STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175541	A. BUILDING _____ B. WING _____	C 01/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TALLGRASS CREEK, INC	13760 METCALF AVENUE OVERLAND PARK, KS 66223

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations #KS00168528. The 2567 was sent electronically on 01/19/22.	F 000		
F 726 SS=D	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.	F 726		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 01/19/2022

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.

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F 726	Continued From page 1	F 726		

This REQUIREMENT is not met as evidenced by:
The facility had a census of 28 residents. The sample included four residents with three reviewed for falls. Based on interview and record review the facility failed to ensure all nursing staff possessed the competencies and skill sets necessary to provide nursing and related services to meet the residents' needs safely, and in a manner that promoted each resident's physical well-being. On 01/07/2022 at approximately 07:30 PM Certified Nurse Aid (CNA) P failed to report Resident (R) 1's fall to a licensed nurse and failed to ensure R1 was assessed by a licensed nurse prior to assisting the resident off the floor.

Findings included:

- R1's electronic medical record (EMR), under the "Diagnosis" tab, listed diagnoses of: age related osteoporosis (a significant loss of bone mass), a cognitive communication deficit (an impairment caused by an underlying cognitive deficit like injury to the brain that controls the ability to think), and anxiety (intense, excessive, and persistent worry and fear about everyday situations).

R1's "Admission Holistic Evaluation" dated 12/29/21 recorded R1 was cognitively intact, understood others and had the ability to make their needs known. The evaluation recorded R1 required limited assistance with most activities of daily living (ADL's) such as transfers, toileting, bathing, etcetera. This same assessment recorded R1 required contact guard assistance with transfers, ambulated with use of a rolling walker and had a history of falls.

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F 726	Continued From page 2	F 726		

The 12/29/21 "Holistic Evaluation" for walking directed staff to remind R1 to go slowly with walking, remembering to take a few seconds before walking; to keep assistive devices near the bed and/or chair, and remind R 1 to keep her walker close and encourage frequent rest periods.

A "Nurses Progress Note" dated 01/07/22 at 08:00 PM documented Licensed Nurse (LN) I was notified by an CNA O that R1 reported a fall. LN I recorded that upon entering R1's room, R1 laid in bed, face up and stated she had fallen "a while ago." The note recorded R1 stated there was a staff member in the room when she fell and identified CNA P as that staff member. The note recorded R1 further stated CNA P helped R1 to stand up and put in R1 in bed. LN I documented R1 complained of right arm pain and assessment revealed the arm was swollen and tender to touch. LN I notified the Advanced Registered Nurse Practitioner (ARNP) who advised R1 be evaluated in the hospital.

The "Facility Investigation" recorded the transcription of an interview between Administrative Staff A and CNA P. The transcription documented CNA P stated the referenced incident occurred on "Friday" [01/07/22] at approximately 07:30 PM. CNA P stated she observed R1 walking from R1's bathroom towards the bed. CNA P saw R1stumble. CNA P reported by the time she was able to get to R1, R1 was on the ground. R1's arm hit the chest by R1's bed. CNA P further reported R1 laid by the bed, on her right side. CNA P asked R1 if R1 was "okay" and R1 replied "yes." CNA P stated she helped R1 into bed. CNA

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P stated she rolled R1 to a sitting position, then stood in front of R1with her hands on R1's waist and lifted R1 from the floor. CNA P reported she then assisted R1 to pivot and get into bed and R1 again denied concern or injury. CNA P reported she did not talk to any facility staff after the incident, she walked by the charge nurse at the nurse's station but did not report R1's fall prior to clocking out and leaving the facility. CNA P stated she had thought about calling someone at the facility to report R1's fall but did not do it.

On 01/11/22 at 02:00 P.M. CNA P was not available for interview.

Interviewed on 01/11/22 at 02:00 P.M. Administrative Nurse D stated if a fall occurred, the care associate should immediately report to the incident to the charge nurse. Administrative Nurse D stated immediate education was conducted with staff to reiterate reporting of falls to nurses, and stated as the investigation progressed, the facility would determine if additional education and or training decisions would be needed.

Review of the facilities undated "Resident Incident Response Guidelines for Team Members" recorded any fall (non-injury included) or other incident must be reported to the nurse immediately.

The facility failed to ensure competent nursing staff provided nursing care to meet R1's needs safely when CNA P failed to report R1's fall to the LN on duty allowing R1 to be assessed by a LN prior to transferring after the fall.