STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175157	A. Building B. Wing	02/29/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of Andover	621 W 21st Andover, KS 67002

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. 41302 The facility reported a census of 94 residents, with three residents sampled for accidents with a mechanical lift. Based on observation, interview, and record review, the facility failed to ensure Resident (R)1 remained free from accident hazards on 02/20/24 when Certified Nurse Aide (CNA) E used a mechanical lift by himself, while transferring R1. As a result, R1 fell from the full body mechanical lift and fractured her pelvis. This failure placed R1 in immediate jeopardy and placed 30 residents, who required a full body mechanical lift for transfers, at risk for injury. Findings Included: - R1's diagnoses from the Electronic Health Record (EHR) included osteomyelitis (local or generalized infection of the bone and bone marrow), multiple sclerosis (MS- progressive disease of the nerve fibers of the brain and spinal cord), paraplegia (paralysis characterized by motor or sensory loss in the lower limbs and trunk), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The 12/14/23 Admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R1 had range of motion impairments on both sides of her lower extremities. The 12/14/23 Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R1 required substantial to total assistance of staff for all ADLs and mobility. The resident had MS and functional quadriplegia (paralysis of all four extremities and sometimes he trunk and internal organs), which placed R1 at further risk for falls. The 12/09/23 Care Plan revealed an 05/25/23 intervention that R1 required the use of a mechanical lift with two staff assistance for transfers. The 12/08/23 Fall Risk assessment documented R1 was a fall risk. The Progress Note dated 02/20/24 at 05:08 PM documented R1 fell during a mechanical lift transfer with CNA E. CNA E indicated R1 slid out of the sling and hit her head on the bed frame, and then he assisted her to the floor. R1 stated she had pain in her neck and the back of her head. (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/20/24 at 12:00 AM, the Progress Note documented R1 recently had a fall and was sent to a local hospital. X-rays revealed a left pubic rami fracture (type of pelvic fracture) which was non-operable. When R1 returned to the facility, R1 had increased pain and an analgesic prescribed for the pain. On 02/20/24, a Witness Statement by CNA E, revealed at approximately 04:30 PM, R1 was about to be transferred from her electric wheelchair to her bed with the mechanical lift and CNA E lifted R1 from the electric wheelchair, and she began to slide from the sling. R1 held onto CNA E's left hand and CNA E lowered R1 to the floor. CNA E then notified the charge nurse. On 02/20/24, a Witness Statement by CNA F, revealed Licensed Nurse (LN) D asked CNA F and CNA G to answer a call light that had been on for a while. They went down to the room, opened the door and R1 was on the floor with no sling around her, and CNA E stood over R1. The lift was behind CNA E and the only sling in the room was crumpled in a ball on her bed. They immediately informed the charge nurse. On 02/20/24, a Witness Statement by CNA G, revealed CNA G was at the nurse station when LN D asked her to go and answer the call light because the resident in the room (roommate) called and she could not understand what she was saying. CNA G went with CNA F and opened the door and saw R1 lying on the floor with CNA E standing over her. The mechanical lift was behind the door and the sling was on her bed. CNA G went back to the nurse station and informed the nurse that R1 was on the floor. On 02/20/24, a Witness Statement by LN D, documented she was at the nurse station when a unit manager alerted her that R1's roommate had called saying R1 fell out of the sling during a transfer to bed. Two CNAs went to the room and came back to report R1 fell . LN D ran down to the room and saw R1 on her back, on the floor, with her head under the bed frame. CNA E reported he attempted to transfer R1 by himself. R1 stated she hit her head and her left leg/thigh hurt. LN D and CNA E placed the mechanical lift sling under R1 and transferred R1 back into bed. Orders obtained (later) and R1 transferred to a local hospital at 06:38 PM. On 02/20/24, a Witness Statement by LN C, documented she answered a phone call from a resident stating she needed help in the room. LN C sent two CNAs to the room to see what she needed. The two quickly returned and stated that R1 was on the floor. When LN C and LN D got to R1's room, they saw CNA E in the room with the mechanical lift above R1, who was on the floor on her back. R1's head was under the bed. CNA E stated he tried to transfer R1 by himself and had to lower her to the floor. R1 stated she hit her head and her leg hurt. After completion of a head-to-toe assessment and neurological assessment, LN C, LN D, and CNA E used a mechanical lift to put R1 back into bed. On 02/29/24 at 12:20 PM, R1 sat in her bed. R1 stated she had her call light on to get staff assistance to the commode. R1 reported staff administer medications for the pain. Two unidentified CNAs entered the room to transfer R1 with a full body mechanical lift. On 02/29/24 at 11:39 AM, Administrative Nurse B stated she expected all nursing staff to know the appropriate and safe protocol with a mechanical lift. Administrative Nurse B stated she always expected two staff present with the use of a mechanical lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 02/29/24 at 12:30 PM, LN C revealed at the time of the fall she had received a call from R1's roommate and could not really understand all she was saying, so she sent two CNAs down to her room to find out what she needed. They came back and told her that R1 was on the floor. She stated CNA E transferred R1 by himself. LN C said there should always be at least two staff when transferring a resident with a mechanical lift. The facility's policy for Limited Lift Program (Safe Patient Handling) revised 08/09/23, documented the facility would provide education, upon hire and annually, to associates on the proper use of lifts in accordance with the manufacturer guidelines. The education would include the need to have two associates present during the transfer. The facility failed to ensure Resident (R)1 remained free from accident hazards when CNA E used a mechanical without two staff present, on 02/20/24, and R1 fell from the full body mechanical lift and fractured her pelvis. On 02/29/24 at 02:00 PM, Administrative Staff A was provided the Immediate Jeopardy (IJ) Template and notified the failure to ensure R1, who required a mechanical lift, remained free from accident hazards when one staff attempted to transfer a resident that required a mechanical lift without another staff member. The facility identified and implemented the following corrective actions completed 02/22/24 at 04:15 PM. 1. Inspection of the full body mechanical lift sheet for tears or frays, completed on 02/21/24 at 03:00 PM. 2. Hoyer (full body mechanical lift) education initiated on 2/21/24. Those not present received phone education, with the last education on 02/22/24 at 04:15 PM. 3. CNA E suspended on 02/21/24 at approximately 10:00 AM and terminated at approximately 03:00 PM per phone call. 4. Quality Assurance Performance Improvement (QAPI) meeting held on 02/21/24 at approximately 12:00 PM. 5. Education of nursing and therapy related to safe Hoyer transfers held on 02/21/24. 6. Audits of resident that required mechanical lift to verify the transfer status, correct sling size, how staff could access the information, completed on 02/21/24 at 05:00 PM. Due to the actions identified and implemented prior to the onsite visit, the deficient practice was deemed past noncompliance at a J scope and severity.