STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265732	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	3060 Ashby Road Overland, MO 63114

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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on observation, interview and record review, the facility failed to ensure residents were free from abuse when an allegation of physical abuse was made for one resident (Resident #1). On 2/1/25 at approximately 10:00 A.M., Registered Nurse (RN) A heard banging on the wall inside the resident's room, and someone yelling, Stop that, stop that, do it again, then a loud slap inside the resident's room and when he/she opened the resident's door he/she saw Certified Nurse Aide (CNA) B holding the resident against the wall. RN A notified the Director of Nurses (DON) of an allegation of abuse and the DON directed RN A not to send CNA B home. CNA B remained in the facility providing care to other residents for over five hours after the allegation was reported. The facility did not immediately begin an investigation into the allegation of abuse. Facility staff were not properly educated on the facility's policies of identifying and reporting abuse to ensure residents were free from abuse. The sample was 8. The census was 49. The Assistant Director of Nurses (ADON) and DON were notified on 2/1/25 at 6:45 P.M. of an Immediate Jeopardy (IJ) which began on 2/1/25. The IJ was removed on 2/4/25 as confirmed by surveyor onsite verification. Review of the facility's Abuse Prevention Program policy, revised December 2016, showed: -Policy Statement: Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation. This includes but is not limited to freedom from corporal punishment, involuntary seclusion, verbal, mental, sexual or physical abuse, and physical or chemical restraint not required to treat the resident's symptoms; -Policy Interpretation and Implementation: -As part of our resident abuse prevention, the administration will: --Protect our residents from abuse by anyone including, but not necessarily limited to: facility staff, other residents, consultants, volunteers, staff from other agencies, family members, legal representatives, friends, visitors, or any other individual; --Develop and implement policies and procedures to aid our facility in preventing abuse, neglect, or mistreatment of our residents; (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	--Require staff training/orientation programs that include such topics as abuse prevention, identification and reporting of abuse, stress management, and handling verbally or physically aggressive resident behavior; --Implement measures to address factors that may lead to abusive situations; --Identify and assess all possible incidents of abuse; --Investigate and report any allegations of abuse within timeframes as required by federal requirements; --Protect residents during abuse investigations. Review of the facility's Abuse Investigation and Reporting policy, revised July 2017, showed: -Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management; -Policy Interpretation and Implementation: --Role of the Administrator: -If an incident or suspected incident of resident abuse, mistreatment, neglect or injury of unknown source is reported, the Administrator will assign the investigation to an appropriate individual; -The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/22/25, showed: -Adequate hearing; -Resident rarely/never understands; -Resident rarely/never understood; -Short and long term memory problem; -Severe impairment for decisions regarding tasks of daily life; -Rejection of care behavior occurred one to three days; -Physical behavioral symptoms occurred one to three days; (continued on next page)

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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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Substantial/maximal assist required for upper and lower body dressing, toileting, and personal hygiene; -Diagnoses include Alzheimer's disease (a progressive and irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to perform everyday tasks), anxiety, and depression. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Current functional performance; -Interventions included extensive assist/one-person physical assist for dressing, personal hygiene and toilet use. Extensive assist/two-person physical assist for dressing, personal hygiene, and toilet use; -Focus: The resident is resistive to care at times with activities of daily living (ADLs) care; -Focus: The resident is/has potential to be physically aggressive; -Interventions included assess and anticipate resident's needs. Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Give the resident as many choices as possible about care and activities. When the resident becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation, and if response is aggressive, staff to walk away calmly and reapproach later. During an interview on 2/1/25 at 1:07 P.M., RN A said at around 10:05 A.M. that morning, he/she heard a voice yelling in the resident's room. The voice sounded threatening and mean, and was yelling, Stop that, stop that, do it again! RN A heard bumping noises inside the room, then a loud slap. The voice yelled, See, I told you, don't do it again! RN A opened the door to the resident's room and saw the resident up against the wall with CNA B standing in front of him/her. The resident's back was to the wall and CNA B had his/her body pushed into the resident's, holding the resident's left arm with his/her right arm. The resident was not attempting to move. When asked if everything was ok, CNA B said yes, sat the resident down on the bed, and immediately left the room. RN A interviewed the resident by asking yes/no questions, but the resident was very confused and was unable to say much. RN A performed a skin assessment and when he/she attempted to check the resident's lower body, the drawstring on the resident's pants was tied so tight, he/she had to cut the string to assess the resident. After assessing the resident, RN A called the DON to inform him of what he/she observed. RN A asked to send CNA B home and the DON said no, the facility was too short on staff. The DON told RN A the resident is very combative and CNA B would never do this type of thing. The DON did not ask RN A for a written statement regarding what happened and said he/she would arrive at the facility soon. RN A left the building at 12:20 P.M., at which time, CNA B was still working in the facility and the DON had not arrived. Observation on 2/1/25 at 2:03 P.M., showed CNA B walked throughout the building, going in and out of resident rooms, providing care to residents. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/1/25 at 2:03 P.M., Licensed Practical Nurse (LPN) H said he/she came in around 12:15 P.M. The DON called him/her in because the nurse from day shift asked the DON to find someone to replace him/her on the schedule. LPN H was not informed of any allegations of abuse. If he/she was made aware of an allegation of abuse perpetrated by an employee, he/she would notify the DON and leave it up to the DON to determine if the employee should be sent home. He/She would not make the decision to send the employee home. The DON is responsible for investigating abuse allegations. During an interview on 2/1/25 at 2:33 P.M., CNA B said the day shift nurse called the DON and told him that he/she was being mean to the resident. The resident is not aggressive, but hits on people. CNA B was in the resident's room this morning, around 9:30 A.M., to get him/her changed and dressed for breakfast. The resident is pretty confused and kept going around the room. Two employees are usually needed to provide care to the resident, but CNA B can do it by him/herself because he/she knows the resident. CNA B told the resident he/she was wet and smelled like pee. He/She kept telling the resident to sit down to change him/her. The resident hit CNA B on the shoulder and CNA B said he/she did not hit the resident back. When the resident tried to hit him/her again, CNA B pushed the resident's arms back. He/She told the resident, Your licks don't hurt me, you need to stop. The resident kept swinging and CNA B pushed the resident's hands while he/she was swinging. CNA B put the resident against the wall so he/she couldn't bend over with CNA B while he/she was trying to pull his/her pants up. When asked to demonstrate how he/she spoke to the resident, CNA B raised his/her voice loudly. He/She said he/she uses a louder pitch to get the resident's attention. The nurse on the day shift was in the hall at the time, and must have heard this. Some people might think there is no way in hell someone should talk to a resident like this, but they don't do this every day and sometimes staff have to raise their voice for a resident to listen. Observation on 2/1/25 at 2:59 P.M., showed LPN H, Certified Medication Technician (CMT) I, and CNA B escorted the resident to his/her room for a skin assessment. LPN H and CMT I said the resident will hit staff. CNA B lifted the resident's shirt in the front and back. When staff attempted to fully remove the shirt for an observation of the resident's arms, the resident shook his/her head no, and wiggled his/her arms away from CNA B. The resident did not attempt to hit staff and left the room. During an attempted interview on 2/1/25 at 3:05 P.M., the resident was confused and was unable to answer specific questions regarding his/her care needs, interactions with staff, or treatment at the facility. During an interview on 2/1/25 at 3:05 P.M., CMT I said the DON called him/her earlier that day and asked which aide was assigned to the resident's hall, which was CNA B. The DON told CMT I the day shift nurse said CNA B was being mean to the resident. The DON did not say anything about sending CNA B home. The resident has Alzheimer's disease. He/She only gets aggressive when he/she has a bowel movement or is receiving care, and then he/she will sucker punch staff. CNA B is the only aide who can provide care to the resident by him/herself. Otherwise, two staff have to provide care so one person can distract the resident and the other person can do the care. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/1/25 at 3:29 P.M., the DON said at around 10:00 A.M., he got a call from RN A. RN A said he/she heard yelling and loud noises coming from the resident's room, like the heads of residents banging on the walls or something. RN A saw CNA B and the resident leaned against the wall while CNA B was getting the resident dressed. RN A wanted to send CNA B home on the basis of abuse and the DON said no, noises are not a good basis to send the employee home. Noises could come from anywhere. He told RN A he would look into it and called the facility. He talked to CMT I, who didn't know what was going on. He has not interviewed the resident or any other staff, yet. Management typically investigates abuse. They get statements from the parties involved and document as necessary. He lets the ADON do most of that, because he is still new and has only been working with the facility for three months. Abuse investigations are conducted in a timely fashion, and the DON did not provide specifics on the definition of timely. During an interview on 2/1/25 at 3:48 P.M., the ADON said the DON did not notify her of the abuse allegation until after 2:30 P.M., when LPN H called to notify her the Department of Health and Senior Services (DHSS) was in the building. The Assistant Administrator was not aware, either. Any employee alleged to have been the perpetrator of abuse should be suspended immediately, pending investigation, to keep all residents safe. CNA B should have been sent home the minute the DON was notified of an abuse allegation. Management should immediately be notified of abuse allegations. An abuse investigation should be started by management the moment they are made aware. Observation on 2/1/25 at 3:48 P.M., showed CNA B in the ADON's office. Review of CNA B's time punches, showed he/she clocked out at 4:42 P.M. During an interview on 2/1/25 at 4:06 P.M., CNA K said the resident has Alzheimer's disease. Staff have to be loud with him/her in order for him/her to understand what they need him/her to do. He/She needs assistance with changing and dressing and can get angry and hit staff when they assist with this. It takes two staff to provide care to the resident on some days. When the resident gets physically aggressive, staff should step back and leave the room. During an interview on 2/1/25 at 4:58 P.M., the Assistant Administrator said staff should engage residents in a normal tone of voice, or speak louder if the resident is hard of hearing. If a resident becomes combative and physically aggressive, staff should leave the room and should not physically engage with the resident. He wasn't notified of the abuse allegation until the ADON contacted him at 2:35 P.M. The day shift nurse reported a concern of abuse to the DON. The alleged incident occurred at 10:00 A.M. The Assistant Administrator should have been notified within 30 minutes to an hour of the DON being notified, and an investigation should have been started right away. The DON should have immediately suspended the CNA pending an investigation to protect the resident and other residents from potential abuse. CNA B should not have remained in the facility, providing care for other residents, for another five hours after the allegation of abuse was reported. (continued on next page)

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During an interview on 2/1/25 at 8:37 P.M., the ADON said the resident was combative when first admitted to the facility, but he/she started anxiety medication and this has not been an issue for a long time. Approach is a lot for the resident. Staff should tell him/her what they want to do and speak to the resident in a low, normal tone of voice. Staff should not yell at the resident; he/she is not hard of hearing. If the resident becomes combative when receiving care, staff should leave and get assistance. Ongoing behaviors and combativeness should be reported to her, but she has not received any reports about this happening. It is not appropriate for staff to keep the resident against the wall when assisting him/her with toileting. Instead, the resident should be taken to the toilet, where he/she can sit down and staff can change him/her. Staff should be educated on the facility's abuse policies. During an interview on 2/1/25 at 2:27 P.M., Housekeeper J said If he/she overheard staff from another department yelling at a resident, or witnessed abusive behavior, he/she would have to wait to tell his/her supervisor. His/Her department does not get involved with what goes on in other departments. Each department handles their own issues. If he/she witnessed yelling or abuse on a weekend, he/she would unfortunately have to wait to speak to his/her supervisor on Monday. During an interview on 2/3/25 at 9:20 A.M., Housekeeper L said he/she has not received training about the facility's abuse policies recently. If he/she heard nursing staff yelling at a resident, or slapping noises coming from a resident's room, he/she would probably tell the nurse. It is not his/her place to get involved with nursing staff, so he/she would not intervene. During an interview on 2/3/25 at 11:29 A.M., the DON said he was not educated on the facility's abuse policies when he began his position with the facility in November 2024. After the abuse allegation was made on 2/1/25, he was in-serviced on the policy. All staff who have worked since the allegation was made, have not been in-serviced in a timely fashion. If any employee hears, witnesses, or suspects abuse, they should intervene first, make sure the resident is safe, then report it to management. During the interview, the DON reviewed the documentation being provided to staff to educate them on the facility's abuse policies. The documentation did not provide guidance for staff to ensure the resident is safe when abuse is suspected, before reporting it to management. NOTE: At the time of the survey, the violation was determined to be at the immediate and serious jeopardy level J. Based on observation, interview, and record review completed during the onsite visit, it was determined the facility had implemented corrective action to address and lower the violation at the time. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action be taken to address Class I violation(s). MO00248906

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of abuse involving one resident (Resident #1) to the State Survey Agency immediately and not later than two hours after the allegation was made. The sample was 8. The census was 49. Review of the facility's Abuse Investigation and Reporting policy, revised July 2017, showed: -Policy Statement: All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management; -Policy Interpretation and Implementation: --Reporting: -All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of an unknown source and misappropriation of property will be reported by the facility Administrator, or his/her designee, to the following persons or agencies, included the State licensing/certification agency responsible for surveying/licensing the facility; -An alleged violation of abuse, neglect, exploitation or mistreatment (including injuries of unknown source and misappropriation of resident property) will be reported immediately, but not later than two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury. Review of Resident #1's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 1/22/25, showed: -Resident rarely/never understands; -Resident rarely/never understood; -Short and long term memory problem; -Severe impairment for decisions regarding tasks of daily life; -Substantial/maximal assist required for upper and lower body dressing, toileting, and personal hygiene; -Diagnoses include Alzheimer's disease (a progressive and irreversible brain disorder that gradually destroys memory, thinking skills, and the ability to perform everyday tasks), anxiety, and depression. Review of the resident's care plan, in use at the time of survey, showed: -Focus: Current functional performance; (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Interventions included extensive assist/one-person physical assist for dressing, personal hygiene and toilet use. Extensive assist/two-person physical assist for dressing, personal hygiene, and toilet use; -Focus: The resident is resistive to care at times with activities of daily living (ADLs) care; -Focus: The resident is/has potential to be physically aggressive; -Interventions included when the resident becomes agitated, intervene before agitation escalates, guide away from the source of distress, engage calmly in conversation, and if response is aggressive, staff to walk away calmly and reapproach later. During an interview on 2/1/25 at 1:07 P.M., Registered Nurse (RN) A said at around 10:05 A.M. that morning, he/she heard a voice yelling in the resident's room. The voice sounded threatening and mean, and was yelling, Stop that, stop that, do it again! RN A heard bumping noises inside the room, then a loud slap. The voice yelled, See, I told you, don't do it again! RN A opened the door to the resident's room and saw the resident up against the wall with Certified Nurse Aide (CNA) B standing in front of him/her. The resident's back was to the wall and CNA B had his/her body pushed into the resident's, holding the resident's left arm with his/her right arm. The resident was not attempting to move. After CNA B left the room, RN A interviewed the resident by asking yes/no questions, but the resident was very confused and was unable to say much. After assessing the resident, RN called the Director of Nurses (DON) to inform him of what he/she observed. During an interview on 2/1/25 at 3:29 P.M., the DON said at around 10:00 A.M., he got a call from RN A. RN A said he/she heard yelling and loud noises coming from the resident's room, like the heads of residents banging on the walls or something. RN A saw CNA B and the resident leaned against the wall while CNA B was getting the resident dressed. RN A wanted to send CNA B home on the basis of abuse. He told RN A he would look into it. He did not report the allegation to the Department of Health and Senior Services (DHSS) because he needed to know more details. He did not know he needed to report all allegations of abuse to DHSS within two hours of being made aware of the allegation. During an interview on 2/1/25 at 3:48 P.M., the Assistant Director of Nurses (ADON) said she was not aware of the allegation of abuse until after 2:30 P.M. Any allegation of abuse should be reported immediately to the manager on duty and Assistant Administrator. All allegations of abuse should be reported to DHSS within two hours. During an interview on 2/1/25 at 4:58 P.M., the Assistant Administrator said he was not aware of the abuse allegation until 2:35 P.M. The nurse reported an allegation of abuse to the DON at 10:00 A.M. The Assistant Administrator should have been notified within 30 minutes to an hour of the DON being notified, and an investigation should have been started right away. Any allegation of abuse should be reported to DHSS within two hours of being made aware of the allegation. MO00248906

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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** Based on observation, interview and record review, the facility failed to provide care and services to ensure residents were free from accident hazards. Certified Nurse Aide (CNA) B performed a Hoyer (mechanical lift) transfer for one resident (Resident #6) without the assistance of a second person, and the resident was struck in the face with the lift, causing injuries to his/her face. The employee failed to report the incident at the time it occurred, and staff failed to perform neurological assessments for 72 hours following the incident, in accordance with facility policy. In a separate incident, Certified Medication Technician (CMT) C performed a Hoyer transfer for the resident without the assistance of a second person, and failed to ensure the resident's physician-ordered fall mats were positioned at bedside before leaving the room. The resident fell from bed, hit his/her face, and required stitches in his/her forehead. In addition, staff failed to utilize appropriate techniques during a two-person Hoyer transfer, resulting in the machine tilting several times while the resident was in the lift. The sample was 8. The census was 49. Review of the facility's Hoyer Lift guidance, revised 9/9/15, showed: -Always have two people when completing transfer; -If there is room, the Hoyer lift is safer when the legs of the lift are wide open. If space allows, keep legs of lift open; -The primary person on the transfer starts to lift the resident slowly in the air. The second person is close to the resident at all times as well; -Once the resident is up, start to move the lift. The primary person steers the lift and makes sure the resident's feet don't hit the lift. The secondary person at the back of the resident is making sure the resident doesn't slide out and helps guide the resident correctly over the chair. Make sure the brakes are locked on the Hoyer lift before lowering the resident; -Align the resident over the wheelchair, slowly start lowering the resident. The secondary person needs to help guide resident and help achieve correct posture. Both staff should make sure that the lift does not hit the resident in head; -Two people are required at all times for safety with mechanical device. Review of the facility's Hoyer Safety Precautions document, undated, showed: -The weight must be centered over the base. When lifting, always keep patient centered over the base and facing the attendant who is operating the lifter; -To reduce the hazard of tipping over, spread adjustable base lifters (legs) to their widest position before lifting anyone. Review of the facility's Neurological Assessment policy, revised October 2010, showed: (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	-Purpose: The purpose of this procedure is to provide guidelines for a neurological assessment: 1) upon physician order; 2) when following an unwitnessed fall; 3) subsequent to a fall with a suspected head injury; or 4) when indicated by resident condition; -General Guidelines: --Neurological assessments are indicated: -Upon physician order; -Following an unwitnessed fall; -Following a fall or other accident/injury involving head trauma; -When indicated by resident's condition; -Steps in the procedure, included perform neurological checks with the frequency as ordered or per falls protocol; -Documentation: --The following information should be recorded in the resident's medical record: -The date and time the procedure was performed; -The name and title of the individual(s) who performed the procedure; -All assessment data obtained during the procedure; -The signature and title of the person recording the data; -Related documents: Neurological Evaluation Flow Sheet. Review of the facility's Post Fall 72-Hour Monitoring Report form, dated July 2008, showed: -This assessment should be completed at the following intervals for follow up for all falls. A fall that is unwitnessed or in which the head is struck, requires neurological checks. Initial assessment, followed by four 15-minute checks, two 30-minute checks, two hourly checks, and once per shift for 72 hours. 1. Review of Resident #6's medical record, showed: -Diagnoses included repeated falls, difficulty walking, generalized muscle weakness, dementia (a general term for loss of memory and other mental abilities severe enough to interfere with daily life), anxiety and depression; -A physician order, dated 6/16/23, to be sure bed is in lowest position and fall mats on the floor while resident is in bed. (continued on next page)

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	265732	A. Building B. Wing	02/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bentleys Extended Care	3060 Ashby Road Overland, MO 63114

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 11/2/24, showed: -Resident rarely/never understood; -Dependent for chair/bed-to-chair transfers. Review of the resident's care plan, in use at the time of survey, showed: -Focus: The resident has an activities of daily living (ADLs) self-care performance deficit related to generalized weakness and deconditioning (a decline in physical fitness and overall health that occurs due to a prolonged period of inactivity or reduced physical activity); -Interventions included the resident requires Hoyer mechanical lift with two staff assistance for transfers; -Focus: The resident is moderate risk for falls related to confusion, deconditioning; -Interventions included follow facility protocol; -Focus: The resident had an actual fall with serious injury on 1/24/25; -The care plan did not include the utilization of fall mats and a low bed as a fall intervention. Review of the resident's incident note, dated 1/15/25 at 7:24 A.M., showed Licensed Practical Nurse (LPN) D documented after clocking in at 10:40 P.M. (1/14/25), LPN D was made aware the resident had a small laceration to his/her forehead, bruise to the bridge of his/her nose, and a swollen top lip from the Hoyer lift. The aide (CNA B) reported that while putting the resident to bed on the evening shift, the Hoyer lift's pendulum swung back and struck the resident in the face. LPN D assessed the resident while he/she was in bed. The laceration and top lip were not actively bleeding. The laceration was cleaned and bandaged. Review of the resident's medical record, showed: -Health status notes documented on 1/16/24 at 4:00 P.M. and 7:11 P.M. for incident follow-up. Scabbed laceration to forehead, bridge of nose purplish bruised with swelling, top lip swollen. -No Post-Fall 72-Monitoring Report forms or neurological assessment (neurocheck) flow sheets following the incident on 1/14/25. During an attempted interview on 2/3/25 at 9:15 A.M., the resident was non-verbal and unresponsive to questions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/3/25 at 10:41 A.M., LPN D said the resident is confused, does not talk, and requires a Hoyer lift for all transfers. On 1/14/25, LPN D came in for the night shift and CNA B, who worked the evening shift, reported the resident was injured during a Hoyer transfer. CNA B reported he/she was transferring the resident with the Hoyer lift at around 8:30 P.M., and the bar on the lift swung back and hit the resident in the face. CNA B did not report the incident to the nurse on evening shift. CNA B did not specify that he/she did the transfer by him/herself. All Hoyer transfers should be performed by two staff. During an interview on 2/3/25 at 2:17 P.M., the Assistant Director of Nurses (ADON) said on 1/14/25, CNA B transferred the resident by him/herself with the Hoyer lift, and the lift hit the resident in the head. CNA B did not give a straight answer when asked why he/she performed the transfer by him/herself. CNA B did not report the incident to the evening shift nurse like he/she should have and instead, reported the incident to the nurse on the night shift. Following the incident an in-service training on Hoyer transfers was conducted with nursing staff. Review of the facility's list of employees and in-service training records, showed: -On 1/16/25, 21 nursing staff, excluding the ADON and Director of Nurses (DON), were employed by the facility; -In-service attendance record, titled Transfers, dated 1/16/25, showed objectives included two-person transfers and mechanical lift transfers, with nine nursing staff in attendance and 11 nursing staff not in attendance. CNA B was not in attendance. During an interview on 2/3/25 at 3:15 P.M., the ADON said he/she could not find neurochecks completed for the resident following his/her head injury on 1/14/25. Neurochecks should have been completed for the 72 hours following the incident. During an interview on 2/4/25 at 1:32 P.M., Physician E said she is Resident #6's physician. She could not recall if she was notified of the incident on 1/14/25. She was not aware of the details of how the resident was injured on 1/14/25. When a resident has an injury like this, she always encourages staff to send the resident out to the hospital because facilities do not have the ability to perform a computed tomography scan (CT scan, uses a computer that takes data from several x-ray images of structures inside the body and converts them into pictures on a monitor) to rule out head injury. She expected staff to perform neurochecks for 72 hours after the resident was injured. 2. Review of Resident #6's incident note, dated 1/24/25 at 4:00 P.M., showed at 1:45 P.M., LPN O was called to the resident's room. Resident noted to be lying on the floor on his/her right side with blood coming from his/her head. Resident alert and oriented to self. 3.5 centimeters (cm) by (x) 1.0 cm x 0.8 cm laceration to forehead above right eyebrow. Staff reported resident was in bed prior to incident. Bed in lowest position. Neurochecks within normal limits. First aide provided. Vitals documented. Physician notified and resident sent out to hospital. Review of the resident's hospital Discharge summary, dated [DATE], showed: -Diagnoses included fall, injury of head, and facial laceration; -Laceration repair completed. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Review of the resident's health status note, dated 1/25/25 at 3:15 A.M., showed resident returned from hospital. Intact sutures noted to right forehead above eyebrow. During an interview on 2/3/25 at 1:34 P.M., Certified Medication Technician (CMT) C said the resident is supposed to have fall mats when in bed, because he/she is a fall risk. On 1/24/25, CMT C used a Hoyer lift by him/herself to transfer the resident to bed. He/She knows Hoyer transfers require two people, but he/she was trying to help the aides. Once he/she got the resident in bed, she lowered the bed but he/she forgot to put down the resident's fall mats. He/She went on break and when he/she came back, someone found the resident on the floor with a busted head. The resident went out to the hospital and got stitches. During an interview on 2/3/25 at 2:17 P.M., the ADON said on 1/24/25, CMT C used the Hoyer lift to transfer the resident to bed by him/herself. He/She did not ensure the resident was straightened in bed and did not put down the resident's fall mats. The resident fell out of bed and hit his/her face, resulting in him/her getting stitches. Following the incident another in-service training on Hoyer transfers was conducted with nursing staff. Review of the facility's list of employees and in-service training records, showed: -On 1/24/25, 24 nursing staff, excluding the ADON and DON, were employed by the facility; -In-service attendance record, titled Transfers, dated 1/24/25, showed objectives included all Hoyer lifts require the use of two persons to transfer and do not transfer any resident that uses a Hoyer lift alone, with 15 nursing staff in attendance and nine nursing staff not in attendance. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	3. Observation on 2/3/25 at 2:18 P.M., showed Resident #6 seated on top of a Hoyer pad in a wheelchair in his/her room. Nurse Aide (NA) F brought a Hoyer lift to the resident's room and positioned it in front of the resident. After securing the loops of the Hoyer pad to the bar on the lift, NA F began pumping the lever to lift the resident. NA G was on the other side of the room assisting the resident's roommate while NA F operated the lift. As NA F pumped the lever, the bar on the Hoyer lift bumped the resident's chin. NA G continued to pump the lever and NA G stopped him/her, suggesting they get a different Hoyer lift. NA F unhooked the Hoyer pad straps from the lift while NA G left the room to get the other Hoyer lift. At 2:24 P.M., NA G and NA F secured the loops of the Hoyer pad to the bar on the other Hoyer lift. NA G operated the machine and lifted the resident so he/she was approximately 20 inches above the bed. NA G positioned the Hoyer to the right side of the resident's bed. While the legs of the Hoyer lift were straight, not in an open position, NA G moved the lift back and forth while attempting to get the lift's legs fully underneath the resident's bed, banging against the bed and furniture, while the resident swung back and forth in the Hoyer pad. NA G did not lock the brakes on the Hoyer legs and used both of his/her hands to push the resident's body toward the center of the bed. The Hoyer lift tilted over and NA G pulled it back down to the ground. NA F began maneuvering the Hoyer lift back and forth, bumping into furniture. At 2:27 P.M., NA G left the room and NA F used both hands to push the resident's body so it was centered over the bed, causing the Hoyer to tilt. NA G re-entered the room and while the resident was suspended over the right side of the bed, NA F pressed a lever on the Hoyer and the resident rapidly dropped several inches, remaining in the sling, hovering over the bed. At 2:29 P.M., NA G left the room and NA F continued to move the Hoyer, banging into furniture. At 2:30 P.M., NA F stepped out into the hall, leaving the resident in the Hoyer, halfway over the right side of the bed. At 2:31 P.M. , both aides re-entered the room. The Hoyer lift legs were straight as NA F moved the lift, and the Hoyer lift tilted. NA F pressed a lever on the lift and the resident dropped rapidly onto the right side of the bed. During an interview on 2/3/25 at 2:34 P.M., NA G said this is his/her first week working at the facility. He/She never received training at the facility about how to use the Hoyer lift and learned from watching others. NA F said he/she has been working with the facility for less than two weeks. He/She never received any training at the facility about how to use the Hoyer lift. No one at the facility has shown him/her how to use the Hoyer lift and he/she only knows from previous jobs. Review of the facility's in-service training record, titled Transfers, dated 1/24/25, showed both NA F and NA G were in attendance. 4. During an interview on 2/4/25 at 6:34 A.M., Registered Nurse (RN) N said all Hoyer transfers require two staff. Any incident that results in injury should be reported to the nurse immediately. If a resident has an unwitnessed fall or hits their head, the nurse should perform neurochecks. Neurochecks should be completed at the intervals indicated on the neurocheck flow sheet for 72 hours to ensure there is no head injury. A resident's specific care needs, such as transfer status and fall interventions, should be indicated on their care plan and communicated to staff in report. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	During an interview on 2/4/25 at 9:40 A.M. with the ADON and DON, the ADON said NAs get three days of orientation in which they learn how to perform transfers through a hands-on demonstration. After orientation, the NA spends three days on the floor being paired with another person, then they are released to work by themselves. A Hoyer transfer must be completed by two staff and both staff should remain in the room at all times. One person should operate the lift while the other person assists with positioning and ensuring the resident is safe. The legs of the Hoyer lift should be locked when the lift is positioned over the area where the resident will be transferred. Staff should ensure the resident is properly positioned over their wheelchair or bed before lowering the resident and the resident should be lowered slowly for safety. Staff should ensure a resident is securely and safety positioned in the center of their bed before leaving the room for safety purposes. Staff should ensure fall mats are positioned on the sides of the bed for residents who are a high fall risk. The DON said staff know if a resident is a fall risk by asking the nurse. The ADON said staff can also tell if a resident requires a fall mat by checking the resident's care plan. Resident #6 has physician orders for fall mats and this information should also be on his/her care plan. Care plans are updated by department heads. Any injuries should be reported to the nurse immediately. If a resident hits their head or has an unwitnessed fall, the nurse should complete a full neurological assessment. Neurochecks should be documented on the neurocheck flow sheet. Neurochecks must be completed at the intervals indicated on the flow sheet for 72 hours after the injury or unwitnessed fall to see if there are any neurological changes. During an interview on 2/4/25 at 11:06 A.M., the Assistant Administrator said he expected staff to report any injury to the nurse on shift at that time so the nurse could assess the resident right away. He expected nurses to document assessments as indicated on the neurological flow sheets for incidents involving head injury. Two staff should be present at all times during a Hoyer lift transfer. The Hoyer lift brakes should be locked when appropriate for safety. He expected staff to utilize proper techniques during a Hoyer transfer and to implement identified interventions, such as fall mats, for residents at risk for falls. A resident's individual fall interventions should be documented on a resident's care plan. MO00248702