STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175508	A. BUILDING _____ B. WING _____	C 07/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS NURSING & REHABILITATIVE CENTER	302 E IOWA STREET HIAWATHA, KS 66434

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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00172762, KS00172770, and KS00172509. The 2567 was sent electronically on 07/18/22.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility identified a census of 43. The sample included three residents and three residents were reviewed for accidents. Based on observations, record review, and interviews, the facility failed to ensure Resident (R) 1 remained free from accidents when facility staff failed to provide one-to-one assistance during ambulation and transfer for R1. This deficient practice resulted in R1 falling in her room and fracturing her left hip. Findings included: - The "Diagnoses" tab of R1's Electronic Medical Record (EMR) documented a diagnosis of dementia (progressive mental disorder characterized by failing memory, confusion) without behavioral disturbance. The "Admission Minimum Data Set (MDS)" dated	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/18/2022

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02/24/22, documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. R1 required limited physical assistance with two staff for bed mobility and transfers; limited physical assistance with one staff for walking, locomotion, dressing, toileting, and personal hygiene. R1 had two or more non-injury falls, and one injury fall since admission.

The "Quarterly MDS" dated 05/25/22, documented a BIMS score of three, which indicated severe cognitive impairment. R1 required extensive physical assistance with one staff for bed mobility, dressing, toileting, and personal hygiene; extensive physical assistance with two staff for transfers and walking in room; limited physical assistance with two staff for walking in corridor. R1 had two or more non-injury falls since last assessment.

The "Cognitive Loss/Dementia Care Area Assessment (CAA)," dated 02/28/22, documented R1 had a BIMS score of three and was able to ambulate with use of walker.

The "Falls CAA," dated 02/28/22, documented R1 required limited assistance with one staff for activities of daily living (ADLs). R1 was unsteady with her gait and needed a walker and staff assistance for safety.

The "Care Plan" dated 03/07/22, documented R1 required limited assistance of one staff with her ADLs, was unsteady with her gait, and needed a walker and staff assistance for safety. Staff continued to monitor R1 with one-to-one assistance with transfers and ambulation. The "Care Plan" directed R1 was limited assistance of

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one staff with ADLs and used a walker as an assistive device.

The "Care Plan" dated 03/07/22, documented R1 was alert and very confused and was one-to-one with transfers.

The "Care Plan" dated 03/07/22, documented R1 had a history of falling and directed staff assisted R1 one-to-one always for ambulation and transfers.

The "Progress Notes" tab of R1's EMR revealed the following:

A "Nursing Note" on 06/24/22 at 10:56 AM, documented at about 07:30 PM on Thursday 06/23/22, Certified Nurse Aide (CNA) M assisted R1 to get ready for bed. CNA M called for Licensed Nurse (LN) G, who responded immediately from nearby, and saw R1 lying on her side in front of her closet. R1's walker was close by, tipped over. CNA M stated that R1 was standing with her walker while CNA M turned the covers down on R1's bed when R1 became weak and went to her knees then onto her side. R1 denied pain and CNA M denied R1 hit her head. R1 was assessed for injuries at knees, shoulders, and elbows with no injuries noted. CNA M and LN G helped R1 into bed. The morning of 06/24/22, around 07:30 AM, CNA M reported a skin tear on R1's left elbow. CNA M reported she was there the previous night when R1 fell and did not see any blood on R1's arm at that time. R1 reported pain in the hip area. Administrative Nurse D assessed range of motion and R1 had pain upon rotation of left leg. R1 was sent to the emergency room (ER) for evaluation to rule out hip fracture.

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A "Nursing Note" on 06/24/22, at 12:12 PM, documented the hospital called the facility and reported R1 had a left side hip fracture. R1 needed surgery and the hospital was looking for another hospital to send R1 to.

A "Nursing Note" on 06/28/22, at 01:36 PM, documented the nurse received report from the hospital. R1 had a left hip hemiarthroplasty (surgical procedure that involves replacing half of the hip joint) and had a healing incision to her left hip.

The "Summary of Care" document from the hospital, dated 06/28/22, documented a diagnosis of closed fracture of the left hip.

The facility's "Investigation" dated 06/29/22, documented around 07:30 PM, on Thursday 06/23/22, CNA M assisted R1 to get ready for bed. CNA M had just given R1 a shower and walked her back to her room. R1 used a walker with one-to-one staff assistance. CNA M reported R1 was standing with her walker and CNA M turned around to pull back the bed covers. When CNA M turned back around, R1 was falling, and CNA M could not reach her to stop the fall. LN G was just outside the door and was there to assess R1. R1 responded to LN G and stated she was fine. LN G's assessment revealed no injuries. R1 was assisted up and to the bed at that time and was able to take several steps into bed without incident. The next morning, R1 complained of more pain and directed the location to her left hip. Administrative Nurse D assessed R1 and noted pain upon rotation of left leg. R1's physician was notified at that time to obtain transfer to ER for evaluation. The ER notified the facility that R1 had left hip fracture

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and was to be transferred to another hospital.

In a "Witness Statement" on 06/24/22, CNA M stated she gave R1 a shower around 06:30 PM then walked back to her room. R1 was standing in the middle of the room and CNA M went to her bed to pull down the covers. CNA M stated when she turned back around, R1 was falling. She stated she tried to get to R1 but was not fast enough and saw her fall to her left side onto the floor. CNA M stated she immediately called for the nurse who was right outside the door. The nurse assessed R1 then they assisted her to her bed.

In a "Witness Statement" on 06/24/22, LN G stated at about 07:30 PM, on Thursday 06/23/22, CNA M assisted R1 to get ready for bed. LN G stated he was down the hall nearby when he heard CNA M call for him. He responded immediately and upon entering the room, saw R1 lying on her left side in front of the closet. R1's walker was tipped over nearby. LN G stated CNA M reported that R1 had been standing alone when she appeared to weaken, went down on her hands and knees, then down to the floor. He stated CNA M reported R1 had not hit her head. LN G stated R1 responded to speech and stated she was fine. His initial assessment revealed no obvious injuries so R1 was lifted with two staff from the floor and walked with two staff to the bed. LN G stated for the short distance of two to three steps, she was able to bear weight on both legs with no indication of pain. R1 was helped to lie down on her back and LN G continued his assessment. LN G stated each leg was lifted and rotated, the knee was bent, then rotated outward at which time R1 did not complain of pain or show any signs of pain.

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On 07/06/22 at 11:30 AM, R1 sat in wheelchair at table in dining room. Staff assisted her with positioning.

On 07/06/22 at 01:30 PM, CNA N stated if a resident was one-to-one with ambulation and transfers, staff needed to be with the resident and always kept their eyes on the resident.

On 07/06/22 at 01:52 PM, LN G stated CNA M helped R1 get ready for bed. He stated he was close by on the unit at the time and heard CNA M call for him. LN G stated when he entered R1's room, she was lying on the floor. LN G stated CNA M reported R1 was standing with walker when CNA M turned to pull the blankets down on bed and R1 had weakened then fell to hands and knees onto the floor. LN G completed an initial assessment, no injuries and no complaints of pain. LN G stated staff lifted R1 two-to-one assist and walked her to bed; R1 did bear weight. He stated he continued R1's assessment and did not see any injuries. LN G stated if a resident was one-to-one staff assistance, staff were always expected to keep hands/eyes on resident.

On 07/06/22 at 02:47 PM, Administrative Nurse D stated R1 fell on 06/23/22. When she came in on 06/24/22, CNA M reported a skin tear on R1 then reported R1 fell on 06/23/22. She stated staff reported to her that R1 was not acting the same, was not walking very well, and acted as though she was in pain. Administrative Nurse D stated she completed an assessment and observed slight rotation in left foot and painful with movement. She stated she expected staff to be cautious if R1 was standing with her walker as R1 had a history of being combative if staff touched

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F 689	Continued From page 6 her. The facility's "Universal Risk for Falls Protocol" policy, dated 2014, directed universal fall precautions were put into place for residents identified without risk and low risk for falls. The facility's "High Risk Fall Protocol" policy, dated 2014, all household team members were notified when a resident was at high risk for falls. The facility failed to ensure R1 remained free from accidents when facility staff failed to provide one-to-one assistance during ambulation and transfer for R1. This deficient practice resulted in R1 falling in her room and fracturing her left hip. On 06/24/22 the facility completed the following corrections: Education was provided to all clinical staff regarding resident mobility and monitoring, safe transfers and ambulation. This deficient practice was cited as past non-compliance.	F 689		