STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E424	A. Building B. Wing	11/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sheridan County Hospital Ltcu	826 18th Street, Box 167 Hoxie, KS 67740

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 26 residents, with three residents reviewed for falls and accidents. Based on record review, observation, and interview, the facility failed to transfer Resident (R) 1 safely with a gait belt, and in the process of the transfer staff lifted R1 by both of her arms and R1 sustained a broken left humerus (upper arm bone). This deficient practice placed R1 at risk for injury, pain, and delayed healing. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of dementia (a progressive mental disorder characterized by failing memory, and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder which causes persistent feelings of sadness), and lymphedema (swelling caused by accumulation of lymph). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status score of four which indicated severely impaired cognition. The MDS documented R1 had impairment on one side of her upper extremity and lower extremity. The MDS documented R1 required moderate assistance with eating, and maximum assistance with oral hygiene, dressing, and bed mobility. The MDS documented R1 was dependent on staff for toileting, bathing, and transfer. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 01/14/24, documented R1 had a diagnosis of dementia. She was oriented to herself but would get confused about situations, times, and dates. The CAA documented that R1 became anxious and would yell at staff to compensate. The Urinary Incontinence/Indwelling Catheter CAA, dated 01/14/24, documented R1 was mostly continent of bladder, was on a toileting schedule during the day and as needed at night. She required extensive assistance with toileting transfers and hygiene from two staff. The Falls CAA, dated 01/14/24, documented R1 was a high risk for falls due to vision loss, weakness, and the non-use of her left arm. The CAA documented R1 required one to two person assist with activities of daily living and transfers for safety. (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	R1's Care Plan documented R1 required extensive assistance from two staff members for transfers (03/23/23). R1 no longer used a walker and relied on a pivot transfer with a gait belt for transfers (03/23/23). The care plan documented R1 complained of pain when a regular gait belt was used so R1 had a green Posey gait belt in her room (01/22/24). The care plan documented R1 was dependent on two staff for toileting transfers and peri care and was not to be left alone in the bathroom (03/10/23). The Incident Note, dated 10/20/24 at 07:50 PM, documented Certified Nurse Aide (CNA) M stepped out into the hallway and called Licensed Nurse (LN) G for assistance. R1 sat on the toilet, barely on the toilet, sideways with her head forward and her body flaccid (limp). R1 was unresponsive and her skin was clammy. She had a slight purple discoloration on her face. LN G lifted R1 off ofoff the toilet and into the wheelchair. R1 had her eyes closed but was making mumbling noises. LN G and CNA M transferred R1 into bed from the wheelchair and LN G heard and felt a loud pop in R1's left arm when they lifted R1 for the transfer. LN G removed R1's shirt and noted R1's left deltoid (upper arm) area bulging out and the left shoulder appeared to be higher than the right. R1 showed no signs and symptoms of discomfort with palpation of the area. The Communication Note, dated 10/20/24 at 07:51 PM, documented staff notified R1's responsible party of the two to three minutes of unresponsiveness, the popping noise heard with the transfer, and the resulting abnormalities of the left upper arm. R1's responsible party agreed to monitor R1 throughout the night unless signs and symptoms of pain and discomfort presented and then wanted R1 to transfer to the emergency room . The Health Status Note, dated 10/20/24 at 08:01 PM, documented that staff notified the on-call administrative staff of R1's unresponsive episode and the popping noise with transfer and subsequent abnormality to the left upper arm. The note documented a plan to monitor the resident throughout the night and send a SBAR (Situation, Background, Assessment, and Recommendation) a structured communication tool used to share information about a patient's condition to the clinic. The Health Status Note, dated 10/20/24 at 09:50 PM, documented R1 rested with her eyes closed. The note documented R1 had no signs and symptoms of discomfort in her upper left arm. The Health Status Note, dated 10/20/24 at 11:43 PM, documented an SBAR with information about the incident to R1's left arm was faxed to the on-call provider at the clinic. CNA M's Witness Statement, dated 10/20/24, documented CNA M put R1 on the toilet. CNA M left the bathroom and came back into the bathroom after pulling down R1's covers. CNA M found R1 unresponsive. CNA M looked out the door and yelled for LN G to come down and help. CNA M and LN G got R1 off the toilet. As CNA M and LN G transferred R1 to bed there was a loud pop. CNA M and LN G got R1's shirt off and R1's arm was swollen. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LN G's Witness Statement, dated 10/20/24, documented on 10/20/24 at approximately 07:45 PM CNA M hollered out in the hallway for LN G to come and assist her in R1's room. Upon entering R1's bathroom, R1 was on the toilet. Her face had a slight purple discoloration, and her skin was clammy. R1 was unresponsive and her body was flaccid; she was barely sitting on the toilet. CNA M pushed the wheelchair underneath R1 and LN G lifted R1 off the toilet and into the chair. R1 remained unresponsive. R1 mumbled a few things while being pushed from the bathroom in the wheelchair but still had not opened her eyes. After getting to R1's bed, R1's body was still flaccid. LN G and CNA M assisted R1 with a two-person lift from the wheelchair to the bed. CNA M stood on R1's right side and LN G was on R1's left side. When staff lifted R1, there was a loud popping noise and LN G felt a slight pressure in R1's left upper arm. LN G immediately pulled down R1's shirt and sleeve and noted R1's left deltoid area had slight swelling and R1's left shoulder was slightly raised compared to the right shoulder. R1 did not demonstrate any signs or symptoms of pain or discomfort. R1 slowly became more responsive. The facility's undated Incident Report documented Administrative Nurse D contacted LN G about the incident. LN G explained that CMA M had called for assistance from the hallway and LN G responded. When LN G got to the bathroom, CNA M was in the bathroom with R1 and R1 was unconscious, seated on the toilet. LN G assisted CMA M in transferring R1 to the wheelchair. Administrative Nurse D asked LN G if a gait belt was used and LN G admitted a gait belt had not been used. R1 was taken from the restroom to her bed. R1 still did not respond appropriately so LN G and CNA M transferred R1 to the bed. During the transfer, staff heard a popping noise and LN G felt R1's arm move against her body. After completing the transfer, LN G assessed R1's arm and it had begun to swell. R1 did not appear to be in any pain. LN G and CNA M both admitted they did not use a gait belt when they transferred R1. CNA M stated she was concerned for R1's immediate safety when R1 was unconscious on the toilet and therefore did not apply the gait belt for that transfer and then when they transferred R1 to the bed from the wheelchair, CNA M did not think to use the gait belt. She said she was just thinking of R1's safety. LN G stated she felt like it was an emergent situation and responded to R1's immediate needs which was getting her to a safe position. Administrative Nurse D counseled LN G and CNA M on gait belt use and ensured they were aware of the resident's care-planned need for gait belts and where to find this information. The facility will continue random audits for appropriate gait belt use. The Plan of Care Note, dated 10/21/24 at 08:24, documented that R1's left arm was swollen and discolored. R1 stated she had slight tenderness in her shoulder area but not in the rest of her arm. R1 rested in bed. The Order Note, dated 10/21/24 at 08:26 AM, documented R1's primary care physician, ordered a two-view left shoulder x-ray for pain. The Plan of Care Note, dated 10/21/24 at 10:00 AM, documented staff were able to get R1 up and transferred to her recliner to eat breakfast. R1 continued to have no complaints of pain or discomfort. The Plan of Care Note, dated 10/21/24 at 11:14 AM, documented the facility received a call from the nurse practitioner and she requested to see R1 in the emergency room to splint her left arm which had a fracture. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The emergency room Discharge Paperwork, dated 10/21/24, documented R1 had a left humerus fracture. Orthopedics (bone specialist) was consulted and advised R1 was not a surgical candidate and recommended a posterior (backside) or sugar-tongue splint to the left arm. Orthopedics wanted R1 to follow up in the clinic with repeat X-rays on Wednesday. The plan of care was discussed with R1's primary care physician and an appointment was made for R1 to see him on Wednesday, 10/23/24 at 02:00 PM for repeat x-rays to be done prior to the appointment and sent to orthopedics. The left posterior arm splint and sling were to remain in place at all times. R1 was non-weight bearing to her left upper extremity. The Order Note, dated 10/21/24 at 01:36 PM, documented R1 was back from the emergency room and would have another x-ray on Wednesday. R1 presented with a left posterior arm splint and sling that was to remain in place at all times. R1 could use over-the-counter Tylenol or ibuprofen (pain medications) as needed for pain or swelling. The note ordered to apply ice to the affected area three to four times daily for thirty minutes for three days, then discontinue. The Radiology Report, dated 10/23/24, documented R1 had sustained a displaced overlapping proximal humerus fracture with some improved alignment. The Health Status Note, dated 10/23/24, documented R1's left humerus x-ray report showed a proximal humerus fracture with some improved alignment with interval splinting. The Health Status Note, dated 11/06/24, documented R1 complained of pain in her left forearm. The CNAs reported R1 had consistently pointed to that area and complained of pain. The nurse pulled pack the ace wrap and encountered cast padding with a sleeve under it. The nurse contacted the on-call provider for advice on how to position and maneuver the left arm for assessment so as not to move the fracture to the left humerus and was advised to bend the elbow like a bicep curl. Upon assessment, a bruise was found on R1's left forearm with black spots in the middle and reddened areas towards the outside which measured 3 centimeters (cm) by 2.6 cm. The findings were reported to the on-call provider, and he advised to return the casting as it had been and loosely wrap the ACE bandage back around the splint. R1's primary care physician will see R1 tomorrow and address the area of concern. The Order Note, dated 11/07/24, documented R1 had a follow-up appointment with her primary care physician regarding her left arm and the pressure area from the splint; padding was placed on the splint. On 11/14/24 at 10:00 AM, observation revealed, R1 sat in her wheelchair with a left splint and sling to her left arm. On 11/14/24 at 10:00 AM, R1 stated she had pain in her left arm and pointed to her left arm with her right hand. On 11/14/24 at 10:15 AM, CNA N stated she never transferred R1 or any other resident without using a gait belt. CNA N stated R1 had complained of pain in her left arm numerous times since breaking it. CNA N stated R1 had just got done showering and the left splint and sling never came off but was wrapped up in a bag to keep it dry. On 11/14/24 at 10:30 AM, LN H stated she expected all staff to use a gait belt with all transfers because it was the only way to ensure resident and staff safety. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 11/14/24 at 01:00 PM, Administrative Nurse D stated she had talked to CNA M and LN G and they admitted they had not used a gait belt for any of R1's transfers the day of the incident. Administrative Nurse D stated there were other ways R1 could have been transferred besides the way staff had transferred her that day. Administrative Nurse D verified she educated all facility staff regarding gait belt use with transfers and following resident care plans on 10/21/24 and was performing gait belt audits randomly throughout varying shifts for four weeks. The facility's Gait Belts and Transfer Policy, revised 03/19/07, documented that gait belts are provided to assist staff in safely transferring or ambulating residents. Note the use of a gait belt in the resident care plan. The facility failed to transfer R1 safely with a gait belt which resulted in a broken left humerus. This deficient practice placed R1 at risk for injury, pain, and delayed healing. On 10/21/24, the facility identified and completed all corrective actions including staff education on following residents' plan of care, use of gait belt use with transfers, and completed gait belt audits randomly for four weeks. All actions were completed before the onsite survey therefore the deficient practice was deemed past noncompliance and remained at a G scope and severity.