STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175560	A. BUILDING _____ B. WING _____	C 10/19/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL VILLAGE	12500 W 137TH ST OVERLAND PARK, KS 66221

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS00175327. The 2567 was sent electronically on 10/26/22.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 31 residents. The sample included three residents reviewed for accidents. Based on record review, interview, and observation the facility failed to ensure one resident was free from avoidable accidents and injury when staff failed to provide two staff members with the use of a Hoyer lift (total body mechanical lift used to transfer residents) to transfer Resident (R)1 from the bed to her wheelchair safely. Subsequently, R1's head hit the Hoyer lift, which resulted in a laceration that required five stitches. Findings included: - R1's "Electronic Medical Record" (EMR), under the "Diagnosis" tab recorded diagnoses of morbid obesity due to excess calories, reduced mobility, history of falling, need for assistance with personal care, and restlessness.	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The "Annual Minimum Data Set" (MDS) assessment dated 12/07/21 recorded R1 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. R1 required extensive assistance of two staff members for activities of daily living (ADL), which included transfers, bed mobility, toilet use, and personal hygiene. R1 was totally dependent on two staff members for dressing, and one staff member for locomotion on and off the unit.

The "ADL Functional Care Area Assessment" (CAA) dated 12/07/21 documented R1 required extensive assistance to total assistance of one to two staff member with ADLs.

The "Quarterly MDS" assessment dated 06/03/22 recorded R1 had a BIMS of 15, which indicated intact cognition. R1's MDS documented total dependence of two staff members for transfers and extensive assistance of two staff members for bed mobility, dressing, and toilet use. R1 required extensive assistance of one staff member for personal hygiene and locomotion on and off the unit.

The "ADL Care Plan" revised 11/03/21 directed two staff members to be present at all times when providing care for R1. An intervention initiated on 12/15/20 directed staff to transfer R1with two staff members when using the Hoyer lift.

R1's EMR recorded an "Incident Note" dated 10/11/22 at 12:46 PM, which documented Licensed Nurse (LN) G was notified to assess R1 because R1 was bleeding. Upon arriving to the scene, LN G noted R1 bleeding from the top of her head, while the [unidentified] staff in

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attendance attempted to clean the blood. LN G observed R1 seemed sleepy and not fully awake, but after arousal, R1 opened her eyes and stated she had pain on her head. R1 was sent to the emergency room via ambulance for further evaluation.

The "Nurse's Note" dated 10/11/22 at 05:36 PM documented R1 received five sutures on the top of her head. The area was left open to air. R1 reported a headache and shortness of breath. R1 received pain medication.

The "Nurse's Note" addendum dated 10/11/22 at 06:07 PM documented R1 reported that her head hurt where she had the wound and sutures. R1 denied a headache.

The notarized "Witness Statement" dated 10/11/22 by Certified Nurse Aide (CNA) N documented CNA M and CNA N planned to get R1 out of bed together. CNA N dressed R1 and placed the sling underneath R1; R1 assisted by rolling side to side. CNA N then attached the sling to the Hoyer claw attachments. CNA N moved R1 towards the chair. CNA M was coming in behind CNA N and the resident to assist, when the bottom portion of the Hoyer claw hit the resident in the head.

The notarized "Witness Statement" dated 10/11/22 by CNA M documented both CNA M and CNA N went in to get R1 up with the Hoyer. CNA M asked CNA N to wait while CNA M stepped out of the room. When CNA M returned to the room, CNA M observed CNA N had moved R1 from the bed to her wheelchair. CNA M saw the Hoyer lift bar that holds the sling was on top of R1's head and R1's head was bleeding. CNA M asked CNA

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N to stay with the resident while CNA M went to get a nurse.

The "Nurse's Note" dated 10/12/22 at 04:06 AM documented R1 complained of generalized pain and received requested pain medication.

The "Incident Note" dated 10/12/22 at 01:40 PM documented R1 reported some head pain, but denied feeling nauseated or dizzy.

The "Skin Only Evaluation Note" dated 10/14/22 at 06:00 AM documented R1 had a skin laceration to the top of the head. The area was painful and firm to touch.

In a "Witness Statement" dated 10/14/22, LN G documented upon entering R1's room there was blood coming from the top of R1's head. LN G recorded CNA N stated the Hoyer lift hit R1.

The "Facility Investigation" signed 10/15/22 documented on 10/11/22 at approximately 09:00 AM R1 incurred a laceration to the crown of her head while being transferred to wheelchair from her bed. CNA M and CNA N were working with R1 getting her ready for the day. After getting the residnet dressed, CNA M told CNA N to wait to transfer R1 with the Hoyer while CNA M stepped out of the room for a minute. CNA N proceeded to place the sling under R1 and transfer R1. At the moment R1 was lowered into the wheelchair, the Hoyer lift tilted and arm of the lift that holds the sling came down on top of R1's head.

On 10/19/22 at 01:35 PM R1 sat in her wheelchair in her room and watched television. R1's hair was pulled back into a low ponytail. R1 had an area on the crown of her head with dried

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black/brown substance that was visible through her hair. R1 stated the area on top of her head was where she received her sutures. R1 revealed that she was transferred by just one CNA and that the Hoyer lift fell and hit her on her head. R1 stated she had a constant headache, but the staff did provide her pain medication to treat the headache. R1 further stated that she was scared to use the Hoyer lift now but still used it because she wanted to get out of bed.

On 10/19/22 at 12:35 PM CNA O stated she always had another staff member with her to use a Hoyer lift to transfer a resident. CNA O further stated she had received training on the Hoyer lift and there are always to be two staff members to use the lift.

On 10/19/22 at 12:40 PM a message was left for agency CNA N. No return call was received.

On 10/19/22 at 02:05 PM Administrative Nurse D stated she expected staff to follow the policy and the manufactures guidance for use of the Hoyer lift.

On 10/19/22 at 02:15 PM Administrative Nurse E stated the investigation, revealed the legs were not spread out on the Hoyer lift during the transfer.

The facility's "Skill Check: Total Dependent Lift (Hoyer)" revised 09/22 directed that there was always two staff members when operating the total body lift. It further directed to open the legs of the base to the widest point, and to leave the legs to the widest position while moving the lift. If the legs must be narrowed when positioning it under the bed you may do so, but the legs must

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F 689	Continued From page 5 return to the widest position as soon as safely possible. The facility failed to ensure R1 was free from avoidable accidents and injuries when facility staff transferred R1 with one staff member utilizing the Hoyer lift. This deficient practice caused actual harm to R1 when she sustained a laceration to the crown of her head. The facility completed all nursing staff in service on education for proper use of Hoyer lift on 10/11/22. The facility implemented corrective measures which included reeducation of all relevant staff on the proper use of mechanical lifts, following the care plan and the residents' rights to be free from abuse, neglect and exploitation. The measures were completed on 10/11/22, prior to the survey, so the deficient practice was cited as past noncompliance at a "G" scope and severity.	F 689		