| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175487 | A. Building<br>B. Wing | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Health Center | 2133 S Elizabeth Street<br>Wichita, KS 67213 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 residents, with 12 residents sampled, including one resident sampled for advanced directives (a written document which indicated the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure Resident (R) 35 who was cognitively intact sign a completed Do Not Resuscitate (DNR- or no code, a legal document or order that means the person does not desire CPR in the event of cardiac arrest), instead they had a family member sign the directive.<br><br>Findings included:<br><br>- Resident (R) 35's Electronic Health Record (EHR) revealed diagnoses of unspecified dementia (progressive mental disorder characterized by failing memory, confusion) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).<br><br>The [DATE] admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R35 had a total mood severity score of 03, indicating minimal depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, ambulation, and transfers. R35 required set up for meals and moderate assistance with bathing.<br><br>The [DATE] Cognitive Loss Care Area Assessment (CAA) documented R35 exhibited forgetfulness in regard to medications and routine. She was not happy to have to reside at the facility, is at risk for elopement (when a cognitively impaired resident leaves the facility without the knowledge or supervision of staff) and was at risk for further decline in cognitive memory status.<br><br>The [DATE] Care Plan documented DNR code dated, [DATE].<br><br>The Physician's Order dated [DATE], documented a Do Not Resuscitate order.<br><br>On [DATE] review of EHR an uploaded document dated [DATE], a signed DNR by R12's family member who was not her durable power of attorney (DPOA- legal document that named a person to make healthcare decisions when the resident was no longer able to) and witnessed by Licensed Bachelor Social Worker (LBSW) D.<br><br>On [DATE] review of the EHR revealed an uploaded hospital note from the physician, dated [DATE], which documented discussed code status with patient, and she wanted to be a full code.<br><br>(continued on next page) |

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.

| 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: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The [DATE] admission Transfer Orders from hospital were marked as a full code.<br><br>On [DATE] at 07:30 AM, R35 stated that she was not asked to sign a DNR and stated that she was not sure if she wanted to continue with the DNR order. R12 stated her daughter was her health care agent.<br><br>On [DATE] at 10:07 AM, Administrative Nurse B reported that R35 should have signed her own DNR and confirmed that R35's daughter is her DPOA.<br><br>On [DATE] at 10:28 AM, LBSW D confirmed that R35's son signed the DNR as R35's DPOA was in the hospital. LBSW D reported that R35 was in the room when the DNR was signed and confirmed the EHR lacked a progress note of the above. She also reported she was unaware of the physician note from the hospital that R35 wanted to be a full code.<br><br>The facility's Advanced Directives policy dated 12/2019 documented advanced directives will be respected in accordance with state law and facility policy. Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advanced directive if they choose to do so. DPOA for healthcare is a document delegating authority to a legal representative to make health care decisions in case the individual delegating the authority subsequently becomes incapacitated.<br><br>The facility failed (R)35 who was cognitively intact, by having a family member that was not her DPOA sign a completed DNR. This deficient practice had the potential to lead to uncommunicated needs specifically to end-of-life care. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - Review of the Electronic Health Record (EHR) for Resident (R) 21 included the diagnoses of cerebral infarction (stroke - 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), diabetes mellitus type 2 (DM 2-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), and generalized muscle weakness.<br><br>The 04/01/24 Significant Change Minimum Data Set (MDS) for R21 documented a Brief Interview of Mental Status score of 15, which indicated intact cognition. The assessment documented that the resident utilized a wheelchair and/or a walker for locomotion. R21 was occasionally incontinent of bowel/bladder and required supervision and setup with all cares except bathing which required substantial/maximum assistance. The assessment documented that R21 received a diuretic (medication to promote the formation and excretion of urine), and opioid (a narcotic pain medication) and a hypoglycemic (a medication to lower the concentration of sugar in the blood).<br><br>The Activities of Daily Living (ADL) Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 04/01/24 documented that R21 was a fall risk.<br><br>The Falls CAA, dated 04/01/24 documented that R21 was at risk for further falls and injury due to history of multiple falls due to decreased safety awareness and noncompliance with safety recommendations from staff.<br><br>The Quarterly MDS, dated 06/26/24 documented a BIMS score of 15. The assessment documented that R21 utilized a wheelchair for locomotion. R21 was occasionally incontinent of bowel/bladder and required substantial/maximal assistance with bathing, partial/moderate assistance with dressing, supervision/setup for eating and toileting/personal hygiene. The assessment documented that R21 received a diuretic, an opioid and hypoglycemic medications.<br><br>The 08/27/24 Care Plan documented on 03/03/21 that R21 was at risk for falls. The listed staff interventions to prevent further falls included fall prevention interventions through 06/07/24.<br><br>Review of the facility's fall investigations revealed on 07/01/24, R21 fell but was not injured. The facility's investigation determined the root cause of the fall was R21 had attempted to self-transfer into a wheelchair unsuccessfully. The facility's investigation report lacked evidence of an immediate fall prevention intervention put in place by the staff on duty at the time of the fall.<br><br>The 08/27/24 Care Plan lacked evidence of a fall prevention intervention related to the fall R21 experienced on 07/01/24.<br><br>On 08/28/24 at 10:46 AM, Certified Nurse Aide (CNA) G stated if a resident fell, the CNA staff stayed with the resident, alerted other staff for assistance, and upon the arrival of the nurse, the CNA followed the instructions given by the nurse.<br><br>On 08/28/24 at 10:57 AM, Certified Medication Aide (CMA) H stated if it was discovered that a resident fell, CNA/CMA staff ensured the resident was safe and alerted other staff for additional assistance, including notifying the nurse, and then the CNA/CMA staff followed the nurse instructions.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175487 | A. Building<br>B. Wing | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Health Center | 2133 S Elizabeth Street<br>Wichita, KS 67213 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 08/28/24 at 11:18 AM, Administrative Nurse B confirmed the lack of a care plan intervention related to R21's fall on 07/01/24. and was unable to provide an explanation as to why the care plan lacked an intervention for the fall on 07/01/24.<br><br>The facility's Goals and Objectives, Care Plans policy, dated 04/2009, documented that the care plans would include goals and objectives that lead to the resident's highest obtainable level of independence. Additionally, documented that when goals and objectives were not met, and the desired outcome not achieved, the care plans would be modified accordingly.<br><br>The facility's Care Plans, Comprehensive Person-Centered policy, dated 04/2022, documented the facility would develop and implement a person-centered care plan for each resident with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Additionally, documented the facility's IDT would review and update the care plans when the desired outcome was not met.<br><br>The facility failed to review and revise the care plan for R21 after R21 fell on [DATE]. This deficient practice had the potential to lead to ongoing increased risk for falls and the possibility of additional injuries from falls.<br><br>The facility reported a census of 43 residents with 13 residents selected for review. Based on observation, interview, and record review, the facility failed to accurately revise four resident's care plans after falls experienced by Residents (R)37, R35, R21, and R12. Additionally, R9's hearing bilateral hearing aides were not addressed on the resident's care plan. This placed the residents at risk for uncommunicated care needs.<br><br>Findings included:<br><br>- Resident (R)37's Electronic Health Record (EHR) revealed diagnoses, which included dementia (progressive mental disorder characterized by failing memory, confusion), weakness, and falls.<br><br>The 08/14/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R37 had a total (mood) severity score of zero, which indicated no depression. R37 required set up assistance for oral care and eating. R37 required moderate assistance with activities of daily living (ADLs), with personal hygiene, and transfers. R37 required total assistance with bathing, toileting, dressing and footwear and was independent with ambulation. R37 had one minor injury fall and two non-injury falls.<br><br>The 08/16/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R37 had actual self-care performance deficits related to a left hand contracture and weakness. The CAA noted R37 required supervision with ambulation related to fast-paced ambulation.<br><br>The 08/16/24 Falls CAA documented R37 had a history of falls and injury related to fluctuation of cognition, and self-care performance. Additionally, R37 had poor memory and decreased safety awareness.<br><br>The 05/22/24 Quarterly MDS documented a BIMS score of 14, indicating intact cognition. R37 required set up assistance for oral care and eating. R37 required maximal assistance with ADLs, personal hygiene, and toileting. R37 required total assistance with bathing, dressing, and footwear and was independent with ambulation and transfers. R37 had one minor injury and two non-injury falls.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The 08/26/24 Care Plan documented fall interventions which included:<br><br>03/25/23, staff were instructed to monitor and assist R37 with toileting, as needed.<br><br>01/16/24, staff instructed to monitor R37 whenever they walked by R37's room and offer assistance; and additionally, provide reminders to use her call light for assistance.<br><br>04/17/24, staff educated R37 on the importance to have staff pick items up off the floor for her.<br><br>07/25/24, R37 worked with therapy. R37 would be encouraged to allow staff to ambulate with her for her safety.<br><br>The 08/26/24 Physician Orders included the following:<br><br>An order dated 12/17/22 for the resident to have an activity level, stand by assistance with transfers, and walking with walker every shift.<br><br>An order dated 04/18/24 for Physical Therapy to consult as needed for falls.<br><br>Review of the Progress Note dated 01/16/24 at 04:46 PM, revealed R37 had an unwitnessed fall when she stated she tried to sit down in the recliner and fell.<br><br>Review of the Progress Note dated 02/11/24 at 04:47 PM, revealed the resident had a witnessed injury fall. R37 tripped over her walker after she tried to ambulate around the walker and sustained a skin-tear and bruise on the left wrist, and a broken left thumb nail. The facility reviewed the resident's care plan and found it to be appropriate at that time.<br><br>The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factors of R37's fall with minor injury on 02/11/24, where R37 sustained a skin-tear and bruise of left wrist.<br><br>Review of the Progress Note dated 03/31/24 at 11:28 AM, revealed R37 had a witnessed fall while out with friends at her church and had a contusion to the back of her head.<br><br>Review of the Progress Note dated 04/17/24 at 07:45 PM, revealed R37 had an unwitnessed fall when she stated she bent over to pick up her slippers and fell.<br><br>Review of the Progress Note dated 05/21/24 at 07:10 PM, revealed R37 had a witnessed fall in the hallway. R37 turned around to go back to her room and fell to the floor.<br><br>Review of the Progress Note dated 05/22/24 at 02:21 PM, revealed R37 had a witnessed fall in the activity room. R37 sat down on a walker that was not locked and she fell to the floor.<br><br>The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R37's fall on 05/21/24 and 05/22/24. The Care Plan was revised on 05/28/24, which included staff educated the resident to not sit on the walker.<br><br>Review of the Progress Note dated 07/09/24 at 09:45 PM, revealed R37 had a witnessed fall after Licensed Nurse (LN) R observed R37 ambulating fast with her four-wheel walker in the hallway. Staff then noted R37 to lean to her right side and fall to the floor. R37 sustained a laceration and bruised<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|

F 0657

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

area on her forehead, bruised right hand, and bruised right arm. R37 complained of back and left wrist pain and she was transferred to the hospital.

Review of the Progress Note dated 07/09/24 revealed R37 had a witnessed injury fall and sustained a laceration (wound to the skin), bruised area on forehead, bruised right hand, and bruised right arm. R37 was transferred to hospital.

Review of the Progress Note dated 07/10/24 at 01:30 AM, revealed R37 transported back to facility by a family member.

The Care Plan lacked an intervention related to the fall on 07/09/24, until 07/25/24 (16 days later), which noted the witnessed injury fall on 07/09/24 for R37, where she sustained a laceration (wound to the skin) and bruised area on forehead, bruised right hand, and bruised right arm. R37 was transferred to the hospital. R37 was encouraged to allow staff to ambulate with her for her safety.

Review of the Progress Note dated 08/12/24 at 10:45 AM, revealed R37 had an unwitnessed fall. R37 stated she was walking to fast with her walker, turned the corner at nurse's station, lost her balance, and fell.

Review of the Progress Note dated 08/12/24 at 05:56 PM, revealed R37 had an unwitnessed fall. The resident was found on the floor, with her backed leaned against her dresser. R37 stated she felt dizzy and hit her head on the padded walker.

The Care Plan lacked an intervention related to the fall on 08/12/24, and only noted R37 had two non-injury falls.

During an interview with R37 on 08/26/24 at 10:04 AM, R37 stated she walked into the door frame when she exited the bathroom. Observation during the interview revealed R37 had a swollen, purple, bruised area ,noted on her forehead.

During an observation on 08/26/24 at 01:00 PM, R37 sat in the dining room eating lunch with her family member. R37 had a white bandage on her forehead.

During an observation on 08/27/24 at 07:35 AM, R37 sat in the dining room eating her breakfast, noted approximately three centimeters (cm) by one centimeter, purple colored bruise on her forehead.

During an observation on 08/27/24 at 09:00 AM, Certified Nurse Aide (CNA) L assisted R37 with toileting hygiene. R37 stood up independently from the toilet, ambulated to the bathroom sink and washed her hands.

During an interview on 08/26/24 at 01:10 PM, R37 stated she bumped her head on her door frame when she exited out of the bathroom earlier today. R37 and her family member laughed about her incident when R37 explained what had happened.

During an interview on 08/27/24 at 09:05 AM, CNA L reported R37 did not like staff to walk with her. CNA L stated she will get mad if we try to.

During an interview on 08/28/24 at 09:46 AM, Certified Medication Aide (CMA) K reported R37 worked with restorative aide three times a week for balance.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER: Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE: 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed that the care plans should be updated with interventions after an event in a timely manner. Administrative Nurse B reported the interdisciplinary team (IDT) would meet weekly and review the events that had occurred over the past week. Administrative Nurse B revealed she was not aware that if a care plan was reviewed and no care plan intervention was completed was inappropriate. Administrative Nurse B reported that the facility is responsible for all the resident's safety.<br><br>The facility's Goals and Objectives, Care Plans policy, dated 04/2009, documented that the care plans would include goals and objectives that lead to the resident's highest obtainable level of independence. Additionally, documented that when goals and objectives were not met, and the desired outcome not achieved, the care plans would be modified accordingly.<br><br>The facility's Care Plans, Comprehensive Person-Centered policy, dated 04/2022, documented the facility would develop and implement a person-centered care plan for each resident with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Additionally, documented the facility's IDT would review and update the care plans when the desired outcome was not met.<br><br>The facility failed to revise R37's care plan after several falls. This placed the resident at risk for uncommunicated care needs. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.<br><br>- Resident (R) 35's Electronic Health Record (EHR) revealed diagnoses of unspecified dementia (progressive mental disorder characterized by failing memory, confusion) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).<br><br>The 06/20/24 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R35 had a total mood severity score of 03, indicating minimal depression and there were no behaviors. She was independent with activities of daily living (ADLs), toileting hygiene, dressing, personal hygiene, ambulation, and transfers. R35 required set up for meals and moderate assistance with bathing. The MDS indicated R35 experienced no falls since admission.<br><br>The 06/20/24 Falls Care Area Assessment (CAA) documented R35 had potential for falls and injury related to unstable blood glucose control, decreased safety awareness, and a history of falls prior to admission.<br><br>The 08/26/24 Care Plan documented fall interventions which included:<br><br>06/25/24, staff were instructed to provide call light within the resident's reach and encourage R35 to use it.<br><br>06/25/24, staff were instructed to encourage R35 to wear nonskid socks or shoes.<br><br>The 08/26/24 Physicians Orders lacked any documentation related to safety or falls.<br><br>Review of the Progress Note dated 08/20/24 at 11:57 PM, revealed R35 had an unwitnessed fall in her room. She stated she slipped on water that she spilled on her floor.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Health Center | 2133 S Elizabeth Street Wichita, KS 67213 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The 08/26/24 Care Plan lacked a fall intervention related to R35's 08/20/24 fall.<br><br>During an interview with R35 on 08/26/24 at 01:37 PM, R35 stated she had a fall last week after she spilled water on her floor.<br><br>During an observation on 08/27/24 at 07:30 AM, R35 made her bed independently and she wore appropriate shoes.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed care plans should be updated with interventions in a timely manner after an event/fall. Administrative Nurse B reported the interdisciplinary team (IDT) met weekly and reviewed the events/falls that occurred over the past week. Administrative Nurse B revealed she was not aware if a care plan was reviewed and no care plan intervention was completed after a fall, that it did not meet regulatory requirements. Administrative Nurse B reported that the facility was responsible for all the resident's safety.<br><br>The facility's Goals and Objectives, Care Plans policy, dated 04/2009, documented that the care plans would include goals and objectives that lead to the resident's highest obtainable level of independence. Additionally, documented that when goals and objectives were not met, and the desired outcome not achieved, the care plans would be modified accordingly.<br><br>The facility's Care Plans, Comprehensive Person-Centered policy, dated 04/2022, documented the facility would develop and implement a person-centered care plan for each resident with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Additionally, documented the facility's IDT would review and update the care plans when the desired outcome was not met.<br><br>The facility failed to revise R35's care plan after a fall. This placed the resident at risk for uncommunicated care needs. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.<br><br>- Resident (R)9's Electronic Health Record (EHR) revealed diagnoses included hearing loss and encephalopathy (broad term for any brain disease that alters brain function or structure).<br><br>The 01/02/24 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition, and R9 had no behaviors noted. R9's total severity score of nine, indicating mild depression. R9 required set up assistance for oral care and eating. R9 required moderate assistance with activities of daily living (ADLs), with toileting and dressing. R9 required total assistance with bathing, personal hygiene, wheelchair mobility, and footwear. R9 had minimal difficulty with hearing, no devices.<br><br>The 01/02/24 Communication Care Area Assessment (CAA) documented R9 had potential for communication issues related to being hard of hearing.<br><br>The 06/19/24 Quarterly MDS documented a BIMS score of 12, indicating moderately impaired cognition. R9 required set up assistance for oral care and independent with eating. Total dependence for bathing, footwear and wheelchair mobility. Supervision for toileting and transfers R9 had adequate hearing with bilateral hearing aides.<br><br>The 08/26/24 Care Plan documented communication interventions which included:<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 06/28/23, staff instructed to approach on R9's left side when communicating and repeat questions as needed.<br><br>The Care Plan lacked any documentation/interventions related to R9's bilateral hearing aides.<br><br>The 08/26/24 Physician Orders included an order dated 04/23/24 for staff to assist the resident with hearing aides; apply in the morning and remove at sleep. Store hearing aides in the medication cart.<br><br>Review of the Progress Note dated on 04/26/24 at 06:36 AM, revealed hearing aide company fitted R9 for hearing aides and education provided.<br><br>During an observation on 08/26/24 at 12:29 PM, R9 had no hearing aides noted in her ears when communicating with her. R9 stated staff did not always place them in her ears.<br><br>During an observation on 08/27/24 at 07:30 AM, R9 had no hearing aides noted in her ears, while she was in bed with her eyes closed.<br><br>During an interview on 08/27/24 at 09:35 AM, Certified Nurse Aide (CNA) I revealed R9 would wear her hearing aides when she allowed or requested them from the staff.<br><br>During an interview on 08/27/24 at 09:40 AM, Certified Medication Aide (CMA) J reported R9 would refuse to wear her hearing aides quite often as R9 did not like the oxygen tubing and the hearing aides on together. CMA J stated that R9 would request the hearing aides when she wanted them.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed that the care plans should be updated with interventions after an event in a timely manner. Administrative Nurse B reported the interdisciplinary team (IDT) would meet weekly and review the events that had occurred over the past week. Administrative Nurse B revealed R9 should have had the hearing aides added to her care plan.<br><br>The facility's Goals and Objectives, Care Plans policy, dated 04/2009, documented that the care plans would include goals and objectives that lead to the resident's highest obtainable level of independence. Additionally, documented that when goals and objectives were not met, and the desired outcome not achieved, the care plans would be modified accordingly.<br><br>The facility's Care Plans, Comprehensive Person-Centered policy, dated 04/2022, documented the facility would develop and implement a person-centered care plan for each resident with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Additionally, documented the facility's IDT would review and update the care plans when the desired outcome was not met.<br><br>The facility failed to revise R9's care plan after she received her new hearing aides. This placed the resident at risk for uncommunicated care needs. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility.<br><br>- Resident (R)12's Electronic Health Record (EHR) revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), weakness and repeated falls.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The 03/27/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R12's total severity score of zero, indicating no depression. R12 required set up assistance for eating. R12 required moderate assistance with activities of daily living (ADLs), with upper body dressing. R12 required maximal assistance with transfers, bathing, toileting, lower body dressing and footwear. R12 refused to ambulate and was independent with wheelchair mobility. R35 had two or more non-injury falls.<br><br>The 03/30/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R12 required assistance with ADLs related to unsteady gait, dizziness, weakness and unwilling to participate in restorative program.<br><br>The 03/30/24 Falls CAA documented R12 had a potential for falls and injury related to decrease safety awareness, weakness, dizziness and impulsive behavior.<br><br>The 06/19/24 Quarterly MDS documented a BIMS score of 14, indicating intact cognition. R12 required set up assistance for oral care and eating. R12 required total dependence with assistance with toileting, footwear and personal hygiene. R12 required maximal assistance with transfers, bathing and dressing. R12 had one minor injury fall.<br><br>The 08/26/24 Care Plan documented fall interventions which included:<br><br>01/08/24 staff were instructed to encourage R12 to participate in restorative program for strengthening. Continue to emphasize to R12 to use call light or call pendant to alert staff with all transfers needed.<br><br>04/15/24 R12 encouraged to work with physical therapy to gain strength and proper transfer technique, and R12 will ask for assistance with transfers.<br><br>The 08/26/24 Physician Orders included Physical Therapy consult as needed for falls, dated 01/10/23.<br><br>Restorative program exercise using step, safety walking, and safety transfer practices for one-six times a week for five-fifteen minutes a day. His exercise regime and walking are not consistent, often declined to participate, dated 02/12/24.<br><br>Review of the Progress Note dated 01/01/24 at 11:17 AM, revealed an unwitnessed fall when he stated he fell while he transferred from his wheelchair to recliner and lost his grip on bar and slid to the floor.<br><br>The Care Plan lacked an intervention related to the fall on 01/01/24, until 01/08/24 (seven days later).<br><br>Review of the Progress Note dated 01/22/24 at 07:45 PM, revealed an unwitnessed fall when he stated he fell while he transferred from his recliner to his wheelchair and landed on the wheelchair in the wrong spot and caused the wheelchair to tip over onto its side.<br><br>Review of the Progress Note dated 04/02/24 at 01:09 PM, revealed two near falls in the morning in his room. R12 was unable to move his legs and feet during a transfer with staff and started to fall to the ground, staff assisted R12 back into his wheelchair. R12 transferred self from wheelchair to<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | recliner and he fell on his left knee, staff assisted him back into recliner.<br><br>The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R12's falls on 01/22/24 and 04/02/24.<br><br>Review of the Progress Note dated 04/15/24 at 04:07 PM, revealed an unwitnessed fall when he stated he fell while he transferred from his recliner to wheelchair. R12's right leg had redness and bruised area noted.<br><br>Review of the Progress Note dated 04/19/24 at 09:33 AM, revealed R12 continued to work with therapy for strengthening with transfers related to several near falls.<br><br>Review of the Progress Note dated 08/16/24 at 05:23 PM, revealed R12 has declined to do safety walking with exercise bar. R35's exercise regime is not consistent, he often refused to participate.<br><br>Review of the Progress Note dated 08/22/24 at 08:24 AM, revealed an unwitnessed fall in his bathroom. He stated he was in his wheelchair, reached up to put an item away on shelf over the toilet and missed the wheelchair when he sat back down and fell to the floor.<br><br>The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R12's fall on 04/19/24 and 08/22/24.<br><br>During an observation on 08/26/24 at 10:53 AM, R12 was seated in his recliner, noted a stop sign taped to the wall on white paper, above a safety transfer bar to remind R12 to call staff for assistance. Nonskid strips on floor in front of his recliner. Red tape outline on the floor in front of his recliner. R12 stated the red tape outline is where he needed to have his wheelchair parked when he transferred. He stated he does not always call the staff. R12 stated he would like to ambulate more than he does.<br><br>During an observation on 08/26/24 at 10:58 AM, R12's call light was wrapped on the position device on his bed located approximately five feet away, as R12 sat in his recliner. R12 stated he would like the call light placed on his tray table next to him.<br><br>During an interview on 08/26/24 at 11:01 AM, Licensed Nurse (LN) Q revealed R12 had a call light pendant placed on a necklace for R12.<br><br>R12, who was present for the interview, then interjected and stated he forgot he had the call light pendant.<br><br>LN Q reported R12 would not always call staff for assistance, and he was a fall risk.<br><br>During an observation on 08/27/24 at 07:20 AM, R12 sat in his wheelchair in his room. He stated he was just leaving to go to breakfast in the dining room.<br><br>During an interview on 08/28/24 at 09:43 AM, Certified Medication Aide (CMA) K reported that R12 like to ride the stationary bike and refused to ambulate when offered. CMA K stated that if R12 completed group exercises he would refuse to participate with the restorative program.<br><br>During an interview on 08/28/24 at 09:45 AM, Certified Nurse Aide (CNA) P reported that R12 would<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | get inpatient and transfer himself when he called for staff assistance.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed that the care plans should be updated with interventions after an event in a timely manner. Administrative Nurse B reported the interdisciplinary team (IDT) would meet weekly and review the events that had occurred over the past week. Administrative Nurse B revealed she was not aware that if a care plan was reviewed and no care plan intervention was completed was inappropriate. Administrative Nurse B reported that the facility is responsible for all the resident's safety.<br><br>The facility's Goals and Objectives, Care Plans policy, dated 04/2009, documented that the care plans would include goals and objectives that lead to the resident's highest obtainable level of independence. Additionally, documented that when goals and objectives were not met, and the desired outcome not achieved, the care plans would be modified accordingly.<br><br>The facility's Care Plans, Comprehensive Person-Centered policy, dated 04/2022, documented the facility would develop and implement a person-centered care plan for each resident with measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs. Additionally, documented the facility's IDT would review and update the care plans when the desired outcome was not met.<br><br>The facility failed to revise R12's care plan after several falls. This placed the resident at risk for uncommunicated care needs. This deficient practice had the potential to have a negative effect on the overall physical and psychosocial well-being of the resident in the facility. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** - Resident (R) 35's Electronic Health Record (EHR) revealed diagnoses of unspecified dementia (progressive mental disorder characterized by failing memory, confusion) and Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure).<br><br>The 06/20/24 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R35 had a total mood severity score of 03, indicating minimal depression and there were no behaviors. She was independent with activities of daily living (ADLs), with toileting hygiene, dressing, personal hygiene, ambulation, and transfers. R35 required set up for meals and moderate assistance with bathing. The MDS indicated R35 experienced no falls since admission.<br><br>The 06/20/24 Falls Care Area Assessment (CAA) documented R35 had potential for falls and injury related to unstable blood glucose control, decreased safety awareness, and a history of falls prior to admission.<br><br>The 08/26/24 Care Plan documented fall interventions which included:<br><br>On 06/25/24, staff were instructed to provide a call light within the resident's reach and encourage R35 to use it.<br><br>On 06/25/24, staff were instructed to encourage R35 to wear nonskid socks or shoes.<br><br>The 08/26/24 Physicians Orders lacked any documentation for safety or falls.<br><br>Review of the Progress Note dated 08/20/24 at 11:57 PM, revealed R35 had an unwitnessed fall in her room she stated she slipped on water that she had spilled on her floor.<br><br>The 08/26/24 Care Plan lacked a fall intervention related to R35's 08/20/24 fall.<br><br>During an interview with R35 on 08/26/24 at 01:37 PM, R35 stated she had a fall last week after she spilled water on her floor.<br><br>During an observation on 08/27/24 at 07:30 AM, R35 made her bed independently she wore appropriate shoes.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed that the care plans should be updated with interventions after an event/fall, in a timely manner. Administrative Nurse B reported the interdisciplinary team (IDT) met weekly and reviewed the events/falls that occurred over the past week. Administrative Nurse B revealed she was not aware that if a care plan was reviewed and no care plan intervention was completed after a fall, that it did not meet regulatory requirements. Administrative Nurse B reported that the facility was responsible for all the resident's safety.<br><br>The facility's Falls and Fall Risk, Managing policy, dated 12/2007 documented that the staff would identify interventions related to a resident's specific risks and causes to prevent falls. Additionally documented that if a resident has repeated falls that staff would implement additional or<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | different interventions, until falls were reduced or stopped or the reason for the falls is identified as unavoidable. Further documented that the staff would include the physician and Consultant Pharmacist to re-evaluate, identify and implement interventions to minimize serious consequences of falling.<br><br>The facility failed to keep R35 safe, related to fall hazards. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs.<br><br>- Resident (R) 37's Electronic Health Record (EHR) revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), weakness, and falls.<br><br>The 08/14/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. R37's total severity score of zero, indicating no depression. R37 required set up assistance for oral care and eating. R37 required moderate assistance with activities of daily living (ADLs), with personal hygiene and transfer. R37 required total assistance with bathing, toileting, dressing and footwear. The resident was independent with ambulation. R37 had one minor injury and two non-injury falls.<br><br>The 08/16/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R37 had actual self-care performance related to left hand contracture and weakness. The CAA noted R37 required supervision with ambulation related to fast-paced ambulation.<br><br>The 08/16/24 Falls CAA documented R37 had a history of falls and injury related to fluctuation of cognition, and self-care performance. Additionally, the resident had poor memory and decreased safety awareness.<br><br>The 05/22/24 Quarterly MDS documented a BIMS score of 14, indicating intact cognition. R37 required set up assistance for oral care and eating. R37 required maximal assistance with ADLs, with personal hygiene and toileting. R37 required total assistance with bathing, dressing, and footwear. The resident independent with ambulation and transfers. R37 had one minor injury and two non-injury falls.<br><br>The 08/26/24 Care Plan documented fall interventions, which included:<br><br>On 03/25/23, staff were instructed to monitor and assist R37 with toileting, as needed.<br><br>On 01/16/24, staff instructed to monitor R37 whenever they walked by R37's room, offer assistance, and additionally, provide reminders to use her call light for assistance.<br><br>On 04/17/24, staff educated R37 on the importance to have staff pick items up off the floor for her.<br><br>On 07/25/24, R37 worked with therapy and the care plan was appropriate at that time. R37 was encouraged to allow staff to ambulate with her for her safety.<br><br>The 08/26/24 Physician Orders included activity level, stand by assistance with transfer and walking with walker every shift, dated 12/17/22; Physical Therapy consult as needed for falls, dated 04/18/24.<br><br>Review of the Progress Note dated 01/16/24 at 04:46 PM, revealed R37 had an unwitnessed fall when<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|

F 0689

Level of Harm - Actual harm

Residents Affected - Few

she stated she tried to sit down in the recliner and fell.

Review of the Progress Note dated 02/11/24 at 04:47 PM, revealed a witnessed injury fall, R37 tripped over her walker after she tried to ambulate around the walker. R37 sustained a skin-tear and bruise on left wrist, and left thumb nail had broken. The note documented the care plan was reviewed, appropriate at that time.

The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R37's fall with minor injury on 02/11/24, where R37 sustained a skin-tear and bruise of left wrist.

Review of the Progress Note dated 03/31/24 at 11:28 AM, revealed R37 had a witnessed fall while out with friends at her church; Noted a contusion to back of her head.

Review of the Progress Note dated 04/17/24 at 07:45 PM, revealed R37 had an unwitnessed fall when she stated she bent over to pick up her slippers and fell.

Review of the Progress Note dated 05/21/24 at 07:10 PM, revealed R37 had a witnessed fall in the hallway. R37 turned around to go back to her room and fell to the floor.

Review of the Progress Note dated 05/22/24 at 02:21 PM, revealed R37 had a witnessed fall in the activity room. R37 sat down on walker that was not locked and she fell to the floor.

The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R37's falls on 05/21/24 and 05/22/24. The Care Plan was revised on 05/28/24, which included: to educate the resident to not sit on the walker.

Review of the Progress Note dated 07/09/24 at 09:45 PM, revealed R37 had a witnessed fall, Licensed Nurse (LN) R observed R37 ambulating fast with her four-wheel walker in the hallway. R37 then noted to lean to her right side and fell to the floor. R37 sustained a laceration and bruised area on her forehead, bruised right hand, and right arm. R37 complained of back and left wrist pain and transferred to the hospital.

Review of the Progress Note dated 07/09/24 witnessed injury fall, R37 sustained a laceration (wound to the skin) and bruised area on forehead, bruised right hand, and right arm. R37 was transferred to hospital.

Review of the Progress Note dated 07/10/24 at 01:30 AM, revealed R37 transported back to facility by a family member.

Review of the Progress Note dated 08/12/24 at 10:45 AM, revealed R37 had an unwitnessed fall. R37 stated she was walking to fast with her walker, turned the corner at nurse's station lost her balance and fell.

Review of the Progress Note dated 08/12/24 at 05:56 PM, revealed R37 had an unwitnessed fall. The resident was found on the floor, with her backed leaned against her dresser. R37 stated she felt dizzy and hit her head on the padded walker.

The Care Plan lacked an intervention related to the fall on 08/12/24, and only noted R37 had two non-injury falls.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | During an interview with R37 on 08/26/24 at 10:04 AM, R37 stated she walked into the door frame when she exited the bathroom. Observation during the interview revealed R37 had a swollen, purple bruised area noted on her forehead.<br><br>During an observation on 08/26/24 at 01:00 PM, R37 sat in the dining room eating lunch with her family member. R37 had a white bandage on her forehead.<br><br>During an observation on 08/27/24 at 07:35 AM, R37 sat in the dining room eating her breakfast, noted approximately three centimeters (cm) by one centimeter, purple colored bruise on her forehead.<br><br>During an observation on 08/27/24 at 09:00 AM, Certified Nurse Aide (CNA) L assisted R37 with toileting hygiene. R37 stood up independently from the toilet, then ambulated to the bathroom sink and washed her hands.<br><br>During an interview on 08/26/24 at 01:10 PM, R37 stated she bumped her head on her door frame when she exited out of the bathroom earlier today. R37 and her family member laughed about her incident when R37 explained what had happened.<br><br>During an interview on 08/27/24 at 09:05 AM, CNA L reported R37 did not like staff to walk with her. CNA L stated she would get mad if they tried to.<br><br>During an interview on 08/28/24 at 09:46 AM, Certified Medication Aide (CMA) K reported R37 worked with a restorative aide three times a week for balance.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed that the care plans should be updated with interventions after an event in a timely manner. Administrative Nurse B reported the interdisciplinary team (IDT) would meet weekly and review the events that had occurred over the past week. Administrative Nurse B revealed she was not aware that if a care plan was reviewed and no care plan intervention was completed it did not meet regulatory requirements. Administrative Nurse B reported that the facility is responsible for all the resident's safety.<br><br>The facility's Falls and Fall Risk, Managing policy, dated 12/2007 documented that the staff would identify interventions related to a resident's specific risks and causes to prevent falls. Additionally documented that if a resident has repeated falls that staff would implement additional or different interventions, until falls were reduced or stopped or the reason for the falls is identified as unavoidable. Further documented that the staff would include the physician and Consultant Pharmacist to re-evaluate, identify and implement interventions to minimize serious consequences of falling.<br><br>The facility failed to keep R37 safe, related to fall hazards. This practice had the potential to lead to negative psychosocial effects related to safety and uncommunicated needs.<br><br>- Resident (R)12's Electronic Health Record (EHR) revealed diagnoses included dementia (progressive mental disorder characterized by failing memory, confusion), weakness and repeated falls.<br><br>The 03/27/24 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 14, indicating intact cognition. R12's total mood severity score of zero, indicated no depression. R12 required set up assistance for eating and required moderate assistance with activities of daily living (ADLs), with upper body dressing. R12 required maximal assistance with transfers, bathing, toileting, lower body dressing, and footwear. R12 refused to ambulate and was independent with<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | wheelchair mobility. R35 had two or more non-injury falls since the prior assessment.<br><br>The 03/30/24 ADL Functional/Rehabilitation Potential Care Area Assessment (CAA) documented R12 required assistance with ADLs related to unsteady gait, dizziness, weakness, and unwilling to participate in restorative program.<br><br>The 03/30/24 Falls CAA documented R12 had a potential for falls and injury related to decrease safety awareness, weakness, dizziness and impulsive behavior.<br><br>The 06/19/24 Quarterly MDS documented a BIMS score of 14, indicating intact cognition. R12 required set up assistance for oral care and eating. R12 required total dependence with assistance with toileting, footwear and personal hygiene. R12 required maximal assistance with transfers, bathing, and dressing. R12 had one minor injury fall since the prior assessment.<br><br>The 08/26/24 Care Plan documented fall interventions for R12, which included:<br><br>On 01/08/24, the staff were to encourage R12 to participate in the restorative program for strengthening, continue to emphasize to R12 to use call light or call pendant to alert staff with all transfers needed.<br><br>On 04/15/24, the staff were to encouraged R12 to work with physical therapy to gain strength and proper transfer technique, and R12 will ask for assistance with transfers.<br><br>The 08/26/24 Physician Orders included a Physical Therapy consult as needed for falls, dated 01/10/23.<br><br>The restorative program included exercise using step, safety walking, and safety transfer practices for one, six times a week, for five-fifteen minutes a day. R12's exercise regime and walking were not consistent, and he often declined to participate, dated 02/12/24.<br><br>Review of the Progress Note dated 01/01/24 at 11:17 AM, revealed R12 experienced an unwitnessed fall when he stated he fell while he transferred from his wheelchair to the recliner and lost his grip on the bar, and slid to the floor.<br><br>The Care Plan lacked an intervention related to R12's fall on 01/01/24, until 01/08/24 (seven days later).<br><br>Review of the Progress Note dated 01/22/24 at 07:45 PM, revealed R12 had an unwitnessed fall when he stated he fell while he transferred from his recliner to his wheelchair and landed on the wheelchair in the wrong spot and caused the wheelchair to tip over onto its side.<br><br>The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R12's falls on 01/22/24.<br><br>Review of the Progress Note dated 04/02/24 at 01:09 PM, revealed two near falls in the morning in his room. R12 was unable to move his legs and feet during a transfer with staff and started to fall to the ground, staff assisted R12 back into his wheelchair. R12 transferred self from his wheelchair to his recliner and he fell on his left knee, and staff assisted him back into the recliner.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175487 | A. Building<br>B. Wing | 08/28/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Health Center | 2133 S Elizabeth Street<br>Wichita, KS 67213 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R12's fall on 04/02/24.<br><br>Review of the Progress Note dated 04/15/24 at 04:07 PM, revealed R12 had an unwitnessed fall when he stated he fell while he transferred from his recliner to the wheelchair. R12's right leg had redness and bruised area noted.<br><br>Review of the Progress Note dated 04/19/24 at 09:33 AM, revealed R12 continued to work with therapy for strengthening with transfers related to several near falls.<br><br>Review of the Progress Note dated 08/16/24 at 05:23 PM, revealed R12 had declined to do a safety walking with exercise bar. R35's exercise regime is not consistent, he often refused to participate.<br><br>Review of the Progress Note dated 08/22/24 at 08:24 AM, revealed R12 had an unwitnessed fall in his bathroom. He stated he was in his wheelchair, reached up to put an item away on shelf over the toilet, and missed the wheelchair when he sat back down and fell to the floor.<br><br>The 08/26/24 Care Plan lacked a fall prevention intervention related to the causal factor of R12's fall on 08/22/24.<br><br>During an observation on 08/26/24 at 10:53 AM, R12 was seated in his recliner, in his room. There was a stop sign taped to the wall on white paper, above a safety transfer bar, to remind R12 to call staff for assistance. Observation revealed nonskid strips on the floor in front of his recliner and a red tape outline on the floor in front of his recliner. R12 stated the red tape outline marked where he needed to have his wheelchair parked when he transferred. He stated he did not always call the staff (for assistance). R12 also stated he would like to ambulate more than he does.<br><br>During an observation on 08/26/24 at 10:58 AM, R12's call light was wrapped on the position device on his bed located approximately five feet away, as R12 sat in his recliner. R12 stated he would like the call light placed on his tray table next to him.<br><br>During an interview on 08/26/24 at 11:01 AM, Licensed Nurse (LN) Q revealed R12 had a call light pendant placed on a necklace for R12.<br><br>R12, who was present for the interview, then interjected and stated he forgot he had the call light pendant.<br><br>During an interview on 08/28/24 at 09:43 AM, Certified Medication Aide (CMA) K reported that R12 would like to ride the stationary bike and refused to ambulate when offered. CMA K stated that if R12 completed group exercises he would refuse to participate with restorative program.<br><br>During an interview on 08/28/24 at 09:45 AM, Certified Nurse Aide (CNA) P reported that R12 would get inpatient and transfer himself when he called for staff assistance.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed that the care plans should be updated with interventions after an event/fall in a timely manner. Administrative Nurse B reported the interdisciplinary team (IDT) would meet weekly and review the events that had occurred over the past week. Administrative Nurse B revealed she was not aware that if a care plan was reviewed and no care plan intervention was completed was inappropriate. Administrative Nurse B reported<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|

F 0689

Level of Harm - Actual harm

Residents Affected - Few

that the facility is responsible for all the resident's safety.

The facility's Falls and Fall Risk, Managing policy, dated 12/2007 documented that the staff would identify interventions related to a resident's specific risks and causes to prevent falls. Additionally documented that if a resident has repeated falls that staff would implement additional or different interventions, until falls were reduced or stopped or the reason for the falls is identified as unavoidable. Further documented that the staff would include the physician and Consultant Pharmacist to re-evaluate, identify and implement interventions to minimize serious consequences of falling.

The facility failed to ensure fall prevention interventions after each fall for R12, to prevent further falls.

The facility reported a census of 43 residents with 12 included in the sample, and eight residents reviewed for accidents. Based on observations, interviews, and record reviews, the facility failed to ensure that four residents remained free of accident hazards related to falls, Resident (R) 21, R35 and R12, and included one resident, R37, who continued to fall and obtained additional injuries. Additionally, the facility failed to ensure that R20 remained free of accident hazards when staff pushed R20's wheelchair without foot pedals and his feet were suspended above the ground. These deficient practices had the potential to negatively affect the physical and psychosocial well-being of the residents.

Findings included:

- Review of the Electronic Health Record (EHR) for Resident (R) 21 included the diagnoses of cerebral infarction (stroke - 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), diabetes mellitus type 2 (DM 2-when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) and generalized muscle weakness.

The Significant Change Minimum Data Set (MDS), dated 04/01/24 documented a Brief Interview of Mental Status score of 15, which indicated intact cognition. The assessment documented that the resident utilized a wheelchair and/or a walker for locomotion. R21 was occasionally incontinent of bowel/bladder and required supervision and setup with all cares except bathing, which required substantial/maximum assistance. The assessment documented that R21 received a diuretic (medication to promote the formation and excretion of urine), and opioid (a narcotic pain medication) and a hypoglycemic (a medication to lower the concentration of sugar in the blood).

The Activities of Daily Living (ADL) Functional / Rehabilitation Potential Care Area Assessment (CAA), dated 04/01/24 documented that R21 was a fall risk.

The Falls CAA, dated 04/01/24 documented R21 as at risk for further falls and injury due to history of multiple falls due to decreased safety awareness and noncompliance with safety recommendations from staff.

The Quarterly MDS, dated 06/26/24 documented a BIMS score of 15, which indicated intact cognition. The assessment documented that R21 utilized a wheelchair for locomotion. R21 was occasionally incontinent of bowel/bladder and required substantial/maximal assistance with bathing, partial/moderate assistance with dressing, supervision/setup for eating, and toileting/personal hygiene. The assessment documented that R21 received a diuretic, an opioid, and hypoglycemic medications.

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Health Center | 2133 S Elizabeth Street Wichita, KS 67213 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br>Level of Harm - Actual harm<br>Residents Affected - Few | The 08/27/24 Care Plan documented on 03/03/21 that R21 was at risk for falls and listed the following interventions:<br>1. On 03/03/21, staff would instruct R21 on proper transfer techniques and to alert the staff for assistance.<br>2. On 04/13/21, staff would provide correct footwear to utilize at night and remind resident to alert the staff for assistance when needed.<br>3. On 02/08/22, staff referred R21 to physical therapy for strengthening and altered gait (manner or style of walking).<br>4. On 03/21/22, R21 was to use a walker for stability during all transfers.<br>5. On 08/27/22, staff added adhesive non-skid strips to the floor in front of R21's recliner to aid in transfers.<br>6. On 10/18/22, staff would educate R21 in the importance of minimizing clutter in her room.<br>7. On 10/27/22, staff would offer to hem up R21's pants to reduce the risk of falls and encourage R21 to ask for assistance.<br>8. On 06/28/23, staff would educate R21 to ensure feet were firmly on the floor before attempting to stand or transfer.<br>9. On 12/18/23, staff would remind the resident to utilize her walker with all ambulation (walking).<br>10. On 02/12/24, staff referred R21 to occupational therapy for strengthening and safety training.<br>The Care Plan lacked documentation or intervention related to the fall on 07/01/24.<br>The Physician's Orders lacked documentation or intervention related to fall prevention/mitigation.<br>Review of the EHR Fall Risk assessments revealed the following:<br>1. On 01/26/23, the facility documented a fall risk of 13, which indicated a high risk for falls.<br>2. On 03/31/23, the facility documented a fall risk of 12, which indicated a high risk for falls.<br>3. On 06/27/23, the facility documented a fall risk of 11, which indicated a high risk for falls.<br>4. On 09/17/23, the facility documented a fall risk of 13, which indicated a high risk for falls.<br>5. On 12/08/23, the facility documented a fall risk of 13, which indicated a high risk for falls.<br>6. On 01/24/24, the facility documented a fall risk of 12, which indicated a high risk for falls.<br>7. On 06/28/24, the facility documented a fall risk of 13, which indicated a high risk for falls.<br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | 8. On 06/22/24, the facility documented a fall risk of 12, which indicated a high risk for falls.<br><br>Review of the facility's fall investigations revealed the following:<br><br>1. On 03/26/24, R21 fell due to weakness, which resulted in a fracture (broken bone) of one of her vertebrae (bones of the spine) and required hospitalization. The Progress Notes documented that resident felt weak and fell in a seated position to the floor from a standing height. The immediate intervention was to send the resident to the hospital by ambulance. The care plan intervention dated 04/01/24, staff referred R21 to physical therapy for safety training and ADL retraining since R21 was wearing a thoracic lumbar sacral orthosis (TLSO - a brace or splint that limits the movement of the spine from mid back area to the sacrum [triangular bone at the base of the spine], often used after surgery or injury to the spine).<br><br>2. On 04/22/24, R21 fell but was not injured. The Progress Notes documented the resident was not wearing appropriate footwear. The fall report documented the immediate intervention was for R21 to wear appropriate footwear with ambulation with the care plan intervention dated 04/22/24 for staff to remind R21 to wear appropriate footwear.<br><br>3. On 05/27/24, R21 fell, but was not injured. The Progress Notes documented that the resident ambulated unassisted and fell to her knees from a standing height due to weakness. The fall report documented the immediate intervention was that staff would ensure the call light was within R21's reach and remind R21 to call for assistance with the care plan intervention dated 05/27/24, staff would always place a call light within R21's reach and encourage its use and encourage R21 to keep personal use items within reach.<br><br>4. On 06/05/24, R21 fell, which resulted in a fracture of her right clavicle (collar bone) but did not require hospitalization. The Progress Notes documented that the resident was ambulating with her walker without the use of shoes or non-skid socks. R21 stated on 08/26/24 at 10:40 AM that she slipped on water and that she was unaware she had spilled on the floor in the bathroom. The fall report documented the immediate intervention of staff to staff to perform visual checks on R21 every two hours with the care plan intervention dated 06/05/24, staff would perform visual checks and offer assistance every two hours for a 24-hour period.<br><br>5. On 07/01/24, R21 fell but was not injured. The facility's investigation determined that the root cause of the fall was that R21 attempted to self-transfer into a wheelchair unsuccessfully. The facility's investigation report lacked an immediate intervention put in place by the staff on duty at the time of the fall, additionally the EHR Care Plan lacked an intervention related to this incident.<br><br>On 08/28/24 at 10:46 AM, Certified Nurse Aide (CNA) G stated that if a resident fell, that CNA staff would stay with the resident and alert other staff for assistance and upon the arrival of the nurse, follow the instructions given by the nurse.<br><br>On 08/28/24 at 10:57 AM, Certified Medication Aide (CMA) H stated that it was discovered that a resident fell, CNA/CMA staff would ensure that the resident was safe and alert other staff for additional assistance including notifying the nurse then would follow the instructions from the nurse.<br><br>On 08/28/24 at 11:18 AM, Administrative Nurse B stated that immediately following a fall, the nurse should fill out a note with any assessment findings and do a fall huddle with the staff on duty to investigate the cause of the fall. The nurse should then initiate an immediate intervention to<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|

F 0689

Level of Harm - Actual harm

Residents Affected - Few

mitigate the risk for falls for the remainder of the shift. The nurse would then notify the physician, resident representative and Administrative Nurse B. Additionally stated that if the fall happened during normal business hours, the interdisciplinary team (IDT - a team of facility staff consisting of members of various departments including but not limited to; dietary, nursing, maintenance, therapy, etc.) would hold an immediate meeting to develop a permanent care plan intervention. If the fall happened outside of normal business hours, then the IDT would meet and develop a permanent care plan intervention the following morning (or on Monday, if the fall happened on a weekend). Administrative Nurse B stated that the above information was the expectation of staff and confirmed the lack of a care plan intervention related to the fall on 07/01/24 and was unable to provide an explanation as to why the care plan lacked an intervention for the fall on 07/01/24.

The facility's Falls and Fall Risk, managing policy, dated 12/2007 documented that the staff would identify interventions related to a resident's specific risks and causes to prevent falls. Additionally documented that if a resident has repeated falls that staff would implement additional or different interventions, until falls were reduced or stopped or the reason for the falls is identified as unavoidable. Further documented that the staff would include the physician and Consultant Pharmacist to re-evaluate, identify and implement interventions to minimize serious consequences of falling.

The facility failed to ensure that R21 remained free of accident hazards related to falls when the facility failed to review and revise the care plan for R21 after R21 fell on [DATE]. This deficient practice had the potential to lead to ongoing increased risk for falls and the possibility of additional injuries from falls.

- Review of the Electronic Health Record (EHR) for Resident (R)20 included the diagnoses of dementia (a progressive mental disorder characterized by failing memory, confusion), osteoporosis (an abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), restlessness and agitation, and repeated falls.

The Annual Minimum Data Set (MDS) dated 12/30/23 documented a Brief Interview of Mental Status (BIMS) score of nine, which indicated moderately impaired cognition. The assessment documented R20 utilized a wheelchair for locomotion and was dependent on staff for all cares except eating and oral hygiene, which required supervision/setup.

The Falls Care Area Assessment (CAA) dated 12/30/23 documented that R20 was at risk for falls secondary to decreased safety awareness, a history of multiple falls and impulsive behaviors.

The Quarterly MDS dated 07/31/24 documented a BIMS score of six, which indicated severely impaired cognition. The assessment documented R20 was dependent on staff for all cares except eating and oral hygiene which required supervision/setup.

The 08/27/24 Care Plan lacked documentation related to use or omission of foot pedals on R20's wheelchair.

The Physician Orders lacked documentation related to foot pedal use on R20's wheelchair.

The Assessments in the EHR lacked documentation of a safety assessment related to locomotion without foot pedals installed on R20's wheelchair.

The Progress Notes reviewed 06/01/24 to 08/27/24 lacked documentation related to the use or

(continued on next page)

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Homestead Health Center | 2133 S Elizabeth Street<br>Wichita, KS 67213 |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0689<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | omission of foot pedals on R20's wheelchair.<br><br>Observation on 08/26/24 at 12:58 PM, revealed staff propelled R20 in his wheelchair. The wheelchair lacked foot pedals and R20 held his feet above the ground by approximately 1 to 2 inches.<br><br>Observation on 08/27/24 at 07:30 AM, revealed R20 sat at a table in the dining area with peers present. The wheelchair lacked foot pedals for R20.<br><br>Observation on 08/28/24 at 11:00 AM, revealed R20 sat at a table in the activity area with peers present and parti[TRUNCATED] |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>The facility reported a census of 43 residents with 12 residents sampled. Based on observation, interview, and record review, the facility failed to ensure one of two medication carts observed were locked while unattended. This deficiency had the potential to affect 21 residents located on the North Unit.<br><br>Findings included:<br><br>- During an observation on 08/27/24 at 12:05 PM, an unlocked medication cart was observed on the North Unit. Licensed Nurse (LN) Q was seated behind the nurse's station desk with her back towards the unlocked medication cart that was positioned on the outside of the nurse's station. LN Q had been communicating with a hospice nurse. The medication cart drawer was opened without LN Q noticing.<br><br>During an interview on 08/27/24 at 12:06 PM, LN Q confirmed that the medication cart was the nurses' treatment cart and should not have been left unlocked as the cart contained medications and treatment supplies. LN Q then locked the cart.<br><br>During an interview on 08/28/24 at 10:07 AM, Administrative Nurse B confirmed the nurses' medication/treatment cart should be locked at all times when not in use.<br><br>The facility's policy Security of Medication Cart dated 04/2007, documented the medication cart shall be secured during medication passes. The medication carts must be securely locked at all times when out of the Certified Medication Aide or Nurse's view. When the medication cart is not being used, it must be locked and parked at the nurses' station or inside the medication room.<br><br>The facility failed to provide proper storage of medications in a safe locked medication cart. This deficient practice had the potential to have a negative effect of the residents in the facility. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>The facility reported a census of 43 residents. Based on observations, interviews, and record review, the facility failed to maintain effective infection control measures when Certified Medication Aide (CMA) H poked a straw through a potentially contaminated plastic film on the top of a cup containing a house supplement shake and then assisted a resident in drinking part of the shake. This deficient practice had the potential to contaminate the shake and lead to food-borne illness.<br><br>Findings included:<br><br>- On 08/28/24 at 11:04 AM, CMA H knocked over a cup that contained an unknown liquid and covered with a plastic film that sat on the medication cart. CMA H picked up the cup, removed a straw from the paper wrapper, and poked the straw through the plastic film. CMA H then walked into Resident (R) 1's room and assisted R1 in drinking approximately half of the liquid.<br><br>On 08/28/24 at 11:11 AM, CMA H identified the liquid as a house supplement nutritional supplement shake and confirmed that she poked the straw through the potentially contaminated plastic film. CMA H stated that she should have sanitized the plastic film prior to inserting the straw or removed a small portion of the covering to insert the straw.<br><br>On 08/28/24 at 11:15 AM, Administrative Nurse B stated the expectation was for staff to peel back the plastic film over a cup before inserting the straw due to infection control concerns as the plastic film could potentially be contaminated during transport from source to the medication cart. Administrative Nurse B went on to say that alternatively, the plastic film could have been sanitized with an isopropyl alcohol pad prior to a straw being poked through the plastic film.<br><br>The facility's Monitoring Compliance with Infection Control policy, dated 04/2024, documented staff would adhere to infection prevention processes.<br><br>The facility failed to maintain an effective infection control program when CMA H poked a straw through a potentially contaminated plastic film on the top of a cup containing a house supplement shake and then assisted a resident in drinking part of the shake. This deficient practice had the potential to contaminate the shake and lead to food-borne illness. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175487 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 08/28/2024 |
|---|---|---|---|
| NAME OF PROVIDER OR SUPPLIER Homestead Health Center | | STREET ADDRESS, CITY, STATE, ZIP CODE 2133 S Elizabeth Street Wichita, KS 67213 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>The facility reported a census of 43 residents with 12 residents sampled. Based on interview and record review, the facility failed to provide the pneumococcal vaccine (vaccine designed to prevent pneumonia [inflammation of the lungs which can be debilitating or lethal in the elderly]) declination form to two of the five residents reviewed, Resident (R) 37 and R38.<br><br>Findings included:<br><br>- Review of the Electronic Health Record (EHR) and the 2023-2024 binder which contained consents and declinations in Administrative Nurse B's office on 08/28/24, lacked documentation of any pneumococcal vaccine declination form for Resident (R) 37 and R38.<br><br>On 08/28/24 at 12:05 PM, Administrative Nurse B reported that R37 said she had the pneumococcal vaccine in the past and would not require one. Administrative Nurse B stated that she would look for the declinations for both residents.<br><br>On 08/28/24 at 12:44 PM, Administrative Nurse B confirmed the facility could not locate any vaccination declinations for R37 and R38. Furthermore, she reported that R37's family did not provide the facility with an immunization record that R37 had received the pneumococcal vaccine in the past, and R38 had always refused any vaccination offered.<br><br>The facility's Pneumococcal Vaccine policy dated 10/2022 documented all residents were offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections. The residents have a right to refuse the vaccine. If refused, appropriate information was documented in the resident's medical record indicating the date of the refusal.<br><br>The facility failed to provide proof of declination of the pneumococcal vaccine for two residents, R37 and R38. |