

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175282	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/28/2024
NAME OF PROVIDER OR SUPPLIER Minneapolis Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 815 N Rothsay Street Minneapolis, KS 67467	

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)
<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204</p> <p>The facility identified a census of 44 residents with three residents reviewed for falls and accidents. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1's safety needs were met during transportation from dialysis (a procedure where impurities or wastes were removed from the blood). On 10/21/24, R1 was picked up from dialysis by transportation driver Certified Nurse's Aide (CNA) M, twenty-one miles from the facility. CNA M failed to strap R1's wheelchair into the van with the front safety harnesses. CNA M stopped at the stop light and when he drove away from the stop light, R1's wheelchair fell backwards in the transportation van and R1 hit his head on the wheelchair ramp. CNA M pulled over and was able to get R1 back in his wheelchair and transported R1 to the emergency room. At the emergency room, R1 was diagnosed with multiple cervical spine (C-the uppermost part of the spine, consisting of seven bones) fractures. The facility's failure to safely anchor the front of R1's wheelchair during van transport placed R1 in immediate jeopardy.</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of chronic subdural hemorrhage (SDH-serious condition, typically caused by head injury, where blood collects between the skull and the surface of the brain), end stage renal disease (ESRD-a terminal disease of the kidneys), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and dependence on a wheelchair. <p>The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of 14, which indicated intact cognition. The MDS documented R1 had impairment on both sides of his upper extremities and impairment on one side of his lower extremities and used a wheelchair for mobility. The MDS documented R1 had not had any falls during the assessment period.</p> <p>The Functional Abilities Care Area Assessment (CAA), dated 01/29/24, documented R1 required staff assistance with all of his activities of daily living (ADLs), was able to make his needs and wants known, and was participating in therapy to regain strength.</p> <p>The Falls CAA, dated 01/29/24, documented R1 had one fall during the assessment period. The CAA documented R1 required assistance with his ADLs but was non-compliant with asking for assistance.</p> <p>(continued on next page)</p>

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 175282	If continuation sheet Page 1 of 5

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>R1's Care Plan documented R1 as dependent on staff for bathing and putting on and taking off his footwear. The care plan documented R1 required substantial/maximum assistance from staff for toileting, dressing, personal hygiene, sit-to-stand, and transfer. The care plan documented R1 as independent with mobility in his wheelchair. The care plan documented R1 as at risk for falls due to vision impairment, impulsivity, poor choices, and weakness.</p> <p>R1's Morse Fall Scale, dated 10/10/24, documented R1 had a fall score of 80, which indicated R1 had a high risk for falls.</p> <p>The Facility Incident Report, documented on 10/21/24 at approximately 11:30 AM Social Services Designee (SSD) X received notification from CMA M stating he picked R1 up from dialysis. CNA M stated R1 was sitting in his wheelchair in the rear of the van and CNA M was driving down the street and stopped at a stoplight. When the light turned green, CNA M started to go and R1's wheelchair tipped backwards causing R1 to strike his head on the ramp at the back of the van. CNA M pulled over and assisted R1 back into a sitting position in his wheelchair and took R1 immediately to the emergency room for evaluation. CNA M was suspended pending investigation. CNA M stated he did not hook up the wheelchair in the front. R1 was released from the emergency room and returned to the facility at approximately 09:20 PM on 10/21/24. R1 had a C6 (cervical fracture at the level of the sixth bone) fracture, and a cervical collar (C-collar: provides support and restricts movement of the neck while neck bones and tissues heal) was in place. The investigation showed R1's wheelchair was not properly secured per staff and resident interviews. The facility re-educated all staff on Abuse, Neglect, and Exploitation (ANE), performed Driver Basic Skills Validation with approved drivers, and implemented a Pre-Transportation Safety Checklist which would be monitored weekly for four weeks, every two weeks for four weeks, and then monthly for four months.</p> <p>CNA M's Witness Statement, dated 10/21/24, documented CNA M stopped at a red light and when it turned green, he accelerated and R1, who was in the wheelchair fell backwards. CNA M stated he went to get R1 out of the van and when he let down the wheelchair ramp R1 slipped out of his wheelchair. CNA M laid R1 down on the wheelchair ramp and got R1's wheelchair out of the van. A man stopped and helped CNA M pick R1 up and set R1 back in the wheelchair. CNA M then strapped R1 down and took R1 to the emergency room. CNA M stated the incident occurred because he did not hook up R1's wheelchair in the front with the safety harnesses.</p> <p>The Nurse's Note, dated 10/21/24 at 12:15 PM, documented R1's next of kin was notified of his fall and R1 being transported to the emergency room.</p> <p>The Nurse's Note, dated 10/21/24 at 12:16 PM, documented R1's primary care physician was notified of his fall.</p> <p>The Emergency Department Report, dated 10/21/24, documented R1 presented to the emergency department for evaluation after falling out of his wheelchair. R1 arrived with a staff from the nursing facility. R1 completed dialysis and the resident's the wheelchair was not secured in the transport vehicle. When the transport vehicle started moving, R1's wheelchair fell backward hitting the back of his head against the floor of the transport vehicle. R1 complained of a headache and posterior neck pain.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Cervical Spine Computed Tomography [CT scan- test that used x-ray technology to make multiple cross-sectional views of organs, bone, soft tissue and blood vessels] Scan Results, dated 10/21/24, documented R1 had sustained an acute bilateral (both sides) C6 lamina fracture, and acute bilateral C6 inferior articulating facet fractures (cervical neck fracture with dislocation), and an acute distracted fracture (a break in a bone where the bone components widen, resulting in an increase in the bone's overall length) of the spinous process of C5.</p> <p>The Assessment and Plan, dated 10/21/24, documented due to R1 having numerous medical comorbidities, it would be ideal to avoid surgery and consider non-surgical interventions as R1 was a high-risk patient. The neurosurgeon advised a cervical collar and to watch healing closely with repeat X-rays. The neurosurgeon discussed with R1 the necessity to wear the cervical collar at all times but said R1 could take it off daily to clean underneath the collar while maintaining cervical spine precautions. The neurosurgeon stressed to R1 to watch for numbness or tingling, worsening pains, trouble using his arms and legs from his baseline, or any changes in bowel or bladder habits. R1 stated he would like to proceed with this course of action. The plan noted to get X-rays in a couple of weeks, allow R1 to discharge, and maintain cervical spine precautions at all times.</p> <p>The Nurse's Note, dated 10/21/24 at 06:43 PM, documented R1's next of kin was updated on R1's condition.</p> <p>The Nurse's Note, dated 10/21/24 at 09:50 PM, documented R1 returned from the emergency room via facility van. R1 returned with a neck brace with instructions not to remove it but once a day for cleaning.</p> <p>The Nurse's Note, dated 10/21/24, documented the facility notified R1's primary care provider at 07:00 PM the C6 fracture from the fall.</p> <p>The Change of Condition Follow Up, dated 10/22/24, documented R1's pain level was a four and R1 stated he was having moderate pain to his neck area. R1 complained of discomfort from the C-collar. Staff administered R1 pain medication. R1 was angry and wanted to remove the C-collar.</p> <p>The Nurse's Note, dated 10/22/24, documented R1 had moderate pain from a fall that had occurred the previous day. R1 needed to be repositioned in his chair every fifteen to thirty minutes the entire shift due to his bottom sliding forward and his body lying to one side in the chair. R1 refused to lie in bed and was given education on how lying in bed could be beneficial to healing and aligning his body. R1 stated, I don't think so. This is fine. R1 continually asked for the C-collar to be removed as it was uncomfortable. Staff educated R1 on why the C-collar could not be removed. R1 initially refused to eat his meals stating he could not eat with the C-collar on and asked for the C-collar to be removed so he could eat. Staff educated R1 that he would have to learn to eat with the C-collar on as it could not be removed. R1 then required one staff assistance for eating and ate all of his food. R1 required two to three staff for all transfers as he was very weak.</p> <p>The Nurse's Note, dated 10/22/24, documented staff brought R1 to the dining room to be assisted with the dinner meal. R1 called the aide a name and stated, I would rather starve to death than have to do this. The aide asked R1 if she could finish helping him eat and R1 said no.</p> <p>The Change of Condition Follow-Up, dated 10/23/24, documented R1 had no complaints, slept well, and awakened easily. R1 stated he was a little achy from the accident.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>The Change of Condition Follow Up, dated 10/23/24, documented R1 was alert and oriented, able to make his needs known and was a little weak.</p> <p>The Change of Condition Follow-Up, dated 10/24/24, documented R1 was sore and weak, verbalizing needs, and had no concerns.</p> <p>The Nurse's Note, dated 10/26/24, documented the nurse went to R1's room to administer medications that morning. R1 sat in his recliner and leaned to his right side, and the C-collar was not positioned correctly on R1. The collar was over R1's chin and covered his mouth and nose region. The nurse sat R1 up straight, supported the C-spine, and placed the C-collar on correctly. R1 asked why he could not wear the collar the way it was because it was comfortable. The nurse educated R1 on the need to wear the collar correctly. R1 stated he did not care, he wanted it off.</p> <p>The Nurse's Note, dated 10/26/24, documented R1 was assisted up to his wheelchair and brought out to the dining room for breakfast so the aide could assist him with his meal. R1 did not argue and was pleasant to the staff. R1 ate 75% of his breakfast and then was assisted back to his recliner in his room. R1 asked to be shaved because his facial hair was bothering him with the collar.</p> <p>The Nurse's Note, dated 10/26/24, documented the nurse was asked by the aide to readjust R1's C-collar as the collar was over his chin and covered his mouth area again. The nurse asked R1 if he was moving the C-collar. R1 denied touching the collar. The nurse educated R1 again on the reason why the C-collar needed to be in the correct position. After properly placing the C-collar, R1 was repositioned in his recliner and propped up with more pillows.</p> <p>The Nurse's Note, dated 10/26/24, documented the nurse went to R1's room to deliver noon medications and saw R1 pulling at the C-collar and moving his head back and forth then grabbing at the Velcro. The nurse asked R1 what he was doing and R1 said sleeping. The nurse again educated R1 that the C-collar must be left in the proper position, or he would not heal properly. R1 stated I don't care. I don't like it on.</p> <p>The Nurse's Note, dated 10/26/24, documented the nurse went to R1's room two more times to re-adjust the C-collar. R1 continued to pull his chin out of the C-collar so that his neck was tucked down. R1 stated he was not touching the C-collar, but staff have seen R1 pulling at the Velcro and chin area and wriggling his head down.</p> <p>The Nurse's Note, dated 10/26/24, documented R1's C-collar was again above his chin covering his mouth and nose. The nurse repositioned the C-collar again and assisted R1 to the wheelchair to come out for the dinner meal.</p> <p>The Nurse's Note, dated 10/27/24, documented the nurse went to R1's room and he had the c-collar on correctly. R1 took his medications without difficulty, transferred to the wheelchair with two staff assist, and complained of pain at a 3 out of 10. R1 came out for breakfast, and he ate 75% of his meal.</p> <p>On 12/28/24 at 12:15 PM, observation revealed R1 sat at the lunch table in his wheelchair being fed by a CNA. R1 had the C-collar in place correctly.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On 12/28/24 at 09:30 AM, Administrative Staff A stated the transportation driver admitted he did not hook up the wheelchair safety straps to the front of R1's wheelchair. Administrative Staff A stated the facility suspended the transportation driver immediately and ended up firing him because of his lack of concern for R1's safety in the transportation van. Administrative Staff A stated re-education had been completed with all the other staff that were trained on transportation. ANE re-education had been completed with all staff on 10/21/24 after the accident had been reported back to the facility. Administrative Staff stated she expected all staff who drove the facility van to have all residents safely and correctly buckled in with all safety straps and harnesses.</p> <p>On 12/28/24 at 12:30 PM, R1 stated he was very upset that this happened to him because it could have been avoided if the driver had just paid attention to what he was doing. R1 stated he was in a lot of pain from his injury. R1 said he was angry that he had to be fed like a baby.</p> <p>The facility's Staff Vehicle Safety Policy and Procedure dated 2021, documented the purpose of the policy was to prevent vehicle accidents and to promote the safety of residents and employees while using facility vehicles. The Resident Securement Checklist, documented Pre-securement: Ensure that the resident is seated properly in the wheelchair. The resident's back should completely touch the seatback without spaces; Evaluate cushion usage for safety; Check that you have all the following equipment: four securement straps per wheelchair, one seat belt per wheelchair, and one shoulder strap per wheelchair; Make sure all the equipment is in good working order; and Check that the securement tracks are clean. Wheelchair Securement: Put the wheelchair into position and lock the brakes; Secure the front straps: anchor straps on the floor track three inches outside the front wheels, ensure straps are at a 30-45 degree angle, secure close to the seat surface, and ensure the track fittings and straps are secure by tugging at them; Secure the rear straps: anchor straps on the floor track three inches outside the rear wheels, ensure straps are at a 30-45 degree angle, secure close to the seat surface, and ensure the track fittings and straps are secure by tugging at them. Lock the brakes. Put on the resident's seat belt with the lap belt buckle on the hip opposite of the shoulder strap to be used. Ensure the belt fits tight across the lap and under the wheelchair armrest.</p> <p>The facility's failure to safely anchor the front of R1's wheelchair during van transport resulted in a cervical spine fracture for R1 and placed R1 in immediate jeopardy.</p> <p>On 10/28/24 at 12:51 PM Administrative Staff A received a copy of the Immediate Jeopardy [IJ] Template and was informed the facility's failure to ensure a safe environment free from preventable accidents evidenced by staff failure to buckle the front wheelchair harness during motor vehicle transport placed R1 in IJ.</p> <p>On 10/21/24, the facility completed ANE education with all facility staff, performed Driver Basic Skills Validation with approved drivers on 10/21/24, implemented a Pre-Transportation Safety Checklist which would be monitored weekly for four weeks, every two weeks for four weeks, and then monthly for four months. CMA M was terminated.</p> <p>Since all corrective actions were completed prior to the onsite survey, the deficient practice was deemed past noncompliance and remained at the scope and severity of J.</p>		