STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175403	A. BUILDING _____ B. WING _____	C 06/21/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHESDA HOME	**408 E MAIN PO BOX 37 GOESSEL, KS 67053**

(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 investigation #KS00171181. The citation was cited as past noncompliance. This 2567 was electronically sent to the facility on 06/28/2022.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 29 residents, including three residents reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 1 remained free from accident hazards, when on 04/23/22, Certified Nurse Aide (CNA) M failed to safely secure R1 in a whirlpool chair with the safety belt or safety bar, and failed to lower the resident's whirlpool chair to the lowest position before the CNA retrieved the resident's wheelchair, which was approximately two feet from the whirlpool chair, to transfer R1. CNA M left the resident suspended with the resident's feet dangling in the air and with no safety belt to secure him in the whirlpool chair while she went to retrieve the wheelchair. At that time, the resident fell forward out of the whirlpool chair, to the floor and onto his left side, where he	F 689	Past noncompliance: no plan of correction required.	

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

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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sustained multiple injuries, that included a left hand skin avulsion (a wound that happens when skin is torn from the body during an accident or other injury) that measured 10 centimeters (cm) by 7 cm, which exposed tendons and veins in his left hand, and a purple left shoulder bruise that measured 22 cm by 19 cm with two skin tears on the bruise that measured 12 cm by 4.5 cm and 6 cm by 1 cm, requiring a trip to the emergency room for treatment.

Findings included:

- The "Physician Order Sheet" (POS), dated 06/16/22, documented R1 with diagnoses of cognitive communication deficit (difficulty with thinking and how someone uses language) and cerebral infarction (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 [stroke]).

The "Annual Minimum Data Set" (MDS), dated 11/19/21, documented the resident with a Brief Interview for Mental Status (BIMS) score of 9, or moderately impaired cognition. The resident required limited assistance of one staff member with toileting, transfers, and bathing. The resident used a wheelchair for mobility.

The "Activities of Daily Living (ADLs) Functional/ Rehabilitation Potential Care Area Assessment" (CAA), dated 11/30/21, advised staff that the resident needed limited to extensive assistance of one staff member with his ADLs.

The "Cognitive Loss/Dementia CAA," dated 11/30/21, advised staff that R1 had moderate cognitive impairment, confusion, and

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forgetfulness. The staff were to provide R1 with reminders, cues, and orientation as needed.

The "Falls CAA," dated 11/30/21, advised staff that R1 had a potential for increased risk for falling due to chronic health conditions, weakness, unsteadiness, and history of falls.

The "Quarterly MDS," dated 04/29/22, documented the resident with a BIMS score of 9, or moderately impaired cognition. The resident required limited assistance of one staff member with toileting, transfers, and bathing. The resident used a wheelchair for mobility.

The "Falls Care Plan," updated 05/12/22, advised staff that the resident was at risk for falling related to a history of falls, poor balance, and hypotension (low blood pressure). The staff received education on 04/23/22 to use the safety belt on the whirlpool chair during the resident's bath, after the fall.

The "ADLs Care Plan," updated 05/12/22, advised staff that the resident required limited to extensive assistance with bathing and transfers.

A "Nursing Note," dated 04/23/22 at 10:57 AM, by Licensed Nurse (LN) G revealed she heard a scream from the spa room and opened the door to find R1 lying on his left side on the floor with his head against the shower stall. R1 received a whirlpool bath with assistance from CNA M. CNA M turned around to grab the wheelchair while the resident was still in the whirlpool chair and the resident fell out of the whirlpool chair onto the floor. The resident had skin trauma to the left occiput (back of head) that measured 2 centimeters (cm) by 2cm, with a L-shaped skin

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tear with edges approximated (to bring together) and the bleeding controlled. The area was edematous (swollen). The resident had a purple left shoulder bruise that measured 22 cm by 19 cm with two skin tears on the bruise that measured 12 cm by 4.5 cm and 6 cm by 1 cm. Two left elbow skin tears measured 14.5 cm by 9 cm and 4 cm by 9 cm assessed. He also sustained a left-hand skin avulsion with tendons and veins exposed that measured 10 cm by 7 cm and a left little finger skin tear that measured 2 cm by 2.5 cm. Staff noted multiple small bruises on the resident's arms. LN G notified Administrative Nurse D and the resident's durable power of attorney. The resident transferred to the hospital emergency room by Emergency Medical Services (EMS).

A "Nursing Note," dated 04/23/22 at 4:02 PM, by LN H revealed a phone report received from the hospital. The elder had skin tears on left hand, elbow, and shoulder from the fall. Treatment included wet to dry dressings on each skin tear secured with paper tape and kerlex (wrap) for wound care.

A "Witness Statement," dated 04/23/22, by CNA M revealed she finished bathing R1and had the bottom half of the resident dressed while in the whirlpool chair. The safety bar was up and to the side of the resident. She turned away from the resident to move the resident's wheelchair and when she turned back around, the resident was on the floor.

Observation, on 06/21/22 at 10:05 AM, Certified Medication Aide (CMA) R and Administrative Nurse E demonstrated use of the whirlpool chair. Administrative Nurse E sat in the chair equipped

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with a safety belt and a safety bar that can be moved up and down in front of a resident sitting in the chair. CMA R secured Administrative Nurse E in the chair by placing the safety belt around her waist and securing it and then lowering the safety bar in front of Nurse E. Staff lifted the chair approximately a foot up in the air so her feet would clear the edge of the whirlpool tub. During the demonstration, CMA R stated after assisting a resident out of the whirlpool bath, the resident should be taken over by the wall to use the grab bar while the aide lowered the chair to the floor. The resident should never be up in the air during drying or dressing them after a bath. The safety belt should remain on the resident and the safety bar down until the resident's feet were safely on the floor.

Interview, on 06/21/22 at 10:10 AM, Administrative Nurse E stated the facility's investigation revealed CNA M assisted R1 out of the whirlpool tub with no safety belt around his waist and the safety bar in the up position. Instead of lowering R1 safely to the floor before getting the wheelchair, CNA M turned her back while he was still up in the air and he tumbled forward, out of the chair and landed on his left side. The staff were to always use the safety belt and bar regardless of the resident's mobility status or cognition during whirlpool baths.

Interview, on 06/21/22 at 10:21 AM, CNA N revealed she was walking by the spa room and heard someone scream. CNA N found R1 lying on the floor and all he said was "I want to go back to my room." CNA N noticed the whirlpool chair was "Too high up in the air." She saw R1 had injuries and his head was laying against the wall. LPN G heard the screaming too and immediately

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came to the spa room and did an assessment. LN G called the Director of Nursing (DON) and the DON instructed LN G to call EMS.

The facility policy "Bathing in Whirlpool," revised 01/16/20, documented ...Whirlpool Tub Bath ...Assist resident to transfer into the whirlpool lift chair. Ensure the seatbelt strap is over the waist of the resident and fastened securely ...

The facility failed to safely secure R1 in a whirlpool chair with the safety belt and safety bar, and failed to lower the resident to the floor before retrieving his wheelchair, which was approximately two feet from the whirlpool chair, to transfer R1. CNA M left the resident suspended with his feet dangling in the air and with no safety belt or safety bar to secure him in the whirlpool chair while she went to retrieve the wheelchair. At that time, the resident fell forward out of the chair to the floor and onto his left side where he sustained multiple injuries, including a left hand skin avulsion that measured 10 centimeters (cm) by 7 cm, which exposed tendons and veins in his hand, and a purple left shoulder bruise that measured 22 cm by 19 cm with two skin tears on the bruise that measured 12 cm by 4.5 cm and 6 cm by 1 cm, requiring a trip to the emergency room for treatment.

This citation was considered to be past non-compliance, when the facility corrected the deficient practice, with implementation and then completion of the following items, on 04/30/22 at 02:26 PM.

1. On 04/23/22, after the resident's fall, education on use of the safety belt/position bar in the whirlpool tub began at 12:30 PM. Facility

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F 689	Continued From page 6 education was completed by 19 of the facility staff members on 04/30/22 at 02:26 PM.	F 689		