STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265850	A. Building B. Wing	08/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Seasons Rehab and Healthcare Center	15600 Woods Chapel Road Kansas City, MO 64139

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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39469 Based on interview, and record review, the facility failed to assess a resident who had fallen before moving him/her and did not call Emergency Medical Services (EMS) in a timely manner for one sampled resident (Resident #1) out of four sampled residents. The facility census was 77 residents. The Administrator was notified on 8/26/24 of Past Non-Compliance (PNC) which occurred on 8/20/24. On 8/20/24 facility administration identified the resident was moved after a fall prior to being assessed by a licensed nurse and the delay in emergency services being notified to transfer the resident to the hospital. The facility completed the investigation, and the facility staff were in-serviced by 8/21/24. Review of the facility's policy, Response to Falls, dated October 24, 2022 showed: -Residents who have experienced a fall would have been promptly assessed and treated for injuries. -After each fall, a Licensed Nurse would have completed a Post-Fall Assessment and Investigation. -Immediate Post Fall Response: -Upon finding a resident in a position indicating a fall, stay with the resident and send another staff member to notify a Licensed Nurse if the first responder was not licensed personnel. -Do not move the resident initially until after an assessment was completed. -Call for assistance. -The Licensed Nurse should have assessed the resident and taken the resident's vitals. -Assess the resident's level of consciousness, position, possible injuries, head injuries, pain, tenderness, swelling, bruising, alignment and range of motion. -If the Licensed Nurse suspects a fractured hip, back or other injury, the Licensed Nurse should have made the resident comfortable until emergency medical services arrived. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The Licensed Nurse would have also completed the Neurological Flow Sheet for any un-witnessed fall, or witnessed fall with known head injury for 72 hours following the fall. 1. Review of Resident #1's face sheet showed he/she was admitted to the facility on [DATE] with the following diagnoses: -Alzheimer's Disease (a progressive disease that destroys memory and other important mental functions). -Dementia (a group of thinking and social symptoms that interferes with daily functioning). -Spinal Stenosis (when the spaces inside the bones of the spine get too small). -Lumbago with Sciatica, left side (anything that causes narrowing of the spinal canal has the potential to compress nerve roots and cause a bulging disc). -Muscle weakness. -Lack of coordination. -Cognitive communication deficit (having trouble reasoning and making decisions while communicating). Review of the resident's Quarterly Minimum Data Set (MDS - a federally mandated assessment tool completed by the facility for care planning), dated 6/21/24 showed: -He/She was moderately cognitively impaired. -He/She did not have any impairment to lower extremities (hip, knee, leg, or foot). -He/She used a walker. -He/She used a cane or crutch. -He/She had prior falls with no major injury. Review of the resident's undated Care Plan showed: -He/She had a self-care performance deficit, required supervision to limited assistance by staff for transfer as necessary. -He/She had impaired cognitive function. -He/She has had actual falls related to poor balance and unsteady gaits; 6/5/24, 6/10/24, 8/5/24, and 8/20/24 (fall with hip fracture). -He/She was at risk for falls and staff needed to follow facility fall protocol. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the Nurses Progress Notes dated 8/20/24 at 6:47 A.M. written by Licensed Practical Nurse (LPN) A showed: -He/She was notified by a staff member of the resident sitting on the floor next to a chair. -He/She arrived to room to see the resident sitting on the floor next to a chair. -Upon assessing the resident he/she noticed there was no bruising but his/her left leg had pain when moving it. -The resident stated he/she had lost his/her balance, fell and hurt his/her leg. -He/She did a full body assessment, gathered vital signs (blood pressure, pulse, respirations,neurological assessment). -The resident was experiencing left leg pain. -An X-ray was ordered for the resident's left leg. -He/She notified the Director of Nursing (DON), Assistant Director of Nursing (ADON), Physician, and Durable Power of Attorney (DPOA -legal statement authorizing another person to make decisions for someone who mentally was not able to). -There was no documentation showing a Certified Nurses Assistant (CNA) moved the resident prior to being assessed by a licensed nurse Review of the facility's undated fall investigation showed: -Statement from CNA D on 8/20/24 showed: -He/She was notified by the resident's roommate that Resident #1 needed help. -He/She entered the resident's room and observed the resident laying on the floor. -He/She asked the resident if he/she was hurt. -The resident responded yes, his/her leg was hurt. -The resident reached out to him/her and grabbed his/her hand to sit up. -Additional staff entered the room to assist with the fall so he/she stepped out. -Review of the witness statement dated 8/20/24 written by Restorative Aide/CNA A on 8/20/24 showed: -A night shift CNA approached him/her stating the resident had fallen. (The RA did not know the CNAs name). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-When he/she entered the room, the resident was in a seated position with his/her legs in front of him/her. -Several other staff members responded to the room. -The resident complained of leg pain. -He/She assisted the resident to a nearby chair for his/her comfort. -Review of the witness statement dated 8/20/24 written by LPN A showed: -A CNA notified him/her the resident had fallen in his/her room. -Several staff had responded to the room. -He/She had completed an initial assessment and initiated fall procedures. -The resident's family was notified. -The family had requested the resident be sent to the hospital. -Review of the witness statement dated 8/20/24 written by LPN B showed: -When he/she had arrived to work he/she had received a report from the off-going shift that the resident had fallen. -The resident's family would like him/her sent to the hospital. -He/She entered the resident's room and observed him/her sitting up in a chair. -An assessment revealed the resident had pain in his/her left shoulder and hip. -The Paramedics arrived and transported the resident to a nearby hospital. -Review of the Investigation Summary dated 8/20/24 showed: -At about 6:20 A.M. CNA D was informed the resident had an unwitnessed fall in his/her room. -The resident was attempting to get up off the floor independently while awaiting clinical assessment secondary to impaired mentation and impulsivity related to a dementia diagnosis. -Clinical staff assisted the resident to a nearby chair to prevent greater potential injury. -The Nurse was informed of the incident and a complete head to toe assessment with no visualized injuries noted. -The resident complained of left hip and shoulder pain. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-The resident's Physician was notified of the fall and an order was received for a STAT (immediate) X-ray. -The DON was notified. -The DPOA was notified via phone and requested the resident be sent to the hospital and not to wait for an in house radiology (X-ray). -911 was called. -Paramedics arrived at the facility. -The resident was taken to the nearby hospital. Review of the video of the resident's fall on on 8/20/24 showed: -At 6:17 A.M. on 8/20/24 the resident was walking in his/her room toward the bathroom when he/she fell backwards into his/her left side. -His/Her roommate was in the room at the time and went to find a staff member to help. -At 6:22 A.M. CNA D entered the room. -The CNA asked if the resident was OK. -CNA D then sat the resident up on the floor as he/she had been laying flat on the floor. -The resident groaned and said he/she was in pain as he/she was moved to a sitting position on the floor. -He/She left the room to find the nurse. -He/She came right back to the resident and asked the resident if his/her leg was ok. -The resident said, No it's not ok. -At 6:23 A.M. Restorative Aide (RA)/CNA A and three other staff members entered the room. -The RA/CNA A asked the resident if he/she was ok, was he/she hurt. -The resident said, I'm hurt alright, my hip and my arm. -The RA/CNA A put a gait belt (a safety assistance device used to help transfer a person) around the resident's waist and with the assistance of one other staff member they assisted the resident up and into a chair. -One of the CNAs put shoes on the resident. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 8/26/24 at 9:10 A.M. CNA B said: -He/She would notify the nurse if he/she had found a resident on the floor. -He/She would not move the resident. -The Nurse would have done an assessment then he/she would do a set of vital signs. -The Administrator and DON have done education on not moving a resident until they were assessed by a Nurse in the last 30 days. During an interview on 8/26/24 at 9:20 A.M. LPN B said: -If a resident was on the floor staff should have contacted a nurse. -The nurse would have done a head to toe assessment and neuro checks on the resident. -If a resident was in pain he/she would have notified the physician. -The physician would have given an order for an X-ray or to have sent the resident to the hospital. -He/She was scheduled to work the day shift on 8/20/24. -The night shift CNA told him/her that the resident had fallen. -The night shift nurse called him/her and gave report. -The night shift nurse had called the physician and had received orders for a portable X-ray. -The family member had called him/her and requested that the resident to go to the hospital. -The family member called him/her and requested the resident go to the hospital. -He/She went to see the resident. -The resident was sitting in a chair. -The resident had a flat affect, (no emotion) on his/her face. -The resident appeared to be in pain. -He/She did a range of motion evaluation on the resident's left shoulder, which was painful (resident verbalized). -He/She was unable to extend the resident's left leg out straight. -The resident said it hurt to move his/her leg. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-He/She called the resident's Nurse Practitioner to get an order to send the resident to the hospital, which he/she received. -He/She called 911 to activate Emergency Services (EMS- Emergency Medical Services). -EMS arrived and took the resident to the hospital. -The reporter was notified the resident had been sent out to the hospital. -The night nurse should have stayed with the resident. -He/She did not think the night nurse had called 911. During an interview on 8/26/24 at 10:00 A.M. CNA C said: -During report at the change of shift at 7:00 A.M., the night CNA (name unknown) reported to him/her that the resident had fallen. -If a resident was on the floor you should get the nurse. -The nurse would do an assessment on the resident. -He/She would not move the resident until the nurse told him/her to. -When he/she first came to work he/she saw the resident sitting in a chair with LPN B doing an assessment on him/her. During an interview on 8/26/24 at 10:10 A.M. the family member said: -The family has a video camera in the resident's room. -At 6:30 A.M. the camera dinged notifying him/her that the resident was moving in the room. -He/She reviewed the video which showed the resident laying on the floor. -He/She reviewed the video at an earlier time which showed at 6:17 A.M. the resident got up and was walking to the bathroom without his/her walker when he/she stumbled over his/her own feet and fell to the floor. -At 7:07 A.M. a nurse(night shift) called him/her and told him/her they were going to do an in-house X-ray. -He/She told the nurse to call an ambulance and send the resident to the hospital. -He/She called the nurse a second time and told him/her to send the resident to the hospital. -At 7:45 A.M. he/she called and talked to (LPN) B and asked him/her to open the resident's door which had been closed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN B said he/she was going to call for an in-house X-ray. -The family member asked the day nurse to call an ambulance to send the resident to the hospital. -At 7:50 A.M. LPN B went into the resident's room to assess him/her. -The resident said it was sore. -At 8:03 A.M. the EMS arrived and took the resident to the hospital. -The resident had previous falls. -The resident was taken to a nearby hospital where he/she had surgery the next morning to repair his/her broken hip. -He/She was very upset because he/she had told the nurses three different times to call EMS to transfer the resident to the hospital. -It was almost two hours after the fall before EMS came to transport the resident to the hospital. -The staff sat the resident up before he/she was assessed by a nurse. -The staff had attempted to walk the resident to breakfast before he/she was assessed by a nurse then sat him/her in a chair with the door closed. -He/She had showed the video to the DON and Administrator. During a telephone interview at 12:35 P.M. on 8/26/24 LPN A said: -He/She was the night nurse when the resident fell . -The resident fell between 6:00 A.M. and 7:00 A.M. on 8/20/24. -A CNA notified him/her that the resident had fallen. -He/She had went into the resident's room and completed an assessment. -The resident said he/she had hip pain. -He/She had documented the assessment on the computer system. -He/She had called the family and the physician to let them know about the fall. -The physician had ordered an X-ray. -The family member wanted the resident to go to the hospital. -He/She did not call 911, but passed it onto the day shift nurse in report. (continued on next page)

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