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	05/14/2026

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. Based on observation, interview, and record review the facility failed to ensure a safe environment free from accidents for Resident (R)1. On 03/28/26, Certified Nurse Aide (CNA) N and CNA M attempted to transfer R1 from his electric scooter to his bed using a full-body mechanical lift. R1's scooter became tangled with the lift, so CNA N turned her back to R1 to move the scooter. During this time, without the hands-on assistance of CNA N, CNA M moved the lift, and R1, who was approximately four feet in the air, began to sway. One of the sling loops came unhooked and R1 fell to the floor. As a result, R1 sustained head injuries, including a concussion (damage to the brain caused by violent jarring or shaking, such as a blow), a frontal skull fracture (a break in the bone forming the forehead), and subarachnoid hemorrhage (bleeding in the space just outside the brain). This deficient practice placed R1 in immediate jeopardy. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of cerebral palsy (a progressive disorder of movement, muscle tone, or posture caused by injury or abnormal development in the immature brain, most often before birth), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear, muscle weakness, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and hypertension (high blood pressure). The Annual Minimum Data Set (MDS) dated 03/31/26 documented R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had impairment on both sides of his lower extremities, he used a wheelchair, and was completely dependent on staff for toileting, showering, dressing, and transfers. The Functional Ability Care Area Assessment (CAA), dated 03/25/26, documented R1 had risks for falls, continued decline in activity of daily living (ADLs), skin breakdown, and pain. The CAA documented R1's plan of care would include a decrease in fall risk. The Fall CAA, dated 03/25/26, documented R1's Care Plan would reflect his current physical function related to ADL, strength and endurance, mobility, decrease in fall risk, and minimize injuries related to falls. R1's Care Plan, initiated 04/13/23, documented R1 required a mechanical Hoyer (total body mechanical lift) with two staff members for assistance during transfer, using the small red sling. The plan directed staff to assist R1 with his ADLs, keep R1's call light within reach, and complete a fall risk assessment. The Fall Risk Assessment, dated 03/28/26, documented R1 had a fall risk score of 16, which indicated R1 was a high fall risk. The Nurse's Note, dated 03/28/26, documented at 12:40 AM, staff summoned Licensed Nurse (LN) G to R1's room. Upon LN G's arrival at R1's room, R1 laid in a supine position between the Hoyer lift's legs with his head facing the door. CNA M and CNA N were present in the room and reported they attempted to transfer R1 from his electric wheelchair to bed. When CNA M and CNA N pushed the Hoyer lift forward towards the bed, the lift got stuck on the carpet. R1 swung side to side, and one strap of the sling came loose, which prompted the fall. R1 sustained a visible laceration (cut) to the left side of his head, R1 voiced neck pain, and staff assessed R1 and noted confusion. At 12:50 AM, the on-call provider ordered staff to transport R1 to the emergency room by the emergency medical personnel. At 12:57 AM, Emergency Medical Services (EMS) arrived at the facility and transferred R1 to the hospital. The emergency room Report, dated 03/28/26, documented R1, who had a history of paraplegia (paralysis characterized by motor or (continued on next page)

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

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	05/14/2026

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	sensory loss in the lower limbs and trunk), was dropped from a mechanical lift and sustained a concussion, an abrasion, a frontal skull fracture, and a subarachnoid hemorrhage. R1 would be admitted to the Intensive Care Unit (ICU) for observation, a repeat computed tomography (CT scan- a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) to be completed later that day, and neurosurgery (a medical field focused on the surgical and nonsurgical treatment of disorders affecting the nervous system) to consult. R1 would be placed on Keppra (seizure medication) for seizure (violent involuntary series of contractions of a group of muscles) prophylaxis (preventative in nature). The Facility Incident Report, dated 04/03/26, documented CNA M and CNA N assisted with a transfer via a mechanical lift on 03/28/26 when R1 slipped out of the sling onto the floor. Staff reported they attempted to transfer R1 from the electric wheelchair to the bed. Based on the investigation, it was found that the leg of the lift became entangled in the electric wheelchair. It was believed that the loops of the lift sling became dislodged, which caused R1 to fall forward. It was reported that the cause of the sling loop coming dislodged was caused by R1 swinging in the sling side to side. Upon further investigation, this scenario was implausible. It is believed, based on the return demonstration, that the loop of the lift sling was not loaded properly. When the lift went into forward motion, this caused the loop of the sling to become dislodged. CNA M's unnotarized Witness Statement, dated 03/28/26, documented at around midnight on 03/28/26, CNA N and CNA M went to transfer R1 from the chair to the bed. CNA M and CNA N got R1 secured on the Hoyer, made sure all four straps were in place, and also crisscrossed at the crotch area. CNA M went to lift R1 into the air and after CNA M got R1 lifted high enough into the air, CNA N went to remove R1's electric wheelchair. When CNA N attempted to move the chair out of the way, CNA M noted the chair got stuck on the leg of the Hoyer. CNA M moved the Hoyer back just a little bit so the chair would maneuver out of the way. The Hoyer seemed to get stuck on the carpet, and the motion caused R1 to swing, which caused the straps that were crisscrossed to come loose from the Hoyer. R1 fell headfirst to the floor. CNA N's unnotarized Witness Statement, dated 03/28/26, documented around 12:40 AM, CNA N and CNA M were putting R1 in bed. CNA N and CNA M got him on the Hoyer lift. CNA N tried to get the electric chair out of the way, and it got stuck. CNA N moved the electric chair back and heard a big bang on the floor. CNA N looked, and there was R1 beside her on the floor. CNA N stated she did not know how R1 ended up on the floor. On 05/14/26 at 10:30 AM, observation revealed R1 lay in bed with the television on. R1's arms were contracted to his chest due to cerebral palsy. R1's eyes wandered around the room as if he could not keep his eyes focused on one point of origin. On 05/14/26 at 10:30 AM, R1 stated he had a lot of pain due to the fall. R1 stated he could not remember much of what happened after he fell. He remembered one of the CNAs saying, Something's not right before the transfer. R1 stated he remained scared to be transferred with a Hoyer lift now and said he wanted three to four staff to be in the room for every transfer. R1 stated he feels a sense of falling every time they get him up in the lift. R1 stated that at the end of the month, he was moving to another facility because the CNAs had let him fall. On 05/14/26 at 11:00 AM, CNA N stated R1's electric scooter got stuck, so she turned her back on R1 and CNA M to try to get the scooter to move out of the way. CNA M jerked the Hoyer lift away from the scooter, and CNA N heard a big bang on the floor and looked and saw R1 on the floor. CNA N stated she thought she had checked the straps on the lift sling, but she could not be sure. On 05/14/26 at 11:30 AM, CNA M stated she and CNA N got R1 up into the lift sling with the Hoyer lift to move him from his electric scooter to his bed. CNA M stated R1's electric scooter got tangled up in the Hoyer lift legs, and she pulled the Hoyer lift away from the scooter. R1 started to sway in the sling and then fell forward headfirst. CNA N ran and got the nurse. CNA M stated she had raised R1 approximately four feet in the air, and that was the height he fell from. CNA M stated they had used the sling that was in the room, which staff had used previously, and were not sure if it was the right sling or not. CNA M stated she was pretty sure she had checked the sling loops to make sure they were secured. On 05/14/26 at 10:00 AM, Administrative Nurse D stated the CNAs did not follow the facility protocol when they transferred R1. (continued on next page)

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	05/14/2026

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	Administrative Nurse D stated both CNAs had been educated on the correct protocol for mechanical lift transfers prior to the accident. Administrative Nurse D stated the CNAs had been terminated for not following the facility's transfer policy. The facility's Limited Lift Program (Safe Patient Handling) Policy, revised 02/20/24, documented that the facility will assess residents for the need for assistance with transfer activities, mobility, or repositioning using a validated mobility assessment by nursing or therapy. Associates will be responsible for utilizing mechanical lifting devices, transferring devices, and proper body mechanics to lift, transfer, and/or pivot non-ambulatory patients as indicated. The facility must ensure the resident environments remain as free of accident hazards as possible and each resident receives adequate supervision and assistance devices to prevent accidents. On 05/14/26 at 01:04 PM, Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was notified that the facility's failure to ensure R1 remained free from accidents placed R1 in IJ. The facility completed corrective actions by 04/01/26, prior to the onsite survey, which included: termination of CNA M and CNA N for improper lift protocol, staff education on the use of mechanical lifts, mechanical lift competency check-off for all CNAs, including return demonstration, and inspection of all lifts and slings for safety. The above corrective actions were verified as completed by the onsite surveyor, therefore the deficient practice was deemed past noncompliance and remained at the scope and severity of J (isolated, immediate jeopardy).