STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175353	A. Building B. Wing	06/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arma Operator, LLC	605 E Melvin Street Arma, KS 66712

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 39 residents with five residents sampled for abuse and neglect. Based on interview and record review, the facility failed to ensure Resident (R)1 remained free from neglect. On [DATE] Certified Nurse Aide (CNA) M and CNA N attempted to transfer R1 from a shower chair to R1's wheelchair without using the full-body mechanical lift as required in R1's Care Plan. R1 could not bear weight so CNA M and CNA N lowered R1 to the floor. The staff attempted to lift R1 off the floor without using the mechanical lift but were unsuccessful, so they obtained the full-body mechanical lift, and both CNA staff lifted R1 into her wheelchair. CNA M and CNA N did not report the incident to Licensed Nurse (LN) G and only reported R1 bent her leg during a transfer and complained of pain. In the early morning hours of [DATE], CNA O and CNA M reported to LN H that R1 complained of leg pain. LN H assessed R1's left knee, which was slightly larger than the right. X-ray results showed R1 had a distal (further away) left femur (thigh bone) fracture and a distal right fibula (one of the bones in the lower leg) fracture. On [DATE] at approximately 02:00 PM, CNA M told CNA O she dropped R1 on the previous shift and asked CNA O what to do. CNA O advised CNA M to report the incident to the nursing staff. Administrative staff were not informed of the incident leading to the fractures until [DATE] at approximately 08:50 PM when CNA O asked Administrative Nurse E if CNA M had reported that R1 was dropped. The facility failed to use the lift per R1's Care Plan and accurately report the occurrence for follow-up care. This neglect placed R1 in immediate jeopardy. Findings included: - R1's Electronic Health Record (EHR) revealed a diagnosis of age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased risk for broken bones). R1's Annual Minimum Data Set (MDS), dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff for most activities of daily living (ADL) including transfers. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated [DATE] documented R1 had impaired cognitive function with disorganized thinking and lacked a sense of reality. The Falls CAA dated [DATE] documented R1 was at risk for falls related to poor safety awareness and a history of falls. (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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R1's Quarterly MDS dated [DATE] documented the BIMS assessment was not completed. Per staff interview, the assessment revealed R1 had memory problems with severely impaired cognition. The assessment documented R1 utilized a wheelchair for locomotion and was dependent on staff for all ADLs except and eating. The MDS documented R1 was dependent on staff for transfers. R1's Care Plan noted on [DATE], staff identified R1 had an ADL self-care deficit related to impaired balance. The plan recorded an intervention, dated [DATE], which directed staff R1 required the use of a full body mechanical lift for transfers with the assistance of two staff. A Nursing: Progress Note documented on [DATE] at 01:48 PM by Licensed Nurse (LN) G with an effective date of [DATE] at 02:00 PM noted R1 received a shower before lunch and reported pain in the left knee after the shower, though the assessment revealed no injuries. LN G documented staff reported R1 raised her leg a little but staff did not hear a pop or anything. LN G documented staff reported R1 was agitated, screaming, and yelling when staff bathed her earlier in the shift. A Nursing: Progress Note dated [DATE] at 11:12 PM by LN H documented R1 complained of left knee pain when staff attempted to reposition her. The note documented R1 required a full body mechanical lift for transfers and staff assisted R1 into bed. The note documented R1's left knee had inward positioning with swelling, but no discoloration. LN H documented an (unnamed) CNA reported that on [DATE] the CNA bent the resident's leg during a transfer and heard a pop. LN H called R1's physician but was unable to reach a nurse so LN H faxed the report to R1's physician. A Nursing: Progress Note dated [DATE] at 11:51 AM by Administrative Nurse D documented R1's physician called and ordered a left hip and left knee X-ray. A Nursing: Progress Note dated [DATE] at 02:35 PM by Administrative Nurse D documented R1's X-ray examination could not be completed until the following day due to weather issues. A Nursing: Progress Note dated [DATE] at 02:38 PM by Administrative Nurse D documented staff notified R1's responsible party the resident's X-ray could not be completed until the following morning due to weather concerns. Administrative Nurse D documented R1's daughter did not want R1 to go to the emergency department (ED) if the resident was comfortable in the facility and noted she was fine with the X-ray examination scheduled for the following morning. A Nursing: Progress Note dated [DATE] at 08:27 AM by Administrative Nurse D with an effective date of [DATE] at 11:24 PM documented an (unnamed) CNA reported she and another (unnamed) staff member transferred R1 on [DATE] without the use of a full body mechanical lift. Administrative Nurse D documented the CNA staff lowered R1 to the ground, but did not notify the nurse of R1's fall. The note documented CNA staff reported to the (unnamed) LN that R1 complained of pain when positioning the mechanical lift sling. A Nursing: Progress Note dated [DATE] at 05:34 AM by LN I documented R1 yelled out during repositioning, but not after repositioning. The note documented R1 had no bruising on her left leg, but she did have some swelling to the left knee with inward positioning. A Nursing: Progress Note dated [DATE] at 08:28 AM by Administrative Nurse D documented staff attempted to call R1's responsible party but were unable to reach her. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing: Progress Note dated [DATE] at 08:30 AM by Administrative Nurse D documented staff notified R1's physician that R1 was lowered to the floor on [DATE]. A Nursing: Progress Note dated [DATE] at 08:56 AM by Administrative Nurse D documented staff notified R1's representative that staff transferred R1 without a mechanical lift and lowered R1 to the floor. A Nursing: Progress Note dated [DATE] at 04:29 PM with an effective time of 12:00 PM by Administrative Nurse D documented R1's physician called the facility and ordered staff to send R1 to the ED for evaluation. Staff notified R1's representative. A Nursing: Progress Note dated [DATE] at 12:21 PM by LN J documented staff received a call with R1's X-ray results. The note documented R1 had a distal femur fracture and staff notified Administrative Nurse D and the charge nurse. A Nursing: Progress Note dated [DATE] at 01:36 PM by LN G documented R1 went to the ED via Emergency Medical Services (EMS). A Nursing: Progress Note dated [DATE] at 05:56 PM by Administrative Nurse D documented R1 was admitted to the hospital for a possible surgical consult. A Nursing: Progress Note dated [DATE] at 06:12 PM by LN G documented staff notified R1's representative. A Nursing: Progress Note dated [DATE] at 01:35 PM by LN K documented the facility received a call from the hospital with report of a diagnosis of a non-surgical left femur fractur; R1 had an immobilizer on the left leg. A Nursing: Progress Note dated [DATE] at 01:00 PM by LN L documented staff repositioned R1 with the assistance of three staff and when R1's right foot was touched, R1 yelled out. LN L contacted R1's physician and requested X-ray orders but was unsuccessful. A Nursing: Progress Note dated [DATE] at 01:15 PM by LN L documented staff contacted R1's representative related to R1's right lower leg and foot pain and that attempts to contact R1's physician was unsuccessful. LN L documented R1's representative agreed to wait and contact R1's physician the following morning and said not to send R1 to the ED. Staff faxed R1's physician with an update and request for X-rays. A Nursing: Progress Note dated [DATE] at 10:09 PM by LN H documented R1 had pain in her right foot and leg with movement. LN H contacted R1's physician's office to report the pain and request an X-ray. A Nursing: Progress Note dated [DATE] at 01:32 PM by LN H documented R1's physician ordered an X-ray of R1's right ankle, knee, hip, and pelvis. LN H documented staff notified R1's representative. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A Nursing: Progress Note dated [DATE] at 03:08 PM, LN H documented the facility received the resident's radiology reports and faxed them to R1's physician. LN H documented the radiology results included a non-displaced (bone edges were together) transverse (across the bone) fracture of the distal right fibula (one of the bones in the lower leg) with associated soft tissue swelling. LN H documented R1's daughter was unable to be contacted via telephone. A Nursing: Progress Note dated [DATE] at 03:55 PM by Administrative Nurse D documented staff called R1's orthopedic (bone specialist) physician for an earlier follow-up appointment related to the discovery of an additional fracture. Administrative Nurse D documented R1's right lower extremity was immobilized until her appointment with the orthopedic physician. Administrative Nurse D documented staff would notify R1's representative when the follow-up appointment was confirmed. A Nursing: Progress Note dated [DATE] at 09:58 AM, Administrative Nurse D documented R1's orthopedic physician called and informed staff R1 did not need to be seen sooner related to the additional fracture. A Nursing: Progress Note dated [DATE] at 10:14 AM by Administrative Nurse D documented staff updated R1's representative on R1's condition and notified them of the resident's orthopedic appointment. A Nursing: Progress Note dated [DATE] at 02:31 AM by LN I documented R1 expired at 01:35 AM. Staff notified Administrative Nurse D at 01:38 AM and R1's daughter at 01:48 AM. The facility's investigation noted on [DATE] at approximately 10:30 AM, CNA M notified LN G that during a transfer, CNA M tucked the mechanical lift sheet (sling) under R1; her knee bent, and the resident complained of pain during the transfer. LN G assessed the area and found no injuries. On [DATE] after breakfast, CNA O and CNA M reported to the nurse (LN H) that R1 complained of left leg pain. LN H observed the inward rotation of R1's left leg and attempted to notify R1's physician and Administrative Nurse D. Administrative Nurse D also assessed R1's leg, notified R1's physician, and received X-ray orders. On [DATE] at 09:17 PM, Administrative Nurse D documented she was contacted by Administrative Nurse E who was told by CNA O that CNA M said she and CNA N dropped R1 during a transfer from the shower chair to R1's wheelchair without the use of a mechanical lift on [DATE]. On the night of [DATE], Administrative Nurse D met with CNA M and CNA O. CNA M stated she did not tell the complete truth about what happened with R1 and verified she did not tell the nurse that they lowered R1 to the ground. CNA M, CNA N, and CNA O were suspended on [DATE] pending the facility's investigation. CNA N's Witness Statement notarized on [DATE] documented that she and CNA M brought R1 to the shower and CMA M told her R1 could stand so they stood the resident and transferred her into the shower chair. CNA N noted she left to assist other residents and when she returned, they again stood R1 to finish dressing and transfer. The statement noted during the transfer, CNA M and CNA N lowered R1 to the ground. CNA N noted she advised CNA M they needed to notify the nurse of R1's fall but CNA M was worried because they did not use the lift per R1's plan of care. CNA M felt both staff would be disciplined and potentially terminated. CNA N documented CNA M persuaded her to try to stand R1 to get her off the floor, but they were unable to do so. The statement recorded CNA N again advised CNA M they needed to get the nurse, but CNA M said they would not report it to the nurse but would use the mechanical lift instead. CNA N noted they retrieved the mechanical lift and assisted R1 to her wheelchair. CNA N documented during this incident CNA M told CNA N to take this to the grave repeatedly until CNA N agreed. CNA N reported CNA M said R1 was fine, just a little sore. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	CNA M's Witness Statement notarized on [DATE] documented on [DATE] CNA M and CNA N transferred R1 from her wheelchair to the shower chair with a [NAME] and pivot method. The statement recorded the first transfer happened without incident but after the shower, they attempted to stand and transfer the resident to her wheelchair, but the resident's knees buckled, and the CNA staff lowered the resident to the floor. The statement noted that staff placed a sling under the resident and used the mechanical lift to get R1 off the floor and into her chair. CNA M documented when she put R1's feet on the foot pedals R1 complained of pain in her left knee. CNA M documented CNA N then stated, Take this to the grave and CNA M agreed. CNA M documented the charge nurse was unaware that they lowered R1 to the floor, but the nurse was notified that R1 complained of left leg and knee pain. CNA M documented there was no obvious swelling or deformity of R1's left leg at the time of the incident. LN H's Witness Statement notarized on [DATE] documented on [DATE] CNA M requested her to assess R1's knee. LN H noted R1's left knee was bigger than the right with no redness or bruising. LN H documented CNA M told her that the previous day ([DATE]), CNA M bent R1's knee, heard a pop, and reported it to the LN on duty at that time. LN H documented she told CNA M to lay R1 down after breakfast for a full assessment. The statement documented LN H assessed R1 after breakfast and noted an inward position of R1's left knee without discoloration. LN H documented she contacted R1's physician and instructed CNA M to notify Administrative Nurse D who also assessed R1. LN H documented she interviewed CNA M who stated she had raised R1's whole leg and bent R1's knee. Administrative Nurse E's Witness Statement notarized on [DATE] documented on [DATE] at approximately 09:15 PM, CNA O told her two other CNAs who worked on [DATE] had dropped R1 on the floor, when they transferred R1 without the mechanical lift. Administrative Nurse E noted CNA O reported CNA M and CNA N transferred R1 from the floor to the wheelchair themselves but failed to report the fall. Administrative Nurse E documented on [DATE] at approximately 09:20 PM, she notified Administrative Nurse D and Administrative Staff A of the incident. LN G's Witness Statement notarized on [DATE] documented on [DATE] before lunch, CNA M reported to her that R1 complained of pain in the left knee. LN G documented she assessed R1's left knee and there was no swelling or discoloration. LN G documented staff reported they raised R1's leg a little bit but did not hear a pop. LN G documented on [DATE] at approximately 08:15 AM, Administrative Nurse D notified her that CNA M and CNA N transferred R1 without using the mechanical lift and R1 had been lowered to the floor. LN G documented she was not aware that R1 was lowered to the floor and the situation was not reported to her by the CNA staff. CNA O's Witness Statement notarized on [DATE] documented on [DATE] at approximately 06:10 AM, she noticed R1 was guarding her leg. She noted CNA M told her that CNA M moved R1's leg on [DATE], hear a pop, and reported it to the nurse. CNA O documented on [DATE] at 02:00 PM, CNA M stated she dropped R1 the previous day and asked CNA O what she would do. CNA O documented she told CNA M to report it, and CNA M said OK. CNA O documented that at approximately 07:30 PM, she contacted Administrative Nurse E and reported the incident to Administrative Nurse E. During an interview on [DATE] at 10:55 AM, CNA Q revealed she did not know about the incident that happened with R1 but had received ANE training since the incident. CNA Q revealed that if a resident fell, or was discovered to have fallen, staff should ensure the resident was safe and call for help which included notifying the nurse. CNA Q said the nurse would then assess the resident, and staff would follow the instructions of the nurse. CNA Q stated that under no circumstances were staff to move a resident who fell without permission from the nurse. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on [DATE] at 11:20 AM, CNA N stated CNA M wanted help to move R1 from the wheelchair to the shower chair using a stand and pivot transfer. CNA N stated she knew that R1 was care planned for a full-body mechanical lift but complied said she with CNA M's desire to do the standing transfer. CNA N said staff transferred R1 from the wheelchair to the shower chair without incident and then she left the room to tend to other duties. CNA N said after CNA M called for her to assist with a pivot transfer back to the wheelchair and using a gait belt, they stood R1 up to fix her clothing and perform a pivot transfer. CNA N said R1 could not remain standing, and they lowered R1 to the ground. CNA N revealed she wanted to go notify the nurse, but CNA M said to not notify the nurse. CNA N revealed that she and CNA M attempted to lift R1 from the ground without a mechanical lift but were unable to complete the task. CNA N said she left the shower area and returned with the full body lift, and they lifted R1 from the floor and into her wheelchair. CNA N said CNA M repeatedly told her that what just happened would be something that they would take to the grave and CNA N agreed. CNA N stated she did not tell anybody until she was questioned by management staff. CNA N said she knew now that if a resident had a fall staff should tell the nurse immediately. During an interview on [DATE] at 11:25 AM, LN G said on [DATE], CNA M reported she lifted R1's leg to get the mechanical lift sling around her leg when she heard or felt a pop. LN G said she assessed R1 and did not find any injury and was not able to elicit a pain response during the assessment. LN G stated staff were expected to not move a resident after a fall until the nurse assessed the resident for injuries and said the nurse would assist in getting the resident off the floor. During an interview on [DATE] at 11:47 AM, Administrative Nurse E reported she was off duty when CNA O contacted her and asked if CNA M was in trouble and said that she knew what happened to R1. Administrative Nurse E said CNA O revealed that CNA M told her they dropped R1 the previous day ([DATE]). Administrative Nurse E said she then contacted Administrative Nurse D and Administrative Staff A and responded to the facility to assist in the investigation. Administrative Nurse E then provided a timeline of the text conversation on [DATE] between herself and CNA O. On [DATE] at 11:55 AM, Administrative Nurse D said when LN H learned of the occurrence, she asked Administrative Nurse D to assess R1 for injury. Administrative Nurse D said when she assessed R1, her left leg was shortened and had internal rotation but no bruising or other signs of injury and noted R1 did have pain. Administrative Nurse D stated after the shift was over, Administrative Nurse E notified her of an allegation that involved CNA M, CNA N, and CNA O. Administrative Nurse D stated CNA O should have immediately notified the nurse on duty or a member of administration when the CNA learned from CNA M what happened on [DATE]. Administrative Nurse D verified R1 sustained a right distal fibula fracture and a left distal femur fracture. Administrative Nurse D said CNA M was terminated, CNA N and CNA O were suspended, and received final written warnings for violating policies. Administrative Nurse D stated all staff received education related to abuse, neglect, and exploitation (ANE) and on immediately reporting suspected ANE events, proper use of the Kardex (a nursing tool that gives a brief overview of the care needs of each resident), following the resident care plans, as well as safe lift usage. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 12:05 PM, Administrative Staff A reported that she was notified by Administrative Nurse D and Administrative Nurse E of an allegation that CNA M and CNA N dropped R1 during a transfer and the incident was not correctly reported to nursing staff or administration. Administrative Staff A stated her, Administrative Nurse D, and Administrative Nurse E came to the facility to obtain witness statements from CNA M and CNA O and to initiate the investigation. Administrative Staff A stated she expected staff who witnessed or discovered a fall not to move the resident until the resident was assessed by a nurse. Administrative Staff A said any staff who learned of an ANE event or had the suspicion of an ANE event should report it immediately to their supervisor or a member of management. During an interview on [DATE] at 12:41 PM, CNA O said on [DATE] at the end of the shift, CNA M told her that on [DATE], CNA M and CNA N dropped R1 onto the floor in the shower area and CNA M heard a crunch but did not report the incident to the nurse. CNA O said she identified the incident as a fall and informed CNA M that she should tell the nurse immediately about what happened. CNA O said later that evening, she contacted Administrative Nurse E to inquire what kind of trouble CNA M and CNA N were in, and Administrative Nurse E denied knowledge of anything that would cause trouble for the CNA, so she told Administrative Nurse E what CNA M had told her at the end of the shift on [DATE]. The facility's Abuse Prevention Program F 600 policy, dated 08/2024, documented residents have the right to be free from abuse and neglect. The policy defined neglect as the failure to provide goods or services to the resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress. The policy defined abuse as the deprivation by an individual of goods and services necessary to attain or maintain physical, mental, or psychological well-being. On [DATE] at 03:00 PM, Administrative Staff A and Administrative Nurse D received the Immediate Jeopardy [IJ] Template and were informed of the IJ for R1. The facility's corrective measures, fully completed by [DATE] included the following, which were verified by the surveyor on-site during the investigation:/ 1. CNA M was suspended from [DATE] to [DATE] and terminated on [DATE]. 2. CNA N and CNA O were suspended from [DATE] to [DATE] and received final written warnings for violating policies on [DATE]. 3. All staff received education related to ANE and immediately reporting suspected ANE events, proper use of the Kardex, following the resident's care planned interventions as well as safe lift usage, completed [DATE] at 08:00 PM. 4. The facility completed pain assessments on all residents for 72 hours to ensure no additional residents were affected. 5. The facility performed random mechanical lift performance audits. 6. The facility held an ad hoc Quality Assurance and Performance Improvement (QAPI) meeting related to the occurrence. (continued on next page)

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