STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265693	A. Building B. Wing	03/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rehabilitation Center of Independence, The	1800 S Swope Drive Independence, MO 64057

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the resident's physician was notified of all injuries sustained after a fall for one sampled resident (Resident #1) out of eight sampled residents. The facility census was 118 residents. Review of the facility Fall Evaluation and Prevention Policy dated 8/2020 showed: -Following a fall, the following steps should be undertaken: --Evaluate the resident promptly in order to identify and treat injuries. --Monitor closely for indications of pain or discomfort in any areas, reddened or discolored areas or other signs of injury. Review of the facility Change of Condition Notification Policy dated 6/2020 showed: -To ensure residents, family, legal representatives, and physicians are informed of changes in the residents condition in a timely manner. -Acute change of condition (ACOC) is a sudden, clinically important deviation from a patient's baseline in physical, cognitive, behavioral, or functional domains. -Clinically important means a deviation that, without intervention, may result in complications or death. -Members if the Interdisciplinary Team (IDT) are expected to report and document signs and symptoms that might represent ACOC. -The facility will promptly inform the resident, consult with the resident's attending physician, and notify the resident's legal representative when the resident endures a significant change in their condition caused by, but not limited to an injury or accident. -The licensed nurse will notify the resident's attending physician when there is an: --Incident/accident involving the resident. (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	--An accident involving the resident which results injury and has the potential for requiring physician intervention. --A decision to transfer or discharge the resident from the facility. -The attending physician will be notified timely with a resident's change in condition. -Notification to the attending physician will include a summary of the condition change and an assessment of the resident's vital signs and system review focusing on the condition and/or sign and symptoms for which the notification is required. -Emergency situations such as intense pain and unexpected bleeding, the nurse will immediately call the attending physician. -The licensed nurse will document the following: --Date, time, and pertinent details of the incident and the subsequent assessment in the nursing notes. --The time the attending physician was contacted, the method by which he/she was contacted, the response time, and whether or not orders were received. --The time the family/responsible party was contacted. --The incident and brief details in the 24-hour report. -Documentation pertaining to a change in the resident's condition will be maintained in the resident's medical record and on the 24-hour report. 1. Review of Resident #1's admission Record showed the resident was admitted on [DATE] with diagnoses including muscle weakness, repeated falls and traumatic subdural hemorrhage with loss of consciousness (most dangerous type of head injury, a collection of blood within the skull pressing on the brain, is potentially life-threatening, usually requires immediate treatment, might include surgery to remove the blood). Review of the resident's Quarterly Minimum Data Set (MDS- a federally mandated assessment instrument completed by facility staff for care planning) dated 1/25/25 showed the resident was cognitively intact. Review of the resident's Fall Investigation dated 3/6/25 showed: -Certified Nursing Assistant (CNA) A reported to Licensed Practical Nurse (LPN) A the resident had fallen. -LPN A assisted the resident off the floor and back to the resident's room. -Injuries documented was a bruise to his/her right front knee and unable to determine injury to face. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Family, Director of Nursing (DON) and physician notified. --The investigation did not include the resident had a history of falls, any past interventions that should have been in place at the time of this fall, and did not include documentation related to the resident's broken teeth as a result of the fall. Review of the resident's Progress Note dated 3/6/25 at 8:27 P.M. showed: -CNA A reported resident had fallen. -Assessed the resident for injuries, broken teeth from an implanted partial was found on the floor and he/she has a bruise to his/her right knee. -Physician called and notified. -Order received for x-ray of his/her right knee. Review of the resident's Order Summary report showed: -X-ray of right knee two views, 3/6/25. -Hydrocodone-Acetaminophen (a narcotic pain medication) 5/325 milligram (mg), given one tablet by mouth every six hours as needed for pain, 8/15/24. Review of the resident's Medication Administration Record (MAR) dated 3/1/25 through 3/31/25 showed one dose of Hydrocodone-Acetaminophen given on 3/5/25 at 5:00 A.M. No documentation of the location of the resident's pain. Review of the residents Controlled Drug Administration Record dated 3/3/25 through 3/12/25 showed: -Hydrocodone-Acetaminophen 5-325 mg, one tablet orally every six hours as needed for pain. -3/2/25 at 11:30 P.M. -3/3/25 at 6:00 P.M. -3/4/25 at 12:00 A.M., 8:00 A.M., and 5:00 P.M. -3/5/25 at 12:00 A.M., 9:00 A.M., and 12:00 P.M. -3/6/25 at 8:00 A.M., and 5:00 P.M. -3/7/25 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. -3/8/25 at 8:00 A.M., 12:00 P.M., 5:00 P.M. and 11:00 P.M. -3/9/25 at 8:00 A.M., 12:00 P.M., 4:00 P.M., 8:00 P.M. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-3/10/25 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. -3/11/25 at 8:00 A.M., 12:00 P.M., and 5:00 P.M. -3/12/25 at 8:00 A.M. --No documentation of the location of the resident's pain. Review of the resident's Progress Note dated 3/7/25 at 4:47 P.M. showed: -He/she denied pain or discomfort at that time. -X-ray was completed on that shift, waiting results. -Pain management with PRN hydrocodone. -Nurse to continue to monitor. -Resident laying in bed. --No documentation related to the resident's broken implanted teeth. Review of the resident's Progress Note dated 3/8/25 at 1:06 P.M. showed: -Denied pain or discomfort at that time. -No findings on x-ray results. -Pain management with PRN hydrocodone. -Nurse to continue to monitor. -Resident laying in bed. --No documentation related to the resident's broken implanted teeth. During an observation and interview on 3/9/25 at 9:25 A.M., the resident said: -He/She was in the room next door when he/she fell. -His/Her right knee was hurting although the x-ray did not show a break. -His/Her front bottom teeth fell out from the fall and needs to be taken care of. -His/Her right hand was sore and complained of pain to his/her chin and where his/her teeth broke in his/her mouth. -Resident's knees were bruised. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Noted bruising to the resident's face under both eyes, both sides of nose extending to top lip, from the left corner of mouth extending downward and under the chin. -There was swelling from between the eyebrows and across the bridge of the nose. -He/She was retrieving his/her cup from the other resident's room at the time of the fall. -He/She was laying in a pool of blood and knew it was bad at that time. -He/She screamed and yelled for help. -He/She has not seen a doctor. -He/She did not go to the Emergency Room. -He/She was not asked if he/she wanted to go to the Emergency Room. -His/Her bottom teeth have not been addressed. -He/She does not know if his/her nose is broken, but it was painful and swollen. During an interview on 3/9/25 at 12:47 P.M. the Director of Nursing (DON) said: -He/She was aware of the resident falling with bruising to his/her right knee and a little bruising to his/her face. -He/She was not aware of any other injuries. -He/She felt the broken partial implanted teeth was reported to the doctor who did not want anything done except neurological checks. -He/She felt the resident's medical needs were met. -According to the nurses the resident had no complaints of pain. -He/She was unaware of the complaints of pain by the resident about his/her right knee, right hand, nose, and mouth. During an interview on 3/10/25 at 7:26 P.M. LPN A said: -CNA A came to get him/her because the resident had fallen. -He/She applied pressure to the laceration on the resident's top lip and got an order to x-ray the right knee. -The right knee was bruised with an abrasion and the resident was complaining of pain. -The resident had blood in his/her mouth and there were teeth on the floor. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She did not recall informing the provider of the laceration and broken teeth, his/her primary concern was the resident's knee due to the complaint of pain. -He/She did not administer any pain medication as he/she did not have keys to the cart containing the resident's PRN medication. During an interview on 3/10/25 at 7:44 P.M. the Physician said: -He/She was in the facility on 3/10/25 and did not see the resident. -He/She was not aware of the resident's fall or other injuries. -He/She was concerned if the resident had been sent to the emergency room or not on the day of the fall. -He/She expects the nurses to call and report all injuries when a resident falls. -He/She was not the provider on call at the time of the resident's fall. During an interview on 3/10/25 at 8:00 P.M. LPN B said: -He/She was informed the resident had a fall when he/she arrived on 3/7/25. -He/She was told there was an x-ray for the resident's knee pain. -Although the resident complained about his/her knee the x-ray was okay. -He/She noticed the resident's face was bruised up, but the resident did not complain of pain. -The resident told him/her they lost a couple of teeth on the bottom when he/she fell. -He/She asked the resident about pain frequently. -He/She offered PRN hydrocodone and administered in the morning and in the afternoon. -He/She did not contact the physician or Nurse Practitioner about the resident's facial injuries or increased use of PRN hydrocodone since the fall. -The resident continued to have bruising and swelling to his/her face. -The resident did not complain of knee pain, only a sore face and wanted to rest. -He/She did not notice any injuries in the mouth but did notice broken teeth. -He/she was aware of the laceration to the top lip just under the right nare. -There was a steri-strip to the laceration, although he/she did not recall when it was removed. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-If he/she was to find a resident that had fallen, he/she would assess the resident, do neuros and vitals, contact the physician and management. -When notifying the physician, be sure to inform of the fall as well as any and all injuries. -Just looking at the resident he/she could tell the resident was sore from the injuries. -He/She felt social services would contact dental for the resident. During an interview on 3/10/25 at 8:37 P.M. LPN C said: -He/She was not in the building at the time the resident fell. -When he/she came in for his/her shift, LPN A advised of the resident's fall. -He/She assumed all contacts had been made, therefore he/she did not feel he/she needed to contact the physician. -He/She documented on the Neurological Assessment Flow Sheet the injuries he/she observed, but not in the progress or nursing notes. -He/She applied steri-strips to the laceration to the resident's top lip. -The resident kept wiping the steri-strip off and had another nurse help with application to ensure the wound edges were approximated and the bleeding stopped. -The resident's nose was swollen from the face plant (falling face first to the ground). -He/She put ice on the resident's nose every 20 minutes and reduced the swelling, but did not document in the progress or nursing notes and did not notify the physician. -He/She was aware the resident's front teeth were cemented in prior to the fall, but did not assess the oral cavity. -He/She was not aware of any orders for the resident's facial injuries. -He/She would not have done anything different than what was already done before he/she arrived. During an interview on 3/10/25 at 8:50 P.M. CNA A said: -He/She heard the resident yelling out. -He/She turned on the light and observed the resident was bleeding from his/her nose and mouth. -The resident told him/her the resident's teeth were missing. -He/She found the resident's teeth on the floor and placed them in a cup. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She went to get LPN A to assess the resident and gave LPN A the resident's teeth. -He/She could not see any injuries in the resident's mouth. -The resident complained about the bridge of his/her nose being painful from the impact of the fall. -He/She applied pressure and ice pack to the resident's face and put the head of the bed up. -The resident's nose was pretty swollen, but felt the ice did help with the swelling. During an interview on 3/11/25 at 7:24 A.M. LPN A said: -The resident was in the room next door when he/she fell. -He/She assisted the resident off the floor and to his/her room. -The resident complained of pain to the right knee when it was touched. -The provider he/she spoke with was the Nurse Practitioner. During an interview on 3/12/25 at 1:58 P.M. the Administrator said: -He/She was aware the resident had fallen and sustained injuries. -When a resident has a fall he/she expects the resident to not be moved until assessed by a nurse. -He/She prefers neuros be done on all residents with a fall. -He/She expects the physician and responsible parties to be notified. -When contacting the physician, he/she expects the physician to be informed of all relevant facts, if the resident hit their head, and any other relevant information specific to the resident. -Nurses are to follow orders if any are given. -Documentation should be done in the risk management and some in the progress notes. -He/She expects all nurses to follow facility policy on charting. -The resident should have been charted on every shift for the first 72 hours in the progress or nursing notes. -Administration of PRN narcotics should be documented on the resident's MAR. -All first aid administered to the resident, including the steri-strips and ice packs should have been documented in the progress or nursing notes. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She expects the physician or Nurse Practitioner to see a resident after a fall within a week or sooner if needed. During an interview on 3/12/25 at 2:32 P.M. the DON said: -When a resident has a fall he/she expects the nurses to assess the resident, obtain vital signs, start neuro checks, check the resident's baseline, and if there are injuries significant enough to send the resident to the Emergency Room. -He/She expects the physician and the family to be notified of the resident's fall and if they were sent to the hospital. -He/She expects the physician to be told how the resident fell, if they hit their head, any suspected injuries, range of motion and complaints of pain. -The on call provider should have been informed of the resident's partial facial injuries. -He/She expects the physician or Nurse Practitioner to see the resident within 3 to 4 days after a fall. -Due to the resident's history of falls and subdural hematoma, he/she should have had facial injuries checked sooner than 5 days after his/her fall. -There should have been more documentation related to the resident's fall and follow up including treatments, interventions and wound measurements. -He/She did not feel there was a negative impact on the resident due to his/her missing teeth and social services was setting up a dental appointment. -PRN narcotics should be documented in the resident's MAR as it triggers for follow up in the electronic system. -There should have been follow up and possible interventions for the resident's wounds to his/her nose and chin as well as other injuries. During an interview on 3/12/25 at 3:31 P.M. the Nurse Practitioner said: -He/She was the provider on call when the resident fell. -He/She did not recall being informed of the resident having any injuries to his/her face or broken teeth. -He/She recalled being informed the resident was having knee pain after the fall and ordering an x-ray to the right knee. -He/She expected to get accurate information and be informed of all injuries post fall. MO00250752