

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  11/26/2024
NAME OF PROVIDER OR SUPPLIER  Life Care Center of Cape Girardeau		STREET ADDRESS, CITY, STATE, ZIP CODE  365 South Broadview Street Cape Girardeau, MO 63703	

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 - 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><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46555</b></p> <p>Based on interview and record review, the facility failed to ensure the environment remained free of accident hazards by not ensuring staff utilized a hooyer lift and an appropriate vehicle to accommodate a wheelchair for one resident (Resident #1) resulting in increased pain and anxiety out of three sampled residents. The facility census was 99.</p> <p>The facility did not provide a policy for transfers.</p> <p>1. Review of Resident #1's medical record showed:</p> <ul style="list-style-type: none"> <li>- An admitted [DATE];</li> <li>- Diagnoses of muscle weakness, reduced mobility, history of falling, and chronic kidney disease (long standing disease of the kidneys);</li> <li>- No documentation of a lift assessment.</li> </ul> <p>Review of the resident's significant change Minimum Data Set (MDS - a federally mandated assessment completed by the facility staff), dated 11/16/24, showed:</p> <ul style="list-style-type: none"> <li>- The resident required maximal assistance with mobility.</li> </ul> <p>Review of the resident's Physical Therapy (PT) evaluation, dated 11/05/24, showed:</p> <ul style="list-style-type: none"> <li>- The resident required a Hoyer lift (a mechanical lift) for transfers.</li> <li>- Review of the resident's comprehensive care plan, dated 11/20/24, showed:</li> <li>- Did not address transfers or mobility concerns with individualized interventions.</li> </ul> <p>During an interview on 11/26/24 at 12:15 P.M., Therapy F said on 11/20/24, Resident #1 was a changed to a Hoyer lift transfer. The resident had not made a lot of progress in the last month as pain and weakness were contributing factors as well as having a lot going on with medical issues.</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 - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/24 at 11:00 A.M., Resident #1 said he/she had an appointment on 11/15/24, at an infusion center. Certified Nursing Assistant (CNA) B was with him/her during the appointment. When it was time to leave, no transportation was available from the facility. He/She was transported in a specialized van or bus so he/she could stay seated in the wheelchair. After waiting for two to three hours, the Activities Director (AD) and Licensed Practical Nurse (LPN) A arrived in the AD's personal small car to take him/her back to the facility. CNA B, the AD, and LPN A folded the resident in half like a folding chair to load him/her in the car. He/She screamed in pain but the three staff members kept pushing. The resident was in so much pain and couldn't remember if the staff used a gait belt during the transfer or if he/she received anything for pain after arriving at the facility. Once the staff was in the process of getting him/her in the car, they couldn't stop. The staff almost dropped the resident during the transfer and that was why they kept pushing to get him/her in the car despite he/she screamed/cried out in pain and begged them to stop. It was a horrible experience. The resident dreaded having to go to the doctor because he/she was fearful and anxious of it happening again. The resident said it was a traumatic and painful experience.</p> <p>During an interview on 11/26/24 at 12:24 P.M., Resident #1 said he/she had some knee and back pain and swelling in his/her knees. After the transfer incident on 11/15/24, his/her knee and back pain was significantly worse for a couple days. His/Her bottom burned and hurt from having to sit for several hours in a urine soiled brief.</p> <p>During an interview on 11/26/24 at 3:50 P.M., Resident #1 said he/she had required a Hoyer lift for transfers for at least a month. The resident said his/her legs did not work and he/she couldn't bear weight.</p> <p>During an interview on 11/26/24 at 3:56 P.M., CNA B said he/she was told to go with Resident #1 to his/her appointment at the infusion center on 11/15/24. They arrived around 8:00 A.M., and the resident was done around 1:00 P.M. He/She called the facility and notified staff they were ready to be picked up. Around 2:00 P.M., CNA B called the facility again and was told the facility transportation was not available, but they were working on it. The resident and CNA B waited another couple of hours. CNA B did not have the items required to provide care for the resident. The Administrator had the AD come in his/her personal car to pick them up. The resident was a Hoyer lift transfer, so when the AD and LPN A arrived in the car, Resident #1 told them he/she could not stand. The resident screamed and cried in pain. CNA B said LPN A were aware Resident #1 was a Hoyer lift transfer but attempted to transfer the resident manually and they almost dropped Resident #1 when they tried to get him/her in the back seat of the small car. When they got back to the facility, more people helped to help get Resident #1 out of the car.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/24 at 11:15 A.M., the AD said on 11/15/24, there were issues getting transportation arranged for Resident #1 to be picked up from the infusion center. Staff spent several hours trying to get an outside transportation agency scheduled and had issues contacting them. The Administrator told the AD (who was also a CNA) and LPN A to pick up Resident #1 because the infusion center was closing. The AD drove his/her own personal car. Resident #1 was a Hoyer lift transfer. Resident #1 appeared to be in a lot of pain during the transfer, screamed out in pain, and told them to stop. Resident #1 was almost dropped during the transfer into the back seat of the car because they thought the back seat would have more room. A gait belt and the Hoyer lift sling that was underneath Resident #1 were used during the manual transfer. The AD got on one side and LPN A got on the other side of the resident while CNA B got in the back seat of the car to pull on the lift sling to try and help pull the resident into the car. The AD was unaware of a plan for what to do if it happened again.</p> <p>During an interview on 11/26/24 at 11:25 A.M., LPN A said Resident #1 went to an appointment on 11/15/24, at an infusion center with CNA B in attendance because the resident was chair bound. CNA B called several times throughout the day telling the facility staff they were waiting on transport to pick them up after the appointment. The Administrator told LPN A someone would have to go get the resident. At the time, LPN A thought the resident transferred with assistance of one staff and didn't realize he/she required a Hoyer lift. The infusion center was closing and he/she knew the resident had sat for at least five hours, was probably soiled, and needed to be changed. When LPN A and the AD arrived at the infusion center, the resident cried because his/her bottom burned since he/she had sat in a urine soiled brief, and was in pain because he/she had missed the scheduled pain medication. LPN A noticed the Hoyer lift sling and the resident said he/she was a Hoyer lift transfer sometimes. It was awkward to transfer the resident into the car. The resident cried, said he/she was in pain, and wanted them to stop with the transfer.</p> <p>During an interview on 11/26/24 at 2:07 P.M., the facility Transport Coordinator said he/she received around five different calls on 11/15/24, about whether the outside transportation agency was going to pick up Resident #1 from the infusion center. He/She told everyone at the facility the outside transportation agency was going to pick up the resident. The resident was on the waiting on the list to be picked up. The waiting list means first come, first serve and this resident was going to be picked up, but had to wait his/her turn. On 11/15/24 at around 4:00 P.M., an unknown person called the outside transportation agency and told them Resident #1 didn't need to be picked up because facility staff went to get the resident.</p> <p>During an interview on 11/26/24 at 2:19 P.M., the outside transportation agency Staff F said Resident #1 wasn't</p> <p>a scheduled run on 11/15/24. For same day appointments, the facility was supposed to call dispatch, but originally someone had left a voicemail for him/her. By the time he/she got the message, the ride had already been put in with dispatch at 2:04 P.M., on 11/15/24. He/She called the infusion center later and the staff there said someone from the facility was there picking up the resident, and their services were not needed.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview on 11/26/24 at 2:53 P.M., the infusion center Staff C said he/she called the facility on 11/15/24, approximately 12 to 13 times and CNA B called too, but couldn't get anyone from the facility to answer the phone. Eventually the facility answered and was told Resident #1 had waited to be picked up for over for two hours, was soiled, needed changed, and was in pain. The facility said they were having issues with the outside transportation agency. The resident appeared to be miserable and in pain. Eventually two facility staff members arrived in what appeared to be a personal car to take the resident back to the facility.</p> <p>During an interview on 11/27/24 at 9:30 A.M., the infusion center Staff E said on 11/15/24, Resident #1 sat a long time in a soiled brief. He/She offered to help CNA B get the resident to the bathroom, but the resident was non-weight bearing and was a Hoyer lift transfer. Eventually, two facility staff members arrived in what appeared to be a personal car. He/She watched from the window as the facility staff to transferred Resident #1 into the car.</p> <p>During an interview on 11/27/24 at 9:40 A.M., the infusion center Staff D said he/she was in the parking lot on 11/15/24, when two facility staff members arrived to transport Resident #1. The resident could not bear any weight on his/her legs. When the facility staff members attempted to pick up the resident, the resident's knees appeared to buckle and he/she heard the resident yell out he/she was going to fall. The facility staff continued to try and get the resident in the car. The resident screamed out in pain and said his/her knees and legs hurt. The resident was a larger person and the staff appeared to struggle to get him/her in the car. The resident appeared to be in significant pain throughout the entire incident.</p> <p>During an interview on 11/26/24 at 12:43 P.M., the Director of Nursing (DON) said they had issues with getting arrangements in place for Resident #1 to be picked up from the infusion center on 11/15/24. She was told LPN A went to get the resident in the facility van, but LPN A realized he/she did not have the correct license to drive the van, so LPN A and the AD took the AD's personal car. She didn't know what happened until they arrived back at the facility. Resident #1 complained of pain with his/her left knee. The resident sat on a Hoyer lift sling when he/she arrived in the car. The resident needed the Hoyer lift due to he/she was normally weaker leading up to his/her infusions and from the appointment.</p> <p>During an interview on 11/26/24 at 4:32 P.M., the Administrator said she knew staff tried to get an outside transportation agency scheduled for Resident #1 on 11/15/24. The infusion center called and said the facility had to get someone there soon because they were closing. They couldn't get the outside transportation agency on the phone so she told LPN A to go pick up the resident since he/she had a license to drive the facility van. She told LPN A to take the AD with him/her. About an hour later, she found out LPN A got to the van and realized he/she did not have the correct license to drive it and instead of coming back in to notify the Administrator, he/she decided to take a personal car to get the resident. Had LPN A notified her, she would have made other arrangements such as an ambulance. She would expect staff to provide appropriate accommodations to residents to ensure they were transferred in a safe manner, either by using a mechanical lift or providing transportation that allowed the residents to be transported in their wheelchairs.</p> <p>Complaint #MO245231</p>		