STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175185	A. Building B. Wing	07/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Smoky Hill Rehabilitation Center	1007 Johnstown Avenue Salina, KS 67401

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43204 The facility identified a census of 75 residents with three residents reviewed for falls and accidents. Based on record review, observation, and interview, the facility failed to provide adequate supervision and intervene during Resident (R) 1's unsafe behaviors to prevent injury. On 06/15/24, R1 repeatedly leaned forward in his wheelchair and then leaned forward too far, fell headfirst to the floor, and sustained a broken nose and a head laceration (cut). This deficient practice also placed R1 at risk for falls, injuries, and pain. Findings included: - R1's Electronic Medical Record (EMR) documented R1 had diagnoses of cerebrovascular accident (CVA-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), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severe cognitive impairment. The MDS documented R1 required moderate to maximum staff assistance for all activities of daily living (ADLs) except eating, which required supervision. The MDS documented R1 had no behaviors during the look-back period. The MDS documented R1 had no falls during the observation period. The Significant Change MDS, dated [DATE], documented the BIMS interview could not be completed due to R1 was rarely/never understood. The MDS documented R1 had short-term and long-term memory problems and did not have the ability to recall the current season, the location of his own room, staff names and faces, or that he was in a nursing home. The MDS documented R1 required maximum assistance from staff for all his ADLs except for eating for which required supervision. The MDS documented R1 had physical and verbal behaviors directed toward others for one to three days during the observation period. The MDS documented R1 had two or more falls with major injuries (bone fractures, joint dislocations, closed head injuries with altered level of consciousness, or subdural hematoma). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/20/24, documented R1 had periods of confusion and yelled at others. (continued on next page)

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.

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The Falls CAA, dated 06/20/24, documented R1 was a fall risk due to his cognitive impairment and his need for assistance with transfers. R1's Care Plan documented R1 had impaired safety awareness and required assistance from two staff for transfers with a full lift. The plan documented R1 was at high risk for falls due to his confusion and history of falls. The plan directed staff to anticipate and meet R1's needs, avoid repositioning furniture, be sure R1's call light was within reach, and encourage R1 to use the call light. The plan directed staff to ensure a safe environment for R1. The staff were to provide R1 with as-needed medication when he became agitated, and a bolster on his bed. The intervention for the fall on 06/15/24 directed staff to continue fall interventions already in place. The Fall Risk Assessment, dated 06/04/24, documented R1 had a fall risk score of 17 and was a high fall risk. The Fall Risk Assessment on 07/05/24, documented R1 had a fall risk score of 27 and was a high fall risk. The Health Status Note, dated 06/15/24, documented the nurse was notified R1 had a fall and hit his nose. Licensed Nurse (LN) G assessed R1 and put R1 in his bed. Staff called Emergency Medical Service (EMS) upon R1's responsible party's request for further evaluation at the hospital. The fall occurred at 01:18 PM and R1 left the facility at 01:50 PM. The Health Status Note, dated 06/15/24, documented R1 had a broken nose and a laceration to his forehead with no acute issues. The Emergency Department Report, dated 06/15/24, documented R1 was seen in the emergency department for a head injury after a fall. The face computed tomography scan (CT scan- a test that uses X-ray technology to make multiple cross-sectional views of organs, bone, soft tissue, and blood vessels) showed an acute comminuted fracture (break or splinter of the bone into more than two fragments) of R1's right and left nasal bone with rightward deviation of the bony nasal septum. There was also a potential chip fracture from the maxillary (upper jawbone) spine. R1's left forehead stellate (radiating from the center in a star-like pattern) laceration was approximated (pulled together) and glued shut. R1's discharge instructions included an instruction that R1 was to see an ear, nose, and throat (ENT) doctor for further evaluation and treatment of the nose fracture. The Health Status Note, dated 06/15/24, documented R1 returned to the facility via the transport van. R1 was awake and alert with confusion. R1 stated, I feel like hell. Certified Nurse Aide (CNA) M's Witness Statement, dated 06/15/24, documented that around 01:30 PM, CNA M was cleaning the dining hall and R1 fell directly on his face. CNA M noted a gash to R1's face, right elbow, and a fractured nose. R1 was assessed by LN G. After R1's vital signs were obtained, the CNA staff lifted R1 with a full lift and placed him back in bed until emergency medical assistance arrived. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	LN G's Witness Statement, dated 06/15/24, documented LN G was outside getting a soda and was alerted R1 had fallen. LN G approached the situation, and the staff were getting R1 up. LN G called R1's responsible party and she requested R1 be sent to the hospital for further evaluation. LN G then collected R1's paperwork and called 911 and informed them of the situation. LN G then called hospice and left a message regarding the situation. The Health Status Note, dated 06/16/24, documented R1 continued on fall follow-up. R1 had been very restless at times since returning from the ER. R1 was given routine Ativan and as needed morphine for pain. R1 was agitated when redirected. The Ear, Nose and Throat Assessment and Plan of Care Document, dated 06/19/24, documented R1 was seen after sustaining a nasal fracture from a fall from his wheelchair four days ago. The physical exam showed a marked deviation of the nasal dorsum to the left with a collapse of the right lateral wall of the nose and airway obstruction internally on that side. Marked external deviation was apparent on examination and a CT scan obtained in the emergency room confirmed the same. R1 had an airway obstruction on the right side. R1 needed to be scheduled for a closed nasal reduction within a few days. The Health Status Note, dated 06/20/24, documented R1 would have surgery to his nose. R1 was to be at the hospital at 09:30 AM for surgery. R1 would be NPO (nothing by mouth) after midnight. The Facility Incident Report, dated 06/20/24, documented on 06/15/24 R1 propelled himself in his wheelchair around the memory care unit. R1 leaned forward in his wheelchair and staff re-directed him multiple times that he needed to sit back in his chair. CNA M was cleaning up the dining room area and turned around to wipe off the table. CNA M heard a sound and turned back around and saw R1 was on the floor. It appeared that R1 fell out of his wheelchair and R1 was bleeding from his nose. CNA M notified LN G and staff notified hospice. Staff notified hospice and EMS and R1's responsible party. R1's responsible party wanted R1 taken to the hospital for evaluation. R1 was evaluated and found to have a broken nose. R1 returned to the facility with an appointment to see an ENT doctor. Education was provided to the staff that R1 should be monitored closely to help mitigate falls. R1 lived in the memory care unit and was monitored closely. R1's Discharge Instructions, dated 06/21/24, documented R1 had surgery for a nasal fracture. R1 was to keep the nasal splint dry, keep the nasal splint on, and not to blow his nose. The Health Status Note, dated 06/21/24, documented the hospital nurse called and reported R1 was on his way back to the facility and had a nose splint in place that needed to be left on for a week, until his next appointment. On 07/08/24 at 10:30 AM, observation revealed R1 sat in his wheelchair self-propelling around the memory care unit. R1's nose appeared healed and there were no signs of bruising. On 07/08/24 at 10:35 AM, CNA M stated when R1 fell she had turned around for just a second and heard R1 fall. CNA M stated R1 had been leaning forward in his wheelchair off and on all morning. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 07/08/24 at 12:45 PM, Administrative Nurse D stated she did not understand what staff were expected to do to keep R1 from falling. Administrative Nurse D stated CNA M had just turned her back on R1 for a moment and he fell . Administrative Nurse D confirmed R1 had been leaning forward in his wheelchair off and on that morning and staff had redirected him verbally. The facility's Managing Falls and Fall Risk Policy, dated December 2007, documented based on previous evaluations and current data, staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try and minimize complications from falling. Staff will identify appropriate interventions to reduce the risk of falls. If a systematic evaluation of a resident's fall risk identifies several possible interventions the staff may choose to prioritize interventions. The facility failed to provide adequate supervision to intervene during R1's unsafe behaviors to prevent injury when R1 repeatedly leaned forward in his wheelchair, then fell , which resulted in a broken nose and a head laceration. This deficient practice also placed R1 at risk for falls, injuries, and pain.