STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265786	A. Building B. Wing	06/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rosewood Rehab and Healthcare Center	1415 West White Oak Independence, MO 64050

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42955 Based on observation, interview, and record review, the facility failed to ensure the resident's environment was clean, safe, and comfortable when on 6/13/24 odors, stains, and debris were noted in the common carpeted areas on the second floor, third floor, and fourth floor and failed to keep the trim in good repair in resident common areas, and one resident's room maintained for cleanliness and sanitation. The facility census was 260 residents. A policy was requested regarding cleaning the carpets and flooring but not provided. 1. Observation on 6/13/24 at 8:40 A.M., showed an musty odor in the air as exiting off the elevator on the second floor. Observation on 6/13/24 at 9:35 A.M., showed the carpeted floors on the fourth floor south had debris scattered over the carpet. Observation on 6/13/24 at 9:42 A.M., showed the carpet in the alcove on the fourth floor north had debris scattered throughout the alcove. Observation on 6/13/24 at 10:02 A.M., showed a large stain on the carpet between rooms [ROOM NUMBERS]. Observation and interview with Family Member A on 6/13/24 at 10:29 A.M., showed: -Family Member A stood on the resident's floor and picked his/her feet up and down which made a sticking sound, showing the floor was dirty and had not been mopped. -He/She said the floors felt like they had not been cleaned. -He/She believed something had been spilled and not cleaned up properly. Observation on 6/13/24 at 10:42 A.M. through 11:54 A.M. showed: -Upon entering the carpeted area of the third floor a stale, musty odor was present. -There were visible stains on all carpets throughout the third floor. (continued on next page)

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-There was trash, food, and debris on the carpets and tile flooring. -Noted trim in the hallways in front of rooms 340, 335, 352, and 334 was missing or unattached with nails exposed. -The floor in the dining room was littered with food, debris, and was sticky when walked on. During an observation on 6/17/24 at 11:34 A.M., the common area close to room [ROOM NUMBER] showed: -Large dark stains on the floor. -Trash, food, and debris on the floor. During an observation on 6/17/24 at 11:40 A.M., the floor at the fourth floor south nurses station showed dark brown/black staining, food, trash and other debris ground into the carpet. During an interview on 6/17/24 at 12:06 P.M., Licensed Practical Nurse (LPN) A said: -He/She was not sure how long it had been since the floor had been cleaned at the fourth floor south nurses station. -He/She grimaced while observing the food and debris on the floor at the fourth floor south nurses desk. -He/She assumed all of the staff would make notice of the condition of the floor. During an observation on 6/17/24 at 11:41 A.M., the common area close to room [ROOM NUMBER] showed: -Food left in a chair for resident use. -Food and debris on the floor. Observation on 6/17/24 at 11:42 A.M., showed the floor in room [ROOM NUMBER] was soiled with a dark brown clay-like substance with the odor of feces. During an observation and interview on 6/17/27 at 11:46 A.M., the Assistant Director of Nursing (ADON) said: -Maintenance and Environmental Services take care of the cleaning and repairs. -The ADON picked up the brown substance, and was unable to clarify what the substance was. Observation on 6/17/27 at 11:59 A.M., showed a soiled brief on the floor of room [ROOM NUMBER]. Observation on 6/17/24 at 12:17 P.M., showed the trim board between rooms [ROOM NUMBERS] was not attached to the wall and hanging outwards to the hallway. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 6/17/24 at 12:22 P.M., the EVSS said: -room [ROOM NUMBER] should have been cleaned the day before. -He/She made sure room [ROOM NUMBER] was cleaned three days before. -He/She had not yet made it to the fourth floor. During an interview on 6/17/27 at 12:25 P.M. the DON said: -Waste on the floor is considered a sanitation and infection control concern. -Nursing staff is to clean the bulk of the waste from the floor, then environmental services is to complete the process to sanitize the area. -The EVSS should be doing daily rounds. During an interview on 6/13/24 at 9:49 A.M., Housekeeper A said: -He/She had worked at the facility part time for four months. -He/She cleaned wherever he/she was told to clean. -It took 5-15 minutes to clean resident rooms. -When he/she cleaned resident rooms he/she swept, mopped all floors, cleaned the toilet, sink and wiped down all surfaces. During an interview on 6/13/24 at 1:04 P.M., Certified Medication Technician (CMT) A said: -The floors were sticky in resident rooms. -He/She used a wet towel and moved it around with his/her foot. -He/She would notify housekeeping of any issues with the floors. During an interview on 6/13/24 at 1:20 P.M., the Director of Environmental Services said: -He/She started this position two weeks ago. -Resident rooms were cleaned daily, sometimes twice a day. -He/She did visual rounds and asked random residents how their cleaning service was and if they had any issues. -He/She did this daily. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Housekeepers were expected to high dust, wipe all surfaces, clean bathrooms, dust and mop all floors in resident rooms. -He/She had no complaints from the residents. -He/She believed the housekeepers were using two different chemicals to clean the sticky floors which caused the stickiness. -Sticky floors should be cleaned with water first then with cleaner. -Carpets were vacuumed daily unless shorthanded. -There was a Floor Technician on each floor of the facility. During an interview on 6/13/24 at 1:22 P.M., the Environmental Services Supervisor (EVSS) said: -The housekeeping staff has been mixing chemicals which made the floors sticky. -He/She was not sure if there were material data sheets for the chemicals to ensure they were mixing chemicals safely. -Carpets should be vacuumed daily in the evening. -He/She was not sure how often the carpets were to be shampooed. -Odors in the building could be resolved by using the carpet extractor to clean the carpets. -His/Her perception of the conditions of the carpets at that time were soiled and old. During an interview on 6/13/24 at 3:58 P.M. the Director of Nursing (DON) said floors were swept every day. During interviews on 6/13/24 at 3:58 P.M. and 4:02 P.M. the Administrator said: -The new Environmental Services Director was working on a schedule for shampooing the carpets. -He/She expected carpets to be cleaned on a regular basis, weekly, and as needed. -He/She expected maintenance to secure any loose or missing floor trim. -The new EVSS was in the process of scheduling the carpet cleaning. -He/She expected the carpets to be cleaned on a regular schedule. -He/She expected the tile floors to be cleaned daily and the carpets to be cleaned weekly and as needed. -He/She expected the facility to be free of odors and the carpets to be clean. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-He/She expected the trim and molding to be replaced or fixed. -It was unacceptable for them to be missing or not repaired. Mo00237303

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** 45403 Based on observation, interview, and record review, the facility failed to ensure the resident environment was free from accident hazards, when one resident (Resident #2) was not secured appropriately with a lap belt in the facility van during transport on 5/20/24. The van abruptly stopped and the resident flew out the wheelchair onto the floor of the van and suffered a femoral fracture of the right leg that required surgical repair. There were 14 residents selected for sample. The facility census was 260. The Administrator was notified on 6/17/27 at 5:30 P.M. of an Immediate Jeopardy (IJ) Past Non-Compliance which occurred on 5/20/24. Prior to any further facility transports, immediate in-servicing was completed for proper placement in the van and safety belt use with each transport. The IJ was corrected 5/21/24. Review of the facility Fall Management Program Policy, dated 10/24/22, showed: -To prevent resident falls and minimize complications with falls through the development of a Fall Management Program. -The facility will provide the highest quality care in the safest environment for the resident residing the facility. Review of Van Driver A's undated employee training record showed: -All new transport drivers undergo a two day ride along with a current driver, followed by three days where the new employee drives while being observed by an experienced driver. -The new driver is not allowed to operate independently until they have demonstrated competency in all areas. -Completed training between 2/29/24 through 3/7/24. Review of the van maintenance records for 5/24 and 6/24 showed no concerns or needs for restraint systems. 1. Review of Resident #2's Admission Record showed the resident admitted on [DATE] with diagnoses including dependence on renal dialysis, acquired absence of left toes, unsteadiness on feet, muscle weakness, abnormalities of gait and mobility, displaced transverse fracture of shaft of right femur. Review of the resident's Minimum Data Set (MDS - a federally mandated assessment instrument completed by facility staff for care planning), dated 5/31/24, showed: -The resident was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-Functional abilities were dependent on wheelchair for mobility, mechanical lift for transfers and impaired range of motion on both sides. Review of the resident's undated Care Plan showed: -Had activities of daily living (ADL) self-care performance deficit related to 2/21/24 Hoyer lift tipped. --Would remain at current ADL function through next review period. ---Staff provided training. ---Resident was propelled in wheelchair. ---Transfer with Hoyer lift and two assist. ---Resident was non-weight bearing. -Was at risk for falls related to impaired mobility. -4/12/24 fall in wheelchair van. --Will have no major injury falls through review. ---4/12/24 staff contacted wheelchair company to have driver educated on properly locking in a wheelchair. ---Different wheelchair was obtained. Review of the resident's Administration Note, dated 5/20/24, showed: -The resident left for dialysis at 9:47 A.M. Review of the resident's Nursing Note, dated 5/20/24, showed: -It was reported at 10:00 A.M. the resident had a fall while out on transport in one of the facility vans on the way to dialysis from the facility. -The driver had to make a hard stop inadvertently, causing the resident to slide out of his/her wheelchair and onto the van floor. -Driver called 911 and the resident was transported to the hospital by (emergency medical services) EMS for evaluation and treatment. Review of the Facility Investigation, dated 5/20/24, showed: -Fall while being transported in the facility van. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-The resident was being transported to dialysis in the facility transport van. -Resident chair was properly secured and seat belt in place. -Mid-transfer a second vehicle cut off the transportation van causing the van driver to hit the brakes to avoid an accident. -Though there was no accident, when the vehicle was coming to an abrupt stop, the resident partially slid out of the wheelchair. -911 was called and EMS transported the resident to the hospital. Review of the resident's Hospital Record, dated 5/20/24, showed: -Presented to the emergency department on 5/20/24 due to right femoral diaphysis (main or midsection (shaft) of a long bone) fracture on the way to dialysis after an abrupt stopped vehicle. -On exam resident was sedated due to recent traction of right leg and unable to give any history. -Orthopedic service had been involved in open reduction, internal fixation (ORIF - a type of surgery used to stabilize and heal a broken bone) has been planned. -Right thigh visibly deformed. -Resident unable to provide much history because of pain. Review of the resident's Orthopedic Consult Note, dated 5/21/24, showed: -Reason for consult: fracture closed. -Extremity pain, extremity swelling, and joint swelling. -To operating room (OR) for Intramedullary nailing (IMN - surgery to repair a broken bone and keep it stable) right femur. Review of the resident's Hospital Discharge Summary, dated 5/23/24, showed: -Discharge diagnosis was acute right displaced right femoral fracture. -Presented on 5/20/24 due to right femoral diaphysis fracture on way to dialysis after an abrupt stop in vehicle while in wheelchair. -Orthopedic consult, IMN right femur 5/21/24. -Resident received one unit packed red blood cells likely related to injury and procedure. -Resident to discharge back to long-term care. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Review of the resident's Progress Note, dated 5/28/24, showed: -Resident had recent fracture, apparently fractured his/her femur in the wheelchair van. -Required surgery. -Recent right femur fracture secondary to a fall, status post ORIF. During an interview on 6/13/24 at 9:51 A.M., the resident said: -He/She was riding in the facility van on 5/20/24. -The wheelchair was secured in place. -The driver slammed on the brakes causing him/her to fall out of the wheelchair. -As a result he/she broke his/her leg. -The fire department had to come help get him/her out of the van to go to the hospital. -He/She had to have an operation to repair the broken leg. -He/She was secured in the facility van with the single shoulder strap. -That is how he/she was always secured in the facility van, other drivers used two straps during transport. -He/She had come to the facility due to an infection in his/her left foot. -He/She got a broken leg riding in the van to dialysis, extending his/her stay. During an observation and interview on 6/13/24 at 1:38 P.M., Van Driver A said: -He/She pointed to the floor explaining how the wheelchair was to be secured in the mid-section of the van. -There were four points to secure each wheel of the wheelchair. -He/She used all four points to secure the resident's wheelchair. -He/She pointed out two separate straps to use to secure the resident in the wheelchair in the center of the van. -There was only one strap used to secure the resident, the shoulder strap, at the time of the resident was injured. -The shoulder strap extended from the top left to the lower right of the resident's body. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-He/She could not use a lap strap due to the resident being too big to be placed in the back of the van. -During the demonstration, he/she was unable to locate and demonstrate the lap belt for the center of the van. -He/She had to slam on the brakes due to another driver pulling in front of the van. -Upon having to slam on the brakes, the resident came out of the wheelchair which resulted in a broken leg. -He/She contacted 911 to help get the resident to the hospital. -All residents being transported in the facility van which use a wheelchair were to be secured in the back of the van due to being more secure. -The shoulder and lap belt is connected, crossing the body from left to right, forming a v-shape in the back of the van. -He/She did not expect to have to slam on the brakes. -The lap belt was to keep the resident secured in place. -He/She said the resident falling out of the wheelchair and sustaining a broken leg was preventable. During an interview on 6/13/24 at 4:02 P.M. the Director of Nursing (DON) said: -The moment Van Driver A alerted staff of the incident on the bus the administrator was involved. -He/She was told the resident had fallen and EMS was called. -The administrator did an investigation. -The lap belt should have been used to prevent to injury. During an interview on 6/13/24 at 4:05 P.M., the Administrator said: -The lap belt should have been in place. -The resident falling out of the chair and sustaining a broken bone was preventable. -The purpose of the seat belts was to ensure the resident was secure and safe. During an interview on 6/17/24 at 3:09 P.M., the Nurse Practitioner said: -The resident broke his/her leg on the way to dialysis. (continued on next page)

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