| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 265825 | A. BUILDING _____ B. WING _____ | C 04/16/2025 |

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| ELSBERRY MISSOURI HEALTH CARE CENTER | 1827 HWY B ELSBERRY, MO 63343 |

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| F 689 SS=G | Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)<br><br>§483.25(d) Accidents.<br>The facility must ensure that -<br>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and<br><br>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, the facility failed to ensure one resident (Resident #3), out of eight sampled residents, was safely transferred from a wheelchair to bed with a mechanical lift. Staff used a lift sling with two torn attachment loops for the transfer, hooking the sling to the lift with the two attachment loops below the torn loops. During the transfer, the lower loops tore, causing the resident to fall from the lift. The resident sustained a laceration to the back of his/her head which required treatment in the emergency room. The facility census was 55.<br><br>On 4/16/25 at 12:55 P.M., the administrator was notified of the past noncompliance which occurred on 4/8/25. On 4/8/25, the administrator became aware of the resident's fall from a mechanical lift during a transfer. Upon discovery, the facility investigated and notified the appropriate parties. Staff reviewed the mechanical lift policy, were educated on what to look for on a lift sling, including frays, tears, and worn areas, when to report the issues found on the sling, and how to exchange it with a new sling located at the Director of Nursing's office or nurses' station on the weekends. The restorative | F 689 | Past noncompliance: no plan of correction required. | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 4/23/25

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.

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| F 689 | Continued From page 1 | F 689 | | |

aide started weekly audits of the lift slings to monitor of frays, tears, etc. then reports the findings to the Director of Nursing and/or Administrator. The deficiency was corrected on 4/10/25.

Review of the facility's Mechanical Lift policy, undated, showed the following:
-A mechanical lift is used appropriately to facilitate transfers of residents;
-Lower lift and place hooks in the appropriate holes of the lift sheet;
-Using lever gently raise and move resident to destination;
-Lower resident and position comfortably.

1. Review of the Drive Medical Full Body Patient Sling Owner's Manual (for the mechanical lift), dated 1/15/16, showed the following:
-The maximum weight capacity was 600 pounds;
-Inspect patient slings for wear prior to each use;
-If signs of tearing, fraying, or wear are found discard the sling immediately, worn out slings are not safe for use and may result in injury or death.

Review of the email sent from Drive DeVilbiss Healthcare's Customer Solutions Complaints Lead sent to the state agency, dated 4/16/25 at 2:08 P.M., showed a sling should not be used if any of the loops are broken, if stitching is torn, or if the label/tags are unreadable and if any of those occur the sling must be replaced.

2. Review of Resident #3's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument required to be completed by facility staff, dated 1/30/25, showed the following:
-The resident had severely impaired cognition;

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| F 689 | Continued From page 2<br>-He/She was dependent on staff for transfers.<br><br>Review of the resident's Care Plan, dated 2/5/25, showed the following:<br>-The resident was nonverbal most of the time;<br>-He/She needed extensive assistance from two staff for transfers and used the mechanical lift as needed.<br><br>Review of the resident's Nurse's Note, dated 4/8/25 at 8:33 A.M., showed the following:<br>-Certified Nurse Aide (CNA) A and CNA B were transferring the resident from wheelchair to bed with the mechanical lift when the bottom of the lift pad broke causing the resident to fall onto the floor;<br>-Staff placed the lift pad on the green loops on all loop holders of the lift while the resident was being transferred;<br>-When the lift sling loops broke, it caused the resident to fall and hit his/her head on the bed frame resulting in a five centimeter laceration to the back of his/her scalp;<br>-The CNAs called the nurses to the resident's room immediately;<br>-The nurses assessed the resident, applied pressure to the back of the resident's head to control bleeding, and received an order from the primary care physician to send to the resident to the emergency department.<br><br>Observation of the resident's lift sling photos, dated 4/8/24 at 11:56 A.M., showed the purple loops and green loops of the bottom two attachment straps were broken and the top left side sustained a rip of approximately 10 inches from the outer aspect of the sling inward toward the center. | F 689 | | |

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| F 689 | Continued From page 3<br>Review of the resident's Nurse's Note, dated 4/8/25 at 1:30 P.M., showed the following:<br>-The emergency department staff called the facility to report the resident's head computed tomography (CT, diagnostic imaging procedure that uses a combination of x-rays and computer technology to produce images of the inside of the body) scan was negative and the resident received three staples to the left, backside of the head;<br>-The hospital planned for the resident to return to the facility.<br><br>During an interview on 4/16/25 at 9:12 A.M., CNA A said the following:<br>-He/She and CNA B used the mechanical lift with the full body sling to transfer the resident from the wheelchair to bed;<br>-The green loops used on the connection straps were not frayed or worn, so they thought it would be safe to use. They were to use the purple loops, but two of them were broken;<br>-As they were transferring the resident, he/she heard a pop sound, the resident went down towards the floor feet first and the resident's head hit the bed frame;<br>-The back of the resident's head was bleeding and CNA B went to get the nurse immediately.<br><br>During an interview on 4/16/25 at 9:18 A.M., CNA B said the following:<br>-He/She and CNA A took the mechanical lift into the resident's room to transfer the resident from the wheelchair to bed;<br>-The purple loops on the lift sling were broken, so they used the green loops for the transfer, which broke;<br>-While CNA B had his/her hands on the resident to help guide, he/she heard the sling pop, then | F 689 | | |

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| F 689 | Continued From page 4<br>the resident started to fall feet first onto the floor and the resident's head hit the bed frame.<br><br>During an interview on 4/16/25 at 9:22 A.M., Laundry Staff C said the following:<br>-The laundry staff wash the lift slings separately in the washing machine and hang them up to dry;<br>-The laundry staff are supposed to look for any frayed or broken areas and report the issues to the nurse so the sling could be replaced;<br>-He/She had not found any damaged lift slings.<br><br>During an interview on 4/16/25 at 10:00 A.M., Restorative Aide (RA) E said the following:<br>-RA E was assigned to complete weekly audits on the lift slings;<br>-The facility had a supply of slings available in case a sling needs to be removed room use;<br>-The facility stored a couple of new lift slings at the nurses' station over the weekends in case a sling needed to be replaced;<br>-He/She was unaware of the frayed/worn sling prior to the incident.<br><br>During an interview on 4/16/25 at 12:10 P.M., the Director of Nursing said the following:<br>-If a lift sling has any broken, frayed, or worn areas it should be reported immediately and the sling taken out of use;<br>-CNA A and CNA B thought the lift sling would be safe to use because the green loops were intact and didn't have any signs of fray;<br>-She educated all staff on not using lift slings with any frayed areas, broken areas, or tears in the material and any issues with a sling must be reported and the sling replaced immediately;<br>-RA E does a weekly audit on the slings to ensure the lift slings are safe for use; | F 689 | | |

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| F 689 | Continued From page 5<br>-She identified the problem after the incident and immediately worked on a plan to prevent this incident from happening again.<br><br>During an interview on 4/16/25 at 12:55 P.M., the Administrator said the following:<br>-Her expectation was the staff checked lift slings before use and exchange the sling with a new one when any issue was identified;<br>-Her staff identified the problem, and a plan was implemented to prevent any further incidents like this from happening in the facility in the future.<br><br>MO252451 | F 689 | | |