STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175300	A. BUILDING _____ B. WING _____	C 11/23/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINA PRESBYTERIAN MANOR	2601 E CRAWFORD STREET SALINA, KS 67401

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F 000	INITIAL COMMENTS The following citations represent the finding of complaint investigation #157734. The 2567 was electronically sent to the facility on 11/25/20.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for	F 656		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 11/25/2020

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F 656	Continued From page 1	F 656		

future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 45 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to follow the care plan for one of three sampled residents, Resident (R) 1, when one staff transferred R1 using a sit to stand mechanical lift (assists from sitting to standing position), the resident fell out of the lift, resulting in a left humerus (left upper arm bone) fracture (broken bone).

Finding included:

- The "Physician Order Sheet," dated 09/02/20 documented R1 had diagnoses of hemiplegia (muscular weakness of one half on the body) following a cerebral infraction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain).

R1's "Quarterly Minimum Data Set" (MDS), dated 10/18/20 documented the resident was cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. The MDS documented the resident had no falls since previous assessment, required extensive physical assistance from two or more staff for transfers,

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F 656	Continued From page 2	F 656		

balance not steady, only able to stabilize with staff assistance, and used a wheelchair for mobility.

The revised "Falls Care Plan," dated 06/01/20, directed staff to use a sit to stand lift with two staff for transfers.

The "Progress Note," dated 11/09/20 at 10:05 PM, documented staff notified Licensed Nurse (LN) G that nursing staff lowered R1 to the floor out of the sit to stand lift. LN G assessed the resident, obtained vital signs which were within normal limits for the resident, noted the left shoulder to be dislocated, and R1 complained of pain rating it 7 out of 10 on a 0-10 pain scale. Staff used the full body lift and assisted R1 off the floor. LN G notified the primary care physician who gave orders to send R1 to the hospital emergency room for evaluation and treatment. At 09:50 PM R1 left the building with emergency medical staff.

The "Hospital Discharge Summary," dated 11/10/20, documented R1 had a left proximal (closer to the body) humerus fracture.

On 11/23/20 at 10:06 AM, observation revealed the resident lying in bed watching television, with purple bruising noted from her shoulder to mid forearm.

On 11/19/20 at 02:19 PM, CNA M stated she worked at the facility through a staffing agency. On 11/09/20 around 09:15 PM, she gave R1 a shower. CNA M asked another staff member to help transfer R1 from the shower chair to the wheelchair, but the staff member stated she did not have time to assist. CNA M raised the sit to stand lift into the standing position and observed

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F 656	Continued From page 3	F 656		

R1 slipped half-way out of the lift, so CNA M went behind R1 to try to stop R1 from slipping. R1's left arm was caught in the sling of the lift, so CNA M removed the sling as carefully as she could while she supported R1, assisted R1 to the ground, then yelled out the shower door for assistance.

On 11/23/20 at 09:54 AM, R1 stated CNA M independently showered R1 in the shower room, when CNA M tried to transfer R1 from the shower chair to her wheelchair R1 fell out of the sit to stand lift and hurt her arm.

On 11/23/20 at 10:59 AM, LN H stated before R1 went to the hospital she required two staff and the sit to stand to transfer. The staff should follow the resident's care plan.

On 11/23/20 at 12:56 PM, CNA N stated R1's care plan listed she required two-person assistance with the sit to stand lift and staff should follow the care plan.

On 11/23/20 at 1:01 PM, Administrative Nurse D stated the care plan should reflect the resident's care needs and staff were expected to follow the care plan. CNA M should not have transferred R1 with the sit to stand lift by herself.

The facility's revised "Care Plan" policy, dated 07/26/19, documented a person-centered plan of care was developed for each resident. An appropriate plan of care with services and items the resident is to receive is developed to ensure the highest level of function the resident may be expected to obtain.

The facility failed to follow R1's care plan, who fell out of the sit to stand mechanical lift resulting in a

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F 656	Continued From page 4 left humerus fracture, placing the resident at risk for further accidents.	F 656		
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 had a census of 45 residents. The sample included three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide adequate supervision to prevent accidents for one of three sampled residents, Resident (R) 1, who fell out of the sit to stand mechanical lift (assists from sitting to standing position) resulting in a left humerus (left upper arm bone) fracture (broken bone). Finding included: - The "Physician Order Sheet," dated 09/02/20 documented R1 had diagnoses of hemiplegia (muscular weakness of one half on the body) following a cerebral infraction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain). R1's "Quarterly Minimum Data Set" (MDS), dated 10/18/20 documented the resident was	F 689		

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F 689	Continued From page 5	F 689		

cognitively intact with a Brief Interview for Mental Status (BIMS) score of 13. The MDS documented the resident had no falls since previous assessment, required extensive physical assistance from two or more staff for transfers, balance not steady, only able to stabilize with staff assistance, and used a wheelchair for mobility.

The revised "Falls Care Plan," dated 06/01/20, directed staff to use a sit to stand lift with two staff for transfers.

The "Physician Order," dated 06/04/20, documented the resident could bear weight as tolerated.

The "Physical Therapy (PT) Therapist Progress and Discharge Summary," dated 06/26/20, documented therapy treated R1 for a diagnosis of flaccid hemiplegia affecting left nondominant side and R1 reached her prior level of function. R1 showed improvement in use of sit to stand lift transfers with staff.

R1's "Fall Risk Assessment Tool," dated 08/23/20, documented a score of 13 (moderate fall risk).

R1's "Fall Risk Assessment Tool," dated 11/09/20, documented a score of 12 (moderate fall risk).

The "Progress Note," dated 11/09/20 at 10:05 PM, documented staff notified Licensed Nurse (LN) G that nursing staff lowered R1 to the floor out of the sit to stand lift. LN G assessed the resident, obtained vital signs which were within normal limits for the resident, noted the left shoulder to be dislocated, and R1 complained of pain rating it 7 out of 10 on a 0-10 pain scale.

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F 689	Continued From page 6	F 689		

Staff used the full body lift and assisted R1 off the floor. LN G notified the primary care physician who gave orders to send R1 to the hospital emergency room for evaluation and treatment. At 09:50 PM R1 left the building with emergency medical staff.

The "Hospital Discharge Summary," dated 11/10/20, documented R1 had a left proximal (closer to the body) humerus fracture.

The "Certified Nurse Aide (CNA)/Certified Medication Aide (CMA) Skills Checklist-Transferring the Resident Using the Stat Assist Mechanical Lift," dated 11/05/20, documented CNA M completed the skill satisfactory.

On 11/23/20 at 10:06 AM, observation revealed the resident lying in bed watching television, with purple bruising noted from her shoulder to mid forearm.

On 11/19/20 at 02:19 PM, CNA M stated she worked at the facility through a staffing agency. On 11/09/20 around 09:15 PM, she gave R1 a shower. CNA M asked another staff member to help transfer R1 from the shower chair to the wheelchair, but the staff member stated she did not have time to assist. CNA M raised the sit to stand lift into the standing position and observed R1 slipped half-way out of the lift, so CNA M went behind R1 to try to stop R1 from slipping. R1's left arm was caught in the sling of the lift, so CNA M removed the sling as carefully as she could while she supported R1, assisted R1 to the ground, then yelled out the shower door for assistance.

On 11/23/20 at 09:54 AM, R1 stated CNA M independently showered R1 in the shower room,

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F 689	Continued From page 7	F 689		

when CNA M tried to transfer R1 from the shower chair to her wheelchair R1 fell out of the sit to stand lift and hurt her arm.

On 11/23/20 at 10:59 AM, LN H stated before R1 went to the hospital she required two staff and the sit to stand to transfer, she currently transferred with the full body lift. LN H stated the facility staff were responsible to train and work with agency staff to ensure safe transfers.

On 11/23/20 at 12:28 PM, LN G stated on 11/09/20 around 09:15 PM she was informed R1 was on the floor of the shower room. She assessed the resident and found the resident's left shoulder was bulging out, so she called the resident's physician who ordered to send R1 to the emergency room. After R1 left the building, LN G did not educate or train the CNAs on proper use of the sit to stand lift. LN G stated she was told the sit to stand lift was "considered the second person" and she allowed staff to transfer residents with one staff member and the sit to stand. LN G stated she did not know the facility's policy for the sit to stand lift.

On 11/23/20 at 12:56 PM, CNA N stated R1 required two staff for the sit to stand lift. CNA N stated she was trained to use two staff when transferring a resident using the sit to stand lift.

On 11/23/20 at 1:01 PM, Administrative Nurse D stated the facility did not have a specific written policy on how many staff members were needed to use the sit to stand lift, staff were trained to use two staff members, and CNA M should not have transferred R1 with the sit to stand lift by herself.

The facility's revised "Lifting & Transferring

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F 689	Continued From page 8 Residents" policy, revised 05/02/10, documented all lifts performed with a mechanical lift must be performed with two staff members present. The facility failed to transfer R1 with assistance of two staff while using a sit to stand lift. R1 fell out of the sit to stand mechanical lift and sustained a left humerus fracture.	F 689		