STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175127	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Legacy at Salina	623 S 3rd Street Salina, KS 67401

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 42 residents with three residents reviewed for falls. Based on record review, observation, and interview, the facility failed to provide a safe environment for Resident (R) 1 during a transfer. On 07/04/24, Certified Nurse's Aide (CNA) M transferred R1 by herself with the sit-to-stand lift. R1's ankle buckled and R1 fell out of the lift sling and sustained a broken left thumb. This deficient practice also placed R1 at risk for falls, injury, and pain. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), dementia (progressive mental disorder characterized by failing memory, confusion), and atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 15 which indicated intact cognition. The MDS documented R1 required the use of a manual wheelchair. The MDS documented R1 had not had any falls during the assessment period. The Activities of Daily Living Care Area Assessment (CAA), dated 09/20/23, documented R1 required extensive assistance for bed mobility, transfers, locomotion, dressing, toileting, and personal hygiene. R1 required total assistance with bathing. The CAA documented R1's balance was unsteady and R1 required a six-to-stand lift (for stabilization) and assistance from two staff for transfers. The CAA documented R1 was alert and oriented with intermittent confusion. The Fall CAA, dated 09/20/23, documented R1 was t risk for falls but had not had any falls during the assessment period. The CAA documented R1's balance was unsteady, and she required two staff assistance with a sit-to-stand lift for stabilization. R1's Care Plan directed staff R1 required two staff assist for bathing, bed mobility, dressing, toileting, and transfer. The plan directed staff to use two staff assist using a sit-to-stand lift to transfer R1. The plan directed staff R1 was a fall risk and to ensure her call light was within reach, follow fall protocols, and to ensure R1 had a safe environment. The Morse Fall Scale, dated 09/28/23, documented R1 had a fall risk score of 55 which indicated R1 was a high risk for falls. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Progress Note, dated 07/04/24, documented Licensed Nurse (LN) G was called to R1's room for a fall to the floor. CNA M used the sit-to-stand lift alone and R1's ankle buckled sideways and R1 slipped to the floor. The fall was witnessed, and R1 had no head injury. LN G found R1 sitting on the floor in her room with her legs between the sit-to-stand lift. R1 complained of right knee pain but denied neck pain, back pain, or other pain. The Progress Note, dated 07/05/24, documented LN H noted R1's left hand was swollen and bruised between her thumb and index finger. LN H contacted R1's primary care physician to obtain an order for a mobile x-ray. The Post Fall Note, dated 07/05/24, documented R1's left hand was swollen and bruised. An x-ray was obtained, and staff awaited results. The Progress Note, dated 07/05/24, documented the x-ray results were received. The impression revealed an irregular lucency (the quality or degree of clarity) at the base of the first metacarpal (thumb) bone may be due to a superimposed acute non-displaced fracture. The results were called to R1's primary care physician. R1's primary care physician returned the phone call and ordered for a thumb spika (splint to secure non-emergency injuries to bones) splint, and ordered staff not use the sit-to-stand lift for transfers. The physician also ordered staff to keep weight off R1's left hand and set a follow up appointment for 07/15/24. Staff notified R1's responsible party who stated she would bring in the spika splint. Staff wereceducated on R1's new transfer status. The Final X-Ray Report, dated 07/05/24, documented an irregular lucency at the base of the first metacarpal bone may be due to superimposed acute nondisplaced fracture. The Progress Note, dated 07/05/24, documented R1's responsible party brought in the spika splint and requested that R1 always be transferred with a full lift even after her fracture was healed to prevent further falls. R1's splint was in place and her pain was being managed by as-needed pain medication. The Post Fall Note, dated 07/06/24, documented R1 had a fracture to her left hand and the pain was being managed with as-needed pain medications. The Post Fall Note, dated 07/07/24, documented R1's pain was being managed by as-needed pain medication. The Post Fall Note, dated 07/07/24, documented R1's left hand splint was in place. R1 had mild bruising and swelling around the thumb and the first digit area. R1's left hand was non-weight bearing. The Progress Note, dated 07/09/24, documented the Interdisciplinary Team (IDT) met that morning regarding R1's prior fall and interventions to prevent future falls. Staff were to ensure R1's feet were properly placed on the sit-to-stand platform. R1's Care Plan was updated, and a mini in-service was posted for staff education. The Progress Note, dated 07/16/24, documented R1's primary care physician ordered the spika splint to be in place twenty-four hours a day/seven days a week except for bathing. A follow up was scheduled in four weeks with an x-ray prior to the appointment. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The undated Facility Incident Report documented CNA M transferred R1 with a stand-up lift. R1's foot was unstable and buckled during the transfer. R1 slipped through the sling to the floor. LN G came to assess R1 and found no injury. The fall follow up assessment the next day, LN H observed swelling to R1's hand, notified R1's family and requested an x-ray from R1's primary care physician. The order was received, x-ray completed and revealed a displaced area. R1's primary care physician requested a splint and full lift until R1's left hand was weight bearing. R1's daughter requested continual use of full lift. CNA M was retrained and put on a performance improvement plan and an in-service was given to all staff. Performance improvement plan will be reviewed at Quality Assurance and Performance Improvement (QAPI) to audit for retraining. CNA M's undated Witness Statement documented R1 was on the sit-to-stand lift when the incident occurred. R1's ankles shifted, and the weight was too much for R1 to bear. LN G's Witness Statement, dated 07/16/24, documented she was called to R1's room by CNA M. LN G found R1 out of the sit to stand sling and sitting on the floor with her legs between the lift. CNA M stated she had used the lift by herself and R1's ankle buckled when she slipped to the floor. R1 denied neck, back or head pain but did complain of right knee discomfort. No deformity noted. On 07/16/24, at 10:00 AM, observation revealed R1 was transferred with the full lift from her bed to her wheelchair. R1 had a splint to her left hand. R1 held the left hand with her right hand through the transfer process. On 07/16/24 at 10:15 AM, CNA N stated that he was educated about always having two staff when a mechanical lift was in use. On 07/16/24 at 10:20 AM, R1 stated Oh yes my hand hurts! R1 rated her left-hand pain at medium. R1 stated the pain sometimes made it difficult for her to sleep. On 07/16/24 at 10:30 AM, Administrative Nurse D stated CNA M was a good CNA, but she was relatively new to the position. Administrative Nurse D stated CNA M was just in a hurry to complete the transfer and did not find another staff to assist her. Administrative Nurse D stated that she had counseled with CNA M about the importance of two staff transfers with a mechanical lift. On 07/16/24 at 11:00 AM, Administrative Staff A, verified CNA M did not follow the facility policy and procedure regarding use of mechanical lift. The facility's Using a Mechanical Lifting Machine Policy, dated July 2017, documented at least two nursing assistants are needed to safely move a resident with a mechanical lift. The facility's Safe Lifting and Movement of Residents Policy, dated July 2017. Documented to protect the safety and well-being of staff and residents and to promote quality care, this facility uses appropriate techniques and devices to lift and move residents. Resident's safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding safe lifting and moving of residents. The facility failed to provide a safe environment for R1 during a transfer. As a result, R1 fell and sustained a broken thumb. This deficient practice also placed R1 at risk for falls, injury, and pain. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility identified and implemented immediate corrective actions, which were completed on 07/10/24 which included: CNA M was retrained on proper mechanical lift protocol and placed on a performance improvement plan. An in-service was completed for all employees regarding when using any mechanical lift two staff members must be present per facility policy and failure to do so could result in immediate suspension and/or termination. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance at a G.