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	175466	A. BUILDING _____ B. WING _____	C 07/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEPOINT WICHITA, LLC	1315 N WEST STREET WICHITA, KS 67203

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation KS00189461 and KS00189424. This 2567 was electronically sent to the facility on 08/08/24.	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 census totaled 88 residents, with three residents in the sample and reviewed for accidents. Based on observation, interview, and record review, the facility failed to provide a safe environment for one resident by the failure to implement interventions to prevent repeated falls with major injury for Resident (R) 2, who had a fall that resulted in a fractured wrist. Findings included: - R2's Physician orders revealed the following diagnoses included chronic respiratory failure, alcoholic cirrhosis of liver (chronic degenerative disease of the liver) with ascites (abnormal fluid buildup in the abdominal cavity), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid) and	F 689		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/08/2024

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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anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).

R2's "Admission Minimum Data Set" (MDS) dated 06/05/24, revealed a "Brief Interview for Mental Status" (BIMS) score of seven, indicating severely impaired cognition. The resident had no behaviors and used a wheelchair for mobility. The resident was independent with toileting, personal hygiene, and ambulation. The resident was able to bend over and pick items off the ground without difficulty. The resident had no toileting plan and was continent of bladder and bowel. The resident had no shortness of breath. She had a terminal diagnosis. R2 had one fall since admission with no injury. Medications included antipsychotic (class of medications used to treat major mental conditions which cause a break from reality), antianxiety (class of medications that calm and relax people), antidepressant (class of medications used to treat mood disorders), diuretics (medication to promote the formation and excretion of urine), and opioid pain medications. The resident required the use of oxygen and received hospice services.

No change of condition assessment done to reflect the residents current status including multiple falls with a fracture to the arm.

The "Care Area Assessments" (CAA) dated 06/05/25 revealed the following:

The "Cognitive Loss/Dementia" CAA revealed R2 was alert and oriented and could make her needs known to staff without difficulty. She was non-compliant at times with staff during cares. Staff were to provide redirection as needed. R2

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could participate in daily cares and activities with minimal difficulty. Staff should always encourage the use of the call light and place it within reach.

The "Functional Abilities" CAA documented R2 required moderate assistance with transfers and mobility and was dependent on staff for bathing.

The "Urinary Incontinence/Indwelling Catheter" CAA documented the resident required supervision assistance with toileting and was continent of urine.

The "Falls" CAA documented the resident was at risk for falls due to weakness, decreased mobility, medication use, history of falls, and a recent admit to hospice. She required moderate assistance with cares, transfers, and mobility. She reported a history of falls at home prior to admission and had one non-injury fall since admission. Staff encouraged the resident to use the call light when she needed assistance and place the call light within reach. Staff provided non-slip footwear for the prevention of falls.

The "Psychotropic Drug Use" CAA documented the resident had a history of depression and received duloxetine (medication used to treat depression) for management of depression. She had a history of anxiety and received alprazolam (medication used to treat antianxiety) for management of anxiety. She had a history of insomnia and received Seroquel (antipsychotic) for management. She had no signs of depression, anxiety, or insomnia. Staff would monitor for signs of depression, anxiety, and insomnia every shift. She was free from adverse effects of antidepressant, antianxiety, and antipsychotic medication use. Staff were to

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monitor for adverse effects of medication use every shift.

Review of the "Fall Risk Assessment" dated 07/08/24 revealed the resident had a high risk for falls.

R2' s fall "Care Plan", dated 06/06/24, revealed the resident had a risk for falls related to impaired vision and poor judgement. Staff were to assist the resident to meals as tolerated and were to assist with bed mobility and transfers as necessary. The Charge Nurse was to monitor for side effects of medication that may increase fall risks and notify the physician. The care plan lacked guidance related to her incontinence.

R2 had a fall on 06/05/24 and the intervention used was staff educated the family to notify staff for assistance and not to help or move the resident.

R2 had a fall on 06/12/24. Interventions was that staff sent R2 to the hospital/ER. Staff was to place a fall mat at the resident's bedside and remove slippers from the resident's room, R2 was to wear non-skid socks and or shoes with grip on the bottom (family would provide). The date initiated in the care plan was 06/13/24.

R2 had a fall on 06/27/2024. Intervention for the fall was staff rearranged the furniture in the resident's room.

R2 would become aggressive with staff when they attempted to redirect her when she sat and/or crawled on the floor. Intervention was staff were to step away and attempt later, and/or attempt to redirect with another staff member,

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dated 07/01/2024.

R2 had a fall on 07/08/24. Intervention was staff replaced/shortened the oxygen tubing due to safety. Hospice/Physician were to review R2's medications, dated 07/09/24.

Revision of the fall care plan on 07/29/2024 included staff removed the fall mat due to the resident tripped over it.

The Nurse's notes dated 06/05/2024 at 07:30 PM, revealed a family member reported the resident fell to her buttocks in her room. Family members informed staff they picked the resident up themselves from the floor and family reported to staff she did not hit her head. The resident denied pain or discomfort. Range of motion (movement of all joints) within normal limit. Staff educated the family to not move the resident if she fell. The nurse's notes lacked root cause of her fall to implement an intervention that caused R2's fall.

The Fall Investigation dated 06/05/24 at approximately 11:10 PM, revealed staff called the charge nurse to the resident's room. The resident was in the bathroom on the floor, with her feet out in front of her and an unspecified type of walker beside on her left side and unlocked. There was feces (bowel movement) on the floor and feces and toilet paper in the toilet. Two staff assisted the resident to stand with a gait belt to a wheelchair, then assisted R2 to her recliner. R2 stated she missed her walker while attempting to sit down and fell to the floor. R2 denied hitting her head. ROM was normal. R2 reported she needed to go to the bathroom. The facility lacked a root cause analysis and an intervention for the fall.

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The Nurse's notes dated 06/10/24 at 03:51 PM, revealed during the weekly skin assessment, R2 had blanchable bruising to her coccyx and left hip from a recent fall.

The Fall Investigation dated 06/12/24 at 05:48 PM, nursing staff heard a loud noise coming from the resident's room. Staff went to check on the resident and could not open her door. The resident was able to move away from the door enough for staff to enter. Staff found the resident on the floor, crying and complaining of pain. The right arm/wrist showed an obvious deformity. The resident pain assessed the pain 10/10. Staff had R2 transferred to the emergency room for evaluation and treatment. The root cause determined was R2 was non-compliant at times. She received medication that heavily medicated her, and she removed her O2 at times.

The Nurse's notes dated 06/12/24 at 11:16 PM, revealed the resident returned to the facility at 10:30 PM. R2 had a wrist fracture, and her right hand was in a cast.

The Nurse's notes dated 06/17/24 at 09:19 PM, revealed the resident had a witnessed fall, by her caregiver who stood in the hall, by her room. She sat on her buttocks and did not hit her head. The facility lacked a root cause analysis or intervention to prevent further falls.

The Nurse's notes dated 06/27/24 at 01:55 AM, revealed a Certified Nursing Assistant (CNA) reported the resident was on the floor at 03:20 AM. R2 was on the floor with only her T-shirt on, her shorts and brief were in the bathroom

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doorway. She had no shoes or socks on. There was a puddle of urine in front of the toilet. The resident was not making enough coherent words to make the nurse understand what she had been doing. No injury.

The Fall Investigation dated 06/27/24 at 03:04 AM, CNA reported the resident was on the floor. Upon entering the room, the resident observed sitting on the floor in front of her bed facing her bed with her feet near the frame of the bed. The resident's side table was sitting to her right, just wearing a T-shirt, her shorts and brief were in the doorway of the bathroom and there was a puddle of urine on the bathroom floor in front of the toilet. Resident was assessed for injuries. No injury. Resident was not talking coherently enough for nurse to understand what happened. Interventions included the resident reeducated to use her call-light when needing to go to the bathroom.

The Nurse's notes dated 07/08/24, a physician visit revealed the resident was on the floor of her room. She reported that she tried to make it to the bathroom and fell. She had a scrape on her head. She denied any loss of consciousness or worsening pain. Per hospice, her pain medications were going to be decreased per family request.

The Fall Investigation dated 07/08/24 at 08:50 AM, the resident found on the floor after staff heard a crash. The resident on top of a fan that was on the floor. She had an abrasion on her forehead, but was not able to tell staff what she hit. She had been removing her O2 tubing and getting it caught on things. The resident said she was going to the bathroom and fell. She said the

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fan hit the wall when she landed on it.

Review of the CNA tasks documentation for toileting from 07/01/24 thru 07/30/24 revealed the resident was limited to substantial assistance all but one day with toileting and was incontinent of urine daily. No toileting schedule documented for the resident.

Observation on 07/29/24 at 12:45 PM revealed the resident appeared frail and weak. She sat on the side of the bed talking quietly to a hospice social worker. The resident had O2 per nasal cannula at 15 liters per minute. Her skin color was jaundiced (a yellow discoloration of the skin and eyes) and her lips were dark.

Observation on 07/29/24 at 03:50 PM, revealed certified nurse's aide (CNA) C and CNA D assisted the resident off the toilet in the bathroom. The resident had O2 per cannula on at 15 Liters per minute, with two concentrators. The resident was very confused and talked about seeing things that were not there. Her lips were very dark and fingertips cyanotic (bluish discoloration of the skin). CNA C changed the resident's wet brief and cleaned up a puddle of urine on the bathroom floor by the door. A gait belt was placed on the resident and CNA C and D ambulated the resident back to her bed. The resident had a slow unsteady gait and had no shoes or socks on. A pair of slip-on slippers were at the side of the bed.

Observation on 07/30/24 at 07:20 AM, the resident was up in her room walking around by herself barefoot. Certified Medication Aide (CMA) E was in the hall and noticed the resident being up. The resident was confused and had her O2

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cannula off and wrapped around the bedside table and on the floor. CMA E entered the resident's room and was attempted to get the resident to sit down on her bed, but the resident continued walking around until CMA E was able to talk the resident into sitting on her bed and replaced her O2. The resident was restless and confused. Her house slippers were at the side of the bed. No other footwear seen in room.

Interview on 07/29/24 at 03:55 PM, CNA C reported sometimes the resident would get up and walk to the bathroom by herself. Staff tried to keep an eye on her to catch her and assist her. She was usually confused and hallucinated seeing things that are not there. She had falls by trying to ambulate on her own and currently had a broken arm.

Interview on 07/29/24 at 04:05 PM, CNA D reported the resident was usually confused. She needed assistance due to being weak when up by herself, but she would get up by herself anyway. She tended to remove her O2 cannula, then could not breathe.

Interview on 07/30/24 at 07:30 AM, CMA E reported R2 was very restless and would not sit for long before she would stand up and ambulate again. She has had multiple falls, but staff do not know how to keep her down to keep her from the falls. She is confused and worse when she took her O2 off, which she did frequently. She had a cast on her arm from a fall about a month ago. She picked at the cast until she got it off. That is the third cast she has had.

Interview on 07/30/24 at 10:00 AM, CNA G reported the resident was not on a toileting

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program. She just would get up and take herself. She has fallen trying to go to the bathroom.

Interview on 07/30/24 at 10:05 AM, Licensed Nurse (LN) H reported the resident did not have a voiding diary and was not on a toileting plan. She thought the resident took herself to the bathroom and staff just checked on her throughout the day, probably about every two hours.

On 07/30/24 at 12:45 PM, Administrative Nurse B reported there was no toileting program. She did think a toileting plan would put staff in the resident room more frequently so the resident would not be trying to toilet herself causing her to have falls with injury.

The facility policy for Accident, Incident, Unusual Occurrence Documentation dated 03/13/24 revealed when a resident experiences an incident or accident, the nurses caring for the resident will record the resident's response. The effect of the incident or accident on the resident including results of a physical examination, and vital signs will be documented. Assessment of the resident may include any or all changes from baseline status reporting changes to the physician. Record new physician orders received and instructions for follow up care or requested notification of changes in condition. The resident's designated responsible party will be notified of the occurrence. The nurse will document the notification of appropriate parties.

The facility failed to provide a safe environment for a cognitively impaired resident, with a history of multiple falls and low vision, to prevent repeated falls, with one fall that resulted in a fractured wrist.

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