STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175332	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	**1100 W 15TH STREET , OTTAWA, Kansas, 66067**

(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
F0000	INITIAL COMMENTS The following citations represent the findings of complaint investigations 2710271, 2695416, 2673409, and 2667842.	F0000		
F0689 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 documented a census of 69 residents. The sample included three residents reviewed for accidents. Based on record review and interview, the facility failed to ensure an environment free from accident hazards for Resident (R) 1, who required staff assistance and a mechanical lift for safe transfers. As a result, R1 sustained a humerus (upper arm bone) fracture of her left arm. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of morbid (severe) obesity (BMI-Body Mass Index of 40 or greater, or a BMI of 35 or greater with one or more serious health conditions), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk).	F0689	"Past Noncompliance - no plan of correction required"	

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 reverse for further 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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F0689 SS = G	Continued from page 1 R1 had an "Annual Minimum Data Set (MDS)," dated 02/10/25, which documented a Brief Interview for Mental Status (BIMS) of seven, which indicated severe cognitive impairment. The assessment also documented R1 required a mechanical lift for transfers, and she was dependent on staff for toileting and bathing activity of daily living (ADL). R1's "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 02/10/25, documented R1 had a BIMS score of less than 13. R1's "Functional Abilities (Self-Care and Mobility) CAA," dated 02/10/25, documented R1 was dependent on staff for transfers. R1's "Quarterly MDS," dated 11/13/25, documented a BIMS score of 12, which indicated moderate cognitive impairment. The assessment also documented R1 had impairment to both sides of her body, and she was dependent on staff for all transfers. The facility's untitled incident report #2710271, dated 01/07/26, documented R1 was transferred by two Certified Nurse Aide (CNA) staff members from her wheelchair to the recliner with a Hoyer lift. R1 sustained a fall to the ground when it appeared the sling came off the Hoyer hook at the left front corner. R1 had complaints of left shoulder pain and right shin pain, and there was a bruise on her right wrist. Staff notified the primary care physician and ordered R1 to be sent to the Emergency Room (ER) for further evaluation. The director of nursing, ER, and R1's legal representative was also notified. While at the ER, R1 was diagnosed with a fracture of the left humerus. R1 returned to the facility wearing a shoulder abduction immobilizer. CNA M's notarized "Complaint Investigation Witness Statement," dated 01/07/26, documented CNA M and CNA N were transferring R1 to her recliner with the Hoyer lift. CNA M was in control of operating the Hoyer and was positioned in front of R1 and guided her to the proper position. As R1 was lowered to the recliner, the top left sling came undone, and R1 slid to the floor. R1 then complained of left shoulder pain.	F0689		

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F0689 SS = G	Continued from page 2 CNA N's notarized "Complaint Investigation Witness Statement," dated 01/07/26, documented CNA N and CNA M were transferring R1 from her wheelchair to the bed and then to the recliner. CNA N documented she was responsible for guiding R1 while she was in the lift sling to the recliner, and she was positioned behind the recliner and used the lift handles to position R1 in the recliner while CNA M lowered R1 down. As R1 was lowered, the strap on the top, left side of the Hoyer came undone, and R1 slid out of the sling and onto the ground. Administrative Nurse E's notarized "Complaint Investigation Witness Statement," dated 01/07/26, documented she was notified on 01/06/26 by the charge nurse and informed R1 sustained a fall while being transferred with the Hoyer lift. She then went to the unit and took CNA M and CNA N into a private room and provided transfer training. Prior to the training, Administrative Nurse E inspected the sling and lift, and both were within normal limits of function. Administrative Nurse E documented that during the training, when CNA M and CNA N placed the strap loops onto the lift, they did not ensure there was tension on the straps prior to raising the lift, which caused the lift sheet to shift off to one side and allowed the loops to come off the lift. R1's hospital "After Visit Summary," dated 01/06/26, documented R1 had a left shoulder fracture which measured 3.1 centimeters (cm). On 01/27/26 at 09:15 AM, CNA O stated there were always two staff when performing lift transfers. CNA O also reported the lift training was provided for all staff a few weeks ago. On 01/27/26 at 10:30 AM, Licensed Nurse (LN) G stated there had been a resident incident regarding a Hoyer accident and she had received lift-transfer training within the last two weeks. She also stated all medical staff who provided direct resident care were provided with the remedial training. On 01/27/26 at 10:43 AM, Administrative Staff A and Administrative Nurse D reported the remedial training for lifts and transfers was provided for all direct resident care staff; there were some part-time staff who had not worked since the lift incident, but they	F0689		

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F0689 SS = G	Continued from page 3 were flagged to receive the training before their next shift to be worked. An all-staff in-service with additional training was also provided, and they implemented an administrative oversight of resident lift transfers for four weeks with a revisit that will take place. They also reported the social worker implemented resident interviews with those cognitively intact and utilized lift transfer, about how the staff were performing the transfers. On 01/27/26 at 11:43 AM, Administrative Staff A reported all full-time staff had received remedial lift and transfer training by 01/10/26, and none were allowed to begin their shift until it was completed. The facility's "Rock Creek Hoyer Lift Reference 2023" documented that, prior to moving a resident, they were always to perform the transfer with two staff, and the staff were to check the sling for rips or tears and to replace the sling if there was any damage. It also documented staff to position the sling loops on the Hoyer. The facility completed corrective actions by 01/10/26, which included education to staff on safe transfers and using the necessary equipment to facilitate safe transfers with the Hoyer lift prior to the onsite survey; therefore, the deficient practice was deemed past noncompliance and remained at the scope and severity of a "G" to represent the actual, but isolated harm to R1.	F0689		