STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175361	A. Building B. Wing	06/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Topside Manor Inc	210 Kansas Avenue Goodland, KS 67735

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** 43204 The facility identified a census of 40 residents with three residents reviewed for falls. Based on record review, observation, and interview, the facility failed to ensure Resident (R) 1 remained free from accidents when staff failed to safely operate a mechanical lift resulting in a fall with injury. On 05/22/24 at approximately 05:00 PM, Certified Nurse Aide (CNA) M prepared R1 for a mechanical lift transfer (by use of a ceiling lift) from her bed to her wheelchair. CNA M failed to ensure the lift sling harness loops were attached to the mechanical lift correctly. During the transfer, R1 fell out of the lift sling to the floor and required emergency transfer and evaluation. R1 was then transferred to a higher level of care to treat a right comminuted (a broken bone that has multiple pieces or fragments at the fracture site) distal (away from the farthest point of origin or attachment) femoral (thigh bone) fracture (broken bone) as a result of the incorrect placement of the harness loops and subsequent fall. This deficient practice also placed R1 at risk for unnecessary injury and pain. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of polyneuropathy (a neurological disorder that causes damage to peripheral nerves in similar areas on both sides of the body), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), heart failure (a condition with low heart output and the body becomes congested with fluid) and hypertension (high blood pressure). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The MDS documented R1 had functional limitation in range of motion on both sides of her upper extremities and lower extremities. The MDS documented R1 required a wheelchair for locomotion pushed by staff. The MDS documented R1 was dependent on staff for oral hygiene, toileting hygiene, showering, dressing, bed mobility, and transfer. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/09/24, documented R1 had moderate cognitive impairment and had difficulty communicating some words and thoughts. The CAA documented R1 was at risk for unmet needs, uncontrolled pain, and mood changes. (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 - Actual harm Residents Affected - Few	The Functional Abilities CAA, dated 01/09/24, documented R1 was dependent on staff for activities of daily living except for eating. The CAA documented R1 was at risk for skin breakdown and falls and the goal was for R1 to have her needs met and avoid complications from her limited mobility. R1's Care Plan documented R1 was on non-weight bearing status due to weakness and pain in her lower extremities (02/20/23). The care plan documented R1 was totally dependent on one staff for transfers using the ceiling lift or two staff members for the full body lift (02/09/23). The care plan documented for transfers, R1 required a basic high lift sling with a height measurement of 36 inches and width measurements of 1) 18 inches and 2) 32 inches. The care plan documented R1 was at moderate risk for falls and R1 would not sustain serious injury (01/23/24). The Fall Risk Evaluation, dated 04/05/24, documented R1 had a score of 17 and was at risk for falls. The evaluation documented R1 had intermittent confusion, had no falls in the last three months, was chair-bound, and required the use of an assistive device (wheelchair). The Fall Risk Evaluation, dated 05/23/24, documented R1 had a score of 19 and was at risk for falls. The evaluation documented R1 had intermittent confusion, had one to two falls in the past three months, was chair-bound, and required the use of an assistive device (wheelchair). The Progress Note, dated 05/22/24 at 05:54 PM, documented Licensed Nurse (LN) G was in the kitchen when she heard yelling over the radio. LN G and CNA N went to R1's room and noted CNA M in R1's room yelling for help. R1 was noted lying on the floor with her feet facing the window and the lift sling above her. LN G asked CNA M to go get therapy to assist. LN G noted R1 had significant internal rotation to her right leg and R1 was yelling out in pain and complained of pain to her bilateral legs. LN G stepped out of the room and left CNA N and the therapy staff at R1's side. LN G placed a call to 911 and requested the Emergency Medical Service (EMS) at about 05:09 PM and called R1's responsible party. LN G went back to R1's room and R1 complained of pain in her head and left leg. LN G did not note any significant deformities with R1's head. LN G did not note any internal rotation to R1's left leg. EMS arrived and staff directed them to R1's room. EMS assessed R1 and was assisted to the gurney via a slide sheet by EMS staff and LN G. LN G inspected the lift sling and noted CNA M had not hooked up the sling correctly and the sling straps were uneven. LN G had therapy staff look at the sling and they noted the inconsistency as well. The Diagnostic Imaging Report, dated 05/22/24 at 05:49 PM, documented R1 was having pain after being dropped. The findings documented R1 had a right comminuted and displaced distal femoral fracture. The Communication/Visit with Physician Note, dated 05/23/24 at 12:11 AM, documented the local hospital reported R1 had a distal femoral fracture and was admitted to the hospital for pain control after R1 was sedated and the fracture re-set. The At Risk Note, dated 05/23/24 at 02:04 PM, documented R1 had a fall with a major injury. A new Triple Check System would be implemented (make sure the sling is in good shape, verify sling size, and verify all straps on the sling are placed correctly) and all nursing staff would have ceiling lift training. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The undated Facility Incident Report, documented on 05/22/24 at 05:00 PM, LN G was called over the radio to R1's room. LN G and CNA N immediately responded to the call. Upon entering R1's room, LN G and CNA M observed CNA M yelling for help. R1 lay on the floor with her feet facing the window and the lift still above her, still connected to the lift. LN G instructed CNA M to request assistance from a therapy staff member and staff paged Certified Medication Aide (CMA) R over the radio to come assist. LN G noted R1 had significant internal rotation of her right leg and R1 yelled and complained of bilateral leg pain. LN G stepped out of R1's room and called 911 at approximately 05:09 PM and then contacted R1's responsible party. When LN G returned to R1's room, R1 voiced complaints of pain in her head and her left leg. EMS arrived and entered R1's room. LN G and Consultant GG remained in the room while EMS assessed R1. R1 was transferred onto the gurney by a slide sheet by two EMS personnel, LN G, and Consultant GG. LN G inspected the lift sling and noted CNA M had not hooked up the sling correctly; the sling straps were uneven at the top hooks. CNA M was placed on suspension pending the investigation. At 12:11 AM, the local hospital reported R1 was admitted to the hospital for a distal femoral fracture and pain control after sedation and resetting the fracture. R1 had not experienced a change of condition within seventy-two hours prior to the incident. CNA M had followed R1's care plan for full-body ceiling lift transfers. CNA M received lift training prior to the incident and was noted to be competent in utilizing the ceiling lifts on 03/25/24. The root cause analysis indicated CNA M had not connected the lift sling correctly. The facility provided education on the ceiling lift policy on 05/23/24 and the lift Triple Check System was initiated; these were placed on all lifts in the facility. The Triple Check System was 1) verify the lift sling is in good working order, 2) verify the sling size, and 3) verify all straps on the sling are placed correctly. R1's Care Plan would be re-evaluated on her return from the hospital. The facility would monitor weekly during At Risk meetings and monthly at the Quality Assurance and Performance Improvement (QAPI) meetings. Consultant GG's Witness Statement, dated 05/23/24, documented that Consultant GG was called by CNA M down the hallway. CNA M stated, You've got to come now. It is an emergency. Consultant GG entered R1's room to find R1 on the floor. R1 was positioned with her head towards the head of the bed and her feet oriented towards the window. R1 showed increased internal rotation of her right lower extremity and extreme plantar flexion of her bilateral ankles though no other visible abnormalities of body alignment were noted. Consultant GG assessed the lift and sling placement as LN G indicated and noted the sling was looped through the green strap on one side and the grey strap on the other. R1 yelled out in pain. R1 was asked to point towards her pain and R1 pointed towards the left femur. LN G requested CNA M to retreat to assist others as needed and document a statement. LN G then requested the occupational therapy assistant and Consultant GG remain with R1 while staff called the emergency team. After one to two minutes, R1 began to complain of posterior head pain. The emergency team arrived, assessed R1, and administered care. R1 was lifted with emergency service members providing leg support on R1's left lateral side, LN G supported R1's head, and Consultant GG on the right lateral side to the gurney. R1 was then escorted to the ambulance. CNA M's Witness Statement, dated 05/28/24, documented at approximately 04:45 PM, CNA M checked and changed R1 and then placed her in her sling to transfer her to her wheelchair for supper. CNA M stated he made sure to cross the legs before picking R1 up on the lift. At approximately 05:00 PM, CNA M lifted R1 up and as he was beginning to lower her to the chair, R1 fell out of the sling. CNA M noted he believed R1 hit her head. CNA M called immediately for LN G. CNA N and LN G came quickly. CNA M was told to get therapy. Upon examining the sling CNA M had just the black loop on the right side. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	CNA N's Witness Statement, dated 05/28/24, documented CNA N was in the kitchen talking to LN G when they heard unrecognizable crying over the radio and it sounded like the commotion was coming from R1's room. LN G and CNA N went quickly to R1's room and when they opened the door CNA M was coming out. CNA M was crying I don't know how. CNA N went to R1 and tried to reassure R1 but LN G intervened so CNA N sat with R1 while LN G assessed. LN G called EMS and called on the radio for therapy to come and assist. When therapy showed up, the therapy staff and CNA N stayed in the room with R1 while LN G went outside the room. LN G came back shortly and told CNA N to go let EMS staff in when they arrived. CNA N went to the dining room and a couple of minutes later EMS arrived; she let them in and told them what room and pointed them over to her. On 06/03/24 at 10:30 AM, observation revealed signage on the ceiling lifts with the triple-check instructions. On 06/03/23 at 10:45 AM, CNA M stated he was so concerned about R1 complaining of pain in her legs and making sure R1's legs were crossed that he forgot to look to make sure the sling was balanced before he transferred R1. CNA M stated he and the other staff had re-training on the Triple Check System. On 06/03/24 at 11:00 AM, Administrative Nurse D stated the incident happened because CNA M did not make sure the lift sling loops were on the same-colored loop and R1 slid out of the lift sling to the floor. Administrative Nurse D stated all the lifts in the facility now have signage with the Triple Check System to remind staff to check all three components. The facility's Lifting Machine, Using a Mechanical (Guldman Ceiling Lift) Policy, revised May 2024, documented the purpose of this procedure is to establish the general principles of safe lifting using a mechanical lifting device. At least one nursing assistant is needed to safely move a resident with a mechanical ceiling lift per Guldman Incorporated. Before using a lifting device, assess the resident's current condition. Measure the resident for proper sling size and purpose according to the manufacturer's guidelines. Select a sling bar that is appropriate for the resident's size and task. Prepare the environment. Make sure the battery is charged. Test the lift controls. Ensure the emergency release feature works. Make sure the lift is stable and locked. Make sure all the necessary equipment (slings, hooks, chains, straps, and supports) is on hand and in good condition. Double-check the sling and machine's weight limits against the resident's weight. Place the sling underneath the resident. Visually check the size to make sure it is not too large or too small. Lower the sling bar closer to the resident. Attach the sling straps to the sling bar. Make sure the sling is securely attached to the clips and that it is properly balanced. Check to make sure the resident's head, neck, and back are supported. Before the resident is lifted, double-check the security of the sling attachment. Examine all hooks, clips, or fasteners. Check the stability of the straps. Ensure the sling bar is securely attached and sound. Lift the resident two inches from the surface to check the stability of the attachments, the fit of the sling, and the weight distribution. The facility failed to ensure staff transferred R1 safely during a mechanical lift transfer to prevent a fall with injury This deficient practice placed R1 at risk for unnecessary injury and pain. All corrective actions were completed on 05/23/24 and included: Education on ceiling lift policy and use was given on 05/23/24 and a lift Triple Check System was initiated; these checks were placed on all lifts in the facility. R1's Care Plan will be re-evaluated on her return from the hospital. The facility will monitor weekly during At Risk meetings and monthly at QAPI meetings. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Since all corrections were completed before the onsite survey, the citation was deemed past noncompliance at a G scope and severity.