

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175377	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2024
NAME OF PROVIDER OR SUPPLIER Trinity Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 510 W Frontview Street Dodge City, KS 67801	
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** 31078</p> <p>The facility census totaled 41 residents with one resident sampled for accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision and ensure a safe and secure environment as free from accident hazards as possible when Housekeeping/Laundry Staff C failed to report a malfunctioning basement door. About six weeks later, on 07/01/24, cognitively impaired Resident (R)1 opened the same malfunctioning, key coded basement door and fell down seven steps to the landing, in her wheelchair. R1 sustained major injuries including a lump to the back of her head and three fractured ribs. This deficient practice placed R1 in immediate jeopardy and at risk for personal injury. (R1)</p> <p>Findings included:</p> <ul style="list-style-type: none"> - R1's electronic medical record (EMR) included the following diagnoses that included cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain) and cognitive impairment (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). <p>The Significant Change in Status Minimum Data Set (MDS) dated [DATE], revealed R1 had a Brief Interview for Mental Status (BIMS) score of three, indicating severe cognitive impairment. The MDS documented the resident wandered daily.</p> <p>The Behavioral Symptoms Care Area Assessment (CAA) dated 03/27/24 revealed R1 wandered around the facility and went into other residents rooms due to her confusion.</p> <p>The Quarterly MDS dated [DATE], revealed R1 had a Brief Interview for Mental Status (BIMS) score of four, indicating severe cognitive impairment. The MDS documented the resident wandered daily.</p> <p>R1's Care Plan revised 02/23/24, revealed R1 required a wheelchair for mobility. Staff were to monitor the resident and document/report to R1's physician of any changes in cognitive function, specifically changes in decision making ability, memory, recall, general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. R1 was at risk for falls related to confusion, muscle weakness, and cerebral infarction. The Care Plan included a 06/16/24 revision for staff to encourage the resident to remain in the common area until staff could assist her to bed.</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: 175377
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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 07/01/24 at 11:15 AM, a fall note revealed Licensed Nurse (LN) B was looking for R1 when a housekeeper notified the nurse the resident fell down the stairs. Upon entering the staircase, the resident was on the landing of the basement stairs on the floor with her wheelchair near her. The resident had her shoes on and a stack of kitchen napkins beside her. LN B asked the resident if she hit her head and R1 stated yes. Three staff assisted R1 into her wheelchair. When asked what she was doing R1 reported, I was walking down the stairs. Staff transported R1 upstairs via a basement elevator. R1 could follow commands and answer most questions. R1 had a bump to the back, left side of her head. R1 reported pain to her upper left back and stated it hurts when staff palpated (touched) her head. LN B provided Tylenol (pain medication), 650 milligrams (mg), as needed (PRN) at 11:23 PM.</p> <p>Review of the facility investigation dated 07/01/24, revealed R1 went through a door with a keylock and fell down the basement stairs (7 stairs). R1 told staff she was walking down the stairs and lost her balance and fell . The resident had a bump to the back, left side of her head and pain to her left upper back. No other injuries found. Staff initiated neuro checks (an assessment to monitor for neurological functions, motor and sensory response and level of consciousness). Staff notified R1's physician and the physician advised staff to apply an ice pack to the affected area. Immediately after the accident, the resident had complaints of pain and the staff administered PRN Tylenol. Later in the day, (untimed) the resident complained of left-sided pain. The nursing staff contacted the physician a second time and received orders for an X-ray of her ribs to the left side. The X-ray revealed three minimally displaced fractures of the left fifth, sixth, and seventh ribs.</p> <p>The Progress Notes dated 07/01/24 at 04:18 PM, revealed the resident complained of pain to her left ribs when staff transferred her from a recliner to a wheelchair. Staff contacted Physician F's office to request an X-ray.</p> <p>On 07/02/2024 at 02:04 PM, the x-ray results revealed R1 ha Minimally displaced fractures of the posterior left 5th, 6th, and 7th ribs.</p> <p>The witness statement by Housekeeping Staff C revealed on 07/02/24 Housekeeping Staff C reported the [malfunctioning basement door] door was not completely shut. The statement revealed if staff let it shut slowly, the door would not latch. Housekeeping Staff C documented it was approximately a month and a half ago, the door did not latch effectively. Housekeeping Staff C documented she told another housekeeper about it but did not report it to maintenance because she did not feel the door was broken, but it was just not latching.</p> <p>Review of the maintenance door logs from 06/03/24 through 07/18/24 showed no malfunction of the doors or the locks.</p> <p>Observation on 07/15/24 at 11:45 AM, revealed the resident in her wheelchair and able to propel her wheelchair without assistance.</p> <p>Observation on 07/15/24 at 01:40 PM, revealed the resident sat in a recliner in the commons area with the TV on.</p> <p>Observation on 07/15/24 at 02:40 PM, revealed Certified Nurse Aide (CNA) D transferred R1 from a recliner in the commons area to a wheelchair. R1 wheeled herself independently to her room with staff walking beside her. Once in her room, CNA D assisted the resident to the toilet. R1 could stand while she held onto the grab bar to transfer to the toilet.</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 07/15/24 at 11:10 AM, Administrative Staff A stated staff were not sure how the resident got the door open. Administrative Staff A reported she knew laundry staff noted the door was not all the way latched about six weeks prior to the incident and did not know if the resident just shook the door handle until it opened or how she opened the door. Administrative Staff A stated the resident was confused but told staff she was walking down the stairs and lost her balance, so staff do not know how she got out the door. Her wheelchair was on the landing next to her when a housekeeping staff saw her on the floor.</p> <p>On 07/15/24 at 11:20 AM, Maintenance Staff H reported the door had a manual lock on it, but it worked fine when he checked the doors. He reported he checked all doors and door locks to make sure they were functioning and documented those on a daily log. He reported the whole locking mechanism was changed and switched it to an electronic lock pad to assure it did not open except with the code.</p> <p>On 07/15/24 at 01:30 PM, Licensed Nurse B reported she did not know how the resident got the door open. LN B said the door had a keypad on it and if a person did not have the code, it should not open. She reported it was about lunch time and the resident had been outside at an activity and as she was coming back in, R1 went through the dining room and picked up a big stack of napkins. LN B saw R1 go by the nurses' station holding onto the napkins. LN B said she watched her go by and was going to finish her charting and then take the resident to the dining room for lunch, but when she looked down the hall, she could not find R1, so she went to look for her. LN B said she looked on in every room, including the chapel and the restrooms, and had all the aides looking as well. LN B said Housekeeping Staff C took LN B to the basement door and LN B saw the resident on the landing of the stairs, going to the basement. LN B said her wheelchair was upright and next to the resident. LN B did range of motion (ROM) and asked R1 if she hit her head the resident reported yes, she hit her head. LN B said R1 had a bump to the back of her head. Several CNAs lifted the resident back into her wheelchair and staff carried her in her wheelchair down the stairs to the basement, then brought her upstairs in the elevator. LN B said she notified Administrative Nurse G, faxed the physician, then put an ice pack on the resident's head. The resident was placed in recliner in the commons area and was there a couple of hours. Staff then went to take her to the bathroom and when they transferred R1, the resident complained of pain in her left side by her ribs. LN B said she notified the physician for an order to get an x ray of her ribs. The physician ordered the X-ray the next day, which revealed three rib fractures. The physician ordered Tramadol (pain pill) and ice for pain. LN B said the maintenance department changed the locks on the door so it could not come open again and said the door is heavy and difficult for staff to open.</p> <p>On 07/15/24 at 02:30 PM, CNA D said they did know how R1 could open the heavy door. CNA D said a housekeeping staff saw R1 and notified the nurse.</p> <p>Review of the undated facility Maintenance policy for doors, documented all doors were to be checked daily for proper function and documented on the door log.</p> <p>On 07/15/24 at 05:20 PM, the IJ template was provided to Administrative Staff A and notified the facility of the failure to ensure a safe and secure environment as free from accident hazards as possible when a housekeeping/laundry staff failed to report a malfunctioning basement door, and about six weeks later, on 07/01/24, cognitively impaired R1 opened the key coded basement door and fell down seven steps to the landing, in her wheelchair and sustained major injuries that included a lump to the back of her head and three fractured ribs, placed the resident in immediate jeopardy.</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 immediate jeopardy was determined to first exist on 07/01/24.</p> <p>The facility identified and implemented the following corrective actions, completed on 07/03/24:</p> <ol style="list-style-type: none"> 1. Doorknob/lock changed, and door closure changed on 07/02/24. 2. All staff received education on Reporting malfunction or equipment not working appropriately immediately to Administration Team. 3. Charge Nurses received education If there is a substantial fall (stairwell, out of transportation vehicle, fall face first out of wheelchair) and Director of Nursing/ Assistant Director of Nursing is present in the building, notify them and have them assess, too; if not present and another Charge Nurse present in the facility have the assess, also. If a resident sustains a substantial fall notify physician via phone, not a fax. 4. The Medical Director notified on 07/03/24. 5. Staff members who have not had education will be educated prior to working their next assigned shift. 6. An ad-hoc QAA meeting held to review this area of concern and the action plan created to ensure system is corrected and sustained 07/03/24. <p>The surveyor verified the above implemented and completed corrective actions while onsite 07/15/24. Due to corrective actions the facility completed prior to the onsite visit, the deficient practice was deemed past non-compliance and existed at a J scope and severity.</p>		