

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265837	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/27/2024
NAME OF PROVIDER OR SUPPLIER  Heisinger Bluffs Healthcare Western Campus		STREET ADDRESS, CITY, STATE, ZIP CODE  1306 West Main Street Jefferson City, MO 65109	

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)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>43024</p> <p>Based on interviews and record review, facility staff failed to notify one resident's (Resident #1) physician or representative in a timely manner of an unwitnessed fall and a room change for one resident (Resident #1). The facility census was 58.</p> <p>1. Review of the facility's fall protocol policy and procedure, undated, showed facility staff are directed the physician or practitioner and the resident representative will be notified of the fall and any change of condition of the resident.</p> <p>Review of the facility's room change policy and procedure, undated, showed facility staff are directed to inform the resident and the resident representative with issuance of notice for a room or roommate change arrangements and will be documented in the resident's record.</p> <p>2. Review of Resident #1's Admission Minimum Data Set (MDS), a federally mandated assessment tool, dated 1/30/24, showed staff assessed the resident as:</p> <ul style="list-style-type: none"> <li>-Moderately cognitively impaired;</li> <li>-Fracture of the hip (a break in the thighbone (femur) of your hip joint), Dementia (the loss of cognitive functioning),</li> <li>-History of fall one month prior to admission with a fracture;</li> <li>-Anticuagulant use.</li> </ul> <p>Review of the facility's room change documentation, dated 2/12/24, showed the resident was moved rooms.</p> <p>Review of the resident's neurological checks, dated 2/17/24, showed staff documented they assessed the resident for an unwitnessed fall at 9:00 A.M.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nurses notes, dated 2/17/24 at 1:50 P.M., showed staff documented the resident's complained about his/her right eye pain at breakfast, eye noted to be slightly bloodshot. Resident ambulated back to his/her room with staff after breakfast without difficulty. On arriving in his/her room this nurse noted the lense from the resident's glasses was sitting on his/her bedside table. When resident was asked what happened to his/her glasses, the resident stated he/she had fallen during the night and broke his/her glasses. No bruising noted at the time. The resident's representative came in to visit and resident reported to representative he/she had fallen. Glasses were found under the bed with frames bent. Resident very anxious after glasses were found with complaint of increased pain, noted that blood to right sclera had increased. Resident representative requested resident be evaluated in emergency room , sent by facility van for evaluation.</p> <p>During an interview on 2/27/24 at 10:59 A.M., the resident representative said he/she was not notified of the resident's room change, he/she and other family members went to visit the resident and had to ask where the resident had been moved too. He/She said he/she was not notified that the resident had a fall until he/she came to visit the resident and saw his/her eye was damaged and requested the resident be sent to the hospital due to increased pain.</p> <p>During an interview on 2/27/24 at 11:58 P.M., the administrator said the resident was moved on 2/12/24 to a private room because of Covid -19 (Coronavirus disease is an infectious respiratory disease caused by the SARS-CoV-2 virus.), he/she said if the resident is moved because of covid there would not be an official form like if there is a room change with a rate change but would expect to see the conversation in the nurses notes. He/She said the Social Services Director (SSD) is in charge of notifying resident's family and representatives of a room change. He/She said this might have not been done because the residents representative is in the building every day and there could have been a conversation about a room change.</p> <p>During an interview on 2/27/24 at 12:05 P.M., Registered Nurse (RN) A said the resident is very confused. He/She said around 7:00 A.M. on 2/17/24, the resident was at the breakfast table and his/her eye was blood shot, the resident said he/she fell last night on 2/16/24. He/She said that is when he/she contacted the physician for orders to send to the hospital and emergency medical services picked the resident up around 11:00 A.M. He/She said he/she had not contacted the resident representative prior to his/her arrival but would have. He/She said the nurse is in charge of contacting the physician and the resident representative after a fall.</p> <p>During an interview on 2/27/24 at 12:24 P.M., the SSD said he/she is often in charge of room change notifications but he/she is not here all the time and then the nurses are responsible for completing the room change notification. He/She said room change notifications should be documented in the nurses notes if they do not have an official form. He/She said room changes happen quickly and frequently on rehab because of covid, but he/she doubts the regulation is any different with notification of a room change because it is a rehab hall.</p> <p>During an interview on 2/27/24 at 1:20 P.M., the administrator said he/she expects both the physician and family to be notified once assessment is complete after a fall.</p> <p>MO00232017</p>		