STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175332	A. BUILDING _____ B. WING _____	C 12/20/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK CREEK OF OTTAWA	1100 W 15TH STREET OTTAWA, KS 66067

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint survey was conducted on 12/20/23 regarding the allegations in KS 00183775. The investigation revealed noncompliance was found related to the allegations and the following deficiencies were cited. The 2567 was electronically sent to the facility on 12/26/23.	F 000		
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 reported a census of 72 residents with three selected for review for falls. Based on observation, interview and record review, the facility failed to ensure staff provided fall intervention as care planned for one Resident (R)2, of the three residents reviewed. Findings included: - Review of Resident (R)2's medical record, revealed diagnoses included lymphedema (swelling caused by accumulation of lymph), diabetes (when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin) with neuropathy (damage of the nerves outside of the brain and spinal cord	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/26/2023

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	F 689		

usually the hands and feet that cause weakness, numbness and pain) and major depressive disorder (major mood disorder).

The "Annual Minimum Data Set" (MDS) dated 06/09/23. assessed the resident with a brief interview for mental status score (BIMS) of 15 which indicated normal cognitive function. The resident required supervision of activities of daily living (ADL) with unsteady balance and required stabilization with staff assistance. The resident had one non injury fall since the prior MDS.

The "Falls Care Area Assessment" (CAA), dated 06/09/23 assess the resident had fall interventions in place, used her walker for ambulation, and staff assisted with ADLs as needed. The resident worked with therapy for strengthening.

The "Quarterly MDS", dated 11/15/23, assessed the resident with a BIMS score of 15, the resident had two noninjury falls and one major non injury fall since the prior MDS.

The "Care Plan" revised 11/29/23, instructed staff the resident had functional deficits related to weakness. The resident slept in her recliner and walked independently with a four wheeled walker. A Fall intervention initiated on 10/14/23, instructed staff to add an appropriately sized piece of dycem (a non-slip material) to her recliner to keep her from sliding out.

Observation on 12/20/23 at 11:00 AM, revealed the resident seated in her recliner in her room. The resident stated she preferred to sleep in her recliner and did have a fall from her recliner about a month ago. She stated she also had falls when

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F 689	Continued From page 2	F 689		

reaching for items, but staff placed her phone charger and hearing aid charger in places that she could reach easily without falling over/out of her chair. The resident stated she should have a piece of non-slip material in the recliner seat to help her from slipping out of the recliner. The resident stated the nonskid strips on the floor in front of her recliner also help her stand. The resident stated she did wear nonskid socks.

Observation, on 12/20/23 at 11:30 AM, revealed the resident ambulated to the dining room with her walker. Her gait was steady.

Observation, on 12/20/23 at 12:20 PM, revealed the resident's recliner lacked the planned piece of non-slip material to prevent slipping/falls.

Interview, on 12/20/23 at 12:20 PM, with Certified Nurse Aide (CNA) M, revealed she was not sure if a fall intervention for the resident included dycem in her recliner, and stated she did not have access to the care plan, but could access the resident's ADL needs. CNA M stated staff taped the resident's phone charger to her table within her reach. The resident wore nonskid socks and had nonskid tapes on the floor in front of her recliner. CNA M stated the resident spent most of her time in her recliner and could ambulate with her walker. CNA M confirmed the resident's recliner lacked the planned dycem.

Interview, on 12/19/23 at 12:45 PM, with Licensed Nurse (LN)G, revealed the resident slept in her recliner and had several falls. LN G stated staff found the resident sitting at the foot of her recliner after reaching for her phone charger. LN G stated the recliner was a lift chair and the resident may have slipped out of the chair. LN G stated the

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resident should have dycem in her recliner and would notify therapy to obtain a piece for her recliner.

Interview, on 12/20/23 at 01:30 PM, with the resident revealed she spilled pop on her recliner and on the dycem about a week ago and tried to rinse it off. She stated she did not know if it was reusable, so she set it on her sink to dry. The resident sat in her recliner on the front edge of the seat.

Interview, on 12/20/23 at 04:00 PM, with Administrative Nurse D, revealed she would expect staff to place the dycem in the resident's recliner as care planned and would investigate the CNA access to the fall interventions on the Kardex (a care plan summary for CNAs) in the electronic medical record.

Interview, on 12/20/23 at 04:15 PM, with Administrative Staff D, revealed the resident may have thrown the dycem away.

The facility policy "Fall Prevention" undated, instructed staff to implement actions to reduce the incidence of additional falls and minimize the potential for injury.

The facility failed to ensure staff provided the dycem to this resident's recliner to prevent slipping falls and possible injury as care planned.