STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175200	A. Building B. Wing	04/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Kenwood View Healthcare and Rehabilitation Center	900 Elmhurst Blvd Salina, KS 67401

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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31247 The facility had a census of 67 residents. The sample included two residents reviewed for accidents. Based on record review and interview, the facility failed to ensure that a Hoyer lift (a mechanical device used to assist in transferring a resident) full body sling strap (a fabric device used to help suspend and attach to the Hoyer lift when transferring a resident) was fully attached to the hook on the lift arm of the Hoyer lift. As a result, Resident (R) 1 slipped from the sling and was lowered to the floor, which resulted in a fractured seventh rib and complications related to internal injuries. Findings included: - R1's Physician's Order, dated 03/07/22, documented diagnoses of disease of the spinal cord, unsteadiness on feet, fibromyalgia (condition of musculoskeletal pain, spasms, stiffness, fatigue and severe sleep disturbance), fracture of neck of left femur (hip fracture) and rheumatoid arthritis (chronic inflammatory disease that affected joints and other organ systems). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. She required extensive assistance of two staff with bed mobility, dressing and personal hygiene. R1 was dependent on two staff for transfers, toilet use, and bathing. She required the use of a wheelchair for mobility and had no history of falls since the prior assessment. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 11/02/21, documented R1 required extensive assistance for bed mobility and did not walk. R1 recently returned from the hospital after repair of a left hip fracture. The Falls CAA, dated 11/02/21, documented R1 had fall risk factors, which resulted from balance problems. Nursing staff assisted R1 with ADLs as needed according to the facility policy and R1 was at risk for fall related injury. R1 worked with therapy and the care plan would include a goal to have no serious fall related injuries. The ADL Care Plan, dated 02/16/22, directed two staff to assist R1 with all of her cares including transfers, positioning, and ADLs to ensure she remained free of falls. Transfers should be completed using a total lift. (continued on next page)

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	A Witnessed Fall incident report dated 04/02/22 at 11:30 AM documented Certified Nurse Aide (CNA) N called Licensed Nurse (LN) G to R1's room as R1 was on the floor. When LN G got to R1's room, CNA N explained the resident fell out of the lift sling assisted by CNA N and CNA M. LN G gathered all vital sign equipment and saw R1 on the floor moaning in pain. R1 pointed to her right ribcage area and stated it was painful. R1 also had a right elbow skin tear. Staff cleansed the skin tear and applied a bandage for protection. Staff notified the on-call physician, who ordered a mobile x-ray for the right ribcage area and right elbow. Staff called for the mobile x-ray. A Nursing Note by LN G on 04/02/22 at 12:04 PM documented R1 fell from the lift sheet during a transfer. Staff assisted R1 to the ground and she did not hit her head. Staff notified the physician, Director of Nursing (DON), and the family. Due to continued acute pain in the right ribcage and right elbow the physician ordered a mobile x-ray. A Nursing Note by LN G on 04/02/22 at 02:24 PM documented the mobile x-ray completed three views of the right ribcage and two views of the humerus (large upper arm bone) area. A Radiology Report, dated 04/02/22, documented a nondisplaced fracture involving the lateral aspect of the right seventh rib. A Nursing Note by LN H on 04/03/22 at 12:55 AM documented the certified medication aide (CMA) reported R1 threw up black vomit and it was on the front of her gown. LN H went to R1's room and saw the gown covered in black vomit. R1 complained of right shoulder pain and arm pain. LN H felt R1's left upper abdominal area with tightness noted and the resident voiced pain. A Nursing Note by LN H on 04/03/22 at 12:57 AM documented she called the on call physician and reported the black vomit with complaints of nausea. Staff informed on call physician that the resident fell earlier and the physician directed staff to send the resident to the hospital. A Radiology Report, dated 04/03/22 at 02:12 AM, documented a traumatic grade 3 liver injury with parenchymal laceration (cut affecting the functioning tissue of the organ) and subcapsular hematoma (accumulation of blood). A Radiology Report, dated 04/03/22 at 02:12 AM, documented mildly displaced fractures of the right ribs seven and nine with small right pneumothorax (puncture of lung) and right lower lobe contusion and small pulmonary laceration (lung bruise and cut). (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Investigation Report documented around 11:30 AM on 04/02/22, CNA M and CNA N transferred R1 from her bed to the wheelchair. The CNAs had R1 in the Hoyer lift when she began to move around and shifted her weight to one side. At that time, the lift sling came unhooked on one corner of the lift, causing R1 to begin to fall. Both aides assisted the resident to the floor. CNA M braced R1 under her head and shoulders and assured the resident did not hit her head as she was lowered to the ground. CNA N held onto R1's right hip and assisted the resident down by her legs. R1 hit her bottom on the ground as they went to the floor. Upon getting R1 to the floor, CNA N noticed the resident was bleeding from a skin tear to her right elbow. The CNAs notified LN G immediately of the incident. LN G entered R1's room and saw CNA M with the resident's head braced. The CNAs described the incident, what happened, and how they lowered the resident. R1 also stated staff lowered her to the ground after beginning to fall from the lift. R1 stated she had generalized pain at the time and did complain of pain in her right rib area. Staff assisted the resident back into bed and LN G called R1's physician and family. Due to R1's right elbow and rib pain, the physician ordered x-rays, but did not direct the facility to send the resident to the emergency department. On 04/11/22 at 10:47 AM, CNA N stated on 04/02/22 she and CNA M went into R1's room to check on her and assist her up for lunch. The Hoyer lift was brought into R1's room and both aides placed a sling under the resident and attached the sling loops to the Hoyer lift. CNA N started raising R1 up with Hoyer lift and CNA M was behind R1 guiding her off of the bed. Staff raised R1 about five inches off the bed, started to move the resident off of the bed, and R1 shifted her bottom which she had a habit of doing. The top sling loop came undone, CNA M grabbed the resident from behind, and CNA N grabbed R1's right side. R1's bottom went to the floor and CNA M held the back of her head, so it didn't touch the floor. Once R1 reached the floor, CNA M sat behind the resident with R1's head in her lap. R1's right arm hit the leg of the Hoyer lift and CNA N felt a skin tear as she touched the resident's arm. CNA N went to the resident's door and called for help. LN G came right into the room and assessed the resident. On 04/11/22 at 01:48 PM, CNA M stated on 04/02/22 CNA N asked her to come and assist R1 from her bed to her wheelchair. CNA N brought the Hoyer lift to R1's room. CNA M placed a sling under the resident, both aides attached the sling loops to the Hoyer lift and called out the colors of the loops to be attached. CNA M stated she prompted R1 to cross her arms on her chest and CNA N started to raise the resident up off of the bed with the Hoyer lift about three inches. As she raised R1 CNA M was behind the resident and held onto the back of the lift sling. The resident was barely off the bed and R1 shifted her weight at her hips and the sling loop closest to R1's head came off of the hook. CNA N grabbed R1 at the waist and CNA M held the resident at her back by the sling. The lift went to the floor and CNA M held onto the resident in the sling and went down to the floor with R1's back and head ending up in CNA M's lap. R1's butt and hips went to the floor, but her head did not hit the floor. R1's right elbow hit the legs of the lift and she received a skin tear. CNA N ran out and got LN G. CNA M asked R1 if she knew what happened and she said yes she fell and her left side hurt. On 04/11/22 at 09:03 AM, Administrative Nurse D verified completion of an in-service with approximately 25 of the 36 aides on 04/07/22 and determined during observation that some of the CNAs attached the sling loops straight up and down and were not leaving the excess sling loops to the side. Administrative Nurse D felt this could be what happened during the fall incident with R1. Education has been provided and will continue to be provided to all of the aides on the proper sling loop placement prior to the aides next day of work. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 04/11/22 at 09:03 AM, Administrative Staff A stated after the investigation and the in-servicing the facility determined the sling loops may not have been attached properly to the Hoyer lift. The facility's undated Accidents and Supervision policy documented the resident environment remains free of accident hazards as is possible and each resident received adequate supervision and assistive devices to prevent accidents. The definition of accident refers to any unexpected or unintentional incident, which results in injury or illness to a resident. The undated Mechanical Lift policy documented a mechanical lift is used appropriately to facilitate transfers of residents. Procedure number six documented to lower the lift and place hooks in the appropriate holes of the lift sling with hooks facing way from resident. The facility failed to ensure the safe transfer of R1 with the use of a Hoyer lift and sling when staff members failed to securely attach the sling strap to the lift arm hook. This deficient practice resulted in an avoidable accident when R1 slipped out of the sling which resulted in a fracture to R1's right rib cage and lacerated liver. On 04/07/22 the facility completed the following corrective actions: Staff were re-educated on Hoyer lift usage, proper placement of slings when doing a transfer, how to properly apply the sling to the lift hooks, and return demonstration of the correct way to transfer a resident from the bed to their wheelchair and back. Education was also given about the importance of always watching the sling while the resident is on the lift and making sure the resident is the only focus at the time. The deficient practice was cited at past non-compliance.