STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265826	A. Building B. Wing	10/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Putnam County Care Center	1814 Oak Street Unionville, MO 63565

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 - 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. 34536 36219 Based on interview and record review, the facility failed to provide oversight and prevent injury for one resident (Resident #1), who was dependent on staff for transfers and bed mobility and had a history of falls from bed on 8/25/24 and 10/1/24, in a review of 12 sampled residents. On 10/7/24, staff failed to ensure interventions to prevent falls from the bed were in place when staff left the resident's bedside while in the resident's room. The resident rolled out of bed and hit his/her head. The resident sustained an intraventricular hemorrhage (bleeding inside the brain) and left hip fracture, which resulted in his/her death. The facility census was 56. The administrator was notified of the Immediate Jeopardy (IJ) on 10/16/24 at 5:10 P.M., which began on 10/7/24. The IJ was removed on 10/16/24 as confirmed by surveyor onsite verification. Review of the facility policy, Safety and Supervision of Residents, revised July 2017, showed the following: -The facility strives to make the environment as free from accident hazards as possible; -Resident safety and supervision and assistance to prevent accidents are facility-wide priorities; -Individualized, resident-centered approach to safety addresses safety and accident hazards for individual residents; -The care team shall target interventions to reduce individual risks related to hazards in the environment, including adequate supervision and assistive devices; -Implementing interventions to reduce accident risks and hazards shall include the following: -Ensuring that interventions are implemented; -Documenting interventions; -Monitoring the effectiveness of interventions shall include the following: (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 - Immediate jeopardy to resident health or safety Residents Affected - Few	-Ensuring that interventions are implemented correctly and consistently; -Evaluating the effectiveness of interventions; -Modifying or replacing interventions as needed; -Evaluating the effectiveness of new or revised interventions; -Resident supervision is a core component of the systems approach to safety. The type and frequency of resident supervision is determined by the individual resident's assessed needs and identified hazards in the environment; -The type and frequency of resident supervision may vary among residents and over time for the same resident. Review of the facility Managing Falls and Fall Risk policy, revised March 2018, showed based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. 1. Review of Resident #1's undated Face Sheet showed the resident's diagnoses included dementia (a chronic condition that causes a decline in mental functioning, such as thinking, remembering and reasoning, to the point that it interferes with daily life), and cerebral infarction (stroke; disrupted blood flow to the brain). Review of the resident's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument completed by facility staff, dated 7/21/24, showed the following: -Severely impaired cognitive skills; -Dependent on staff for transfers and bed mobility; -Required substantial/maximal assistance for rolling left and right in bed. Review of the resident's Care Plan, dated 8/1/24, showed the following: -The resident was at risk for falling due to limited mobility; -Ensure the resident was positioned in the center of the bed and positioned with a pillow to the side of the resident. -Two staff were to assist the resident with transfers. Review of the resident's Progress Notes, dated 8/25/24 at 12:30 A.M., showed a certified nurse assistant (CNA) found the resident on the floor. The resident slid off a low bed onto the floor mat. The resident landed on his/her right side. The resident had red bruising on his/her right hip, right upper thigh, on his/her right side, right elbow and left thigh. The resident had a 1 centimeter (cm) abrasion on his/her right shoulder surrounded by red bruising. (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 Care Plan showed no documentation staff evaluated the current interventions or implemented new interviews to prevent falls after the resident fell out of bed on 8/25/24. Review of the resident's Physician Order Sheet (POS), dated October 2024, showed an order for 81 milligrams (mg) of aspirin once daily in the morning. Review of the resident's Progress Notes, dated 10/1/24 at 6:25 A.M., showed staff found the resident on the fall mat. It appeared the resident was rolled up in his/her bed covers and that he/she rolled out of bed. No injuries noted. Review of the resident's Care Plan, updated 10/1/24, showed the resident rolled out of bed. Re-educate staff on positioning the resident with pillows to the side of the resident. Review of the resident's Progress Notes, dated 10/7/24 at 8:00 A.M., showed Licensed Practical Nurse (LPN) C documented the following: -Staff called him/her to the resident's room due to the resident rolling off the side of the bed while staff were getting the resident ready to get up, cleaned, changed, and dressed for the day; -When LPN C entered the resident's room, the resident laid on the floor next to his/her bed which was a little lower than waist high. The fall mat had been picked up off the floor. There were a few drops of blood on the floor under the resident's head; -The CNA said he/she was in the room getting the resident ready when the resident rolled over and off the side of the bed; -The resident had a raised area to the left side of his/her head that was purple in color with a small abrasion to one side and a laceration to the other side. The resident had a large amount of blood in his/her hair. The abrasion measured 1 centimeter (cm) by 0.4 cm and the laceration measured 1.5 cm by 0.2 cm. The laceration was actively bleeding; -The fall was witnessed, the fall mat was not in place, and the bed was not in the low position; -Notified administration and the resident's emergency contact and expressed the resident should be seen in the emergency room (ER) due to raised area with laceration to left side of head. Notified the resident's physician of the fall and injuries and received orders to send the resident to local hospital emergency room (ER) for evaluation and treatment; -All current fall interventions were not in place at the time of the fall. Review of the resident's care plan, updated 10/7/24, showed staff witnessed the resident roll off the side of his/her bed. Staff were educated on all current fall interventions for the resident. During interviews on 10/15/24 at 3:26 P.M., 10/16/24 at 10:25 A.M., and on 10/16/24 at 5:41 P.M., CNA A said the following: (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 and CNA B had raised the resident's bed to perform peri care and to prepare to transfer the resident out of bed for breakfast. The resident was on his/her left side facing the wall in the middle of the bed (the left side of the resident's bed was against the wall). The mechanical lift sling was under the resident; -He/She and CNA B realized they forgot to bring the mechanical lift into the room. CNA B left the room to retrieve the lift; -He/She stayed in the resident's room and lowered the bed somewhat, but not all the way back down to a low position. The resident was not moving and appeared to be sleeping. He/She had never seen the resident move around much. The resident did not have any pillows behind him/her because they were prepared to get the resident out of bed. He/She removed the fall mat from in front of the bed and moved it to the side and began to straighten up the room by folding clothes and blankets on the resident's recliner (the recliner sat approximately five feet from right side of the bed). He/She turned his/her back away from the resident for less than five minutes and the resident rolled out of the right side of the bed; -He/She was aware the resident fell out of bed on 10/1/24. The facility had implemented putting pillows around the resident after that fall. He/She did not put the pillows around the resident on 10/7/24 because he/she was getting the resident up and was not leaving the resident in bed. During interview on 10/15/24 at 12:57 P.M., CNA B said the following: -When he/she first entered to the resident's room to assist CNA A, the resident's bed was in the low position, the fall mat was on the floor next to the right side of the bed and there were pillows around the resident. He/She and CNA A raised the bed to perform peri care and placed the mechanical lift sling under the resident. The resident was not moving around in the bed; -He/She left the room to get the mechanical lift. Before he/she left the room, the resident was in the center of the bed facing the wall. The resident did not have any pillows around him/her. The resident was not moving around at all on his/her own; -The mechanical lift was down the hall and he/she was probably gone approximately two minutes to get the lift. He/She did not know exactly what happened while he/she was out of the room; -When he/she returned to the room with the mechanical lift, the fall mat was not on the floor and the resident lay on the floor; -The resident had rolled out of bed in the past and moved/rolled around in the bed when he/she was in pain. During an interview on 10/16/24 at 10:00 A.M., Licensed Practical Nurse (LPN) C said the following: -When he/she arrived to the room after the resident's fall, the bed position was between knee and thigh height. The resident lay directly on the floor to the right side of the bed facing the bed on his/her left side. The fall mat was not on the floor next to the bed. Blood was visible on the floor and the resident had a goose egg and laceration on the left side of his/her head. The resident was sent to the hospital emergency room for evaluation; (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-On 10/7/24 at 10:36 A.M., a CT scan (a computed tomography scan is a non-invasive medical imaging procedure that uses X-rays to create detailed, cross-sectional images of the inside of the body) of the abdomen and pelvis showed a minimally displaced left intertrochanteric fracture (a break in the upper part of the thigh bone, or femur, between the greater and lesser trochanters); -On 10/7/24 at 12:21 P.M., a CT scan of the head showed an acute intraventricular hemorrhage (bleeding inside or around the spaces in the brain). Review of the resident's progress notes, dated 10/14/24 at 6:45 P.M., showed the hospital notified the facility the resident passed away this evening. During interview on 10/16/24 at 1:39 P.M., hospital Physician D, one of the physicians who cared for the resident while in the hospital, said the resident's fall from his/her bed was a major factor in his/her death. Review of the resident's death certificate, dated 10/21/24, showed the following: -The resident passed away on 10/14/24; -Causes of Death: 1. Acute hemorrhage within basilar cisterna (fluid-filled spaces in the brain), 2. Intraventricular hemorrhage within the left lateral ventricle; -Other Significant Conditions Contributing to Death: Left hip fracture; -Describe How Injury Occurred: Resident fell out of bed; -Certified by the Medical Examiner/Coroner. NOTE: At the time of the survey, the violation was determined to be at the immediate jeopardy level J. Based on interview and record review completed during the onsite visit, it was determined the facility had implemented corrective action to remove the IJ violation at the time. A final revisit will be conducted to determine if the facility is in substantial compliance with participation requirements. At the time of exit, the severity of the deficiency was lowered to the D level. This statement does not denote that the facility has complied with State law (Section 198.026.1 RSMo.) requiring that prompt remedial action to be taken to address Class I violation(s). MO-243218 MO-243314