STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. The 2567 was sent electronically on 05/16/23.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning.	F 636		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

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SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 636	Continued From page 1	F 636		

(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)
(iii)Not less than once every 12 months.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 21 residents. The sample included 12 residents. Based on record review, observation and interview the facility failed to complete the required "Annual Minimum Data Set" (MDS) for Resident (R) 12 which placed the resident at risk for inappropriate care and unmet needs.

Findings included:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 636	Continued From page 2	F 636		

- R12's "Quarterly Minimum Data Set" (MDS), dated 03/14/23, documented R12 had severe cognitive impairment, required extensive assistance of two staff for activities of daily living, and frequently incontinent of urine and bowel. The MDS further documented R12 had scheduled pain medication regimen, took an antianxiety medication (class of medications that calm and relax people with excessive anxiety- mental or emotional reaction characterized by apprehension, uncertainty and irrational fear, nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression- abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), diuretic (medication to promote the formation and excretion of urine) and opioid (used to treat pain) daily. R12 had a condition or chronic disease that may result in a life expectance of less than six months and received hospice care.

R12 had a completed "Annual MDS" assessment with Care Area Assessments, dated 03/29/22. Review of R12's completed MDS lacked a comprehensive MDS since the last annual MDS over one year ago.

On 05/01/23 at 02:31 PM, observation revealed R12 laid on a low air loss mattress, in bed, covered with blankets after staff attempted to feed the midday meal and hospice staff visited.

On 05/03/23 at 02:00 PM, Administrative Nurse E verified a quarterly MDS had been completed on 03/14/23 and an annual assessment should have been completed instead.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 636	Continued From page 3 The facility's undated "MDS Assessment Scheduling-Assessment Timing" policy, documented assessments must be conducted based on the resident's length of stay and the length of time between Assessment Reference Date (ARD). The federal Omnibus Budget Reconciliation Act (OBRA) assessments may be scheduled early if a nursing home wanted to stagger due dates for assessments. As a result, more than three OBRS Quarterly assessments may be completed on particular resident in a given year, to the Annual may be completed early to ensure that regulatory time frames between assessments are met. The facility failed to complete an annual/comprehensive MDS assessment for R12 which placed the resident at risk of inappropriate care and unmet care needs.	F 636		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 656	Continued From page 4 under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: The facility had a census 21 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for Resident (R)12 who received hospice (special care to people who are near the end of life)services, which placed the resident at risk for unmet care needs.	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 656	Continued From page 5	F 656		

Findings included:

- R12's Electronic Medical Record (EMR) recorded diagnoses of hypertension (elevated blood pressure), osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk), chronic pain, major depressive disorder (major mood disorder), edema (swelling resulting from an excessive accumulation of fluid in the body tissues) and sleep related hypoventilation (breathing at an abnormally slow rate).

The "Quarterly Minimum Data Set" (MDS), dated 03/14/23, documented R12 had severe cognitive impairment and required extensive assistance of two staff for activities of daily living. R12 was frequently incontinent of urine and bowel. The MDS further documented R12 had scheduled pain medication regimen, took an antianxiety medication (class of medications that calm and relax people with excessive anxiety- mental or emotional reaction characterized by apprehension, uncertainty and irrational fear, nervousness, or tension), antidepressant (class of medications used to treat mood disorders and relieve symptoms of depression), diuretic (medication to promote the formation and excretion of urine) and opioid (used to treat pain) daily. R12 had a condition or chronic diseased that may result in a life expectance of less than six months and received hospice care.

The "Psychotropic Drug Use Care Area Assessment" (CAA), dated 03/22/22, documented R12 was on hospice care, had signs of depression related to declining status and recent loss of R12's spouse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 656	Continued From page 6	F 656		

R12's "Care Plan" lacked hospice problem, goals, and treatment interventions.

The "Physician Orders", dated 05/13/20, documented admission to hospice and "Do No Resuscitate" (DNR - a written legal order to withhold cardiopulmonary resuscitation, in respect of the wishes of a person in case their heart stopped or they stopped breathing).

The "Progress Note", dated 04/27/23 at 01:00 PM, documented the hospice nurse visited with no changes in cares or medications. R12 slept through the visit.

On 05/01/23 at 02:31 PM, observation revealed R12 laid on a low air loss mattress, in bed, covered with blankets after staff attempted to feed the midday meal and hospice staff visited.

On 05/01/23 at 10:00 AM, Consultant Staff GG reported R12 was on hospice services for approximately three years.

On 05/03/23 at 08:34 AM, Administrative Nurse D stated the care plan should reflect R12's hospice services and care for the resident.

The facility's "Care Plans, Comprehensive Person-Centered" policy, dated 03/2022, documented a comprehensive, person centered care plan that includes measurable objectives and timetable to meet the resident's psychosocial and functional needs is developed and implemented for each resident, which included which professional services are responsible for each element of care and reflect currently recognized standards of practice for problem areas and conditions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 656	Continued From page 7 The facility failed to develop a comprehensive care plan related to care and services provided by hospice for R12 which placed the resident at risk of unmet care needs.	F 656		
F 689 SS=D	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 had a census of 21 residents. The sample included 12 residents with one of five reviewed for accidents and/or falls. Based on observation, record review, and interviews, the facility failed to identify and implement interventions to prevent further falls for Resident (R)21. This placed the resident at risk for further falls and fall related injuries. Findings included: -- R21's Electronic Medical Record (EMR) recorded diagnoses of radiculopathy (a disease of the root of a nerve such as a pinched nerve or a tumor) of lumbar (lower portion of spine) region, chronic kidney disease, diabetes mellitus (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), hemiplegia (paralysis of one side of the body) and hemiparesis (muscular weakness of one half of	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

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SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 689	Continued From page 8	F 689		

the body) following 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) affecting left non-dominant side, major depressive disorder (abnormal emotional state characterized by exaggerated feelings of sadness, worthlessness, emptiness and hopelessness), and hypertension (elevated blood pressure).

The "Annual Minimum Data Set" dated 03/14/23, recorded R21 had severe cognitive impairment, required extensive assistance of one staff for activities of daily living, was not steady and only able to stabilize with staff assistance with walking and turning around facing the opposite direction, and had functional range of motion affecting one side upper and lower extremities. The MDS further documented had no current toileting program and was occasionally incontinent of urine and bowel, had pain which limited day to day activities, and a fall with injury.

The "Fall Care Area Assessment" (CAA) dated 03/23/23, documented R21 had a significant fall history related to very poor balance and safety awareness following a stroke with left sided weakness and deficits, and at times does well but was generally unsteady and at high risk for falls. The CAA further documented R21 became upset with staff when falls occurred and frequently blamed staff for falls. R21 insists on doing cares on own at times and staff to provided education of the risks associated with falls and ensure understanding.

The "Fall Care Plan" documented R21 was a risk for falls related to recent history of stroke with left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

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F 689	Continued From page 9	F 689		

sided weakness. The care plan recorded fall, injuries, and interventions as follows:

On 05/20/22 at 10:42 PM, stood with bare feet in the shower, had small pink discoloration to middle left side of back. The intervention of do not stand R21 on towels or use shoes or gripper socks.

On 05/22/22 at 04:14 PM, R21 found sitting on floor by stool after taking self to bathroom. R21 sent to emergency room due to left ear bleeding and require two sutures to left ear. The intervention to continued education and room checks.

On 06/22/22 at 06:04 PM, R21 found on the floor in front of toilet, without injury, and the intervention to re-educated to the use of call light and pendant and had R21 demonstrated the use correctly.

On 07/05/22 at 05:06 PM, found on floor in front of recliner. The intervention placed was to encouraged R21 to ask for assistance with cares.

On 07/19/22 at 00:12 AM, R21 slid out of recliner attempting to pick up a pillow off the floor. R21 broke open a scab to a skin rear from a previous fall. The intervention was to reeducate R21 to use call button and ask for assistance.

On 08/02/22 at 03:20 AM, R21 found sitting in front of his recliner, footrest up, opened scab to skin tear and new steri-strips applied. The intervention was to remove wooded pedestal and continue to provide education to resident not to attempt self-transfers.

On 10/15/22 at 08:30 PM, staff assisted R21 in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

the bathroom, staff turned away from resident to obtain a gait belt, when R21 tried to stand and fell. No new intervention for preventing further falls.

On 11/03/22 at 03:53 PM, staff noted R21 sat on the floor of his room. No injuries found. The interventions to keep phone within reach and educate R21 on asking for staff assistance.

On 11/23/22 at 08:45 PM, R21 slid from his recliner trying to pick something off the floor. R21 received two skin tears to his right elbow. The intervention to provided activities that promote exercise and strength building where possible and encourage to ask for help more often.

On 12/20/22 at 08:19 PM, R21was with staff in the shower room when R21 stood from the chair and fell on buttocks. No injury noted. The intervention to hold shower bars while standing in the shower and education provided on safe choices.

On 02/20/23 at 03:18 AM staff heard a loud bang, found R21 on floor by his bed, and gripper socks on upside down. R21 had a skin tear to the top of right hand and right elbow and an abrasion to left back. The intervention to ensure gripper socks were worn correctly and to continue to encourage use of call bell and wait for assistance.

On 04/20/23 at 05:35 AM, staff heard a loud bang and found R21 on the floor by his bed. R21 reported he hit his left forehead and had a hematoma, and skin tears to right wrist and left upper arm and steri-strips applied. The intervention to provide education to allow staff enough time to respond to the call light before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

getting up.

On 05/01/23 at 05:20 AM, staff heard noise from R21's room and found resident in the bathroom sitting between the sink and shower. R21 had skin tear to left upper arm and steri-strips applied. The intervention to educate to the use of alternate call light if pendant does not work.

On 05/01/23 at 03:00 PM, observation revealed facility staff reminding R21 not to walk alone. R21 stated he wanted to check out of the facility, and he could walk.

On 05/02/23 at 02:04 PM, Certified Nurse Aide M stated R21 had memory problems and to prevent falls the staff take him to the bathroom and check on him frequently and encouraged him to call for assistance.

On 05/03/23 at 08:39 AM, Administrative Nurse D verified R21 had memory issues and the fall interventions of educating and remind R21 to use his call light and call for assistance was not successful in preventing R21 from falling and other interventions should have been attempted.

The facility's "Falls and Fall Risk, Managing" policy, dates 03/2018, documented based on previous evaluation and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. If the resident continues to fall, staff will re-evaluate the situation and whether it is appropriate to continue or change current interventions.

The facility failed to identify and implement

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175565	A. BUILDING _____ B. WING _____	05/03/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SUNPORCH OF SMITH COUNTY	920 E KANSAS AVE SMITH CENTER, KS 66967

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12 approrpiate, resident-centered interventions to prevent falls for R21 who was severely cognitively imapired. This placed the resident at risk for further falls and fall related injuries.	F 689		