STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265765	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lutheran Nursing Home	202 South West Street Concordia, MO 64020

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** 35013 Based on observation, interview and record review, the facility staff failed to follow the facility policy and the resident's care plan by transferring one sampled resident, (Resident #1) without using two staff or using a gait belt, out of five sampled residents. The facility census was 54 residents. The Administrator was notified on 7/8/24 Past Non-Compliance which occurred on 6/23/24. An all nursing staff in-service was completed on resident transfers prior to start of the next shift. The deficiency was corrected 6/25/24. Review of the facility policy for Safe Lifting and Movements of Residents revised July 2017 showed: -The purpose of the policy was to protect the safety and well-being of staff and residents, and to promote quality care, using appropriate techniques and devices to lift and move residents. -The manual lifting of residents was to be eliminated whenever feasible. -The facility nursing staff along with the rehabilitation staff was to assess individual residents' needs for transfer assistance on an ongoing basis, documenting the residents' transferring and/or lifting needs in the residents' care plan. -All facility staff responsible for direct resident care was to have been trained in the use of manual (gait/transfer belts, lateral boards) and mechanical lifting devices. 1. Review of Resident #1's facility Admission Record showed he/she was admitted on [DATE] with the following diagnose: -Alzheimer's disease-(a slowly progressive disease of the brain that is characterized by impairment of memory and eventually by disturbances in reasoning, planning, language, and perception) -Muscle weakness. -Abnormal gait and mobility. -Repeated falls. (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	Review of the resident's Nursing Care Plan revised on 3/26/24 showed: -He/she needed assistance from facility staff with Activities of Daily Living (ADLs) such as transferring. -He/she liked to go to bed after dinner. -Due to the resident's Alzheimer's disease and dementia, he/she had increased behaviors, becoming emotional and crying during the evening time. -The facility staff was to talk with the resident and hold his/her hand when he/she was emotional. -The facility staff was to use one to two staff to assist the resident with transfers. -The facility staff was to use a gait belt to transfer the resident. Review of the resident's quarterly Minimum Data Set (MDS-a federally mandated assessment tool completed by facility staff and used for care planning) dated 5/16/24 showed: -He/she was not cognitively intact and not interviewable. -He/she required partial to moderate assistance from facility staff to transfer from the chair to the bed. Review of the resident's Physician Order Sheet (POS) dated 5/20/24 showed the facility staff was to use a gait belt for transferring the resident. Observation of an un-timed video taken via a camera placed in the resident's room and provided by the resident's family dated 6/23/24 showed: -Certified Nursing Assistant (CNA) A wheeled the resident into the resident's room via wheelchair. -The resident was flailing his/her arms and appeared to be yelling. -The resident picked up what appeared to be a stuffed animal and threw it at CNA A. -CNA A prepared the bed for the resident and locked the wheelchair. -CNA A then took the resident under his/her arms and transferred him/her into the bed without using a gait belt or obtaining assistance from another staff member, causing the resident to fall onto the bed. -CNA A then placed the resident's legs into the bed and covered him/her up with a blanket. -CNA A turned off the lights and the resident calmed down. During an interview on 7/8/24 at 12:14 P.M., CNA A said: (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she came on the shift and immediately needed to get the resident to his/her room and into bed so he/she could calm down. -He/she asked around for help, but everyone was busy. -He/she knew the resident was a two-person transfer as well as that a gait belt was required for the resident's transfer. -He/she did not have a gait belt and the resident was so upset he/she just wanted to get him/her into bed. -The resident had spit on him/her earlier as well as thrown water in his/her face so knew the resident calmed down once he/she got into bed. -He/she just did what he/she had to do to get the resident calmed down. -The resident was not hurt, and he/she meant no harm. During an interview on 7/8/24 at 12:30 P.M., Licensed Practical Nurse (LPN) A said: -If the resident became agitated, he/she calmed down once he/she was placed into bed. -CNA A should have obtained assistance and used a gait belt to transfer the resident into the bed. -If CNA A was having issues obtaining help for the transfer, he/she should have waited to transfer the resident. -He/she did not recall CNA A asking him/her for assistance. Observation of Resident #1 on 7/8/24 at 12:45 P.M., showed: -The resident was in his/her wheelchair in the dining room. -When asked how he/she was and if he/she was doing okay, he/she just smiled. -When asked if he/she had issues with any staff or had been injured during a transfer, he/she just smiled. During an interview on 7/8/24 at 1:00 P.M., the Director of Nursing (DON) said: -He/she would have expected CNA A to follow the physician's order and the nursing care plan and obtain assistance with the resident's transfer from the wheelchair to the bed. -He/she would have expected CNA A to have used a gait belt to transfer the resident. During an interview on 7/8/24 at 1:10 P.M., the facility Administrator said: -He/she would have expected the CNA to have a gait belt available prior to his/her shift began. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/she would have expected CNA A to both obtain assistance for the resident's transfer and use the gait belt during the transfer. -He/she would have expected the CNA to not complete the transfer until he/she had assistance and a gait belt. MO00238041