STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265870	A. Building B. Wing	04/21/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Northland Rehabilitation & Health Care Center	4301 NE Parvin Road Kansas City, MO 64117

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 - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to properly transfer resident (Resident #1), in a safe manner, when staff did not use two staff members and the sit to stand lift (a mechanical lift used to transfer residents) from bed to shower chair, as directed in the resident's plan of care. The resident fell, resulting in a fracture to the right femur. Facility census was 95. On 04/21/2026 the Administrator was notified of the past noncompliance that began on 03/30/2026. The Administrator immediately began an investigation and audit to identify incorrect care plans. The administrator implemented corrective actions to include re-education for nursing staff to provide care as directed in each resident's care plan and Kardex. An interdisciplinary team meeting was conducted immediately following the incident and included nursing, therapy and leadership review of the event. Weekly audits regarding resident transfers on random shifts were implemented and will be conducted for four weeks then monthly for three months to ensure compliance. Results will be reviewed in quality assurance meetings for ongoing compliance. The noncompliance was corrected on 03/31/2026. Review of the facility's undated policy titled, Fall Prevention, showed:-The purpose of the Fall Management Program is to develop, implement, monitor and evaluate an interdisciplinary team falls prevention approach and manage strategies and interventions that foster resident independence and quality of life;-The Fall Management Program promotes safety, prevention, and education of both Staff and residents; -The Facility shall ensure that a Fall Management Program will be maintained to reduce the incidence of falls and risk of injury to the resident and promote independence and safety;-A fall is the unintentional coming to rest on the ground, floor, or other lower level; -Serious injury includes but not limited to fracture;-Residents found to be at high risk for falls are placed on the Fall Program, and Interventions are implemented to meet individual needs;1. Review of Resident #1's electronic medical record showed diagnoses included: Multiple Sclerosis (a chronic autoimmune disease affecting the central nervous system that damages the myelin sheath protecting nerve cells, leading to a range of neurological symptoms like vision problems, numbness, weakness, balance issues and cognitive difficulties), anxiety disorder (a mental health disorder characterized by severe, ongoing anxiety that interferes with daily activities), fracture of shaft of right femur, history of falls. Review of the quarterly Minimum Data Set (MDS, a federally mandated assessment completed by staff) dated 03/03/26 showed:-He/She scored 14 on the Brief Interview for Mental Status (BIMS, a structured evaluation aimed at evaluating aspects of cognition in elderly residents) indicating no cognitive decline;-He/She displayed no behaviors during the assessment period;-He/She had impairment to both lower extremities and used a wheelchair for mobility;-He/She required moderate assistance with Activities of Daily Living (ADLs);-He/She was dependent on staff in transferring;-He/She had one fall since the last MDS assessment with major injury.Review of the comprehensive care plan, dated 03/31/26, showed:-Interventions related to risk for falls, multiple sclerosis, ADLs;-Before the fall on 03/31/26, he/she required the assistance of two staff members and the sit to stand lift for transfers;-The care plan was updated on 03/31/26 that the resident now required the assistance of two staff members and the Hoyer lift (a lift that lifts the resident completely off of the ground with a sling);-Interventions also included the resident has a history of (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 - Actual harm Residents Affected - Few	manipulation of staff, telling them he/she can do more than he/she is physically able to do. Review of the resident's emergency room medical record dated 03/31/26 showed:-The resident was transferred to the emergency room by Emergency Medical Services (EMS) on 03/31/26 at 6:30 P.M. from the facility; -The resident had a fall at the facility and was complaining of pain in the right leg; -The emergency room performed x-rays of the resident's right knee and right pelvis/hip; -The x-ray showed the resident had a nondisplaced right distal femur fracture (a break in the lower part of the thighbone just above the knee, where the bone cracks but remains in proper alignment without significant shifting); -The resident was placed in an immobilizing brace for the right knee and discharged back to the facility;-He/She was to be non-weight bearing on the right leg until he/she followed up with the orthopedic surgeon. Review of the resident's progress notes on 04/21/26 showed:-The resident was seen by the orthopedic surgeon on 04/19/26;- The orthopedic surgeon gave an order for the resident be weight bearing as tolerated and approved to bear weight during transfers;-The resident was to stop using the immobilizer to the right knee, and to work on range of motion;-The resident was to follow up with the orthopedic surgeon in four weeks.-On 03/31/26, the resident was being transferred by Certified Nurses' Assistant (CNA) A from the bed to the shower chair at 11:30 A.M. when CNA A lowered the resident to the floor;-Licensed Practical Nurse (LPN) A was called to the room to assess the resident;-LPN A reported the resident was sitting on the floor with his/her legs extended in front of him/her, leaning against the side of the bed;-CNA A reported to LPN A that he/she was transferring the resident alone;-The shower chair moved and CNA A had to lower the resident to the floor;-LPN A assessed the resident, and he/she did not appear to have any acute injuries at that time;-The resident told LPN A that his/her legs gave out during the transfer;-CNA A reported the shower chair was locked;-Later, the resident complained to LPN A that he/she was having pain in the right knee;-LPN A notified the nurse practitioner, who ordered for the resident to have x-rays done of his/her knee;-X-ray results showed an acute non-displaced fracture of the distal femur;-The resident was sent to the local hospital for evaluation;-He/She returned to the facility with an immobilizer to the right knee and a follow up appointment with the orthopedic surgeon. During an interview on 04/21/26 at 9:17 A.M., the resident said:-CNA A entered the resident's room that morning to assist him/her with a shower;-CNA A brought the shower chair into the room, set it up next to the bed and locked the wheels;-CNA A used a gait belt to transfer the resident;-CNA A was alone and no other staff were assisting with the transfer;-The resident stood and was beginning to turn toward the shower chair when his/her legs gave out and CNA A had to lower the resident to the floor; -The resident came to rest on floor with his/her right leg underneath him/her;-The resident asked CNA A to move the resident's right leg from underneath him/her to out in front on him/her;-The resident did not know how staff were supposed to transfer him/her, but that other staff have used the sit to stand life and two people; -Later in the day, the resident began having pain in the right knee and was sent to the emergency room for x-rays;-The x-rays showed a fracture in his/her right femur;-The resident came back from the emergency room with a brace to his/her knee. During an interview on 04/29/26 at 12:59 P.M., CNA A said: -On 03/31/26, CNA A was transferring the resident from the bed to the shower chair;-CNA A situated the shower chair near the bed and locked all four wheels;-He/She began to assist the resident transferring from the bed to the shower chair, using a gait belt;-As he/she was assisting the resident, the shower chair moved;-CNA A was unable to move the resident back to the bed, and slowly assisted the resident to sitting on the floor;-CNA A does not recall the exact position the resident's legs were in when he/she was lowered to the floor, but does recall readjusting the resident's legs to in front of the resident to make the resident more comfortable;-CNA A called for the charge nurse to assess the resident; -CNA A had not worked with the resident in quite some time;-CNA A believed the resident was a one person assist with a gait belt; -The resident told CNA A that he/she could transfer with only one staff member and no lift; -CNA A was aware that the resident's transfer needs can be found in the care plan and Kardex;-The staff can also ask the charge nurse if they are unsure how a resident should be transferred;-CNA A did not check the resident's (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	care plan or Kardex to determine the resident's transfer needs;-He/She should have checked the care plan and Kardex before he/she tried to transfer the resident. During an interview on 04/29/26 at 12:09 P.M., the Director of Nursing (DON) said when transferring residents, he/she expected the staff to always follow the comprehensive care plan, Kardex instructions and recommendations from the therapy staff. If the resident tells the staff something that does not match the care plan, he/she expected the staff to check the care plan or check with the charge nurse before proceeding with transferring the resident. Nursing staff have been re-education to follow the care plan and Kardex. During an interview on 04/21/26 at 9:45 A.M., the Administrator said it was his/her expectation that staff will follow the resident's care plan for the safest and most appropriate way to transfer the resident. She conducted an investigation into the incident and implement corrective actions to address the facility failure. During an interview on 04/29/26 at 12:34 P.M., the resident's physician said:-Staff should always follow the direction of the comprehensive care plan and/or direction of the therapy staff when transferring a resident; -If a resident required the assistance of two staff members to transfer, a staff member should never attempt this alone; -If a staff member is unsure of how to transfer a resident, or if a resident tells the staff something different than what is on the care plan, the staff should always check with the charge nurse before attempting to transfer the resident. Intake 2970142