STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175295	A. Building B. Wing	01/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smith Center Health and Rehab	117 W 1st Street #369 Smith Center, KS 66967

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 35 residents with three residents reviewed for accidents. Based on record review, observation, and interview, the facility failed to provide a safe environment free from preventable accidents for Resident (R) 1. On 01/15/25 at approximately 09:20 AM, Certified Nurse Aide (CNA) M and CNA N transferred R1 from his wheelchair to his recliner using a Hoyer (total body mechanical lift) lift. The CNAs used the lift to suspend R1 into the air due to limited space in R1's room. CNA M turned around to position R1's recliner for R1 to sit in, turned back around to assist R1 into the recliner, and the right top lift sling strap dislodged and R1 slid out of the lift sling onto the floor. R1 hit the right side of his head and came to rest on his right side. The facility transferred R1 to the hospital where they diagnosed the resident with a fractured neck. This deficient practice placed R1 at risk for death, injury, pain, and a decrease in daily function. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of atrial fibrillation (rapid, irregular heartbeat), abnormalities of gait and mobility, muscle weakness, repeated falls, and dysphagia (difficulty swallowing). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of six, which indicated severely impaired cognition. The MDS documented R1 had bilateral upper extremity impairment and bilateral lower extremity impairment. The MDS documented R1 required substantial staff assistance for eating, bathing, upper body dressing, and personal hygiene. The MDS documented R1 was dependent on staff for oral hygiene, toileting, lower body dressing, bed mobility, and transfer. The MDS documented R1 had not had any falls during the assessment period. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 08/07/24, documented R1 had a BIMS score of 7, which indicated severely impaired cognition, had a history of false beliefs and delusions, and vivid scary dreams. The Functional Abilities CAA, dated 08/07/24, documented R1 required two staff assistance with his Activities of Daily Living (ADLs) to maintain safety. The CAA documented a full mechanical lift was utilized to transfer R1 as he was unable to bear his weight. The Falls CAA, dated 08/07/24, documented R1 as at risk for falls due to poor balance, weakness, and variable mentation. (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	The Care Plan documented R1 required up to total assistance of one to two staff for bed mobility, transfers, dressing, grooming, hygiene, toileting, and bathing. (06/11/24) The care plan directed staff R1 required assistance with obtaining the correct utensils when eating and getting food onto the fork or spoon when R1 had difficulty and required a divided plate with large-handled utensils. (07/14/23) The care plan documented R1 as a fall risk and directed staff R1 was non-ambulatory and required a full lift for transfer, ensure R1 had on appropriate footwear when ambulating or mobilizing in his wheelchair, and R1 required a safe environment. (09/12/19) The Fall Risk Evaluation, dated 10/18/23, documented R1 had a fall risk score of 10, which indicated R1as a high fall risk. The EMR lacked a more recent Fall Risk Evaluation. The undated Facility Incident Report, documented on 01/15/25 at approximately 09:20 AM, CNA M, and CNA N transferred R1 from his wheelchair to his recliner using a Hoyer mechanical lift. The CNAs used the lift to suspend R1 into the air due to limited space in R1's room. CNA M turned around to position R1's recliner, for R1 to sit in, and then turned back around to assist R1 into the recliner and R1 slid out of the lift sling onto the floor. The right top lift sling strap had come unhooked from the lift cradle. R1 fell to the floor hitting the right side of his head and came to rest on his right side. CNA M called for nurse assistance in R1's room. Licensed Nurse (LN) G entered R1's room and observed R1 on the floor with his head next to the foot of his bed lying almost perpendicular to the bed on his right side. Administrative Nurse D reported to R1's room and assisted LN G in assessing R1 for obvious signs of injury. R1 denied pain during the initial assessment, pupils were reactive, and R1 was unable to complete a full neuro check due to R1's position. Due to the severity of the fall, R1 was not moved. R1 was given a pillow for comfort and an ice pack for the hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) on the right side of his head. R1 initially denied pain, but began to complain of head, neck, and shoulder pain while on the floor. The Hoyer lift was in the room with three of the straps on the sling still attached to the lift and the right top sling was unhooked. The correct Hoyer sling had been used. LN H arrived to R1's room and was directed to call Emergency Medical Services (EMS) to send R1 to the local hospital for evaluation. EMS was notified at 09:25 AM and arrived at the facility at 09:30 AM and R1 left via ambulance. R1's son was notified of the fall and transported to the hospital at 09:45 AM. Upon investigation, staff reported the Hoyer lift sling straps had come unhooked from the Hoyer lift before while it was in use, but staff had not reported it to administration because it had not resulted in any injury CNA M's Notarized Witness Statement, dated 01/15/25, documented CNA N and CNA M transferred R1 from his wheelchair to go to his recliner. After lifting R1 with the lift, CNA M stated she turned to pull out R1's recliner from the wall and when she turned back around R1 was falling from the sling. The sling had come unhooked from the lift and R1 fell to his right side then slid the rest of the way out. CNA M called over the walkie for a nurse. CNA N's Notarized Witness Statement, dated 01/15/25, documented at approximately 09:20 AM, CNA M and CNA N transferred R1 from his wheelchair to his recliner. After lifting R1, CNA M turned around to pull the recliner from the wall and CNA N stated she was starting to move the lift towards the recliner and R1 started to fall out of his sling. CNA N stated she tried to catch R1, but he had already landed on the floor on his right side and then slid the rest of the way out. LN G's Notarized Witness Statement, dated 01/15/25, documented LN G heard the page (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	for a nurse to respond to R1's room. LN G entered R1's room at approximately 09:20 AM and R1 was lying on the floor nearly perpendicular to his bed with his head toward the foot of the bed on his right side. CNA M and CNA N were present in R1's room. CNA M and CNA N stated they were transferring R1 with the full lift and while R1 was suspended in the air, staff were adjusting the wheelchair out of the path of the transfer, and CNA M turned to move the recliner forward and turned back around and R1 was falling to the floor. R1 landed on his head on the floor according to CNAs report. The full lift remained in R1's room and three of the lift sling straps remained attached to the lift and the front right side sling strap was no longer connected to the lift. CNA M and CNA N stated the right front lift strap came off of the hook during the transfer and caused R1 to slide out of the suspended sling and fall to the ground. LN G assessed R1 and asked R1 if he was okay and R1 replied, Yes, I think so. R1 denied pain at that time. CNA M sat on the floor beside R1. LN G assessed R1's head and noted a fluid-filled hematoma to the right center top of the head. A small amount of bleeding was noted from a pinpoint area to the top of the resident's head/forehead. Administrative Nurse D and LN H entered the resident's room. Administrative Nurse D instructed LN J to call for the ambulance and notify the emergency room , R1's primary care provider, and R1's responsible party. R1 left with EMS by ambulance on a scoop board. The Radiology Report, dated 01/15/25, documented R1 sustained an acute type II odontoid process (neck) fracture without significant displacement. The Discharge Instructions, dated 01/16/25, documented R1's diagnoses were neck fracture and urinary tract infection. The discharge instructions directed R1 to wear the C-collar (medical device to prevent movement of the neck) for six to eight weeks. A follow-up appointment was scheduled for 02/04/25. The Discharge Summary, dated 01/16/25, documented R1 was a [AGE] year-old male who admitted to the hospital after sustaining a neck fracture after a fall from a Hoyer lift. R1 hit his forehead on the floor when he fell , which resulted in a hematoma to his forehead and neck fracture. R1's case was discussed with neurosurgery who recommended C-collar placement for six to eight weeks to allow for healing. R1 admitted to the hospital overnight for pain control and to ensure he tolerated the C-collar. The neurosurgeon stated at R1's age he could refuse the C-collar as long as R1's family understood the risks of an unstable neck fracture and the potential for a spinal cord injury without the C-collar. Given R1's age, and previous status at the nursing home, R1's prognosis was noted to be guarded. If R1 continued to decline it would be appropriate for comfort care measures at the nursing home. On 01/21/25 at 10:45 AM R1 laid in bed with his eyes closed. The head of the bed was up at 40 degrees. R1 wore a C-Collar around his neck. R1's chin continually dropped below the chin holder of the C-collar, and LN I placed her hand on R1's forehead pushed his head up and replaced the C-collar under R1's chin. R1 had a large purple bruise on his right temple. R1 did not open his eyes or respond verbally. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 01/21/25 at 10:45 AM, LN I stated R1 was running a temperature and she called his doctor to report the findings. LN I stated she felt like R1 had stasis pneumonia as his lungs were course. LN I stated no CNA had ever reported to her the straps on the Hoyer lift would come off intermittently, otherwise the facility would not have been using that Hoyer lift. LN I stated after R1 came back with the C-collar there was no way he could eat normal food, so the facility had speech therapy consult and they changed R1's diet to pureed with nectar consistency fluids and R1 was a full assist for eating and drinking. LN I stated right after R1 came back she gave him a drink of water through a straw, R1 was so very thirsty, kept drinking, and then ended up coughing. LN I thought R1 aspirated at that time. On 01/21/25 at 11:00 AM, CNA M stated she and CNA N went into R1's room to get him from his wheelchair to his recliner after breakfast. CNA M stated they lifted R1 into the air and CNA N removed the wheelchair while CNA M positioned R1's recliner away from the wall so he could be sat down. When CNA M turned around, R1 was falling from the lift sling. CNA M stated she hated that Hoyer lift because the lift sling hooks would come off of the Hoyer attachments. CNA M stated she reported this finding to the administration but was told to just watch the straps. On 01/21/25 at 11:15 AM, Administrative Nurse D stated R1's fall was completely preventable if the CNAs reported the lift sling straps were coming off during transfers. Administrative Nurse D stated the CNAs reported another time that the straps came off and it was when a resident was barely off the bed and the lower strap came unhooked and dropped the resident's leg about two inches to the bed. Administrative Nurse D stated the Hoyer lift had been removed from the facility and was inaccessible to staff. The facility rented another Hoyer lift from a medical equipment provider. The facility educated all current staff to notify administration when equipment was not working properly. The facility educated all current staff on how to use the new lift safely and lift use competencies were completed for all current staff. The facility's Accidents Policy, revised 08/2022, documented our facility strives to make the environment as free from accident hazards as possible. Resident safety and supervision and assistance to prevent accidents are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through a combination of employee training, employee monitoring, and reporting processes, Quality Assurance reviews of safety and incident/accident reports, and facility-wide commitment to safety at all levels of the organization including staff, residents and families. Employees shall be trained and in serviced on potential hazards and how to identify and report accident hazards and try to prevent avoidable accidents. The facility's Safe Lifting and Movement of Residents Policy, revised 10/2009, documented in order 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. Staff responsible for direct resident care will be trained in the use of manual and mechanical lifting devices. Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Staff will be observed for competency in using mechanical lifts periodically for adherence to policies and procedures regarding use of equipment and safe lifting techniques. Maintenance Staff shall perform routine checks and maintenance of equipment used for lifting to ensure that it remains in good working order. All equipment design and use will meet or exceed guidelines and regulations concerning resident safety. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The facility failed to provide a safe environment free from preventable accidents for R1. This deficient practice placed R1 at risk for death, injury, pain, and a decrease in daily function. On 01/21/25 at 12:20 PM, Administrative Staff A and Administrative Nurse D were provided the IJ template and notified the facility failed to provide a safe environment free from preventable accidents for R1. The facility identified and implemented immediate corrective actions, which were completed on 01/15/25 and prior to the start of the survey on 01/21/25 and included: the Hoyer lift was removed from use and could no longer be accessed by staff. A new lift was rented from a medical equipment company, education was provided to current nursing staff on how to use the new lift, current staff were educated on the need to notify administration when equipment is not working properly, and Total Mechanical Lift competency was completed for all current nursing staff. The corrective actions were verified on-site on 01/21/25 at 11:30 AM. Due to the corrective action completed before the onsite survey, the citation was deemed past noncompliance at a J scope and severity.