STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175165	A. Building B. Wing	06/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rolling Hills Health Center	2400 SW Urish Road Topeka, KS 66614

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** The facility documented a census of 41 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. This deficient practice also placed R1 at risk for pain and impaired independence. Findings included: - The Electronic Medical Record (EMR) for R1 documented diagnoses of pleural effusion (abnormal accumulation of fluid in the lungs), chronic obstructive pulmonary disease (COPD - a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems), polyosteoarthritis (joint pain or arthritis that affects five or more joints simultaneously), and age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk). R1 had an Entry Minimum Data Set (MDS) dated [DATE] when R1 admitted to the facility. A Discharge Assessment Return Anticipated MDS dated 10/12/24, documented an unplanned discharge to the hospital. The staff interview for resident cognition revealed R1 had some cognitive difficulty in new situations. The MDS noted R1 used a wheelchair and depended on staff for propelling in the wheelchair at least 50 feet, with the ability to make two turns. The MDS documented R1 was dependent on staff for toileting hygiene. The MDS documented R1 required substantial to maximal assistance for dressing, transfers from seated-to-lying or seated-to-standing positions, and bed-to-chair transfers. The MDS further documented R1 required substantial to maximal assistance for transfers to and from the toilet and shower or tub. R1 had an Entry MDS dated [DATE] when R1 readmitted to the facility, with no BIMS completed. A Discharge Assessment Return Anticipated MDS dated [DATE] (after the incident) documented a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The MDS noted the resident had no rejection of care behaviors. R1's Baseline Care Plan dated 10/10/24, documented R1 required one-person physical assistance for transfers, toileting, dressing, and bathing. The Baseline Care Plan documented R1 used a wheelchair. (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 - Actual harm Residents Affected - Few	R1's Care Plan, initiated and created on 10/18/24 after the incident, directed staff R1 could not reposition herself and needed a Hoyer (full-body mechanical lift) lift for transfer though R1 often declined the use of the Hoyer. The plan, dated 10/18/24, directed staff if R1 declined the Hoyer the staff should use two staff and a gait belt. R1's Care Plan Note documented R1 fell at home and had broken ribs and poor endurance due to pain. The note recorded the provider ordered medications to address the pain. The note documented a recommendation to use the sit-to-stand lift or the Hoyer due to rib pain when using the gait belt. An Occupational Therapy Daily Note with a service date of 10/15/24 documented R1 had a shower and was able to demonstrate the ability to wash and dry her hair and body with moderate assistance. R1 was able to stand from the shower bench seat and use a grab bar with moderate to maximal assistance from two staff. The note documented R1 was very fatigued after the showering task. The note further documented R1 completed a stand pivot transfer from the wheelchair to the bed with maximal assistance from two staff but was unable to take steps due to fatigue. The note documented R1 was moved to a Hoyer lift for transfers with staff assistance of two due to fatigue. A Physical Therapy Daily Note with a service date of 10/16/24, documented R1 demonstrated fair tolerance to activities on 10/16/24 with increased time and frequent rests. The note documented a recommendation for the continued use of the total body lift for transfers with nursing staff. R1's 10/16/24 Medicare A Progress Note documented R1 was alert and oriented, had an unsteady gait that required supervision, impaired balance, and weakness. The note recorded R1 required assistance with transfers. R1's Transfer to Hospital Summary note dated 10/17/24, documented staff assisted R1 to the shower with a two-person assist as R1 declined to allow the Certified Nurse Aides (CNA) to use the lift. The note documented R1 stated she had not allowed the CNAs to use a lift. R1 sat on the shower chair and needed scooted back. R1 and the CNAs stated the CNAs placed their arms under R1 ' s shoulders and assisted R1 to scoot back in the shower chair, and they all heard a popping noise and alerted the nurse. The note documented upon the nurse's assessment, R1 cried and stated her pain was rated a 10 (pain rating on a zero to 10 scale, with zero meaning no pain and 10 meaning the worst imaginable) in her right upper arm. The note further documented there appeared to be a bump between R1 ' s shoulder and her elbow and R1 ' s right arm was extremely painful but R1 denied pain anywhere else. The staff stabilized R1 ' s arm so it did not shift, in case there was a fracture. The note documented R1 was adamant she wanted to stand up to transfer and not use a lift. The note documented R1's doctor was on site, assessed R1, and asked for R1 to go to the emergency room for evaluation. R1 agreed to the transfer. The note documented staff notified R1 ' s family and Durable Power of Attorney (DPOA) and R1 was transferred to the emergency room via ambulance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility ' s untitled incident report #1593 dated 10/17/24 documented staff assisted R1 with her shower. Once R1 transferred to the shower chair, she needed to be scooted back in the chair so Certified Nurse Aide (CNA) M assisted R1 with scooting. The report documented during the activity, staff heard a popping noise from R1 ' s right arm. The report documented R1 declined to allow the CNAs to use a lift to transfer her and R1 told the CNAs she would stand and transfer. The report documented R1 stated she felt her right upper arm pop and then had severe pain at that time. R1 went to the hospital, and an injury was identified to R1 ' s right upper arm. The report documented the CNAs used their arms under R1 ' s arms in order to boost the resident and when the CNAs lifted R1, they heard a popping noise from R1 ' s right arm. The report documented the CNAs did not use a gait belt for the transfer and the CNAs misplaced their arms in relation to R1 ' s arm. The report documented all staff would be educated on safe transfer techniques of residents. The report further noted the facility educated the two CNAs involved in R1's transfer incident on the safe transferring of residents and the use of a gait belt unless the resident was independent at the time of the incident. CNA M ' s notarized Complaint Investigation Witness Statement dated 10/17/24, documented CNA M and CNA N went to give R1 a shower. The CNAs asked R1 multiple times how she transferred and R1 stated she did not want the full body lift or gait belt, and she could stand and pivot. The statement documented the CNAs assisted R1 to the side of the bed and R1 transferred to the shower chair. The statement noted R1 asked to be scooted back in the chair, so CNA M and CNA N placed their arms under R1 ' s arms and moved R1. They heard a pop and immediately stopped. CNA M documented she went to get the nurse and CNA N stayed with R1. CNA N ' s notarized Complaint Investigation Witness Statement dated 10/17/24, documented CNA N went into R1 ' s room to transfer her into a shower chair. Both CNA M and CNA N asked R1 if she wanted to use the gait belt because R1 refused the full-body lift, and she told the CNAs No and said she could stand and do it. CNA N ' s statement documented R1 stood up and moved into the shower chair but wanted to be moved back into the chair, so CNA N placed her forearm under one of R1's arms and CNA M put hers under the resident's other arm and moved R1 back. CNA N documented that when they moved R1 back, she heard a crack sound in R1 ' s right arm. CNA N noted she held R1 ' s arm in place until Administrative Nurse D came in and made a sling to prop R1 ' s arm up. CNA N documented staff asked R1 if she thought the staff hurt her on purpose and R1 stated no, the staff had tried to help her. Administrative Nurse D ' s notarized Complaint Investigation Witness Statement dated 10/17/24, documented Administrative Nurse D interviewed R1 following the incident. Administrative Nurse D documented R1 reported both CNA M and CNA N offered a lift transfer but R1 told CNA M and CNA N she did not want to use a lift and would stand to transfer from the bed to the wheelchair or shower chair. Administrative Nurse D noted R1 transferred to the shower chair with assistance from CNA M and CNA N with no problem. R1 stated she needed to scoot back in the shower chair and asked the CNAs to help. Administrative Nurse D documented R1 reported the CNAs put their arms under hers, then attempted to lift her, and that was when the resident felt her right arm pop and experienced pain. R1's hospital Discharge Summary dated 11/07/24 documented R1 was admitted on [DATE] with a humerus fracture. The summary noted R1 was boosted under her arms, heard a pop, and had immediate pain. An X-ray confirmed the humeral fracture. The summary noted orthopedic (bone specialists) surgery performed an open reduction and internal fixation (a surgical procedure to repair broken bones) on 10/19/24. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 06/02/25 at 01:40 PM, CNA O stated he received lift and transfer training at the time he was hired CNA O stated if a staff member made a mistake during a transfer, the facility provided education for all staff related to safe transfers as a response. CNA O stated he would never grab a resident by, or under, the arms to transfer or reposition them. CNA O stated grabbing a resident by or under the arms could cause bruising, skin tears, or other injuries. CNA O stated if a resident was supposed to use a lift but refused, he would find another way to reposition them by using a lift sling to slide the resident back into the chair, but not pull on the resident ' s body. CNA O stated staff knew how a resident transferred by viewing the care plan. CNA O also stated staff can use a lift to transfer a resident if they believe transferring the resident without a lift would be unsafe. On 06/02/25 at 02:10 PM, Licensed Nurse (LN) G stated therapy made the determination if a resident required a lift and then communicated that information to staff. LN G stated therapy did a good job of informing staff of how residents need to be transferred. LN G stated residents have (dry erase) boards in their room that also instruct staff on how the residents transfer and the information should also be on the care plan. LN G stated if a resident needed a full-body lift but refused the use of the lift or a gait belt, staff should notify the charge nurse. LN G stated staff should never grab a resident by or under their arms to transfer or reposition the resident and it was inappropriate to do so. LN G stated if staff grabbed a resident by or under their arms, it could cause dislocations, skin tears, or other injuries. On 06/02/25 at 02:43 PM, Administrative Staff A stated Administrative Nurse D was out of the facility and unavailable for an interview. Administrative Staff A said the facility provided lift and transfer training annually and if needed, additional training was provided. Administrative Staff A stated therapy also provided some training with staff when a resident transitioned from a Hoyer use to walking. She stated therapy placed signs in resident rooms with instructions on how the resident transferred. Administrative Staff A stated staff could also find information regarding how a resident transferred by reviewing the resident ' s care plan, and the CNAs also had the information on care cards they carried with them. Administrative Staff A stated that R1 refused for staff to use a gait belt or lift at the time of the occurrence. Administrative Staff A stated R1 asked to be scooted back in the chair as she was too far forward so staff each placed one arm under R1's arms, grabbed R1 ' s pants with their other hand, and attempted to slide R1 back. Administrative Staff A stated she could not confirm this action was appropriate but R1 had refused both the gait belt and Hoyer lift. The facility ' s undated Accidents and Occurrences policy documented it is the policy to ensure that each resident receives adequate supervision and assistive devices to prevent occurrences. Staff shall be trained to provide emergency care in the case of an accident. The policy documented to ensure relevant, individualized interventions have been added to the care plan, if casual factors are determined to have a potential impact on other residents, ensure system-wide interventions are implemented. The facility completed corrective actions by 01/30/25 that included education to staff on safe transfers and using the necessary equipment to facilitate safe transfers 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.