

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER John Knox Village Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 NW Pryor Road Lees Summit, MO 64081	
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 - Minimal harm or potential for actual harm</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** 42984</p> <p>Based on interview and record review, the facility staff failed to follow the facility guidelines for using mechanical lifts by transferring one sampled resident, (Resident #1) out of three sampled residents, using an incorrect sling for this resident on a Hoyer lift, (a medical device used to assist lifting and transferring individuals with limited mobility), which caused him/her to slip from the sling onto the floor without injury. The facility census was 116 residents.</p> <p>The Administrator was notified on 7/16/24 of Past Non-Compliance which occurred on 7/2/24. An all nursing staff in-service was completed on resident transfers by 7/9/24. The deficiency was corrected 7/9/24.</p> <p>Review of the undated facility General Guidelines for Using Mechanical Lifts showed:</p> <ul style="list-style-type: none"> -Two people were always to be used when using a Hoyer lift. -Staff were to make sure to use the correct size sling. -The correct size was noted on the resident profile. -The sling was to be left in the resident's room so the correct size would be available when needed. -All slings were color coded: orange for small; yellow for medium; blue for large; black for extra large. -If a change was needed in the size of a sling, the charge nurse should be informed and/or the restorative aide so the resident could be reevaluated. -If the sling was missing, staff should check the clean linen room or the bath house. -If staff were unable to find the correct size or type, a charge nurse, a restorative aide (RA), manager or house supervisor should be informed in order to obtain the correct size. <p>Review of the undated hygiene sling product description showed:</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
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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-He/She was assisted by two staff using a large hygiene sling and a Hoyer lift.</p> <p>-The resident slipped through the large hygiene sling and hit his/her head on the floor with his/her feet following.</p> <p>-The nurse was alerted to the incident and went to the resident's room.</p> <p>-The resident was on his/her back and had a blanket under his/her head.</p> <p>-The nurse immediately called the facility emergency medical system (EMS) to dispatch an ambulance.</p> <p>-The resident's vital signs were checked.</p> <p>-The resident was able to tell the nurse where he/she was and his/her name.</p> <p>-The EMS arrived and stabilized the resident's neck with a brace.</p> <p>-The resident was assisted onto a stretcher and then transported to the hospital.</p> <p>Review of LPN A's Witness Statement dated 7/2/24 at 4:14 P.M. showed:</p> <p>-Certified Nursing Assistant (CNA) B and CNA C were using a Hoyer lift to transfer the resident to his/her bed.</p> <p>-Both CNAs stated they used the hygiene sling that was already under the resident.</p> <p>-CNA B was using the remote device to lift the resident up.</p> <p>-CNA C was on the other side about to hold the hygiene sling to transport to the bed.</p> <p>-Before CNA C could grab onto the hygiene sling, the resident slipped through the open part of the hyginesling and fell on to the floor.</p> <p>-CNA C put a rolled blanket under the resident's head and CNA B alerted the nurse.</p> <p>Review of the resident's patient profile dated 7/8/24, which had been in use showed he/she had been using a small sling for the Hoyer lift.</p> <p>During an interview on 7/12/24 at 11:25 A.M., the Assistant Director of Nursing (ADON) said:</p> <p>-The hygiene sling used for the resident should absolutely not have been used because it was way too big for him/her.</p> <p>-There was a list with 42 residents who used lifts which showed which lift should be used.</p> <p>-Staff were not to assume that just because a sling was with the resident it is the correct one to use.</p> <p>(continued on next page)</p>

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff were trained on use of the Hoyer lift in their orientation.</p> <p>During an interview on 7/12/24 at 11:45 A.M., CNA A said:</p> <p>-Hygiene slings had a hole in the back to keep the sling off sores or injuries, where the other slings did not.</p> <p>-The Hoyer lift only would lift the residents about three feet in the air, to clear the bed.</p> <p>-The hygiene sling was only used for one resident, which was not Resident #1.</p> <p>-It is possible that the slings could have gotten mixed up or they ran out of clean slings.</p> <p>-He/She did not think the hygiene sling should have been used with this resident, and typically it was not used for him/her. It never should have been used with him/her.</p> <p>During an interview on 7/12/24 at 12:15 P.M., Restorative Aide (RA) A said:</p> <p>-He/She did the training of staff on the use of the Hoyer lift and slings.</p> <p>-Staff would have been trained on the full-body slings and vests, and possibly the hygiene slings.</p> <p>-The hygiene sling was to be used with the Hoyer lift.</p> <p>-The hygiene sling was for people so they could use the restroom, since it had a hole in the back.</p> <p>-The staff possibly grabbed the wrong sling to use.</p> <p>-Only one resident in the facility used the hygiene sling, because he/she had a lower back wound.</p> <p>-The resident should not have had the hygiene sling used for him/her.</p> <p>-The resident profiles were updated daily and they showed which type of sling a resident used.</p> <p>-The facility had annual training on the use of the Hoyer lift.</p> <p>-All slings were green in color and they had different colored tags on the back ; orange for small; yellow for medium; blue for large; and black for extra large. Only the tag color would be different.</p> <p>-The staff got four to five inservices a year on use of the lifts.</p> <p>-A resident's weight was used to determine sling size.</p> <p>During an interview on 7/12/24 at 12:55 P.M., CNA B said:</p> <p>-He/She was on the sixth day of his/her orientation at the facility.</p> <p>(continued on next page)</p>		

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