STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175294	A. BUILDING _____ B. WING _____	C 05/25/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDICALODGES GODDARD	501 EASY STREET GODDARD, KS 67052

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00176726, KS00176980, and KS00180331. This 2567 was electronically set to the facility on 06/05/23.	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 48 residents, with four residents sampled, including three reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to ensure staff performed a safe transfer for Resident (R) 4, when the sling (unknown age) ripped and R4 fell three feet from a mechanical lift and resulted in a laceration to the back of her head that required two staples. Findings included: - R4's diagnoses from the "Electronic Health Record" (EHR) documented obesity, gout (inflammation of the joints), depression (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, and emptiness), and respiratory failure (lack of	F 689		

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

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oxygen).

The 03/27/23 "Admission Minimum Data Set" (MDS) documented a "Brief Interview for Mental Status" (BIMS) score of 15, indicating intact cognition. R4 required extensive assistance of two staff for transfers. R4 had no falls since the prior assessment.

The 03/10/23 "Care Plan" documented R4 was at risk for falls. R4 required the use of a mechanical lift and two staff for transfers. The "Care Plan" did not include interventions related to sling use until a revision on 05/21/23, after the fall, which directed staff to audit slings prior to use.

Review of the "Fall Investigation" dated 05/21/23, documented at approximately 10:00 AM, R4 was in bed and facility staff used a full body mechanical lift to transfer the resident to her recliner. As staff moved R4 in the mechanical lift, the sling (the harness-type material that connects to the lift and is used to hold the resident during transfers) broke and R4 fell about three feet to the floor. R4 had hit her head and sustained a laceration to the back of her head. Staff applied pressure to the laceration which took approximately 20 minutes to stop the bleeding. R4 was transported to the emergency room by emergency services, where R4 received staples to close the laceration. R4 returned to the facility. All slings in use were audited after the fall.

The "Witness Statement" for the incident on 05/21/23 for R4, by Certified Nurse Aid (CNA) E, documented CNA D asked her to assist in getting R4 up. R4 was already in the sling. CNA D lifted R4 with the mechanical lift and the top strap on the sling snapped. CNA E noted R4 was in the air

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F 689	Continued From page 2	F 689		

and fell to the floor. CNA D stayed with R4, and CNA E went to get the LN.

The "Witness Statement" for the incident on 05/21/23 for R4, by CNA D, documented another staff member assisted with putting R4 in the sling. CNA D started to maneuver the mechanical lift over the recliner, the sling ripped, and R4 fell and hit her head on the leg part of the mechanical lift.

Review of "Progress Note" dated 05/21/23, documented R4 did not lose consciousness, was alert and oriented. R4 complained of head and back pain, and she had a large bump to the back of her head. The bleeding subsided and R4's head was wrapped in a pressure dressing. R4 was being transferred in a mechanical lift when the strap gave way, and R4 fell from about three feet. Two CNAs were present during this and immediately got Licensed Nurse (LN) C for help. LN J entered R4's room to help, applied pressure to R4's head for about 20 minutes, and was able to stop the bleeding. A pressure dressing was then applied around her head and staff telephoned for emergency services (EMS) to transport R4 to the hospital.

Review of "Progress Note" dated 05/21/23, documented R4 returned to the facility around 03:30 PM. R4 received two staples to the laceration on the back of her head and was given pain medication at the emergency room. R4 had directions to follow up in seven days with her provider to remove the staples. The staff administered pain medication to R4 when she stated she had pain to her back and hips.

On 05/24/23 at 10:09 AM, observed R4 laid in her bed, in the regular height position, two CNAs

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were present, and a sling was under R4, as they prepared to get R4 up for the day. The two CNAs transferred R4 to her recliner.

On 05/24/23 at 10:39 AM, R4 reported on that morning (05/21/23) she was in the lift with CNA D and CNA E there, and then she fell. R4 stated now she is leery of the mechanical lift, but the staff are good at talking to her during the transfers. R4 stated she went to the emergency room and got two staples in her head.

On 05/24/23 at 11:09 AM, Laundry Staff H reported she did launder the slings for the mechanical lifts. Laundry Staff H reported she did inspect the slings each time they were laundered. Laundry Staff H reported she would report to her supervisor if she noted any frayed or ripped areas.

On 05/24/23 at 11:40 AM, Laundry Staff I reported she did inspect the slings when she washed them. Laundry Staff I reported she would "tug" on the straps and look for rips or tears.

On 05/25/23 at 06:40 AM, Maintenance Staff G reported the labels on the slings had worn off and were unreadable. He did not know the length of time they had been in use. Maintenance Staff G reported he inspected the slings as they were laundered but had no way of tracking each specific sling. Maintenance Staff G reported when he called the manufacturer, they informed him of the suggested length of time for use of a sling, was five years. They also had informed him of things to look for, such as slick or shiny spots at stress points.

On 05/25/23 at 09:45 AM, Certified Nurse Aide

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(CNA) E reported on the morning of 05/21/23 she was called into R4's room to assist CNA D with the transfer, CNA D already had R4 in the sling. They began the transfer and R4 fell. CNA E went to get the LN.

On 05/25/23 at 10:00 AM, Administrative Staff K revealed she completed an audit on all of the slings in use and discarded six of the nine. Administrative Staff K stated she discarded them due to tearing away from stitching at the shoulder areas on the netting material, and one had the handle on the back of the sling, pulling apart. None of them were discarded due to damage to the straps.

On 04/27/23 at 10:30 AM, Administrative Nurse B revealed she expected all the staff to have the knowledge to use the mechanical lifts safely. Administrative Nurse B reported that she had looked at the broken strap that led to the fall and saw no rips, tears, or fraying that could have caused it. Administrative Nurse B reported all the slings they ordered were rated for up to 600 pounds.

The facilities 12/2022 "Fall Management" policy documented the facility strived to minimize the risk for resident falls and to reduce injuries associated with resident falls.

The facility failed to provide adequate assistive devices to prevent accidents, when R4 fell from a mechanical lift when the sling ripped on 05/21/23, which resulted in two staples to the back of R4's head.