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	175379	A. BUILDING _____ B. WING _____	C 07/30/2020

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MENNONITE FRIENDSHIP COMMUNITIES INC	**600 W BLANCHARD AVENUE SOUTH HUTCHINSON, KS 67505**

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS001514346.	F 000		
F 689 SS=G	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 census totaled 88 residents, with three residents sampled for lift use. Based on observation, interview, and record review, the facility failed to transfer resident (R) 1 in a safe manner by not correctly utilizing the sling and failing to repair broken/missing tile in the bathhouse, which resulted from a fall when the wheel of the sit-to-stand lift (a device for residents who have difficulty standing up on their own from a seated position used for transfers) became stuck in the floor where the tile was missing. R1 sustained a fractured hip as a result of the fall. Findings included: - Review of R1's diagnoses from the "Physician Order Sheet" dated 07/30/20 included fall from a non-moving wheelchair and left femur fracture (broken long leg bone). Review of the "Significant Change Minimum Date Set" (MDS) dated 07/26/19 documented a "Brief	F 689		

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

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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Interview for Mental Status" (BIMS) score of 14, which indicated intact cognition. R1 required extensive physical assistance of two or more staff members for transfers, bed mobility, dressing, and toilet use and was totally dependent on staff for bathing. The MDS documented no falls since prior assessment and received restorative services for range of motion.

Review of the "Care Area Assessment" (CAA) dated 07/26/19 for "Activities of Daily Living" (ADL) documented R1 no longer ambulated due to bilateral lower extremity weakness, required assistance from two staff members, and used a sit-to-stand lift for all transfers. The "Falls CAA" documented bilateral lower extremity weakness, impaired gait/balance, and two staff members required to use the sit-to-stand lift.

Review of R1's "Care Plan" dated 05/06/20 lacked information or instruction regarding the use of R1's unique sling with the sit-to-stand lift.

Review of "Therapy Notes" dated 10/22/19 through 11/01/19 documented therapy educated nursing staff on the placement of R1's sling using the sit-to-stand lift. Documentation included return demonstration with nursing staff to ensure proper use of the sling with the sit-to-stand lift. The therapy notes included to continue training with nursing staff on the set-up and use of the new sling. Therapy also provided written instructions with pictures for nursing staff to ensure safe transfers.

Review of the "Transfer Instructions" dated 11/01/19 to use R1's sling to transfer with the sit-to-stand lift stressed the importance of providing bilateral lower extremity support by

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using the leg straps on the sling during transfers. The information instructed staff to place sheepskin between leg straps and all four straps attached to the lift for transfers, and it was only acceptable to un-attach straps at the commode/toilet. The information for safety instructed staff to keep R1 over a transfer surface while pulling up pants to prevent R1 from sliding/slipping out of the sling.

A review of the "Nursing Note" dated 07/17/20 at 01:35 PM documented the unidentified certified nurse assistant (CNA) requested the licensed nurse (LN) D to assess R1 who was sitting on the floor in front of her wheelchair in the bathhouse. The nurse document R1 stated she slid out her chair and did not complain of pain to her left leg until right after staff used the full body lift (a device used to transfer residents who cannot move their body on their own) to assist R1 off of the floor. The nurse documented, "Approx 2 hours later resident complained of increased pain to left leg and right hip, call placed to PCP [primary care provider] and order received to sent to ER to eval and treat if indicated."

Review of the "Nursing Note" for R1 dated 07/19/20 at 06:28 AM revealed on 07/18/20 she admitted to an acute care hospital.

Review of the "Nursing Note" dated 07/21/20 at 04:34 PM document R1's return to facility with dressings to the left hip and noted R1 yelled out when staff transferred from her from the wheelchair to her bed with the Hoyer lift.

Review of the "Nursing Note" for R1 dated 07/22/20 at 03:36 PM revealed a physician's order for hospice services of family's choice.

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F 689	Continued From page 3 Review of the "Facility Investigation" report dated 07/17/20 revealed the leg part of the sling had to be unhooked from the lift to position it under R1's leg and lacked information regarding the sling's position on R1 during the transfer and before the fall. Review of the "Work Order" dated 01/08/20 for the Meadowlark Lane/Southeast Bathing Suite documented, "Floor has tiles missing." Review of the "Work Order" dated 07/18/20 for the Meadowlark Lane/Southeast Bathing Suite documented "Installed some floor tile." Review of the "Work Order" dated 07/29/20 documented, "There are multiple tile missing on the bathing suite floor that need repaired ASAP. We just had an accident involving a resident. The lift wheel got caught in a missing tile dip." Completion notes documented replacement of loose and broken tile on 07/25/20. An observation on 07/29/20 at 11:35 AM of the bathhouse revealed flooring that consisted of 2x2 inch tile, in which broken and missing tile was repaired or replaced with other tiles of similar colors. An observation on 07/29/20 at 11:55 AM revealed R1 resting in bed with family in the room. The family mostly kept the door closed and occasionally opened to communicate with staff. An observation on 07/29/20 at 06:20 PM revealed R1 was in bed on her back with eyes partially closed, covers on, and lights were down. An unidentified family member in R1's room stated	F 689		

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R1 could not recover after the hip surgery and reported R1 had been unresponsive since they arrived a couple of hours prior.

An interview on 07/29/20 at 04:37 PM with CNA K stated she told the nurse if something needed to be fixed and the nurse put in the work order for maintenance, and if it was urgent, the nurse also called maintenance.

An interview on 07/29/20 at 04:58 PM with CNA J stated when something needed repaired or replaced, he notified the charge nurse who placed a maintenance request.

An interview on 07/29/20 at 06:30 PM with CNA I stated he first noticed the tiles in the bathhouse were loose and cracked in May 2020 and noted the bath aid reported and complained about it several times.

An interview on 07/29/20 at 06:40 PM with CNA H stated she first noticed the tile in disrepair a couple of months ago, and that she reported it to an unidentified staff member.

An interview on 07/30/20 at 10:38 AM with CNA L stated she noticed broken tile in the bathhouse approximately three months ago. She described the tile as broken and partially missing. CNA L stated at the time there was no way around the broken tile because it was at the entrance to the bathtub, and exactly where the wheels to the lift had to roll over to position a resident into the bathtub. CNA L stated that sometimes wheels on the bath chair would catch on the broken tile during transfers to the tub.

An interview on 07/30/20 at 10:44 AM with CNA G

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stated she used a sit to stand lift during transfers with R1 although R1 could not hold onto the lift very long and staff needed to be quick during transfers. R1 refused the full-body lift. CNA G stated she did not experience any other accidents with transferring R1 using the sit-to-stand lift. CNA G Stated there were missing tiles in the bathhouse for at least a couple of months before the incident and several broken/cracked tiles, including five or six missing tile pieces in the bathhouse at the time of the event. The missing tile on the floor was in front of where R1's wheelchair was parked in the bathhouse, and the bath chair was placed next to the wheelchair. CNA G explained there was no other place in the bathhouse that had enough space to transfer a resident using a lift. CNA G stated that other lifts have gotten caught up over the broken tile in the bathhouse, in which there were a total of five residents that required the use of a sit-to-stand lift for transfers to take a bath. She reported the missing tile and safety concerns several times to nursing and management, but maintenance did not repair the tile until after the incident with R1. When asked if the lift and sling were appropriate for R1, CNA G stated therapy worked with staff and R1 on the sit-to-stand lift with a special sling that went underneath each leg, but said staff had not been applying the sling correctly for transfers. CNA G reported they did not position the leg support parts of sling underneath R1's legs prior to the transfer in the bathhouse when R1 fell onto the floor. CNA G further explained the leg parts of the sling were just hooked onto the lift to keep them out of the way. CNA G stated when she transferred R1 from the bath chair to her wheelchair using the sit-to-stand lift, one of the lift wheels got stuck in the floor where the tile was missing, and she did not get R1 positioned far

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enough back in her wheelchair because the lift wheel was stuck and wouldn't move. CNA G stated her thigh was positioned underneath R1's bottom to keep her from falling out of her wheelchair, and they had to unhook the sling from the lift to get it positioned underneath R1's legs so they could use the lift to get her placed further back into her wheelchair. CNA G reported she was unable to get the sling positioned underneath R1's leg before she fell onto her bottom with both legs straight out in front of her.

An interview on 07/30/20 at 11:09 AM with LN D stated she was on duty at the time of the incident. LN D explained unidentified CNA(s) notified her R1 slid out of her chair in the bathhouse because a wheel got stuck in the floor where the tile was missing. LN D stated that CNA G and CNA P had to jerk on the lift to try to free the wheel, which caused R1 to scoot further out of her wheelchair. LN D reported R1 used a sling that went through her legs to keep her from falling should she let go of the lift, but the staff did not tell her how they positioned R1's sling at the time of the incident. LN D stated that she believed the missing tile caused R1 to fall.

An interview on 07/29/20 at 05:32 PM with LN E stated R1 used a sit-to-stand lift and refused to use the full lift. LN E said she knew about the broken/missing tile about a month before the incident and did not place a work order because unidentified staff told her that upper management knew about it.

An interview on 07/30/20 at 01:07 PM with Therapy Staff F revealed CNA staff were to apply R1's leg straps with lambs' wool between sling material and thighs before transfers. When asked

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if it was ever acceptable to place the leg straps along the outside of R1's legs, Therapy Staff F stated all unit staff received extensive education for how to use R1's sling which included to never lift R1 away from any transfer surface without first applying the sling leg straps under R1's legs, and never place the sling on the outside of R1's legs.

A phone interview on 07/29/20 at 7:04 PM Maintenance Staff M stated they were notified about the broken/missing tile 01/08/20 and contacted someone for a bid to replace the entire bathhouse flooring. Maintenance Staff M said, "Somewhere it stalled out, and we never revisited. As workloads go, it was not on the front burner, and other things got put on top of it." Maintenance Staff M stated he did not view the broken/missing tile in the bathhouse as a safety hazard and did not see it as urgent to repair as it should have been. Maintenance Staff M stated after the incident with R1 in the bathhouse, he replaced the missing tiles and also replaced/repaired several cracked and loose tiles. Maintenance Staff M reported that fixing the broken/missing tile sooner would have prevented an accident from occurring.

An interview on 07/29/20 at 5:48 PM with Administrative Nurse B stated in January or February 2020, staff reported issues with the bath chair and using lifts in the bathhouse due to broken/missing tile, in which she talked with maintenance about the concerns and the maintenance departments planned to replace the flooring in the bathhouse.

An interview on 07/30/20 at 11:55 AM with Administrative Nurse B stated she nursing notified her via a phone call that R1 fell during the

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use of the lift to transfer her from bath chair to wheelchair because the lift wheel got stuck on the floor where the tile was missing. The staff could not get R1 positioned far enough back in her wheelchair. Administrative Nurse B stated R1 fell when staff had to unhook the sling from the lift to reposition the sling and explained the sling had a part that went up under R1's leg, and staff must not transfer R1 without the leg straps positioned correctly in her legs. Administrative Nurse B stated she was trained by therapy staff to position R1's sling under her legs for transfers. Upon further review of the facility's investigative report, the Administrative Nurse acknowledged the information was unclear and pursued clarification from therapy for proper sling position for R1, and from nursing staff for exactly how R1's sling was positioned prior to the incident.

An interview on 07/30/20 at 12:55 PM with Administrative Nurse B and CNA G stated R1's sling was hooked up to the lift, but was not positioned under her legs during transfer when she fell. CNA G further explained the leg part of the sling needed to be unhooked so that she could get it positioned underneath her leg and hook it back up to keep R1 from falling, but R1 slid off of her chair onto her bottom with both legs straight out in front of her. CNA G stated they would have been able to get R1 back into her wheelchair, and R1 would not have slid down with her legs forward in front of her had the sling been positioned correctly in her legs.

An interview on 07/30/20 at 11:18 AM with Administrative Nurse C stated R1 used the sit-to-stand lift with a special sling that involved the use of leg straps that went underneath each leg to prevent her from slipping out during

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transfers and reported that all unit staff were educated by therapy on how to use R1's sling properly. When asked if staff transferred R1 without using the leg straps, Administrative Nurse C stated it was never acceptable to use the sling without first positioning the leg straps. Administrative Nurse C stated sometime after she began her position on the unit in April 2020, she was informed of the broken/missing tile in the bathhouse and placed a work order for maintenance to repair. Administrative Nurse C stated she did not follow up on work orders after maintenance received them. Administrative Nurse C said she did not observe or look at the broken/missing tile in the bathhouse, but if the tile were intact, the fall would not have occurred.

An interview on 07/29/20 at 06:40 PM with Administrator A stated the first work order for the tile was on 01/08/20, and maintenance staff were getting bids to replace all the tile flooring in that bathhouse. Administrator A stated she was unaware of any safety concerns staff had using lift equipment in the bathhouse with the missing tile and stated the missing tile was a safety issue and needed fixed pretty fast.

An interview on 07/30/20 at 2:14 PM with Physician Extender N stated R1 fell out of her wheelchair and was diagnosed with a femur fracture from the fall that required major hip surgery with general anesthesia. Physician Extender N stated R1 had no history of upper leg or hip pain before the fall and stated the physician saw R1 in May 2020, and noted that R1 was doing well. Physician Extender N reported the fall and fracture contributed to R1's declined health status and receiving hospice services.

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An interview on 07/30/20 at 03:51 PM with Physician Extender O stated she saw R1 in the facility on 07/22/20. Physician Extender O stated the left hip fracture was caused by the fall when R1 fell out of her wheelchair on 07/17/20. Physician Extender O reported R1 declined severely after the fall, and on 07/22/20 she provided orders for hospice due to a significant decline in health status post fracture, left hip repair, edema (swelling), and hypotension (low blood pressure). She reported the fall with fracture requiring surgery caused R1's body to "go over the edge into the failure of different organ systems." Physician Extender O stated there was "nothing else" that would have caused such a decline in her health requiring hospice services during that period.

The facility's policy titled, "Lifts and Transfers," dated 05/23/19 documented nursing staff were to followed therapy's recommendations for transfers and staff should only transfer residents as determined by assessment and care planned.

The facility's policy titled, "Medicare-Sling Positioning, Lifting, and Transferring," dated December 2018, for positioning the sling from a seated position instructed, "Gently raise resident's thigh, pulling the leg straps underneath. Repeat same procedure for other thigh. . . Crisscross the leg straps as shown with one strap passing through the other. Attach straps to adjacent sling support hooks." The policy said, "Only a Licensed Nurse or Therapist can change the method of transfer of a resident. If a change is made, the licensed nurse must make the change to the resident's care plan, inform the Clinical Care and MDS Coordinators and send out an alert in POC ["Point of Care" is a mobile app that runs on wall

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F 689	Continued From page 11 kiosks and/or mobile devices that enables care staff to document care provided to residents] to inform the direct care staff of the change." Upon request on 07/30/20, the facility did not provide a policy for physical environment/safety hazards/maintenance repairs. The facility failed to ensure staff safely transferred R1 and failed to repair broken/missing tile in the bathhouse. R1 sustained a hip fracture as a result of an unsafe transfer by the misuse of a sling and using a sit-to-stand lift over a floor in disrepair with broken/missing tile.	F 689		