STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265752	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lawrence County Manor	915 Carl Allen Street Mount Vernon, MO 65712

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 - Minimal harm or potential for 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** 28865 Based on interview and record review, the facility failed to ensure an environment as free from accident hazards as possible when staff failed to follow proper technique during a mechanical lift transfer of one resident (Resident #1). The facility census was 68. The Director of Nursing (DON) was notified by facility staff on 04/24/24 of the noncompliance that occurred on 04/24/24. The DON and Administrator made an online self-report to the Department of Health and Senior Services, began an investigation, and began in-servicing with all nursing staff regarding transfers on 04/24/24. The facility implemented monitoring of the resident involved and all residents who required a two person assistance transfer assistance with a Hoyer lift (mechanical lift normally used to transfer non-weight bearing residents) to ensure transfers were completed safely and as required with two staff. The noncompliance was corrected on 04/25/24. Review of the facility policy titled, Safe Lifting and Movement of Residents, with a revision date of July 2017, showed the following: -In order to protect the safety and well-being of staff and residents, and promote quality care, this facility uses appropriate techniques and devices to lift and move residents; -Resident safety, dignity, comfort, and medical condition will be incorporated into goals and decisions regarding the safe lifting and moving of residents; -Mechanical lifting devices shall be used for heavy lifting, including lifting and moving residents when necessary. Two staff members must be present when operating a mechanical lifting device. 1. Review of Resident #1's face sheet (a brief resident profile sheet) showed the following: -admitted [DATE]: -Diagnoses included joint pain and Alzheimer (brain disorder that slowly destroys memory and thinking skills and eventually the ability to carry out the simplest tasks). Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff), dated 03/25/24, showed the following: (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Cognition severely impaired; -Dependent on staff for transfers, mobility, dressing, toileting, and bathing; -No falls with injury since admission. Review of the resident's Care Plan, dated 04/02/24, showed the following: -Required maximum staff assistance with activities of daily living; -Impaired visual function; -Impaired cognition and thought process due to dementia; -Limited physical ability due to Alzheimer, weakness, and contractures; -High risk for falls related to confusion. Review of of the resident's Progress Notes showed the following: -On 04/24/24, at 6:15 A.M., a certified nurse aide (CNA) reported possible injury to resident during transfer. The resident's right lower extremity (RLE) was caught or hit during the transfer and the resident began complaining of increased pain. The nurse's assessment of RLE showed a protruding area mid shin, tender to the touch. Staff administered pain medication immediately. Staff transferred the resident back to bed, stabilized leg, and ordered X-ray. -On 04/24/24, at 7:58 A.M., nurse arrived to work and report showed that during a transfer out of bed this morning resident either hit the foot of the bed or the Hoyer lift with right calf. The resident was crying in pain and pain medication had been administered per orders. Resident's leg had a hematoma and slight indent was noted to the shin area; -On 04/24/24, at 2:25 P.M., the physician reviewed the X-ray results and did not believe the resident was a candidate for surgery. The physician ordered a long leg splint that goes from above the knee to below the ankle, ace wrapped to immobilize the leg. Review of the resident's X-ray report, dated 04/24/24, showed an acute midshaft tibial (long bone in lower leg) fracture and osteopenia (a decrease in bone mineral density). Review of the resident's Care Plan, dated 04/24/24, showed the following update: -On 04/24/24, resident transferred by staff in Hoyer lift and right leg became entangled. Resident had large hematoma (bruising) immediately noted to right mid-calf. An X-ray showed mid-shaft fracture to right mid-calf. Staff to ensure that there are two staff for Hoyer lift transfers, sling is in proper position and right size, placement of my limbs during transfers, and make sure no obstacles in the path of the lift and resident. -Resident to wear a long leg splint above knee and below ankle. Resident is non-weight bearing and staying in bed until splint is applied. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24, at 3:15 P.M., Nurse Aide (NA) A said the following: -He/she had training on use of a Hoyer lift when transferring a resident from bed to a chair and from chair to bed; -There should always be two staff when using the Hoyer lift; -The resident required total assistance from staff with transferring and mobility; -The resident required the use of a Hoyer mechanical lift for all transfers; -The resident was very fragile; -The resident complained of pain frequently; -On 04/24/24, he/she and CNA B were getting the resident up and dressed for the day; -CNA B controlled the mechanical lift while the resident was in the lift and he/she was supposed to guide the resident's legs and feet to ensure safety; -The mechanical lift sling had been placed on the resident and the resident was hooked up to the lift while lying in bed; -NA A stepped away from the resident in the lift to look for the resident's slipper; -CNA B did not notice he/she had walked away -NA A walked approximately six feet away from the resident when the resident yelled out in pain, -CNA B lifted the resident in the air using the mechanical lift while NA A was six feet away from the resident and he/she thinks the residents leg hit something while being lift; -NA A said he/she should not have stepped away from the resident during a transfer; -There should always be two staff when using a mechanical lift, one runs the lift and the other ensures the legs and feet are safe. During an interview on 05/09/24, at 3:40 P.M., Registered Nurse (RN) C said the following: -Hoyer lift transfers always require two staff members; -One staff guided while the other staff is driving the Hoyer lift; -The staff should never step away from the resident during the transfer; -If the staff have to walk away then the resident should be put back down until both staff can safely transfer the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24, at 3:45 P.M., Licensed Practical Nurse (LPN) D said the following: -When transferring a resident with a Hoyer lift there should always be two staff present; -The resident required the use of a Hoyer lift with all transfers; -The resident would [NAME] his/her legs straight out and become stiff; -The resident was very tiny and brittle. During an interview on 05/09/24, at 4:48 P.M., the DON said when transferring a resident using a Hoyer lift there should always be two staff. One staff should control the mechanical lift and the other staff member should guide the residents legs and feet. The staff should never walk away from the resident until the transfer is completed. During an interview on 05/09/24, at 4:51 P.M., the Administrator said there should always be two staff when transferring a resident using a Hoyer lift. One staff should control the mechanical lift and the other staff member control the resident so the residents legs and feet don't swing. The staff should never step away from the resident until the transfer is completed. If the staff have to step away the staff need to communicate with each other and the staff should stop the transfer until it is safe to transfer the resident. MO00235175