400 and #402 manually transferred the resident from the bed to the wheelchair and the resident's right leg became positioned underneath the wheelchair during the transfer. Both staff reported the resident's leg was gently moved and repositioned. Review of the progress notes dated [DATE] at 12:00 P.M., revealed Resident #17 was transferred to the emergency room due to a change in condition; decreased appetite, fluid intake and distended abdomen. She later returned to the facility at 8:50 P.M. with no new orders per the progress note authored by LPN #153. Review of the hospice consultation (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	progress notes dated [DATE] revealed since Resident #17's her emergency department evaluation and fractures were identified she has notably declined. Resident #17 has not been eating, drinking or taking pills. She was eligible for hospice admission due to recent fractures and ongoing decline and appeared to be end of life. A progress note dated [DATE] authored by LPN #203 revealed Resident #17 was scheduled to be admitted to hospice. Resident #17 was unable to swallow and speech therapy recommended nothing by mouth. Resident #17's family stated she would sign up with hospice on [DATE] and admit to in-patient hospice. On [DATE] at 12:48 P.M. Resident #17 was discharged from the facility to the inpatient hospice unit. Review of the death certificate revealed Resident #17 expired on [DATE] due to complications from multiple fractures and unwitnessed fall to floor. During an interview on [DATE] at 2:26 P.M., Family member #410 Yes and she is #410. stated Resident #17 started to complain of the right leg pain while the family member was visiting at the facility. The facility called the police and made her leave, stating she was causing a commotion, but she was unsure of the nurse's name who called the police or why the police were needed. On [DATE], when she came in around 2:00 P.M., Resident #17's legs were swollen. Family member #410 reported it to the nurse and the nurse said she probably pulled a muscle. Then on [DATE] both legs were red, hot and swollen. The right leg was swollen from the hip down. Family Member #410 mentioned it again and the facility said they would get an X-ray, but it did not get done until Sunday [DATE]. Family Member #410 confirmed the resident was discharged to a hospice provider for in-patient care on [DATE] due to a decline in her condition. Resident #17 was not eating or drinking after she sustained the multiple fractures. Family Member #410 confirmed the resident died at the hospice facility. During an interview on [DATE] at 2:32 P.M., LPN #203 stated the facility noticed the X-ray results in the morning on [DATE] and notified the Nurse Practitioner #415 and got Resident #17 sent out. LPN #203 stated the facility did not know what happened and they started an investigation. They found out the two CNAs transferred the resident, and she required a mechanical sling lift for transfers. At the hospital, additional fractures were identified. During an interview on [DATE] at 11:32 A.M., LPN #401 stated she was the nurse on duty on [DATE] and no incident was reported to her. LPN #401 stated she was initially going to assist with transferring Resident #17 to the wheelchair then another staff member showed up. The nurse exited the room and CNA #400, and CNA #402 manually transferred the resident from the bed to the wheelchair and the resident's right leg became positioned underneath the wheelchair during the transfer but there was nothing concerning to report at the time. During an interview on [DATE] at 12:19 P.M., CNA # 400 stated she did not get report from the previous shift when she arrived and did not have access to the computer to complete any charting. Towards the end of the shift, a man came up the hallway and told the aide he was there to bring a mattress (a new air mattress for Resident #17). He said he needed Resident #17 out of bed. The aide and the nurse were going to transfer her, but the CNA stated she had no idea she used a mechanical sling lift. The nurse said she would help transfer and the CNA said she assumed the nurse knew how the resident transferred. The nurse and the CNA sat her up at the side of the bed and at that time CNA #400's relief came to the room (CNA #402). She asked if she could help. She replaced the nurse and nothing was said. We lifted Resident #17 under the arms and by the back of her pants and stood her up. CNA #400 was on the right side, and the other aide was on the left side. The CNA reported they sat her down and backed up the wheelchair. Her right leg was underneath her wheelchair, and the other aide repositioned her leg. Resident #17 seemed fine, she did not appear uncomfortable. The other aide wheeled her out into the hallway and CNA #400 gave report. The CNA stated she did not know there was an issue until a few days later when she had to send the facility an email with her statement. She stated she did not have access to point click care but did try multiple times to notify someone (but did not specify who). During an interview on [DATE] at 1:14 P.M., CNA #402 stated she was coming on for her shift that evening when she entered the resident's room (Resident #17). An agency aide and an agency nurse (later identified to be facility LPN #401) were in the room. CNA #402 and the other aide got Resident #17 up in the wheelchair. CNA #402 stated she was just trying to make sure (continued on next page)		

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #17 did not fall. There was not a lift pad in the room nor was there a mechanical sling lift in the hall. And the mattress guy was waiting in the hallway. The resident did not yell out in pain or say anything during the transfer. She appeared to be fine. Afterwards CNA #402 reported she went out and told the nurse to go and assess Resident #17. The daughter came in and was upset that her mom did not have her oxygen on and the nurse ended up calling the police, so I don't think she assessed her. I also told the night shift nurse what happened when she came in and I don't believe she assessed her either. CNA #402 reported someone from the facility called her four days later and asked her to come in and write a statement and suspended her, then she was terminated. The resident seemed fine through the night. She didn't sleep that well but did not have any complaints either. During an interview on [DATE] at 12:00 P.M., the DON stated initially the QAPI stated she had a fall because when the facility received the X-ray results, they assumed there was a fall and immediately started the QAPI. During the investigation they discovered the two CNAs involved transferred her without the use of the lift. There was no reason why they should have, they had access to her plan of care and the DON stated she and HR verified the two staff had access to the resident's care plan to know the resident's transfer abilities. They were immediately suspended pending investigation, then terminated. The nurse who was initially assisting was brand new but was responsible to ensure the aides followed the resident's care plan. The DON verified there was no notification made to the medical provider with the multiple complaints of pain or change in assessment and the staff should report changes in resident condition when it occurs. Review of the policy titled Change in condition policy dated [DATE] revealed the facility will promptly identify, assess, and respond to any significant change in a resident's physical, mental, or psychosocial condition. The licensed nurse will ensure timely notification of the physician and resident representative and implement appropriate interventions to maintain the resident's health and safety. All staff are responsible for observing resident's and immediately reporting any change in condition to the licensed nurse. This violation is a recite to the complaint survey completed [DATE].		