STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175445	A. BUILDING _____ B. WING _____	C 02/07/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PIONEER RIDGE RETIREMENT COMMUNITY	4851 HARVARD ROAD LAWRENCE, KS 66049

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS001711768. The 2567 was sent on 02/20/23.	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 reported a census of 49 residents. The sample included three residents at risk for falls. Based on record review, observations, and interviews, the facility failed to ensure staff provided care planned fall interventions for Resident (R) 1 to prevent a fall. On 01/26/22 at 01:34 PM, R1 fell from a Sit-To-Stand lift (mechanical device used to help mobility impaired residents transition from a seated to a standing position) when one staff member assisted in the transfer, instead of the care planned two staff assistance. Consequently, the inappropriately applied lift sling, separated on one side of the lift, and caused R1 to fall backwards, striking R1's head on the tile floor. R1 sustained a scalp laceration which bled profusely, required emergency medical treatment, seven staples, and a four day stay at a local hospital. Findings include:	F 689	Past noncompliance: no plan of correction required.	

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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- R1's Electronic Medical Record (EMR), under the "Diagnosis" tab, listed diagnoses of: hemiplegia and hemiparesis following cerebral infarction affecting the left side, (a stroke which caused paralysis of partial or total body function on one side of the body), cerebral palsy (a group of disorders that affect a person's ability to move and maintain balance and posture), and traumatic subarachnoid hemorrhage with loss of conscious (bleeding in the brain and loss of consciousness following an injury to the head).

The "Quarterly Minimum Data Set" (MDS) assessment dated 01/19/23 documented R1 had a Brief Interview for Mental Status score of 14 which indicated R1's cognition was intact. The MDS documented R1 required extensive assistance of two staff members with most activities of daily living (ADL), such as bed mobility, transfers, dressing, toilet use, and personal hygiene. The MDS recorded R1 had impairment of upper and lower extremities on one side of R1's body. The assessment further documented R1 was unsteady and unable to stabilize without human assistance during transfers. R1 was six feet, one inch tall, weighed 205 pounds, and used a wheelchair maneuvered by staff for ambulation.

Review of R1's "Care Plan" revised 10/17/22 recorded R1 was at risk for falls, and documented R1 could not ambulate, used a wheelchair propelled by staff for locomotion. The care plan documented R1 transferred by use of a Sit-to-Stand lift and two staff member assistance. Staff were further directed to assist R1 with placement of R1's right upper extremity on the lift.

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A "Nurse Progress Notes" dated 01/26/23 at 03:27 PM recorded staff notified R1's responsible party of R1's fall and transfer to the hospital emergency department.

A "Nurse Progress Notes" dated 01/26/23 at 04:17 PM recorded R1 transferred to the hospital with a diagnosis of subarachnoid hemorrhage (brain bleed).

The EMR lacked further documentation related to the residents fall which included analysis of how the fall occurred or nursing observations of the resident at the time of the fall.

The "Hospital Consultation/Progress Notes" dated 01/27/23 at 06:52 PM documented R1 had a fall with small bifrontal contusions (blood or bleeding under the skin due to trauma) and possible scattered traumatic subarachnoid hemorrhage (SAH) in the left frontal area. R1's posterior scalp laceration was washed and repaired at the bedside with 5 milliliters (ml) lidocaine (local anesthetic) and seven staples. A dressing was applied using Xeroform (petrolatum based non-adherent bandage to maintain a moist wound area) gauze, four by four pads, and bleeding was controlled.

A "Nurse Progress Notes" dated 01/30/23 at 05:18 PM recorded R1 returned to the facility at 03:49 PM (four days after a fall) with two emergency medical staff, on a stretcher. Multiple bruises were noted, with incision to the posterior area of the head, and seven staples in place. This same note documented that per the hospital, R1 was to be transferred with a Hoyer lift (full body lift).

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Review of the "Facility's Investigation" documented on 01/26/23 at approximately 01:45 PM, Certified Nurse Aide (CNA) N reported R1's shirt was put on while R1 was seated; then the staff stood R1 up with the Sit-To-Stand lift to pull R1's pants up. CNA N maintained the lift harness and/or sling was attached correctly. The investigation speculated that the left sided loop of the sling/harness became dislodged while CNA N pulled in an upward motion and adjusted R1's pants. The investigation concluded that if an additional staff member had been present while the lift was moved toward the wheelchair, it would have been unlikely that the fall could have been prevented.

The notarized "Witness Statement" dated 01/26/23 signed by CNA N documented CNA N gave R1 a shower and placed R1 in the Sit-To-Stand Lift. The loops on the lift sling were secured. During the transfer, R1 fell from the lift in the middle of the transfer and hit his head on the tile floor.

The notarized "Witness Statement" dated 01/26/23 signed by Licensed Nurse (LN) G documented someone screamed "come here." LN G went to the shower room and found R1 on the floor laying on his back with his legs laid across the base of the stand-up lift; the sling remained attached to the lift, on one side. R1 had his clothes on. LN G noted there was a large amount of blood on the floor beneath R1's head and R1 stated he fell. LN G raised R1's head and noted gushing blood and told the other nurse to call 911. LN G documented CNA N was in the shower room with the resident.

The notarized "Witness Statement" dated

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01/26/23 signed by LN I documented on 01/26/23 at 01:40 PM, LN G was near the shower room and heard yelling and banging noises. The statement noted LN G opened the door and CNA N stated the lift sling fell off the lift. LN I documented R1 was laying on R1's back on the floor, with the Sit-to-Stand lift in front of R1, and the sling hung from the side of the lift.

On 02/07/23 at 10:30 AM CNA M demonstrated use of the Sit-to-Stand lift with the sling and stated, two people were typically used with the Sit-To-Stand lifts.

On 02/07/23 at 11:03 AM R1 sat in a Broda (a specialty cushioned wheelchair) chair in the facility dining room engaged in a bingo game with other residents. R1's scalp wound was clean and dry, with seven metal staples clearly visible.

Interviewed on 02/07/23 at 11:03 AM, R1 remembered the event up to the fall but could not remember immediately after the fall. R1 stated he was in the shower and had his shirt, socks, and shoes on. R1 said his pants and brief were pulled up to his knees. R1 said he was raised in the lift and "the young man was not very experienced." R1 said he was unsure what happened but though staff said the loop came off. R1 could not recall if the sling waist belt was attached. He said he fell and hit the floor and maybe blacked out because he did not remember much after that. R1 said he could not remember if the lift tipped and or the base lift legs were widened. R1 stated the young man who performed the transfer was just not quick enough to keep R1 from falling. R1 stated he never had any previous falls.

Interviewed on 02/07/23 at 12:00 PM, LN H said

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she was not working when R1 fell but stated there was supposed to be two persons assisting with the lifts.

Interviewed on 02/07/23 at 12:10 PM, LN I stated she responded to the shower room after the resident fell, the other nurse was already there, so LN I activated emergency medicals services (EMS). LN, I said she observed the lift sling was hanging on the right side of the lift.

Interviewed on 02/07/23 at 12:45 PM, Administrative Nurse D reported he was not present in the facility when R1 fell but said she assisted with the investigation. Administrative Nurse D noted the investigation omitted if CNA N operated the lift alone.

Interviewed on 02/07/23 at 12:45 PM, Administrative Staff A acknowledged the lift was used improperly and stated CNA N, as well as all staff, received instruction on the use of lifts.

The facility's undated "Following the Care Plan" policy directed the certified nursing assistant worksheet was updated with the care plan either daily or as needed and must be followed when assisting residents with their activities of daily living.

The facility failed to ensure staff followed R1's care plan which directed two staff for use of the lift for transfers. As a result, R1 fell from the lift and received an injury that required emergent hospitalization, treatment, and staples.

On 01/27/23, prior to the survey, the facility completed corrections related to the incident which included, training and in-service education

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F 689	Continued From page 6 on following resident care plans, and use of the lift which included ensuring adequate staff were present. Due to the corrective measures implemented prior to the survey, the deficient practice was cited as past noncompliance at a "G" (isolated, with actual harm) scope and severity.	F 689		