STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175267	A. Building B. Wing	05/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shawnee Gardens Healthcare & Rehab Center	6416 Long Street Shawnee, KS 66216

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** 42966 The facility identified a census of 120 residents. The sample included three residents reviewed for falls. Based on record review and interviews, the facility failed to identify and implement appropriate, resident-centered interventions to prevent falls for Resident (R) 1, who was cognitively impaired. The facility further failed to ensure R1 received post-fall care including neurological evaluations and nursing assessments following an unwitnessed fall that resulted in obvious head trauma on 04/27/24 at 03:28 AM. R1 was later sent out to the hospital on 04/27/24 at 08:45 AM where he was found to have nasal bone fractures and multiple rib fractures. This also placed R1 at risk for increased pain and other complications. Findings included: - R1 admitted to the facility on [DATE] and discharged to the hospital 04/27/24. The Diagnoses tab of R1's Electronic Medical Record (EMR) documented diagnoses of generalized muscle weakness, difficulty in walking, altered mental status, and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The Admission Minimum Data Set (MDS) dated [DATE], documented R1 had a Brief Interview for Mental Status (BIMS) score of zero, which indicated severe cognitive impairment. R1 had two or more non-injury falls since admission. The Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/15/24, documented R1 had a diagnosis of vascular dementia and had a BIMS score of zero. The Falls CAA dated 04/15/24, documented R1 required staff assistance for activities of daily living (ADLs) completion. R1 was a high risk for falls. R1's Care Plan dated 04/02/24, documented R1 was at risk for falls related to impaired mobility, confusion, gait/balance problems, and unawareness of safety needs. The plan documented interventions for staff to anticipate and meet R1's needs. Staff were to make sure R1's call light was within reach and encourage him to use it for assistance as needed. The plan directed staff to educate R1 about safety reminders and what to do if a fall occurred; staff followed facility fall protocol. (continued on next page)

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	R1's Care Plan documented the following interventions added after actual falls: An intervention, dated 04/02/24, for staff education to orientate R1 to new surroundings and the use of the call light with ADL help. An intervention, dated 04/08/23, instructed staff to put a sign in R1's room directing R1 to ask for assistance before walking on his own. An intervention, dated 04/10/24, documented pharmacy would do a medication review. An intervention, dated 04/13/24, documented staff received education to provide R1 with an activity while he was awake. An intervention, dated 04/16/24, directed staff to make sure R1's wheelchair was locked and placed next to his bed while he was in bed. An intervention, dated 04/22/24, documented R1 would be added to the restorative (care provided to maintain a person's highest level of physical, mental, and psychosocial function to prevent declines that impact quality of life) nursing program for mobility, strength, and balance. An intervention, dated 04/24/24, documented that R1 had the right to fall, and he continued to fall with interventions in place. The Orders tab of R1's EMR documented an order with a start date of 04/02/24 for apixaban (anticoagulant medication- medication used to prevent blood from thickening or clotting), five milligrams (mg) two times a day for anticoagulant. The facility provided the following root cause analysis and intervention documentation upon request: The fall on 04/03/24 at 01:30 AM recorded the root cause of the fall as R1 was in a new environment and was not using the call light or asking for assistance with ADL. The intervention documented staff received education to help orientate R1 to his new surroundings and use the call light for assistance. The fall on 04/07/24 at 07:15 PM recorded the root cause of the fall as R1 had memory issues and was in a new environment. The intervention documented that staff placed a sign in R1's room to call for assistance. The fall on 04/10/24 at 05:30 AM recorded the root cause of the fall as R1 had an increase in falls with no identifiable cause at that time with possible medication side effects. The intervention documented the consultant pharmacist would conduct a medication review. The fall on 04/13/24 at 05:30 AM recorded the root cause of the fall as R1 was awake and appeared to be curious about the phone jack. The intervention documented staff were educated to provide R1 with an activity while he was awake. The fall on 04/17/24 at 05:00 AM recorded the root cause of the fall as R1 did not remember to check that his brakes were locked on his wheelchair before initiating a transfer. The intervention documented staff received education to make sure R1's wheelchair was placed next to his bed with the brakes locked while he was in the bed. The fall on 04/22/24 at 08:45 PM recorded the root cause of the fall as R1 continued to not use his call light for assistance with getting in and out of his bed, and it appeared he was unable to remember to lock his wheelchair brakes. The intervention documented R1 would be placed on a restorative program. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall on 04/23/24 at 11:30 PM recorded the root cause of the fall as R1 did not have the ability to recall education or known physical limitations. The intervention directed R1 had the right to fall, and he continued to fall with interventions in place. The fall on 04/24/24 recorded the root cause of the fall as R1 did not have the ability to be educated regarding his imitations secondary to his cognitive problems. The intervention documented R1 continued to fall with interventions in place. R1's EMR, under the Notes tab, documented an Incident Note, on 04/22/24 at 11:20 PM, which recorded staff observed R1 sitting on the floor near his bed and R1 was unable to communicate how the fall occurred. R1 denied pain or discomfort and had a skin tear on his left elbow which was cleaned and had Steri-strips (adhesive wound closures) applied. The nursing staff lifted R1 off the floor and onto the bed. An Incident Note, on 04/23/24 at 11:59 PM, documented R1 sat in his wheelchair in the dining room and continuously attempted to stand up without assistance. R1's wheelchair slipped out from under him during one of his attempts to stand and he landed on his buttocks. Two staff members witnessed the fall. An Incident Note, on 04/24/24 at 04:14 AM, documented R1 laid on the floor beside his bed with his head near the foot of the bed. R1 had his covers under his head, and he had pulled his dry incontinence brief off. R1 did not voice any complaints of pain or discomfort and he moved his extremities independently without any indications of pain. Staff assisted R1 to his wheelchair and brought him to the dining area for supervision. Staff initiated neurological checks. An Incident Note, on 04/24/24 at 06:39 AM, documented staff left a message with R1's provider's answering service regarding R1's two non-injury falls. R1 slept approximately two hours during the night and was very difficult to redirect. He refused snacks and drinks when offered and was checked and changed as required. An Interdisciplinary Team (IDT) Note, on 04/25/24 at 10:53 AM, documented R1 had a balance problem and needed assistance for support during transfers. No wandering behavior had been reported. R1 had eight falls in the last monthmonth, and he received staff support for transfers and safety needs. R1 was care planned for a right to fall and he continued to work with therapy, but he was forgetful at times. Staff continued to monitor for any changes. In an Incident Note on 04/27/24 at 04:53 AM, Licensed Nurse (LN) G documented R1 was found in another resident's room on the floor. R1 was lying prone (face down) with a head injury. R1 was unable to recall how he fell and what he was doing before the fall. R1 had two small skin tears along the nose and a hematoma (a collection of blood trapped in the tissues of the skin or an organ, resulting from trauma) between his eyebrows. Vitals signs and neurological checks were performed and R1's wounds were cleaned and dressed. Ice was applied to the swelling between his eyebrows. R1's physician and family were notified. The Assessments tab revealed Neuro Checks- 15 minutes for an hour on 04/27/24 were completed at 03:30 AM, 03:45 AM, 04:00 AM, and 04:15 AM. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R1's clinical record lacked evidence that neurological checks were completed after 04:15 AM on 04/27/24. In an Incident Note on 04/27/24 at 08:44 AM, LN H documented R1's family called the unit to follow up on R1's fall incident. LN H assessed R1 and consulted with Administrative Nurse D and the Nurse Practitioner (NP). R1 was sent to the hospital to rule out any possible complications at 08:45 AM. A Trauma History and Physical on 04/27/24 at 03:50 PM documented R1 admitted to trauma services after sustaining a fall. R1's catalog of injuries included bilateral nasal bone fractures and fractures of his right fifth through seventh ribs and his left sixth rib. The facility's undated investigative report documented that on 04/27/24 at approximately 03:28 AM, R1 was found in another resident's room lying prone on the floor with a head injury. R1 was unable to recall how he fell or what he was doing before the fall. Vital signs and neurological checks were completed and the skin tears on R1's face were cleaned and dressed. Staff noted a hematoma between R1's eyes and applied an ice pack to assist with swelling prevention. Staff notified the family, on-call management, and physician and received an order to send R1 out for evaluation and treatment at the hospital. The hospital notes indicated R1 had nasal fractures as well as bilateral rib fractures. On 05/01/24 at 12:22 PM, Administrative Staff A stated neurological checks were completed under the Assessments tab and if there were only 15-minute checks in R1's EMR from 04/27/24, then that was all they had. On 05/01/24 at 12:59 PM, LN I stated if there was an unwitnessed fall when in doubt, send the resident to the hospital. She stated if the resident had a visible injury, she checked vital signs, performed neurological checks, and then called 911 immediately, especially if the resident was on anticoagulant medications. LN I stated if the resident did not go to the hospital, neurological checks were completed every 15 minutes for an hour, every 30 minutes for an hour, every hour for four hours, and every four hours. She stated when a resident had a fall, a risk management was completed which populated the neurological checks in the computer for the nurse to complete. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/01/24 at 01:25 PM, Administrative Nurse D stated if a resident had an unwitnessed fall, staff were expected to assess for injuries, make sure the resident was safe, and notify her, management, the provider, and the family. She stated the nurse completed the risk management and the assessments that populated, which included pain, fall assessment, neurological checks, and change in condition. Administrative Nurse D stated if a resident fell and had injuries on their head, she expected the nurse to call the provider and receive orders to send out or any other orders the provider gave. She stated neurological checks were completed every 15 minutes times four, every 30 minutes times four, every hour times four, every four hours times four, and maybe daily for four times. Administrative Nurse D stated if a resident was on neurological checks, she expected the nurse to pass that on in the report so that the checks were continued. She stated neurological checks were continued past an hour after a fall. She stated on 04/27/24, she was not notified that night of R1's fall but LN H called her to inform her R1 had a fall that night and was acting a little different and informed her the previous nurse did not send him out. Administrative Nurse D stated she told LN H to notify the provider of what happened and then notify the family. She stated she expected if a resident was on anticoagulant medications, the nurse assessed the resident and called the on-call provider for orders. Administrative Nurse D stated she educated LN G to always check a resident's diagnosis and orders to see what medications they were on and even if the nurse did not see any bleeding, the nurse was to tell the doctor the resident was on an anticoagulant medication. On 05/01/24 at 05:26 PM, LN H stated on 04/27/24, she arrived at the unit around 08:00 AM after she was pulled from another unit when LN G's relief did not show up. She stated LN G was already gone and she received a written report. LN H stated R1 had a dressing on his forehead between his eyebrows onto his nose and did not appear to be bleeding through the dressing. She stated R1's family called as soon as she had arrived at the unit and asked about his fall. LN H asked R1's family to give her a few minutes to find out what happened. She stated she read a note in R1's chart that said he was found in another resident's room. LN H stated she called Administrative Nurse D, who did not know about the fall and called the on-call provider. She stated she told the provider R1 had clear airways, his vitals were within normal limits, and he was on an anticoagulant medication. She received an order to send R1 to the hospital for evaluation. LN H stated the written report she received said R1 was found in another resident's room and had a skin tear on his nose. She did not recall if the written report mentioned neurological checks for R1. On 05/02/24 at 03:40 PM, LN G stated on 04/27/24, he returned from break and the aides told him R1 was found on the floor in the room next to his. He stated when he entered the room, R1's face was bleeding. LN G stated he cleaned the wound, took R1's vital signs which were good, and did a quick neurological assessment which revealed his pupils were reactive. He stated R1 did not complain of any pain or a headache and he denied any dizziness. LN G stated they helped R1 off of the floor and brought him to the nurse's station. He continued to check R1's vital signs and pupils every 15 minutes, applied a dressing to R1's nose, and applied an ice pack to his nose which seemed to help. LN G stated he called R1's representative and notified her of his fall then let her talk to R1. He then notified the on-call service for the provider and was told the provider would call him back, but he did not receive a call back before the end of his shift. LN G stated neurological checks were completed every 15 minutes times four, every 30 minutes times four-, and every hour times four after a fall. He stated he had called on-call provider service before 04:00 AM and his shift ended at 07:00 AM. LN G stated he did not try to call the on-call provider again before his shift ended since R1 was stable and had the same cognition as he usually had. LN G stated he did not check to see if R1 was on an anticoagulant medication but if he had and had seen he was on an anticoagulant, he would have sent R1 to the hospital. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/07/24 at 10:21 AM, Certified Nurse Aide (CNA) M stated on 04/27/24, R1 kept getting out of his recliner and walking around. She stated she redirected him back to his wheelchair or his recliner. CNA M stated she went to break and when she returned, the nurse went to break, and she began her rounds. She stated a female resident came into the hallway, which was strange. CNA M went into her room and found R1 on the floor. She stated R1's fall interventions were redirecting him back to his room and completing frequent rounds every hour. She stated he did not have a fall mat and he was checked and changed every two hours for incontinence. The facility's Accidents and Supervision policy, not dated, directed the resident's environment remained as free from accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents which included identifying hazards and risks, evaluating, and analyzing hazards and risks, implementing interventions to reduce hazards and risks, and monitoring for effectiveness and modifying interventions when necessary. The facility's Nursing Services and Sufficient Staff policy, not dated, directed the facility provided sufficient staff with appropriate competencies and skill sets to assure resident safety. The policy directed the facility ensured licensed nurses had the specific competencies and skill sets necessary to care for resident's needs as identified through resident assessments and described in the plan of care. The policy directed providing care included but was not limited to, assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs. The facility's Head Injury policy, revised on 10/16/23, directed the facility reported head injuries to the physician and implement interventions to prevent further injury. The policy directed the facility notified the physician and followed orders for care; performed neurological checks as indicated or as specified by the physician; continued monitoring for 72 hours following the incident; and notified the family and documented all assessments, actions, and notifications. The facility failed to identify and implement appropriate, resident-centered interventions to prevent falls for R1 and failed to ensure R1 received post-fall care including neurological evaluations and nursing assessments following an unwitnessed fall. R1 sustained nasal bone fractures and multiple rib fractures. This also placed R1 at risk for increased pain and other complications.