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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265795	A. Building B. Wing	03/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kingswood	10000 Wornall Road Kansas City, MO 64114

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 - 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, facility staff failed to follow facility policy for using mechanical lifts for one sampled resident, (Resident #1) out of five sampled residents. Facility staff failed to use two staff to transfer the resident using a Hoyer lift (a medical device used to assist lifting and transferring individuals with limited mobility) and failed to inspect the lift sling for safety on 2/26/25. During the transfer, the sling strap broke and the resident fell to the floor. The resident sustained a subdural hematoma (a type of bleeding that occurs inside the skull in the outermost membrane surrounding the brain) and a fractured right hip and was admitted to the hospital intensive care unit (ICU). The facility census was 59 residents. The Director of Nursing (DON) was notified on 3/4/25 at 5:12 P.M. of the past noncompliance Immediate Jeopardy (IJ) which began on 2/26/25. The administrator and DON inspected all lift slings being used by residents. The administrator and maintenance director inspected all lifts to ensure they were working properly. The facility in-serviced all staff on the facility's mechanical lift policy. Certified Nurse Aide (CNA) A received one-on-one training regarding the facility's mechanical lift policy. The facility policy of inspecting lift slings was changed from quarterly to monthly. The IJ was corrected 2/27/25. Review of the facility's undated Using a Mechanical Lifting Machine policy showed: -A general guideline that at least two nursing assistants were needed to safely move a resident with a mechanical lift. -Staff should make sure all necessary equipment, (slings, hooks, chains, straps and supports) were on hand and in good condition. -Any worn, frayed or ripped slings should be discarded. Review of CNA A's facility Orientation Check list, dated 8/21/23, showed the initialed check list did not include the use of lift devices. 1. Review of Resident #1's Profile Face Sheet showed the resident was admitted to the facility on [DATE] with the following diagnoses: -Cerebral palsy, unspecified, (a group of disorders which affect movement, posture and balance). (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Spinal Stenosis, unspecified, (a condition where spaces between the spine narrow and put pressure on the nerves that travel through it). -History of falling. -Primary osteoarthritis, (a joint disease that causes pain, stiffness and loss of movement), both hands. Review of the resident's undated Physician's Orders showed an order for Eliquis (a medication which thins the blood) 5 milligrams (mg) tablet by mouth twice a day for cerebral palsy with a start date of 12/31/24. Review of the resident's undated Care Plan showed: -The resident had impaired functional status regarding bed mobility, transfers, walking, toileting, and locomotion. Interventions were that he/she was a two-person transfer using a Hoyer lift with two assists. The start date was 1/4/23. -The resident was at risk for falling related to the extensive need for assistance with activities of daily living and transfers. The resident had fall on 6/12/24 during a transfer using a sit-to-stand device, per his/her request, with two staff members present. Interventions were that the resident and staff were educated to use a Hoyer lift as he/she was unable to stand or assist with transfers. The start date was 6/20/24. -The resident was on anticoagulant therapy (medications that prevent blood clots) for deep vein thrombosis (a condition in which a blood clot forms in a deep blood vessel). Interventions were to assess and monitor for signs and symptoms of bleeding, abnormal bruising, blood in urine, blood in stools, bloody vomit, and nose bleeds. The start date was 12/30/24. Review of the resident's Incident Report, dated 2/26/25, showed: -The incident happened on 2/26/25 at 9:15 A.M. -The resident fell out of a Hoyer lift. -The Hoyer sling broke. -He/She was safely assisted up in his/her chair. -He/She was noted with a hematoma on the back left side of his/her head after assessment. -He/She had a suspected closed head injury. -He/She was supervised by staff. Review of the resident's Interdisciplinary Notes, dated 2/26/25 at 10:55 A.M., showed: -The resident fell out of the Hoyer lift that morning. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The Hoyer strap broke. -The resident hit his/her head; hematoma noted of the left side back of the resident's head. -Orders received to send the resident out to the emergency room (ER) to be further evaluated. -The resident was taking Eliquis, twice a day, 5 mg orally. -The resident's family emergency contact was contacted and the doctor noted. -The resident went to the hospital. Review of the facility undated Suspected Abuse Investigation showed: -The occurrence type was a mechanical lift error. -The occurrence was first known on 2/26/25 at approximately 10:00 A.M. -On Wednesday, 2/26/25 CNA A attempted to transfer the resident with a mechanical lift. -CNA A admitted to not having a second person for assistance, knowing that was the facility policy. -During the transfer, a strap on the mechanical lift sling broke causing the resident to bump the back of his/her head. -CNA A immediately notified his/her nurse, Licensed Practical Nurse (LPN) A and the Director of Nursing (DON) who assessed the resident for injury and pain. -The resident complained of no pain after the initial fall and only had a small bump on the back of his/her head. Review of the resident's Interdisciplinary Note, dated 2/27/25 at 7:14 A.M., showed. -The resident arrived back at the facility on 2/26/25 after lunch. -He/She was transferred back to his/her bed by paramedics and two staff. -He/She did not want to be bothered. -He/She appeared to be in no apparent distress or discomfort. -At the hospital several tests were done, however the resident returned from the hospital with only the finding of constipation. -He/She was treated for constipation and returned to the facility. Review of the resident's Interdisciplinary Note, dated 2/27/25 at 12:54 A.M., showed: (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was sent back to the hospital on 2/26/25 due to altered level of consciousness at approximately 7:45 P.M. He/She was not able to keep his/her eyes open and was non-verbal. -He/She was admitted to the ICU with a left hip fracture and brain bleed per the ER charge nurse. -6:00 A.M. follow up on resident in neuro department; his/her vital signs were stable, repeat computerized tomography (CT) scan (a medical imaging technique that uses x-rays to create detailed images of inside the body) was done; results were pending. Review of the resident's hospital CT abdomen and pelvis scan report, dated 2/26/25 at 9:30 P.M., showed a left femoral neck fracture with severe varus angulation (a condition in which a limb angles inward at the joint). Review of the resident's hospital radiology report, dated 2/26/25 at 11:15 P.M., showed a left femoral subcapital fracture (a type of hip fracture that occurs just below the head of the thigh bone), with severe varus angulation with no dislocation. Review of the resident's hospital orthopedic (a branch of medicine that focuses on the musculoskeletal system) consult note, dated 2/27/25, showed: -The resident was returned to the hospital ED on the evening of 2/26/25 due to altered mental status. -He/She initially presented to the ED that morning after a fall from a Hoyer lift at his/her facility. -Per chart review at that time showed he/she was evaluated and returned to the facility. -Repeated imaging showed he/she had a left hip fracture as well as a subdural hematoma. -Orthopedics was consulted for evaluation of his/her fracture. -On exam, the patient was non-responsive to questioning/commands. -Per nursing staff, the patient had been non-verbal since admission. Review of the resident's hospital diagnosis assessment plan, dated 2/26/25 at 10:33 P.M., showed: -The resident had a history of cerebral palsy and was not able to walk at baseline. -He/She presented in the morning as a trauma activation due to a fall from a Hoyer lift, on Eliquis. -He/She was subsequently discharged back to his/her nursing facility. -He/She presented this evening secondary to continued lethargy (state of mental or physical fatigue, lack of energy or sluggishness) throughout the day. (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 3/4/25 at 10:40 A.M., LPN A said: -It was the day shift when the resident fell. -CNA A came and got him/her and told him/her the resident fell. -He/She went into the room and the resident was laying on the floor. -He/She assessed the resident and LPN A and CNA A began to get him/her up into his/her wheelchair. That is when when they noticed a bump on his/her head. -The bump was about the size of a half dollar, but was not red or bleeding. -He/She called the Nurse Practitioner and told him/her the resident fell. He/She was told to send the resident to the hospital. -The resident was on a blood thinner. -The resident was in his/her wheelchair and placed in the hallway. -The resident was taken to the hospital due to the bump on his/her head. -The hospital sent the resident back within a few hours and said he/she was fine, except for being constipated and he/she had been given an enema. -The hospital ran a lot of tests on the resident, including a CT of the head and concluded everything was normal. -Later, the night nurse noticed a change in the resident's condition and had him/her sent back to to the hospital. -CNA A said he/she put the resident on the lift without assistance, but did not say why. -It was not common for only one person to use the lift and it was against policy. -There was always someone to help. He/She would have gotten another staff person before he/she went into the resident's room. If another staff person was not available at the time, other cares could be done until they were. -The staff had been trained to inspect the slings before using them. It was the staff person's responsibility who was using the sling to check and see if it was in good condition. -Staff were educated there were supposed to be two staff when using a mechanical lift; they received education every year. During an interview on 3/4/25 at 11:50 A.M., Maintenance Staff A said: (continued on next page)

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