

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/05/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175558	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/23/2022
NAME OF PROVIDER OR SUPPLIER THE HEALTHCARE RESORT OF LEAWOOD - IRON HORSE HLTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5401 W 143RD STREET LEAWOOD, KS 66224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS The following citations represent the findings of complaint visit #KS00172135. The 2567 was sent on 07/05/22.	F 000			
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 53 residents. The sample included three residents, with three residents reviewed for accidents. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free of accidents when facility staff failed to use a gait belt (belt used to help transfer a person from one place to another) during a transfer in the bathroom, which resulted in a fall. This deficient practice resulted in a fracture of R1's right femur (thigh bone). Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented diagnoses of displaced fracture of base of neck of right femur subsequent encounter for closed fracture with routine healing, difficulty in walking, generalized weakness, vascular dementia (a progressive	F 689			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/05/2022

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 689	Continued From page 1 mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain) without behavioral disturbance, and history of falling. The "Annual Minimum Data Set (MDS)" dated 05/04/22, documented R1 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R1 required extensive physical assistance with two staff for bed mobility and walking; extensive physical assistance with one staff for transfers, locomotion, dressing, toileting, and personal hygiene. R1 had no falls since the last assessment. The "Quarterly MDS" dated 06/07/22, documented a BIMS was not assessed for R1. R1 required extensive physical assistance with one staff for bed mobility, locomotion, and dressing; limited physical assistance with one staff for personal hygiene; extensive physical assistance with two staff for transfers and toileting. R1 had a fall with fracture in the last six months. The "Activities of Daily Living (ADL) Functional/Rehabilitation Potential Care Area Assessment (CAA)" dated 05/06/22, documented R1 required assistance of staff with all ADLs. The "Falls CAA" dated 05/06/22, documented R1 was at risk for injury/falls related to diagnoses and required assistance with ADLs. The "Care Plan" dated 03/30/18, directed R1 had ADL self-care performance deficit and documented an intervention, last revised 12/03/18, which documented that R1 required one staff participation to use toilet. The "Care	F 689			

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F 689	Continued From page 2 Plan" documented an intervention, revised on 08/20/18, which noted that R1 required one staff assistance with transfers. The "Care Plan" was revised on 06/15/22 with an intervention that noted R1 required two staff assistance with transfers with a gait belt. The "Notes" tab of R1's EMR revealed the following: A "Nursing Note" on 05/26/22 at 10:00 AM documented Certified Nurse Aide (CNA) M informed a nurse that R1 had a non-injury fall during transfer from the toilet to her wheelchair. R1 attempted to sit down before the wheelchair was under her and R1 fell on her buttocks. Assessment completed, with no complaints of pain. The nurse and CNA M assisted R1 back to the wheelchair. A "Nursing Note" on 05/26/22 at 12:46 PM documented R1 complained of pain to her right knee. Consultant G was notified and ordered two to three view x-rays to the resident's right knee. A "Nurse Practitioner (NP)/Physician Assistant (PA) Progress Note" on 05/26/22 at 03:16 PM documented non-face-to-face completed. Nursing staff called to notify of a witnessed fall in the bathroom. R1 complained of right lower extremity pain and requested x-rays. In further discussion with the nurse, Consultant G needed the nurse to narrow down area of pain. After the nurse's assessment, it was determined that R1's main pain was in her right knee. X-ray ordered for two to three views of the resident's knee. A "Nursing Note" on 05/26/22 at 11:15 PM documented x-ray results of the right knee, two	F 689			

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F 689	Continued From page 3 view study, showed no fracture, dislocation, or bony erosion, soft tissue swelling noted. A "NP/PA Progress Note" on 05/27/22 at 03:09 PM documented R1 was seen and examined following a recent fall. Yesterday she had a witnessed fall in the bathroom and complained of right leg pain. Upon further assessment from the nurse, R1's main pain was in her knee. X-ray of the knee ordered, which was within normal limits. Today upon assessment of R1, she complained of pain in her right groin and was unable to bear weight. Hip x-ray to be obtained. A "Nursing Note" on 05/28/22 at 05:32 AM documented R1 had a right hip x-ray done. Results came back indicating R1 had an impacted slightly displaced sub-capital (femoral neck) fracture of the right femur. NP gave an order to send R1 to hospital. A "Fall Committee Interdisciplinary Team (IDT) Note" on 05/28/22 at 01:58 PM documented IDT reviewed witnessed fall with fracture on 05/26/22 at 10:00 AM. R1 was assisted by CNA M off of toilet and into wheelchair. CNA M was attempting to get pants pulled up while R1 was attempting to sit down. CNA M was unable to get wheelchair underneath R1 and she fell to her bottom. Fall was witnessed, care plan was being followed at time of fall. The facility's "Investigation" dated 06/06/22, documented R1 had a witnessed fall on 05/26/22. The fall occurred during a transfer by CNA M in the restroom. Immediate education was given to CNA M regarding transfers. On 05/26/22, x-rays were completed of R1's knee, in which they resulted negative on 05/27/22. R1 complained of	F 689			

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F 689	Continued From page 4 further pain, in which, additional x-rays were taking in the evening on 05/27/22 of R1's right hip. The x-rays noted on 05/28/22 at 05:20 AM that R1 had a right side impacted slightly displaced right sub-capital fracture. R1 was transported to the hospital for further follow-up and surgery. Upon further investigation into the fall, it was found that CNA M failed to use a gait belt. Prior to the fall, R1 was an assist of one staff with gait belt. In a "Fall Witness Statement" on 05/26/22 at 09:58 AM, CNA M stated R1 just finished using the restroom and when CNA M was pulling up her pants, R1 hurried up, and tried to sit down before CNA M told her to and she fell on her bottom. On 06/23/22 at 01:56 PM, R1 sat in her wheelchair in her room and watched television. R1 was hard of hearing but was able to communicate with surveyor. R1's feet rested on foot pedals, shoes were worn, and call light was within reach. R1 appeared comfortable and without signs of distress or discomfort. On 06/23/22 at 01:56 PM, R1 stated she had a fall and broke her hip. She stated an aide was helping her transfer, did not lock the brakes to her wheelchair, and she fell. On 06/23/22 at 02:03 PM, CNA N stated residents were transferred using a gait belt or a mechanical lift, whichever was applicable for the resident. She stated falls were prevented by ensuring resident wore nonskid shoes/socks, staff answered call lights in a timely manner, and staff used a gait belt with transfers. On 06/23/22 at 02:06 PM, Licensed Nurse (LN) G	F 689			

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F 689	Continued From page 5 stated depending on the resident, they were transferred with one or two staff using a gait belt. She stated falls were prevented by ensuring the resident wore the correct socks/shoes, advising resident to get their bearings before standing, staff anticipating resident needs, ensuring proper lighting in room, ensuring call light was within reach, and staff used a gait belt with transfers. LN G stated on 05/26/22, CNA M was taking R1 to the bathroom and R1 fell while CNA M was in the bathroom. CNA M informed LN G R1 had a witnessed fall and LN G entered the room. LN G stated when she entered R1's bathroom, R1's wheelchair was to her side and R1 sat on her buttocks facing the toilet. She stated R1 did not complain of pain at the time, but later that day she complained of pain and an x-ray was obtained of her knee, it was negative. LN G stated CNA M informed her R1 sat down before the wheelchair was behind her. On 06/23/22 at 02:22 PM, Administrative Nurse D stated R1 fell on 05/26/22 during a transfer. R1 had complained of knee pain and an x-ray was obtained, it was negative. R1 continued to complain of pain and after an assessment was completed, the NP ordered a hip x-ray. Administrative Nurse D stated the hip x-ray was positive and R1 was sent to the hospital for evaluation. She stated she expected staff to follow the care plan for fall preventions and any resident that was unsteady or had a change in condition should have a gait belt utilized during transfers at a minimum. On 06/23/22 at 02:35 PM, Administrative Staff A stated R1's family informed her that staff had not been using a gait belt with R1. Once R1 returned from the hospital, R1's family requested she	F 689			

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F 689	Continued From page 6 become a two person assist with gait belt for transfers. Administrative Staff A stated on 05/26/22, R1 was in the bathroom and stood up to transfer off the toilet, R1 became weak, and staff did not have anywhere to grab onto R1 to prevent the fall. The facility's "Transfer/Gait Belt" policy, last revised September 2021, directed gait belt transfers required one or two-person transfers depending on the residents' ability to cooperate with the procedure and bear weight. The "policy" directed staff placed a gait belt around resident's waist and during the transfer, four fingers were held up under the gait belt with thumbs in a downward position. The facility failed to ensure R1 remained free of accidents when facility staff failed to use a gait belt transfer in the bathroom which resulted in a fall. This deficient practice resulted in a fracture of R1's right femur.	F 689			