STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

(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 A Targeted Infection Control Survey/COVID-19 Focused Survey was conducted on 09/27/22. The facility was found to be in compliance with CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. The following citations represent the findings of a partial extended survey with the complaint investigations #174911 and #175055. This 2567 was electronically sent to the facility on 10/07/2022.	F 000		
F 600 SS=J	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: The facility reported a total of 41 residents with three residents in the sample with one resident reviewed for lack of supervision. Based on observation, record review, and interview the	F 600		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 1	F 600		

facility neglected to ensure cognitively impaired Resident (R) 1's safety while she remained outside of the facility, unsupervised, from 03:00 PM to approximately 04:50 PM (1 hour and 50 minutes), in temperatures of about 97 degrees Fahrenheit (F). The facility further failed to check on the resident's wellbeing or provide her fluids. This failure resulted in R1 having an altered mental status, a body temperature of 102.5 degrees F, required emergency medical services response, and she transferred/admitted to the local hospital. This failure placed R1 in immediate jeopardy.

Findings included:

- Review of the "Physician Order Sheet" dated 05/17/21, revealed a diagnosis of hypokalemia (low level of potassium in the blood), dehydration (occurs when more fluid is loss than taken in), and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Annual Minimum Date Set" (MDS) dated 12/22/21, revealed a Brief Mental Interview Status (BIMS) score of seven, indicating severely impaired cognition. Review of the resident's ability to perform activities of daily living (ADL) revealed R1 as independent with walking in room and corridor. The resident required set up help only with locomotion on and off the unit no falls indicated.

The "Quarterly MDS" dated 07/11/22, revealed (BIMS) score of four, which indicated severely impaired cognition. R1 continued to be independent with ADLs with one fall indicated during the seven day look back period.

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F 600	Continued From page 2	F 600		

The "Cognitive Loss/ Dementia CAA" dated 12/22/21, revealed R1 had dementia and could not recall the year, month, or day of the week. R1 reported it was 2016, a workday, cold outside, probably February, and could not recall the three words asked during the assessment.

The "Care Plan" with a target date of 12/07/22, instructed staff that R1 required assistance with ADL's, had decreased mobility, poor safety awareness, and impaired mental status. R1 used a walker and staff were to provide stand by assistance for safety and to use a wheelchair as needed.

A "Nurses Note" dated 09/03/22 at 05:16 PM, by Licensed Nurse (LN) C revealed R1 sat on the porch in the sun. When LN C attempted to assist R1 inside the facility for supper, R1 had difficulty with ambulation. LN C placed a gait belt around R1's waist and assisted her to stand. R1 was unable to move her legs and she was placed in a wheelchair and brought into the building. LN C noted R1 had altered mental status and was not responding well. R1's temperature on a temporal thermometer measured 102.5 degrees F. Ice packs were placed under each of the resident's arms and cold wash cloths were placed on her head and neck. LN C placed a call to the physician and obtained an order to send the resident to the emergency room for evaluation and treatment.

A "Nurses Note" dated 09/03/22 at 07:30 PM, revealed hospital staff called the facility to inform them the resident was being kept overnight for fluids and oral potassium (a medication to increase low potassium level).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 3	F 600		

The "Hospital Admission Record" dated 09/03/22 at 05:22 PM, revealed the resident admitted with a diagnosis of heat exhaustion (condition where the body overheats, cannot cool itself down, usually caused by exposure to high temperature), dehydration (abnormal depletion of body fluids, especially dangerous for older adults), and acute kidney injury (ineffective tissue prefusion).

Review of the facility's surveillance video revealed the following timeline, which establishes the exact amount of time R1 remained outside the facility in 97-degrees F weather, and Licensed Nursing staff did not check on R1 from 03:00 PM until 04:40 PM on 09/03/22:

09/03/22 at 03:00 PM, Certified Nurse Aide (CNA) F let R1 outside on the porch.

09/03/22 at 03:11 PM, LN C in the area and did not check on R1.

09/03/22 at 03:15 PM, LN C left the lobby without checking on R1, who remained outside in the heat, sitting on the porch.

09/03/22 at 03:52 PM, LN C in the lobby with another resident.

09/03/22 at 04:03 PM, LN C left the lobby.

09/03/22 at 04:10 PM, LN C in the lobby.

09/03/22 at 04:11 PM, LN C left the lobby.

09/03/22 at 04:15 PM, CNA F in the lobby.

09/03/22 at 04:17 PM, CNA F left the lobby.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 600	Continued From page 4	F 600		

09/03/22 at 04:35 PM, CNA F was in the lobby and propelled an unidentified resident out of the lobby.

09/03/22 at 04:40 PM, LN C exited the front lobby doors and checked on R1 sitting outside.

09/03/22 at 04:44 PM, LN C returned into the building for LN D to assist with R1.

09/03/22 at 04:50 PM, LN C and LN D assisted R1 into the building using a wheelchair.

09/03/22 at 05:07 PM Emergency Medical Services arrived at the facility.

09/03/22 at 05:15 PM, R1 left with EMS.

Interview, on 09/27/22 at 07:10 PM, with LN C revealed on 09/03/22 she took her lunch at 02:45 PM and returned to the facility at 03:15 PM. LN C stated R1 was sitting outside in the heat, on the porch. LN C stated at 04:15 PM, R1 was outside on the porch. LN C reported she thought the resident was outside about one hour or less and not sure on how long she was out there. LN C revealed R1 drank one and half glasses of water when she was brought back into the facility. R1 was warm and her temporal temperature was 102.5 degrees F. Staff placed ice bags under both of the resident's arms and staff further placed a cool cloth on R1's head and neck. LN C stated she contacted the physician and received orders to send R1 into the emergency room for evaluation and treatment.

Interview, on 09/27/22 at 07:30 AM, with LN D revealed on 09/03/22 at 03:15 PM, LN C requested help with R1 who was sat in a chair

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 600	Continued From page 5	F 600		

outside the front door. R1 appeared to have an altered mental status, due to her temperature being 102.5 degrees F, ice bags and cool clothes were placed under the arms, head, and neck. After R1 left the building, staff discovered that a Certified Nurse Aide (CNA) F had taken R1 outside between 04:00 PM and 04:20 PM.

Interview, on 09/27/22 at 12:10 PM, with Certified Nurse Aide (CNA) F indicated between 04:00 PM and 04:30 PM the CNA assisted the resident outside. CNA F was unaware if R1 had any fluids with her.

Interview, 09/27/22 at 09:28 PM, with Administrative Staff B stated she expected staff to supervise a resident with cognitive impairment who requested to go outside. Administrative Staff B stated the facility did not have a policy on monitoring of residents while outside.

The facility failed to ensure R1's safety while she sat outside of the facility on the porch for a minimum of 1.25 hours in extreme heat of 97 degrees F and was transferred to the Emergency room with a temperature of 102.5 degrees F and altered mental status.

On 09/27/22 at 04:35 PM, Administrative Staff A and Administrative Nurse B were provided with the IJ template by email to notify them that the facility failed to ensure proper safety on 09/03/22 when Resident R1 (cognitively impaired) was left outside on the porch in the sun for unknown duration of time during extreme heat of 97 degrees (F). The deficient practices were likely to cause serious harm, injury, or death. The failure to ensure a safe environment during extreme inclement weather constituted immediate

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WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 600	Continued From page 6 jeopardy for this resident. The facility identified and corrected the deficient practice on 09/27/22 at 06:25 PM, when the following was implemented: 1. All staff were educated on the routine resident's checks. 2. The facility established a monitoring log on residents sitting outside, 3. The facility placed a thermometer at the front entrance and gazebo. 4. Implemented administrative staff conducting random routine resident checks daily each shift for seven days then weekly for four weeks results of all audits will be forwarded to the QAA committee for review. The facility identified and corrected the deficient practice on 09/28/22 at 08:00 AM, for the incident on 09/03/22, with the education completed on 09/27/22 at 06:25 PM, implementing monitoring of the cognitively impaired residents who must have a staff member, friend, or family member with them while outside at all times. If temperatures are below 50 degrees (F) or above 90 degrees (F) residents are encouraged to come back into the building after 30 minutes. The surveyor verified the implementation of the IJ removal plan while on site on 09/28/22, the deficient practice remained at a G scope and severity.	F 600		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 7	F 609		

§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 43 residents, that included three residents reviewed for accidents. Based on observations, interview, and record review, the facility failed to report an injury accident/fall for one of three sampled residents, Resident (R1) 1, to the state agency within five days of the occurrence, as required.

Findings included:

- R1's 09/28/22 signed "Physician Orders Sheet" (POS) documented the facility admitted the

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	175327	A. BUILDING _____ B. WING _____	10/03/2022

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WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 609	Continued From page 8	F 609		

resident on 02/14/22 with the following diagnoses: osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), disorders of bone density and structure, multiple sites (your bones have changed in more than one place), dementia (progressive mental disorder characterized by failing memory, confusion), and non-displaced fracturing (broken bone in one location without change of alignment) involving the midline calvarium (bones which cover and protect the brain) with overlaying soft tissue swelling.

The 02/21/22 "Admission Minimum Data Set" (MDS) documented the resident had a "Brief Interview of Mental Status" (BIMS) score of three, which indicated severely impaired cognition. She required limited assistance with transfers and supervision with ambulating. The resident was not steady on her feet, and able to stabilize without staff assistance. The resident did not utilize a mobility device.

The 02/24/22 "Falls Care Area Assessment" (CAA) documented the resident was at risk for falls related to impaired mobility.

The resident's "Fall Care Plan", dated 02/18/22, instructed staff to provide appropriate footwear when transferring and ambulating, remind the resident to use the call light for safety, ensure a clutter free environment, adequate lighting, and that personal items were within her reach. A revision on 08/12/22, included staff to ensure the resident was wearing non-skid soled house slippers.

The "Nurse's Note" dated 09/25/22 at 02:48 PM revealed LN G documented on 09/25/22 at 01:12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 9	F 609		

PM, staff observed R1 lying supine (on her back) on the floor, knees bent, and her hands were holding the right side of her head. An assessment revealed a golf ball sized, red area to the back of the resident's head. The resident's cognition declined, she was slower to respond, had her eyes closed, and would only speak when staff stated her name. At approximately 01:14 PM, LN G called the physician to send the resident to the Emergency Department (ED) for evaluation and treatment. At approximately 01:15 PM, LN G called 911 for R1 to be transported to the ED by Emergency Medical Services (EMS). EMS arrived at the facility at 01:25 PM and transported the resident to the ED.

The "Nurse's Note" on 09/25/22 at 04:54 PM, documented LN G received a call from the ED with the computerized tomography (CT) Scan (diagnostic imagining scan that emphasizes on a specific area) results indicating a subdural hematoma (collection of blood on the surface of the brain and nondisplaced skull fracture.

On 09/29/22 at 10:30 AM, LN G reported that on 09/22/22 at approximately 01:13 PM, CNA M informed her R1 fell in the unoccupied, unsecured room in the memory care unit. LN G reported she observed the resident lying supine, with knees bent, and the resident holding the right side of her head. LN G reported the (unsecured) door fell against the bathroom wall and was being removed from the unoccupied room by staff when she arrived. LN G reported upon assessment she observed a golf ball size, red circle to the back of the resident's head and said the resident showed decline from her normal baseline. LN G reported when the resident returned from the acute hospital, she appeared lethargic (a feeling of

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WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 609	Continued From page 10	F 609		

fatigue, tiredness and exhaustion both physically and mentally), did not respond to verbal stimuli (stimulation in verbal communication), kept her eyes closed, or showed no facial expression (gesture with facial muscles) for approximately 48 hours. LN G reported approximately three days after the fall on 09/25/22, the resident returned to her normal baseline.

On 09/29/22 at 10:45 AM, CNA M reported R1 was not in her room when she completed visual checks, prior to her going on her break at 01:30 PM (on 09/22/22). CNA M noted the unoccupied room door stood open. CNA M reported when she entered the room, a brown door was leaning against the bathroom wall. CNA M reported she moved the door from the bathroom wall and leaned the door against the wall across from the bathroom. R1 was lying on her back, on the floor, with knees bent, and holding her head with both hands. CNA M reported she immediately called LN G to advised her that R1 fell in the unoccupied room.

On 09/29/22 at 10:50 AM Maintenance staff U reported he did not know who asked him to remove the bathroom door. Maintenance staff U reported he was in a hurry, and he placed the door in the unsecured and unoccupied room (on the memory care unit). He reported he failed to place the door in a secured location.

Review of the facility's video surveillance revealed on 08/12/22 at 01:01 PM the staff removed the bathroom door and placed it in the unsecured room.

On 09/29/22 further review of the facility video surveillance, from 09/25/22 at 12:35 PM, revealed

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WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 609	Continued From page 11 the resident stood at the nurse's desk in the Memory Care Unit and the door to the unsecured room was not open. Later that same day, at approximately 01:40 PM, the staff removed the bathroom door from the unsecured room and placed it in a different secured room. On 10/03/22 at 10:52 AM Administrative Staff A reported that the resident's fall on 09/25/22 should have been reported to the State of Kansas within 24 hours, and she failed to report this fall. The facility lacked a policy for reporting to State agency within 24 hours of time of injury fall or Hazardous Areas. The facility failed to report this severely confused resident's injury fall to the state agency within five days of the occurrences, as required.	F 609		
F 689 SS=J	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 43 residents and identified 10 that resided on the memory care unit. The sample of four residents included three reviewed for accidents. Based on observations, interview, and record review, the facility failed to provide an environment as free as possible of	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINFIELD SENIOR LIVING COMMUNITY	1320 WHEAT RD WINFIELD, KS 67156

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F 689	Continued From page 12	F 689		

accident hazards for one of the three residents, cognitively impaired Resident (R1), on 08/12/22 at 01:01 PM, when the facility staff removed the bathroom door from the residents' room and placed the bathroom door in another room just across the hall, that was unsecured and unoccupied, on the Memory Care Unit. On 09/25/22, at approximately 01:12 PM, Certified Nurse Aide (CNA) M observed that R1 was not in her room. CNA M observed the door to the unsecured and unoccupied room entrance door stood open and the removed bathroom door stood leaning against the bathroom wall, that was previously leaning against the wall across from the bathroom. CNA M observed R1 in the room lying on her back, with knees upward, holding her head, and with a golf ball size red circle noted to the back of her head. CNA M notified Licensed Nurse G immediately. At approximately 01:15 PM, LN G called 911 to have R1 transported to the Emergency Department (ED) for evaluation and treatment by Emergency Medical Services (EMS). These failures placed R1 in immediate jeopardy and placed the other 9 residents of the memory care unit at risk for harm or injury.

Findings included:

- R1's 09/28/22 signed "Physician Orders Sheet" (POS) documented the facility admitted the resident on 02/14/22 with the following diagnoses: osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), disorders of bone density and structure, multiple sites (your bones have changed in more than one place), dementia (progressive mental disorder characterized by failing memory, confusion), and non-displaced fracturing (broken bone in one location without

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175327	A. BUILDING _____ B. WING _____	10/03/2022

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(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 689	Continued From page 13	F 689		

change of alignment) involving the midline calvarium (bones which cover and protect the brain) with overlaying soft tissue swelling.

The 02/21/22 "Admission Minimum Data Set" (MDS) documented the resident had a "Brief Interview of Mental Status" (BIMS) score of three, which indicated severely impaired cognition. She required limited assistance with transfers and supervision with ambulating. The resident was not steady on her feet, and able to stabilize without staff assistance. The resident did not utilize a mobility device.

The 02/24/22 "Cognitive Loss/Dementia Care Area Assessment" (CAA) documented the resident frequently wandered into other residents' rooms while residing in a previous Long-Term Care (LTC) facility. The resident continued to wander into other residents' rooms in the current facility's secured memory unit.

The 02/24/22 "Activities of Daily Living [ADL] Functional Rehabilitation Potential Care Area Assessment" (CAA) documented the resident required assistance with ADL related to impaired mobility. R1 wore a Wander Guard (device worn by residents that trigger an alarm to alert staff when the resident came within range of the transmitter, usually posted near an exit door) for safety.

The 02/24/22 "Falls Care Area Assessment" (CAA) documented the resident was at risk for falls related to impaired mobility.

The 08/13/22 "Quarterly MDS" documented the resident had a BIMS score of four , which indicated severely impaired cognition. The

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	175327	A. BUILDING _____ B. WING _____	10/03/2022

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F 689	Continued From page 14	F 689		

resident required one-person extensive assistance with toileting and one-person supervision with transfer and ambulating. The resident was not steady, but able to stabilize without staff assistance. The resident did not utilize a mobility device.

The resident's "Fall Care Plan", dated 02/18/22, instructed staff to provide appropriate footwear when transferring and ambulating, remind the resident to use the call light for safety, ensure a clutter free environment, adequate lighting, and that personal items were within her reach. A revision on 08/12/22, included staff to ensure the resident was wearing non-skid soled house slippers.

The "Nurse's Note" dated 09/25/22 at 02:48 PM revealed LN G documented on 09/25/22 at 01:12 PM staff observed R1 lying supine (on her back) on the floor, knees bent, and her hands were holding the right side of her head. An assessment revealed a golf ball sized, red area to the back of the resident's head. The resident's cognition declined, she was slower to respond, had her eyes closed, and would only speak when staff stated her name. At approximately 01:14 PM, LN G called the physician to send the resident to the Emergency Department (ED) for evaluation and treatment. At approximately 01:15 PM, LN G called 911 for R1 to be transported to the ED by Emergency Medical Services (EMS). EMS arrived at the facility at 01:25 PM and transported the resident to the ED.

The "Nurse's Note" on 09/25/22 at 04:54 PM documented LN G received a call from the ED with the computerized tomography (CT) Scan (diagnostic imagining scan that emphasizes on a

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F 689	Continued From page 15	F 689		

specific area) results indicating a subdural hematoma (collection of blood on the surface of the brain and nondisplaced skull fracture.

The "Nurse's Note" on 09/25/22 at 05:16 PM, documented the resident turned from the acute hospital on comfort care as requested by the resident's family member.

Review of the resident's head CT Scan, completed on 09/25/22 at the ED, revealed a small subdural hematoma, and anon-displaced fracturing involving midline calvarium with overlying soft tissue swelling.

On 09/29/22 at 10:30 AM, LN G reported that on 09/22/22 at approximately 01:13 PM, CNA M informed her R1 fell in the unoccupied, unsecured room in the memory care unit. LN G reported she observed the resident lying supine, with knees bent, and the resident holding the right side of her head. LN G reported the (unsecured) door fell against the bathroom wall and was being removed from the unoccupied room by staff when she arrived. LN G reported upon assessment she observed a golf ball size, red circle to the back of the resident's head and said the resident showed decline from her normal baseline. LN G reported when the resident returned from the acute hospital, she appeared lethargic (a feeling of fatigue, tiredness and exhaustion both physically and mentally), did not respond to verbal stimuli (stimulation in verbal communication), kept her eyes closed, or showed no facial expression (gesture with facial muscles) for approximately 48 hours. LN G reported approximately three days after the fall on 09/25/22, the resident returned to her normal baseline.

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F 689	Continued From page 16	F 689		

On 09/29/22 at 10:45 AM, CNA M reported R1 was not in her room when she completed visual checks, prior to her going on her break at 01:30 PM (on 09/22/22). CNA M noted the unoccupied room door stood open. CNA M reported when she entered the room, a brown door was leaning against the bathroom wall. CNA M reported she moved the door from the bathroom wall and leaned the door against the wall across from the bathroom. R1 was lying on her back, on the floor, with knees bent, and holding her head with both hands. CNA M reported she immediately called LN G to advised her that R1 fell in the unoccupied room.

On 09/29/22 at 10:50 AM, Maintenance staff U reported he did not know who asked him to remove the bathroom door. Maintenance staff U reported he was in a hurry, and he placed the door in the unsecured and unoccupied room (on the memory care unit). He reported he failed to place the door in a secured location.

Review of the facility's video surveillance revealed on 08/12/22 at 01:01 PM, the staff removed the bathroom door and placed it in the unsecured room.

On 09/29/22 further review of the facility video surveillance, from 09/25/22 at 12:35 PM, revealed the resident stood at the nurse's desk in the Memory Care Unit and the door to the unsecured room was not open. Later that same day, at approximately 01:40 PM, the staff removed the bathroom door from the unsecured room and placed it in a different secured room.

On 09/29/22 at 01:22 PM, Administrative Nurse D reported the maintenance staff should not have

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F 689	Continued From page 17	F 689		

left the door in the unsecured and unoccupied room.

On 10/03/22 at 10:52 AM, Administrative Staff A reported the door should have been placed in a secured location after the staff removed the door. The door was removed on 08/12/22 at 01:01 PM, from a room and placed in the unoccupied, unsecured room across the hall (in the memory care unit).

The facility "Hazardous Areas, Devices and Equipment" Policy, Revised 07/2017, documented it was the policy that all hazardous areas will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. The policy documented a hazard is defined open areas or items that should be locked when not in use.

The facility failed to provide an environment as free of accidental hazards as possible for the 10 cognitively impaired residents residing in the memory care unit, including Resident (R1), when on 08/12/22, at 01:01 PM, the facility staff removed the bathroom door from the residents' room, and placed the bathroom door in an unsecured and unoccupied room next to the resident's room on the Memory Care Unit. On 09/25/22 at approximately 01:12 PM, CNA M observed R1 was not in her room. CNA M observed the door to the unsecured and unoccupied room entrance door was opened and the bathroom door from the resident's room was leaned against the bathroom wall, that was previously leaning against the wall adjacent from the bathroom . CNA M observed R1 in the unsecured room lying on her back, with knees

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F 689	Continued From page 18	F 689		

upward, holding her head, and with a golf ball size red circle noted to the back of her head. CNA M notified Licensed Nurse G immediately. At approximately 01:15 PM, LN G called 911 to have R1 transported to the Emergency Department (ED) for evaluation and treatment by Emergency Medical Services (EMS), where the resident was found to have a subdural hematoma and fractured skull. These failures placed R1 in immediate jeopardy.

The facility provided an acceptable plan of removal of the immediately jeopardy, on 10/03/22 at 04:45 PM. The plan included the following:
1. The unsecured door was removed on 09/27/22.
2. Maintenance educated on "Removal of Unsecured Door" on 09/27/22.
3. Unoccupied rooms in Memory Care have been secured on 10/03/22.
4. All staff were educated on the "Need to Ensure Environment Free of Accident Hazard" and "Appropriate Supervision for Cognitively Impaired Resident's" on 10/03/22 beginning at 03:47 PM, that were currently working. Sign posted that no one is allowed to work until educated on P/P.
5. Staff members who have not had education will be educated prior to working their next shift.
6. New hires will be educated upon hire.
7. Complete a Full House Environmental Round on the Memory Care Unit.

On 10/03/22 at 04:45 PM, the survey team verified onsite that the facility implemented the IJ removal plan, the deficient practice remained at a G scope and severity.