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	175309	A. BUILDING _____ B. WING _____	C 11/17/2021

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ARKANSAS CITY PRESBYTERIAN MANOR	1711 N 4TH STREET ARKANSAS CITY, KS 67005

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #165106 and #166542. This 2567 was electronically sent to the facility on 11/18/21.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 42 residents with five residents selected for review for adequate assistance to keep them free from accident hazards. Based on observation, interview, and record review, the facility failed to ensure staff transferred two residents appropriately with a mechanical lift (a device used to assist with transfers for a person who is unable to stand on their own, or can bear minimal weight when standing) for Resident (R)1, which resulted in a skin tear (a wound that occurs when the layers of skin separate or peel back), and for R4, placing her at risk for injury. Findings included: - The "Physician Orders," dated 11/09/21, for Resident (R)1, included diagnoses of Parkinson's (slowly progressive neurologic disorder	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/18/2021

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.

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characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness) with Lewy Body dementia (type of progressive neurodegenerative dementia closely associated with Parkinson's disease primarily affecting older adults.), and osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain) of knees.

The "Quarterly Minimum Data Set" (MDS), dated 06/07/21, assessed R1 with a short and long term memory problem and severely impaired decision making. She was totally dependent on two or more staff for transfers and bathing and had impaired range of motion to her upper and lower extremities.

The "Annual MDS," dated 08/31/21, revealed no changes from the prior assessment.

The "Pressure Ulcer/Injury Care Area Assessment," dated 09/13/21, indicated that R1required two persons to assist her with repositioning and transfers and required total assistance for most activities of daily living (ADL's).

The "Care Plan," dated 09/10/21, indicated R1 required two staff to assist her with transfers with the "Hoyer" (type of mechanical lift) lift and required two staff to assist her in/out of the whirlpool.

The "Witness Statement," dated 10/20/21, by CNA M, revealed that she had asked for help getting R1 into the chair to give her a bath and after she got done, she pulled R1 out of the tub and "hooked her up" and thought she "Could do it

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without hurting her" but as she was going sideways she was holding up both resident legs, one slipped from her arm, and R1's foot went in between the two vinyl straps of the chair.

The "Witness Statement," dated 10/20/21, Licensed Nurse (LN) G, revealed that a CNA stated she transferred the resident out of the whirlpool by herself, into her "Broda" chair (a brand of wheelchairs that can be tilted, reclined, and the leg rests adjusted) via the "Hoyer" lift, and the CNA caught R1's left foot in the straps of the "Broda" chair that are above the footrest. A skin tear was on the top of her left foot.

The "Interdisciplinary Note" (IDT), dated 10/20/21 at 09:30 AM, indicated that a Certified Nurse Aide (CNA) called for the nurse to come to the bathhouse. R1 had a skin tear to the top of her left foot, the nurse measured the area, cleansed the area, and applied a dressing.

The "Skin Evaluation Record," dated 10/20/21 at 08:54 AM, revealed R1 had a skin tear to the top of her left foot that measured 5.0 centimeters (cm) long by 5.5 cm wide and was 0.4 cm deep. The wound edge was irregular and flat, and the surrounding skin was thin and fragile. The wound had a moderate amount of bloody drainage present.

The facility investigation, completed on 10/25/21, revealed CNA M failed to follow R1's care plan as well as the facility's policy for mechanical lifts when she transferred R1 unassisted with a "Hoyer" lift. That failure resulted in a skin injury to R1 believed to be acquired as R1 was being lowered into her chair and the distal (located away from the center of the body) one third of her

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foot slid between the vinyl supports.

On 11/16/21 at 08:49 AM, CNA N and Certified Medication Aide (CMA) R observed transferring R1 from her "Broda" chair to her bed using the "Hoyer" lift.

On 11/16/21 at 12:45 PM, CMA R stated at least two staff should assist with transfers with the "Hoyer" lift, that included transfers in and out of the shower chair. CMA R stated she was aware that information on how to transfer residents was in the care plan.

On 11/16/21 at 12:54 PM, CNA S stated two staff required for R1's transfers with the "Hoyer" lift. CNA S reported guidance how to transfer the resident should be in the care plan.

On 11/16/21 at 01:00 PM, CNA O reported staff should use two staff to transfer with the "Hoyer" lift. CNA O reported guidance how to transfer the resident should be in the care plan.

On 11/16/21 at 01:54 PM, CNA M stated that upon hire almost three months ago, the facility went over transfers with the "Hoyer" lift and should have two staff members assisting with the transfer. CNA M stated that on 10/20/21, she thought she could transfer R1 without doing any harm and once she realized what she had done she called for a nurse. CNA M stated the care plan had information on how to transfer a resident and the facility staff trained her during orientation on transfers with the lift.

On 11/16/21 at 02:57 PM, Administrative Nurse D stated the requirements for transfers with the lifts are gone over during the interview before hire and

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reiterated daily. The orientation checklist sheet goes over transfers with the stand lift and the "Hoyer" lift. The information on how to transfer a resident was available in the computerized charting. Administrative Nurse D stated she expected the staff to use two to assist for all lift transfers.

On 11/16/21 at 03:17 PM, CNA P stated two staff were to assist with resident transfers with the "Hoyer" lift and information on how to transfer a resident was in the care plan.

On 11/16/21 at 03:22 PM, CNA T stated two staff should assist with transfers using the "Hoyer" lift and the facility had always made that known.

The facility policy "Lifting and Transferring Residents," dated 05/02/2019, included nurses were to assess and determine lifting and transfer requirements and the procedure used for each resident. All residents must be lifted or transferred according to the determined procedure. The appropriated procedure for each resident appears in the resident care plan. All lifts performed with a mechanical lift must be performed with two staff members present.

The facility failed to ensure staff transferred the resident appropriately with the lift which resulted with the resident receiving a skin tear.

- The "Physician Orders," dated 11/02/21, for Resident (R)4, included a diagnosis of degenerative joint disease (a type of arthritis [inflammation of a joint characterized by pain, swelling, heat, redness and limitation of movement] that occurs when flexible tissue at the

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ends of bones wears down gradually and worsens over time).

The "Annual Minimum Data Set" (MDS), dated 07/19/21, assessed R4 with a "Brief Interview of Mental Status" (BIMS) score of 15, indicating intact cognition. She required assistance of two or more staff for transfers, assist of one in part of the bathing activity, and had limited range of motion to one side of her lower extremities.

The "ADL (Activities of Daily Living Care Area Assessment" (CAA), dated 07/29/21, indicated R4 required extensive assistance with transfers and bathing, and required a sit to stand mechanical lift (a device used to assist with transfers for a person who can bear minimal weight when standing) for her safety due to her knees giving out without notice.

The "Quarterly MDS," dated 10/14/21, assessed R4 with the same BIMS score, no changes to her transfer assistance, and was totally dependent of one staff for bathing.

The "Care Plan," dated 11/08/21, indicated the resident required extensive assist for transfers and staff should use a sit to stand lift for all transfers with contact guard assistance of two staff members.

The "Mechanical Lift Competency Checklist," dated 10/29/21, for Certified Nurse Aide (CNA) M, had a check mark in the line that read "ask another staff member to assist you."

On 11/16/21 at 11:44 AM, R4 stated she required assistance for transfers with the sit to stand lift and that one staff assists with her transfers.

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On 11/16/21 at 12:45 PM, CMA R stated at least two staff should assist with transfers with the sit to stand lift, and she was aware that information on how to transfer residents was in the care plan.

On 11/16/21 at 12:54 PM, CNA S stated two staff required for R1's transfers with the sit to stand lift. CNA S reported guidance how to transfer the resident should be in the care plan.

On 11/16/21 at 01:00 PM, CNA O reported staff should use two staff to transfer with the sit to stand lift. CNA O reported guidance how to transfer the resident should be in the care plan.

On 11/16/21 at 01:54 PM, CNA M stated that upon hire almost three months ago, the facility went over transfers with the mechanical lift and should have two staff members assisting with the transfer. CNA M stated the care plan had information on how to transfer a resident and the facility staff trained her during orientation on transfers with the lift. CNA M verified she has transferred R4 to the shower using the sit to stand lift by herself.

On 11/16/21 at 02:57 PM, Administrative Nurse D stated the requirements for transfers with the lifts are gone over during the interview before hire and reiterated daily. The orientation checklist sheet goes over transfers with the stand lift. The information on how to transfer a resident was available in the computerized charting. Administrative Nurse D stated she expected the staff to use two to assist for all lift transfers.

On 11/16/21 at 03:17 PM, CNA P stated two staff are to assist with transfers with the sit to stand lift

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and information was available on the resident "care guide" in the computer.

On 11/16/21 at 04:08 PM, R4 stated that whenever she gets a bath, whoever is assisting with the bath transfers her to the whirlpool chair and then assists with the transfer out of the whirlpool chair without assistance of a second staff member.

On 11/17/21 at 07:37 AM, Administrative Nurse D observed to exit the bath house pushing the sit to stand lift and Certified Medication Aide (CMA) R observed propelling R4's wheelchair out of the bath house.

On 11/17/21 at 09:30 AM, R4 activated call light and CNA Q responded, who then requested another staff to assist her, and the sit to stand lift was moved to R4's room.

The facility policy "Lifting and Transferring Residents," dated 05/02/2019, included nurses were to assess and determine lifting and transfer requirements and the procedure used for each resident. All residents must be lifted or transferred according to the determined procedure. The appropriated procedure for each resident appears in the resident care plan. All lifts performed with a mechanical lift must be performed with two staff members present.

The facility failed to ensure staff transferred the resident appropriately with the lift placing R4 at risk for injury.