STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175264	A. Building B. Wing	07/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Columbus	101 Lee Avenue Columbus, KS 66725

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	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40689 The facility reported a census of 30 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure dependent Resident (R) 1 remained free from accidents when Certified Nurse Aide (CNA) M transferred R1 without a second staff member present to assist in a mechanical lift transfer. CNA M further failed to secure one of the leg straps to the mechanical lift, which caused R1 to fall from the lift, face forward onto the floor. These failures resulted in a laceration (a tear in skin) to the left ear that measured 2.0 centimeters (cm) by 0.1 cm, a hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to the left temple, and an acute left hip fracture (broken bone) involving the proximal (nearer to a point of reference or attachment) femoral (thigh bone) neck. This deficient practice placed the resident in immediate jeopardy. Findings include: - R1's Physician Order Sheet (POS) dated 07/01/24, revealed diagnoses included cerebral palsy (progressive disorder of movement, muscle tone or posture caused by injury or abnormal development in the immature brain, most often before birth), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), and osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). The 12/14/23 Annual Minimum Data Set (MDS), documented the resident had moderately impaired cognition. R1 required a wheelchair for mobility and a mechanical lift for transfers due to functional limitations in bilateral (both) lower and upper extremities. The resident was totally dependent on staff for Activities of Daily Living (ADL). The ADL Functional/Rehabilitation Potential CAA, dated 12/14/23, documented the resident required assistance with ADL. The 06/13/24 Quarterly MDS documented the resident had moderately impaired cognition, required a wheelchair for mobility, and a mechanical lift for transfers. R1's Fall Care Plan, dated 03/24/24, instructed staff that R1 had potential for falls. The plan further instructed staff to keep the resident's bed in a low position and the fall alert tag on the wheelchair. The resident had a reclining high-back wheelchair propelled by staff and utilized a mechanical lift for transfers. (continued on next page)

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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's ADL Care Plan, dated 03/25/24, instructed staff R1 required assistance related to her debility due to cerebral palsy. The revised ADL Care Plan dated 05/23/24, instructed staff the resident required the mechanical lift for transfers. R1's Fall Risk Assessment, dated 12/18/23, documented a score of 12, which indicated a moderate risk for falls. R1's Skin/Wound Condition Assessment, dated 07/09/24, documented a laceration to her left ear that measured 2.0 cm by 0.1 cm and a hematoma to her face (left side of head [temple]). Review of R1's pelvis X-ray report, dated 07/09/24, documented possible occult left femoral neck fracture (upper part of the hip joint), with noted minimal offset of the left femoral neck. The report also noted the presence of osseous (bone) demineralization consistent with osteoarthrosis (chronic arthritis without inflammation). Review of R1's maxillofacial (face and jaw) computed tomography scan (CT scan- test in which x-ray technology is used to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels) on 07/09/24 documented edema (swelling resulting from an excessive accumulation of fluid in the body tissues) and a hematoma in the soft tissues along the left face and calvarium (upper domelike portion of the skull that excludes the lower jaw and facial parts). Review of R1's pelvis CT scan on 07/09/24 documented an acute left hip fracture involving the femoral neck. Review of the 07/09/24 at 08:50 PM Nursing Note revealed on 07/09/24 at 06:00 PM, Licensed Nurse (LN) G heard a noise and Certified Nurse Aide (CNA) M yelled for her. LN G went to the resident's room and observed the resident lying on the floor near the closet on her stomach with the mechanical lift above her. The lift sheet was still attached to the mechanical lift, except one strap at the bottom that had come loose, and the resident had fallen out of the lift sheet and onto the floor. CNA M reported she thought one of the straps broke on the mechanical lift but upon inspection it was still intact, appeared to be in good condition, but was not attached to the mechanical lift. The mechanical lift was raised approximately four feet (ft) in the air. CNA M reported the resident hit her head on the floor when the resident fell out of the lift sheet. LN G observed a raised area on the left side of R1's head (temple) which measured 4.5 centimeters (cm) by 5.5 cm. The resident had a skin tear to the left upper front of her ear and was bleeding. The laceration measured 2.0 by 0.1 cm. No other areas noted to her skin at the time of the assessment. The resident was non-verbal and was unable to explain what happened. LN G, CNA M, and CNA N assisted R1 from the floor to her bed with the mechanical lift. Emergency Medical Services (EMS) transported R1 to the Emergency Department (ED). Review of the 07/09/24 at 06:30 PM Administrator Note revealed Administrative Staff A was advised that CNA M transferred R1 utilizing the mechanical lift and a loop was not secured on the left side that caused the resident to fall forward onto the left side of her head. At 06:45 PM, Administrative Staff A arrived at the facility and inspected the newer appearing lift sling. The lift sling appeared to not have tears or concerns. The lift sling was within expiration date. The resident laid in her bed waiting for an ambulance transfer, with LN G at her bedside, and staff noted a hematoma to the left side of R1's head. Administrative Nurse D assessed the resident upon ambulance arrival and EMS transported R1 shortly after. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the 07/09/24 at 09:07 PM Nurse Note by Administrative Nurse D, revealed Administrative Nurse D assessed the resident with Emergency Medical Services (EMS) staff, prior to the resident leaving the facility. Administrative Nurse D noted R1 had a hematoma on the left side of her head above her left ear and a small skin tear to her left ear. When asked if the resident was in pain, R1 nodded her head yes. When asked if her head hurt, the resident nodded her head yes. When asked if her back hurt, the resident nodded her head yes. EMS then transported the resident to acute care. During an interview on 07/11/24 at 12:01 PM, Certified Nurse Aide (CNA) M reported on the day of R1's fall nursing staff were elsewhere, she was rushing, and attempted to transfer the resident from the recliner to the resident's bed with the mechanical lift by herself. CNA M reported the left leg strap was not secured at the time of the transfer. The resident flipped forward out of the lift sling onto the floor, landed on her stomach, and CNA M then screamed for the charge nurse, LN G. LN G assessed the resident prior to CNA M and LN G transferring the resident with the mechanical lift from the floor to the resident's bed. CNA M stated R1 had a hematoma on the left side of her temple and a laceration on her left ear that caused the ear to bleed. CNA M said she should not have utilized the mechanical lift by herself and said there should be two nursing staff for mechanical lift transfers and three nursing staff members if the resident had a catheter. CNA M reported that Administrative Nurse D educated her that evening related to the facility's Skills Check-Total Dependent Lift that included the expectation to always have two staff during transfer with the mechanical lift, for safety. CNA M stated that she was suspended her that evening. During an interview on 07/11/24 at 12:06 PM, CNA N reported she was in another resident's room when she heard CNA M yell for help. When she got to R1's room, she observed R1 on the floor on her stomach. CNA N confirmed it took two staff to transfer a resident with a mechanical lift. During an interview on 07/11/24 at 12:08 PM, LN G reported she heard a thud and CNA N yelled for help. LN G reported when she entered R1's room, she observed R1 on the floor on her stomach. R1 had a hematoma on her left temple and a laceration to her left ear. LN G said the facility called EMS to transport the resident to the ED. During an interview on 07/11/24 at 01:36 PM, Administrative Nurse D confirmed the facility expected the nursing staff to always have two nursing staff during transfers with a mechanical lift. Administrative Nurse D said the nursing staff should not transfer residents with one staff utilizing the mechanical lift. During an interview on 07/11/24 at 04:01 PM, Administrative Staff A reported staff notified her on 07/09/24 at approximately 06:50 PM and she arrived at the facility at 07:00 PM. Administrative Staff A said she inspected the mechanical lift and found no mechanical failure, and she removed CNA M from the floor and interviewed her. CNA M reported to her that she had not attached one of the lift sling clips to the mechanical lift that caused the resident to slide out of the sling, onto the floor, landing on her stomach. This caused a hematoma on R1's left temple, laceration to her left ear, and the CT (computed tomography) scan showed an acute left femoral neck fracture. The facility's Skills Check-Total Dependent Lift included the expectation to always have two staff during transfer with the mechanical lift, for safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 07/11/24 at 04:47 PM, the IJ template was provided to Administrative Staff A and notified the facility failure to ensure dependent Resident (R)1 remained free from accidents when Certified Nurse Aide (CNA) M transferred R1 without a second staff to assist in a mechanical lift transfer and CNA M further failed to secure one of the leg straps to the mechanical lift, which caused R1 to fall from the lift, face forward onto the floor. These failures resulted in a laceration to R1's left ear, a hematoma to R1's left temple, and an acute left hip fracture. This deficient practice placed the resident in immediate jeopardy. The immediate jeopardy was determined to first exist on 07/09/24 at 08:50 PM, when CNA N transferred R1 without another staff member present. The facility identified and implemented the following corrective actions, completed on 07/10/24: On 07/09/24 at 07:00 PM, the facility suspended CNA N. The facility updated R1's care plan related to ADL, on 07/09/24. An immediate quality assurance and performance improvement (QAPI) meeting held on 07/09/24 at 10:40 PM. Nursing staff education provided on 07/09/24 at 08:00 PM through 07/10/24 at 05:00 PM related to mechanical lift skills check offs and training. Due to the corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.