

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  265848	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  01/10/2024
NAME OF PROVIDER OR SUPPLIER  Communities of Wildwood Ranch		STREET ADDRESS, CITY, STATE, ZIP CODE  3222 South John Duffy Drive Joplin, MO 64804	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 34871</p> <p>Based on interview and record review, the facility staff failed to ensure an environment as free from accident hazards of possible for all residents, when the facility failed to ensure staff were aware of where to find care planned fall interventions and followed care planned fall intervention for one resident (Resident #1) resulting the resident falling from his/her bed, while not in the low position, and left unattended. The fall resulted in facial injuries and skin tears requiring the resident to be sent to the hospital. The facility census was 111.</p> <p>Review of the facility's policy Falls and Fall Risk, revised March 2018, showed the following:</p> <ul style="list-style-type: none"> <li>-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;</li> <li>-Environmental factors that contribute to the risk of falls include incorrect bed height or width;</li> <li>-Resident conditions that may contribute to the risk of falls include delirium and cognitive impairment;</li> <li>-The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls;</li> <li>-If falling recurs despite initial interventions, staff will implement additional or different interventions, or indicate why the current approach remains relevant;</li> <li>-If interventions have been successful in preventing falling, staff will continue the interventions or reconsider whether these measures are still needed if a problem that required the interventions has resolved.</li> </ul> <p>1. Review of Resident #1's face sheet (admission data) showed the following:</p> <ul style="list-style-type: none"> <li>-admitted [DATE];</li> </ul> <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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Diagnoses included vascular dementia (problems with reasoning, planning, judgment, memory and other thought processes caused by brain damage from impaired blood flow to the brain) without behavioral disturbance, unsteadiness on feet, and muscle weakness.</p> <p>Review of the resident's fall risk assessment, dated 10/13/23, showed the following:</p> <ul style="list-style-type: none"> <li>-No history of falling within three months;</li> <li>-Ambulatory aide: None/bed rest/nurse assistance;</li> <li>-Gait: Impaired;</li> <li>-Mental status: Overestimates abilities/forgets limitations;</li> <li>-Resident is low risk: Implement standard fall prevention interventions.</li> </ul> <p>Review of the resident's care plan, revised on 10/14/23, showed the following:</p> <ul style="list-style-type: none"> <li>-The resident was at risk for falls. The resident prefers to be as independent as possible;</li> <li>-The resident will have no major injury related to falls.</li> </ul> <p>Review of the resident's quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff), dated 10/15/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Severely impaired cognitive skills;</li> <li>-No behaviors;</li> <li>-Mobility: Roll left to right with substantial/maximum assistance;</li> <li>-Sit to lying: Ability to move from sitting on side of bed to lying flat on bed with substantial/maximum assistance.</li> </ul> <p>Review of the resident's care plan, updated 10/18/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Place the resident's bed in the low position when the resident is in bed.</li> </ul> <p>Review of the resident's progress note dated 12/19/23, at 3:40 A.M., showed a certified nurse aide (CNA) called nurse to resident's room. The resident sat on the floor beside his/her bed. The resident said he/she just rolled off. The resident had a small skin tear to his/her left pinky finger.</p> <p>Review of the resident's care plan, updated 12/19/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Staff to ensure the resident is positioned in the bed appropriately prior to leaving unattended.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Review of the resident's nursing note dated 12/30/23, at 4:32 P.M. showed Licensed Practical Nurse (LPN) H documented staff heard the resident call for help. Staff found the resident on the floor after he/she fell out of his/her bed. The resident was noted to have multiple injuries including right facial lacerations, left eye hematoma (bruise), left hand skin tear, and right knee skin tear. The resident was alert and oriented times two per his/her baseline and conversed with the staff. Staff called emergency services to transport to the hospital.</p> <p>Review of the resident's care plan, dated 12/30/23, showed the following:</p> <ul style="list-style-type: none"> <li>-Staff to ensure the resident's bed in lowest position prior to leaving the resident unattended in his/her room.</li> </ul> <p>During interviews on 01/10/24, at 12:10 P.M. and 2:03 P.M., CNA D said the following:</p> <ul style="list-style-type: none"> <li>-On 12/30/23, at approximately 3:45 P.M., he/she changed and dressed the resident in his/her bed and placed the Hoyer sling (Hoyer lift - lift used to transfer non-weight bearing residents) under the resident;</li> <li>-He/she raised the resident's bed to change the resident;</li> <li>-He/she left the resident in bed with the bed up and went to get the Hoyer lift in another resident room;</li> <li>-The resident had never got out of his/her bed or tried to stand up on own;</li> <li>-He/she should not had left the resident's bed up in the higher position;</li> <li>-He/she did not know the resident was at risk for falls;</li> <li>-He/she thinks the resident sat up on the bed, hoisted legs over the side of the bed, and hit the metal on the bedside table which was in close proximity of the resident's bed;</li> <li>-He/she did not know the resident rolled out of his/her bed in a prior incident on 12/19/23;</li> <li>-Resident's who are fall risk should have this addressed in their care plans;</li> <li>-He/she did not know where to find the care plans. The care plans are probably in the charting on the computer.</li> </ul> <p>During interviews on 01/10/24, at 12:54 P.M. and 2:38 P.M., LPN F said the following:</p> <ul style="list-style-type: none"> <li>-The resident sometimes tried to get out of bed;</li> <li>-On 12/30/23, he/she found the resident face down on the floor. He/she thinks the resident hit the bedside table on the metal on the bottom of the bedside table;</li> <li>-He/she did not know of the incident on 12/19/23 of the resident rolling out of bed;</li> </ul> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-Staff know a resident is at risk for falls through their history, dementia, confusion or if they fell at home;</p> <p>-Staff should not leave a resident up in raised bed;</p> <p>-The care plan team consists of the department heads;</p> <p>-The aides should report to the Director of Nursing (DON) if the resident has a decline. Staff discuss the resident and update the care plan;</p> <p>-Staff communicate to the aides with charting, care plans, and the report from aides on shift to shift report;</p> <p>-He/she expects the nurse aides to know residents who are a fall risk;</p> <p>-He/she expects for staff to not leave a resident alone in a bed that is raised high.</p> <p>During an interview on 01/11/24, at 8:09 A.M., LPN H said the following:</p> <p>-Staff assisted the resident with a Hoyer lift for transfers;</p> <p>-The resident did not try to get out of bed;</p> <p>-He/she did not know of the 12/19/23 incident of the resident rolling out of bed;</p> <p>-On 12/30/23, CNA D left the resident's bed in a high position when he/she assisted the resident to get out of bed;</p> <p>-He/she found the resident on the floor with lacerations to the face and significant facial injury and multiple hematomas;</p> <p>-The resident's bed was in a high position;</p> <p>-He/she expects staff to leave the resident bed in a low position if leave the resident;</p> <p>-Staff knew if a resident is at risk for falls due to dementia, wandering and the resident not know own limitations;</p> <p>-The nurse aides have a document which contains the resident census and how the resident transfers;</p> <p>-The care plan should show if a resident is at risk for falls and fall interventions;</p> <p>-The nurse aides have access to the care plans in their documentation and the internet portal;</p> <p>-Nurses inform the nurse aides verbally if a resident has updated fall interventions;</p> <p>-Registered Nurse (RN) G updates the care plans;</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>-The charge nurses give report to the nurse aides. The nurse aides have a paper with details of each resident care needs. Staff find out if a resident had a fall in the CNA report and communication between staff;</p> <p>-Staff should not leave a resident if the bed is high. Staff should make sure the bed is in the lowest position when they leave the resident;</p> <p>-Two staff should be in the room during a Hoyer lift transfer with a resident.</p> <p>During an interview on 01/10/24, at 3:25 P.M., the Administrator said the following:</p> <p>-Staff should know a resident at risk for falls in the residents' chart;</p> <p>-The nurse aides have access to residents' care plans;</p> <p>-Staff communicate in the morning and at the shift report of a resident fall;</p> <p>-Staff knew of updated fall interventions through the nursing report, word of mouth and the care plan;</p> <p>-The nurse aides complete shift report with each other.</p> <p>During an interview on 01/11/24, at 12:07 P.M., the Medical Director said the following:</p> <p>-He expects staff to be aware of residents at risk for falls and fall interventions;</p> <p>-He expects staff to not leave a resident with the bed in a high position.</p> <p>MO00229548, MO00229685</p>		