STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265479	A. Building B. Wing	08/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sikeston Convalescent Center	103 Kennedy Drive Sikeston, MO 63801

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 42699 Based on interview and record review, the facility failed to notify a resident's family in a timely manor, after a transfer where the resident's left leg became entangled in the wheelchair resulting in pain and subsequent injury, for one resident (Resident #1) out of six sampled residents. The facility also failed to notify the resident's family/responsible party when the resident was transferred to the hospital related to increased pain in the affected leg which was determined to be a fractured femur. The facility census was 66. The facility did not provide a policy regarding the guidelines to notify the resident's family/representative. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated, 06/11/2024, showed: - Diagnoses of hypertension (high blood pressure), peripheral vascular disease (condition in which narrowed blood vessels reduces blood flow to the limbs), heart failure, and diabetes mellitus (high blood sugar); -BIMS score 8, indicating moderate cognitive impairment; -Speech clear and usually makes self understood; -Usually understands others; -No behaviors; -No scheduled pain medication; -Receives as needed pain medication; -Dependent on helper for chair to bed transfers. Review of the resident's medical record showed: (continued on next page)

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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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-On 08/06/24 at 8:14 A.M., late entry note put in by the Director of Nursing (DON) regarding incident on 08/01/24 at 4:30 P.M. showed: This nurse was walking into the dining room when resident asked to see me. He/she said he/she did not want to eat supper and wanted to go back to his/her room. This nurse pushed him/her via wheelchair back to his/her room when he/she said his/her left leg hurt and he/she wanted a pain pill. The resident continued to state that during a transfer with two aides, the resident's left leg got caught when transferring to the wheelchair. This nurse assessed the left leg. No abnormalities were noted, no bruising or swelling. He/she did ask for pain medication which was administered; -No documentation of family/responsible party notified of the transfer resulting in the resident's leg being caught and the resident's complaints of pain; -On 08/05/24 at 8:55 P.M. note by Registered Nurse (RN) D showed Resident #1 was sent to the hospital for a left leg injury that was causing substantial pain. The on call nurse practitioner was called and gave an order to send the resident out; -No documentation showed the family/responsible party was notified of the resident's transfer to the hospital emergency room . -On 08/06/24 at 7:16 A.M., a nurse's note showed the hospital called and Resident #1 was admitted for left leg femur fracture; -No documentation the family/responsible party was notified of the resident's admission to the hospital. During an interview on 08/14/23 at 9:40 A.M., Licensed Practical Nurse (LPN) C said if there was an incident, the family/responsible party should be notified, as well as the physician. LPN C said anytime a resident is sent to the hospital the family/responsible party is to be notified. During an interview on 08/13/24 at 11:50 A.M., the DON said, he/she did not call the family/responsible party when Resident #1 reported his/her leg was bent back during a transfer into the wheelchair by two aides, reported pain, and requested a pain pill. The DON said the nurse that sent the resident to the hospital should have made the family/responsible party aware of the transfer. During an interview on 08/14/24 at 10:50 A.M., RN D said he/she had not been made aware of an incident related to Resident #1's leg being injured during a transfer. RN D said on 08/05/24 Resident #1 had not acted like himself/herself and appeared in pain. RN D said an unidentified certified nurse aide (CNA) asked him/her to look at Resident #1's leg because the resident complained of pain and the CNA reported he/she had heard the resident's leg got hurt during a transfer earlier in the week. RN D assessed the left leg with no visible abnormalities noted. RN D said Resident #1 complained of significant pain with movement of the left leg. RN D called the on-call nurse practitioner and an order was obtained to send the resident to the emergency room (ER) for assessment. RN D said he/she failed to call and notify the family/responsible party of Resident #1's transfer to the ER. RN D said the family should have been (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 08/12/24 at 3:04 P.M., the resident's Responsible Party (RP) said when he/she visited Resident #1 on 08/03/24, the resident complained of left leg pain and would say don't touch it. The RP thought Resident #1 was sore or uncomfortable as nothing had been reported to him/her. The RP said on 08/06/24 he/she went to visit Resident #1 at the nursing home and was unable to find him/her and was told by staff Resident #1 was sent to the hospital on 08/05/24. The RP said he/she had not been notified there had been an incident nor was he/she notified when Resident #1 was sent to the hospital. During an interview on 08/13/23 at 4:39 P.M., the Administrator said he/she would expect the nurse to notify the family/responsible party if a resident is going to the hospital. Complaint #MO00240456

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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 42699 Based on interview, and record review the facility failed to provide a safe transfer per facility policy and the resident's assessed level of assistance needed when one Nurse Aide attempted to transfer the resident, who was a two person transfer, alone by bear hugging the resident and attempting to pivot him/her, twisting the resident's left leg and resulting in a left femur fracture and loss of the ability to bear weight on the left leg for one resident (Resident #1) out of six sampled residents. The census was 66. On 08/14/24 at 4:00 P.M., the Administrator was notified of the past non-compliance immediate jeopardy (IJ) which began on 08/02/24. The facility immediately conducted an investigation and inserviced staff on the Resident Transfer Safety policy. The IJ was corrected on 08/08/24. Review of the facility's policy titled, Resident Handling Policy, revised 2000 showed: -Policy exists to ensure a safe working environment for resident handlers; -Policy is to be reviewed and signed by all staff who perform or may perform resident handling; -Initial screening will be performed on all residents to assess transfer and ambulation status; -Resident transfer status will be reviewed via care plan time frame and on an as needed basis; -Transfers will be designated into one of the following categories: (I) Independent transfer, (1) One person transfer, (1+) One person transfer with assistive device, (2) Two person transfer or (M) Mechanical transfer [Hoyer, electric lift, etcetera]; -Mandatory gait belts for all resident handling with exception of bed mobility and medical contraindications; -Resident transfer status will be documented in the resident's chart and above the bed as to inform the staff of appropriate transfer use; -Policy is to be followed at all times and failure to adhere to will result in disciplinary action. 1. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by the facility staff, dated, 06/11/2024, showed: - Diagnoses of hypertension (high blood pressure), peripheral vascular disease (condition in which narrowed blood vessels reduces blood flow to the limbs), heart failure, and diabetes mellitus (high blood sugar); -BIMS score 8, indicating moderate cognitive impairment; -Speech clear and usually makes self understood; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Usually understands others; -No behaviors; -No scheduled pain medication; -Receives as needed pain medication; -Dependent on helper for chair to bed transfers requiring two or more helpers to complete the activity. Review of the resident's care plan, last reviewed on 04/15/24, showed it did not address the resident's ability to perform activities of daily living such as transferring from bed to wheelchair. Review of the resident's medical record showed: -On 08/06/24 at 8:14 A.M., a late entry note was entered into the electronic medical record for 08/01/24 at 4:30 P.M. said a nurse was walking into the dining room when Resident #1 reported he/she did not want to eat supper and wanted to go back to his/her room. This nurse pushed him/her via wheelchair back to his/her room when he/she said his/her leg hurt and he/she wanted a pain pill. The resident states that during an earlier transfer with two aides, the resident's left leg got caught when transferring to the wheelchair. This nurse assessed the left leg. No abnormalities were noted, no bruising or swelling. He/she did ask for pain medication which was administered. -On 08/03/24 at 1:56 A.M., a nurse's note indicated an unidentified certified nurse aide (CNA) was performing bed checks and the resident stated his/her left leg was hurting. The left leg had no visible abnormalities noted. No edema/discoloration. The resident appeared to have altered mental status (AMS) and was alert to himself/herself. The resident was requesting an as needed (PRN) pain pill. Vital signs oxygen 92% on room air, pulse rate 75 and blood pressure (BP) 88/58. This nurse rechecked the BP and it was 88/56. This nurse then contacted the on call nurse practitioner, who said to monitor the resident's BP and to give a PRN pain pill. The blood pressure was rechecked 30 mins after the pain pill was given and was 93/61. The blood pressure was checked again 30 mins later and read 115/68. No new complaints from resident at this time. The bed was lowered and the call light was within reach; -On 08/03/24 at 6:56 A.M., a nurse's note showed the resident did not wish to get up this morning due to left leg pain. The resident states it hurts to move, but is not painful to touch. BP this A.M. was 110/72; -On 08/05/24 at 8:55 P.M., a nurse's note showed Resident #1 was sent to the hospital for a left leg injury that was causing substantial pain. The on call nurse practitioner was called and gave an order to send the resident out; -On 08/06/24 at 7:16 A.M., a nurse's note showed the hospital called and Resident #1 was admitted for a left leg femur fracture. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/13/24 at 1:55 P.M., NA A said he/she had been providing incontinent care with CNA B for Resident #1 before dinner at approximately 4:15 P.M. NA A said he/she and CNA B had previously transferred Resident #1 into bed using a 2 person assist. NA A said after completing incontinent care on Resident #1 he/she did not wait for CNA B to return to assist and bearhugged Resident #1 to transfer from the bed to wheelchair. During the transfer, NA A reported Resident #1's weight caused the resident to slide and the left leg slide under the wheelchair and got entangled in the wheel. NA A pulled Resident #1 up and his/her left leg landed in the seat of the wheelchair. NA A was holding Resident #1 up off the ground when CNA B returned to the room. CNA B then assisted NA A with transferring Resident #1 into the wheelchair. NA A said a gait belt was not used at any time during the transfer process and it should have been. NA A said he/she should not have transferred the resident by himself/herself, but thought CNA B had told him/her to just pick the resident up. NA A had been shown how to find a resident's transfer status in the electronic record system. NA A said he/she did not report the incident as he/she thought CNA B was reporting it to the nurse. During interviews on 08/13/24 at 2:19 P.M. and 08/14/24 at 11:45 A.M., CNA B said he/she assisted NA A with a transfer of Resident #1 from the wheelchair into bed. NA A provided incontinent care for Resident #1 as CNA B provided care to Resident #2. CNA B said he/she finished incontinent care on Resident #2 and transported Resident #2 to the dining room for dinner. CNA B said he/she told NA A he/she would be right back to assist with Resident #1. Upon returning to the room, CNA B saw NA A leaning back bearhugging and holding Resident #1 off the ground with the resident's left leg caught up in the seat of the wheelchair. CNA B said he/she assisted NA A by holding onto Resident #1's pants and helping move the resident forward to get the leg out of the seat of the wheelchair and then to sit in the wheelchair. CNA B said the resident complained of nausea after the transfer. CNA B said neither he/she nor NA A used a a gait belt during the transfer. CNA B said Resident #1 is a two person assist and Hoyer lift as needed. CNA B said he/she did not immediately report the incident. CNA B said, about 20 minutes later, he/she spoke with the DON regarding the incident. CNA B confirmed the incident regarding Resident #1 took place on 08/02/24. CNA B said Resident #1 would say Oh, no anytime when going in to provide care after the incident happened, but CNA B didn't think much about it being pain related and thought Resident #1 was just traumatized from the bad transfer. During interviews on 08/13/24 at 11:50 A.M. and 1:00 P.M., the Director of Nursing (DON) said on 08/01/24 around dinner time, Resident #1 asked him/her to push him/her back to his/her room from the dining room because his/her leg hurt and he/she wanted a pain pill. Resident #1 told the DON, during a transfer earlier in the day his/her leg got tangled in the wheelchair when the aides where moving him/her and the leg was hurting and wanted a pain pill. The DON assessed the leg and no abnormalities were noted. The incident had not been reported to the DON by the aides at that time. The DON said he/she asked CNA B what happened during the transfer with Resident #1 and CNA B said NA A transferred the resident by himself/herself and the resident's leg got caught up in the wheelchair. The DON did not start an investigation since he/she had talked with CNA B. The DON did speak with NA A to get a statement regarding what happened during the transfer of the resident. The DON said staff are able to see how a resident transfers on PCC (Point Click Care, facility's electronic medical record) under the area of the system the CNA's document in, as well as it is sometimes listed in the special instructions. The DON confirmed Resident #1 was to a 2 person assist and at times required as needed transferring with Hoyer lift. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/14/24 at 9:40 A.M., Licensed Practical Nurse (LPN) C said he/she was not notified Resident #1 had been involved in an incident regarding his/her leg getting tangled in a wheelchair. LPN C said during his/her night shift rotation on 08/02/24 the resident was complaining of left leg pain, as well as had some altered mental status and his/her blood pressure was low. LPN C said he/she called the on-call nurse practitioner. LPN C said he/she was told to monitor the blood pressure and give pain medication as ordered for the leg pain. LPN C said he/she would have reported the incident to the on-call nurse practitioner and asked for an x-ray had he/she been made aware of the incident that had occurred regarding Resident #1. During an interview on 08/13/24 at 3:15 P.M., LPN E said he/she had not been made aware of an incident regarding Resident #1's leg. LPN E said it was reported during shift change on 08/03/24 around 7:00 A.M. by night shift nurse, LPN C, the resident complained of left leg pain. LPN E said he/she did not observe Resident #1 complain during the day. LPN E said had Resident #1 complained of pain he/she would have repositioned the resident first then tried pain medication if repositioning was ineffective. If the resident still had pain, LPN E said he/she would have notified the physician to see if an x-ray was needed. LPN E said if a resident has had a fall or there is an incident and resident had pain an x-ray is normally ordered to rule out any issue, as well as pain management and monitoring. During an interview on 08/14/24 at 10:50 A.M., Registered Nurse (RN) D said he/she had not been made aware of an incident related to Resident #1s leg being injured during a transfer. RN D said on 08/05/24 Resident #1 had not acted like himself/herself and appeared in pain. RN D said an unidentified CNA reported he/she had heard the resident's leg got hurt during a transfer earlier in the week. RN D questioned Resident #1 and assessed the left leg and the resident complained of significant pain. RN D called the on call nurse practitioner and obtained an order to send to the ER for assessment. During an interview on 8/13/24 at 2:38 P.M., the CNA Instructor said he/she goes through the orientation process with the newly hired CNAs. The CNAs/ NAs are trained where to go in the PCC to find a resident's information on diet, transfer status, bowel and bladder status, etc. The CNA Instructor said he/she teaches the NAs how to use the gait belt and Hoyer lift, and then requires a return demonstration of the gait belt and Hoyer lift prior to signing off that skill. Review of NA A's orientation paperwork showed NA A had a signed competency regarding the resident handling policy dated 07/22/24 and signed off competency on lifting techniques and moving a resident on 07/23/24. During an interview on 08/14/24 at 1:00 P.M., the DON confirmed nursing would not have been able to see that an incident had occurred with Resident #1 as the late entry note was not put into the system until 08/06/24. The DON confirmed the late entry regarding the incident had been put in on the wrong date and the incident regarding Resident #1 took place on 08/02/24 at approximately 4:30 P.M. The DON said he/she did not report the incident to the charge nurses so they would be aware and could monitor the resident as the resident had complained of pain. The DON said the incident should have been reported to the charge nurse's so the resident could be monitored. The DON said he/she would expect all staff to utilize the appropriate transfer technique. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 08/14/24 at 12:53 P.M., the Administrator said he/she would have expected the incident to have been reported to the oncoming nursing staff so the resident could be monitored, as the documented incident note was a late entry and would not have been available for all nursing staff to see. During an interview on 08/14/24 at 10:10 A.M., the Nurse Practitioner (NP) said he/she had not been notified of an incident regarding Resident #1's leg being entangled in his/her wheelchair resulting in pain. The NP said he/she would have ordered an x-ray if an incident occurred to rule out possible injury. NP said he/she would expect the resident's plan of care to be followed. Complaint #MO00240456