STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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	F 000		

The following citations represent the findings of partial extended survey and complaint investigations #KS00173584 and KS00173420.

On 08/02/22 at 05:15 PM the facilty received a copy of the "Immediate Jeopardy [IJ] Template" and was informed of the IJ for Resident (R) 1.

R1, who was cognitively impaired, admitted to the facility on 07/14/22 with a diagnosis of traumatic subdural (collection of blood on the surface of the brain due to injury) hemorrhage (an escape of blood from a ruptured blood vessel) due to a fall at home. On 07/14/22 R1 fell in the facility. Staff implemented nonskid socks. No root cause analysis was conducted, and no plan of care developed to address R1's fall risk. On 07/15/22 R1 fell in her room, unwitnessed by staff. R1 complained of pain and was sent to the emergency room via EMS. R1 was diagnosed with a proximal humerus (the upper arm bone close to the shoulder) fracture and her broken arm placed in a sling. The facility did not implement any interventions at that time to prevent further falls or injuries. From 07/20/22 through 07/23/22 R1 had multiple falls. On 07/23/22 R1 slid from her wheelchair. A few minutes later, R1 fell in her room. The clinical record recorded R1 did not have nonskid socks and had no other preventative measures in place. R1 complained of pain in the right hip which required x-rays. On 08/1/22 and 08/2/22 R1 was observed on the floor mat in her room. The facility failed to identify and implement preventative measures to address falls, safety and supervision needs for R1 who had multiple falls including one which resulted in a fracture. This placed R1 in

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 08/16/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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	Continued From page 1 immediate jeopardy. On 08/02/22 the facility implemented the following corrective actions to address the immediate jeopardy (IJ): The Medical Director was notified of IJ at 06:12 pm on August 2, 2022. Resident #1 incidents were reviewed. Root cause was established, and interventions and care plan updated for R1 to include the following: Immediate 1:1 24/7 to ensure residents safety Perimeter Mattress Non-Skid Socks Fall mats to be placed at bedside at all times Comfort measures -repositioning Assessment of sling to ensure that arm is positioned comfortably Anticipate residents needs and offer foods/fluids frequently. Resident is always to be transferred with a gait belt. Bed at lowest position. Nursing staff has been in serviced on these interventions. Director of Nursing verified that the resident's interventions were in place. An Interdisciplinary Team (IDT) review of residents with frequent falls was completed 08/02/22. Interventions and care plans were updated as necessary. Review of all resident fall assessments was completed on 08/02/22. Resident designated as being at high risk for falls had their falls and plan of care reviewed for intervention effectiveness and care plan updated as necessary. DON and designees verified that interventions were in place. Education with floor staff regarding fall	F 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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	Continued From page 2 prevention, interventions and Resident specific education on plan of care for Resident #1 was initiated 08/02/22. After removal of the immediacy was verified, the deficient practice remained at a scope and severity of a "G" The 2567 was sent electronically on 08/16/22.	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 609	Continued From page 3	F 609		

incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

The facility identified a census of 69 residents. The sample included three residents reviewed for accidents. Based on record review, interview, and observation the facility failed to identify an incident as an allegation of abuse or neglect and failed to report, to the State Agency (SA), as required. This placed Resident (R)1 at risk for unidentified or ongoing abuse and/or neglect.

Findings included:

- R1's Electronic Medical Record (EMR), under the "Diagnosis" tab recorded diagnose of traumatic subdural hemorrhage without loss of consciousness, sprain of joints and ligaments of unspecified parts of neck, wedge compression fracture (when forced together bone surfaces caused a bone to break) of unspecified lumbar vertebra, muscle weakness, need for assistance with personal care, difficulty in walking, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Entry Minimum Data Set" (MDS) dated 07/14/22 documented R1 admitted to the facility on 07/14/22.

The "Initial Care Plan" assessment dated 07/14/22, completed on 07/26/22, documented R1 was at risk for falls related to confusion

An "Incident Note" dated 07/15/22 at 09:00 PM documented R1 was found on the floor by unidentified nursing staff and could not move her left arm. R1 remained on the floor with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 609	Continued From page 4	F 609		

unidentified nursing staff until the ambulance removed her.

The "Risk Investigation 1664" dated 07/15/22 at 09:00 PM documented R1 was found on the floor in her room, pain in her left shoulder and R1 could not mover her arm. The ambulance was called. R1 stated she was attempting to go to the bathroom and wanted help getting up. The immediate action was R1 was left on the floor with unidentified staff present until the ambulance arrived to the accident.

The "Risk Investigation 1665" dated 07/15/22 at 09:00 PM documented R1 was found on the floor by unidentified nursing staff and could not mover her left arm. The ambulance was called to the facility to remove R1 from the floor and take R1 to the emergency department. The immediate action was the ambulance was called to remove R1 from the floor and transport R1 to the hospital.

The "Nursing Note" dated 07/15/22 at 09:07 PM documented R1 was found on the floor in her room by unidentified nursing staff and could not move her left arm. R1 was removed from the floor by the ambulance staff.

The "Hospital Visit Documentation" dated 07/16/22 at 12:40 AM documented a shoulder fracture, closed fracture of neck of left humerus.

On 08/03/22 at 11:55 AM Administrative Nurse D stated she was learning what needed to be reported. Administrative Nurse D revealed she knew this was an unwitnessed fall, resulting in with a major injury, and that it should have been reported. Administrative Nurse D further revealed that there was a meeting to discuss R1's falls but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 609	Continued From page 5 could not recall exactly what was determined. Administrative Nurse D stated she reported events to Administrative Staff A, and he called the SA. On 08/03/22 at 12:35 PM Administrative Staff A stated R1's unwitnessed fall with fracture was not reported to the SA. The facilities "Abuse: Prevention of and Prohibition Against" policy revised 01/2022 documented allegations of abuse, neglect, misappropriation of resident property, or exploitation will be reported outside the facility and to the appropriate State or Federal agencies in the applicable timeframes, as per this policy and applicable regulations. The facility failed to identify an unwitnessed incident which resulted in injury to R1 as an allegation of abuse and/or neglect and failed to report to the SA as required. This placed R1 at risk for unidentified and/or ongoing abuse and/or neglect.	F 609		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission.	F 655		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 655	Continued From page 6	F 655		

(ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to-
(A) Initial goals based on admission orders.
(B) Physician orders.
(C) Dietary orders.
(D) Therapy services.
(E) Social services.
(F) PASARR recommendation, if applicable.

§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan-
(i) Is developed within 48 hours of the resident's admission.
(ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section).

§483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:
(i) The initial goals of the resident.
(ii) A summary of the resident's medications and dietary instructions.
(iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.
(iv) Any updated information based on the details of the comprehensive care plan, as necessary.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 69 residents. The sample included three residents reviewed for baseline care plans. Based on record review, interview, and observations, the facility failed to develop and implement a baseline care plan within 48 hours of admission for Resident (R) 1.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 655	Continued From page 7	F 655		

This placed R1 at increased risk for unidentified and/or unmet care needs.

Findings included:

- R1's Electronic Medical Record (EMR), under the "Diagnoses" tab recorded diagnose of traumatic subdural hemorrhage (collection of blood on the surface of the brain) without loss of consciousness, sprain of joints and ligaments of unspecified parts of neck, wedge compression fracture (when forced together bone surfaces caused a bone to break) of unspecified lumbar vertebra, muscle weakness, need for assistance with personal care, difficulty in walking, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Entry Minimum Data Set" (MDS) dated 07/14/22 documented R1 admitted to the facility on 07/14/22.

The "Initial Admission Record" assessment dated 07/14/22 completed 07/14/22 documented R1 used a walker for mobility and that R1 was ambulatory or self-mobile in a wheelchair.

The "Fall Risk Evaluation" assessment dated 07/14/22 completed 07/15/22 documented R1 scored a 17 on the assessment, which indicated she was a high fall risk.

The "Initial Care Plan" assessment dated 07/14/22, but not signed and completed until 07/26/22, documented R1 was at risk for falls related to confusion, deconditioning, gai/balance problems, incontinence, poor communication/comprehension, unaware of safety needs. The assessment directed staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 655	Continued From page 8	F 655		

be sure the call light was within reach and encourage to use the call light for assistance as needed, bed in the lowest position, educate resident/family/caregivers about safety reminders and what to do if a fall occurs, and floor mats at bedside.

The "Initial Care Plan" lacked interventions addressing falls upon admission and updates after R1 fell on 07/14/22, 07/15/22. (refer to F689)

On 08/02/22 at 02:38 PM LN H stated R1 was very confused and was constantly up and down. LN H revealed that when she worked, R1 would sit in a wheelchair at the nurse's station. LN H further revealed that staff would do one on one with her when it was viewed as needed, in that moment, but one-to -one was not ordered. LN H stated when a resident fell, the resident was assessed, vital signs checked, and staff attempted to figure out what happened or caused the fall. Staff completed the risk investigation paperwork, notified the appropriate individuals, and started neurological checks if the fall was unwitnessed or the resident was confused. LN H stated she expected to see some type of intervention put into place.

On 08/03/22 at 11:05 AM Certified Medication Aide (CMA) R stated that to knew how to provide cares for R1 based on the care plan on the Kardex (a medical-patient information system). CMA R stated that when a resident fell, CMA R reported the fall to the nurse and CMA R sat with the resident until the nurse was able to assess the resident. CMA R further stated that interventions put into place related to a fall would go on the Kardex to alert floor staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 655	Continued From page 9 On 08/03/22 at 11:55 AM Administrative Nurse D stated that she expected nursing staff to have the baseline care plan completed within 12 hours, but nursing staff had 24 hours to complete it. CNA/CMAs know there is a JOT sheet (quickly written sheet of what the residents needed for cares) that is handed out for staff when a resident admits and that initially tells the staff how to care for the resident while the baseline care plan is being completed. The JOT sheet should have been completed immediately. With R1's fall risk, Administrative Nurse D stated, she expected that to be completed timely. Administrative Nurse D revealed that without the baseline care plan or Kardex, staff would not know the proper interventions to keep the R1 safe. The facility's "Comprehensive Person-Centered Care Planning" policy revised 08/2017 documented within 48 hours of the resident's admission, the facility would develop and implement a baseline care plan that included instructions needed to provide effective and person-centered care. The facility failed to develop and implement a baseline person-centered care plan for R1 who was at risk for falls.	F 655		
F 689 SS=J	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	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 10	F 689		

accidents.
This REQUIREMENT is not met as evidenced by:
The facility identified a census of 69 residents. The sample included three residents reviewed for falls. Based on record review, interview, and observations, the facility failed to provide adequate supervision and implement interventions aimed to prevent falls for Resident (R) 1, who was at high risk for falls and had a Brief Interview for Mental Status (BIMS) score of six indicating severe cognitive impairment. R1 admitted to the facility on 07/14/22 with a diagnosis of traumatic subdural (collection of blood on the surface of the brain due to injury) hemorrhage (an escape of blood from a ruptured blood vessel) due to a fall at home. On 07/14/22 R1 fell in the facility and staff implemented nonskid socks. No root cause analysis was conducted, and no plan of care developed to address R1's fall risk. On 07/15/22 R1 had an unwitnessed fall in her room, she complained of pain and was sent to the emergency room via Emergency Management Services (EMS). R1 was diagnosed with a proximal humerus (the upper arm bone close to the shoulder) fracture and her broken arm was placed in a sling. The facility did not implement any interventions at that time to prevent further falls or injuries. From 07/20/22 through 07/23/22 R1 had multiple falls. On 07/23/22 R1 slid from her wheelchair. A few minutes later, R1 fell in her room. The clinical record recorded R1 did not have nonskid socks and had no other preventative measures in place. R1 complained of pain in the right hip which required x-rays. On 08/01/22 and 08/02/22 R1 was observed on the floor mat in her room. The facility failed to identify and implement preventative measures to address falls, safety

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 11	F 689		

and supervision needs for R1 who had multiple falls including one which resulted in a fracture. This placed R1 in immediate jeopardy.

Findings included:

- R1's Electronic Medical Record (EMR), under the "Diagnosis" tab recorded diagnoses of traumatic subdural hemorrhage without loss of consciousness, sprain of joints and ligaments of unspecified parts of neck, wedge compression fracture (when forced together bone surfaces caused a bone to break) of unspecified lumbar vertebra (back bones), muscle weakness, need for assistance with personal care, difficulty in walking, and dementia (progressive mental disorder characterized by failing memory, confusion).

The "Entry Minimum Data Set" (MDS) dated 07/14/22 documented R1 admitted to the facility on 07/14/22.

Review of the "Hospital Paperwork" dated 07/06/22 documented R1 fell at home on 06/20/22 and could not fully turn her head to the right The paperwork further documented a subacute subdural hematoma (a solid swelling of clotted blood within the tissues), and lumbar (lower part of the back) three compression fracture.

The "Initial Admission Record" assessment dated 07/14/22 completed 07/14/22 documented R1 used a walker for mobility and noted that R1 was ambulatory or self-mobile in a wheelchair.

The "Fall Risk Evaluation" assessment dated 07/14/22 completed 07/15/22 documented R1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 12	F 689		

scored a 17 on the assessment, which indicated she was a high fall risk.

The "Initial Care Plan" assessment dated 07/14/22, completed on 07/26/22, documented R1 was at risk for falls related to confusion, deconditioning, gait/balance problems, incontinence, poor communication/comprehension, and being unaware of safety needs. The assessment directed staff to be sure the call light was within reach and encourage R1 to use the call light for assistance as needed; keep bed in the lowest position; educate resident/family/caregivers about safety reminders and what to do if a fall occurs, and to keep floor mats at bedside.

The "Nursing Note" dated 07/14/22 at 03:38 PM documented R1 fell at bedside. R1 stated she was trying to make her bed and fell. The note recorded staff added non-skid socks upon admission and R1 should have her call light within reach.

The "Risk Investigation" dated 07/14/22 at 03:42 PM documented R1 was observed on the floor next to the bed, with her back against the wall. The investigation documented unidentified staff were with R1 just prior to the fall and R1 was in bed. Staff immediately looked over R1 and her range of motion (ROM) was within normal limits without signs or symptoms of pain or grimace noted. Staff assisted R1 to bed and therapy brought a wheelchair and began R1's evaluation immediately.

The "Neurological Flow Sheet" dated 07/14/22 documented neurological checks were completed 03:30 PM, 03:45 PM, 04:00 PM, 04:15 PM, 04:30

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 13	F 689		

PM, 05:30 PM 06:30 PM, 07:30 PM, 08:30 PM, 09:30 PM, 07/15/22 01:30 AM, and 05:30 AM.

The "Neurological Flow Sheet" dated 07/14/22 lacked checks for 07/15/22 09:30 AM, 01:30 PM, and 05:30 PM.

The "Fall Risk Evaluation" assessment dated 07/15/22 completed 07/16/22 documented R1 scored a 14 on the assessment, which indicated she was a high fall risk.

The "Nursing Note" dated 07/15/22 at 07:16 AM documented R1 continued follow up fall. R1 was documented to have insomnia (difficulty sleeping) and was a high fall risk related to baseline confusion. Nursing staff documented one on one supervision for safety.

The "Nurse Practitioner/Physician's Assistant Progress Note" dated 07/15/22 at 10:11 AM documented R1 sat at the nurse's station in her wheelchair.

The "Incident Note" dated 07/15/22 at 09:00 PM documented R1 was found on the floor by staff and could not move her left arm. R1 remained on the floor until emergency services (EMS) arrived and moved her.

The "Nursing Note" dated 07/15/22 at 09:07 PM documented staff found R1 on the floor in her room and could not move her left arm. R1 was removed from the floor by the ambulance staff.

The "Risk Investigation 1664" dated 07/15/22 at 09:00 PM documented R1 was found on the floor in her room with pain in her left shoulder and R1 could not move her arm. The ambulance was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 14	F 689		

called. When asked what happened, R1 stated she was attempting to go to the bathroom and wanted help getting up. The immediate action was R1 was left on the floor with staff present until the ambulance arrived. The investigation lacked analysis of causative factors and identification of interventions to prevent future falls.

The "Risk Investigation 1665" dated 07/15/22 at 09:00 PM documented unidentified nursing staff found R1 on the floor and she could not mover her left arm. The ambulance was called to the facility to assist R1 from the floor and take R1 to the emergency department. The immediate action was the ambulance was called to remove R1 from the floor and transport to the hospital. The investigation lacked analysis of causative factors and identification of interventions to prevent future falls.

The "Hospital Visit Documentation" dated 07/16/22 at 12:40 AM documented R1 had a shoulder fracture, closed fracture of left humerus.

R1's clinical record lacked evidence interventions were added to R1's plan of care to address her safety needs, fall risks, and the need for the sling for her broken arm.

The "Nursing Note" dated 07/17/22 at 04:45 AM documented R1 was unable to relax with an ice pack on her shoulder. The note documented R1 refused to keep the sling on her left arm.

The "Nursing Note" dated 07/20/22 at 05:54 AM documented R1 sat on the floor next to the bed around 01:00 AM. Unidentified nursing staff walked past R1's room and noted R1 crawling on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 15	F 689		

the floor. Upon assessment no new injuries were noted.

R1's clinical record lacked evidence interventions were added to R1's plan of care to address her safety needs and fall risks; the record lacked evidence neurological checks were completed for the unwitnessed fall on 07/20/22.

The "Weekly Skilled Review Note" dated 07/21/22 at 09:35 AM documented R1 had frequent falls, decreased safety, advanced dementia, decreased insight, and a new fracture to left humeral fracture with decreased compliance wearing the sling.

The "Risk Investigation 1670" dated 07/22/22 at 07:00 AM documented an unidentified nurse was notified by an unidentified CNA that R1 was found on the floor in R1's room, lying next to the bed. No immediate action was documented. The investigation lacked analysis of causative factors and identification of interventions to prevent future falls.

The "Risk Investigation 1671" dated 07/22/22 at 07:00 AM documented R1 found on the floor in R1's room by unidentified staff lying on the floor next to the bed. The immediate action taken was unidentified nurse notified, nurse assessment, vital signs and neurological checks obtained; peri-care (cleaning of the genitals) was provided.

The facility was unable to provide evidence of neurological checks performed after the unwitnessed fall on 07/22/22.

The "Nursing Note" dated 07/22/22 at 10:54 AM documented unidentified nursing staff reported

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 16	F 689		

R1 was on the floor in the room. R1 laid in supine position on the floor and yelled for help. The note documented R1 did not use the call light; non-skid socks were not on; no fall mat or perimeter mattress was in place; R1 was incontinent. The note further documented R1 slid out of her wheelchair at the nurse's station at 10:45 AM. R1 reported increased pain at left leg and new x-ray ordered for left hip and left femur.

The EMR lacked a risk investigation for this fall. R1's clinical record lacked evidence the facility implemented interventions to prevent future falls.

The facility was unable to provide evidence of neurological checks performed after the unwitnessed fall on 07/22/22.

The "Nursing Note" dated 07/22/22 at 01:28 PM documented arthritic changes to R1's left hip, no obvious signs of fracture.

The "Nursing Note" dated 07/23/22 at 05:57 AM documented R1 was on a low bed with a perimeter mattress in place next to the bed. R1 was crawling out of bed and was discovered by staff sitting on the perimeter mattress; two staff assisted R1 off the mattress on the floor with the use of a gait belt.

The EMR lacked a risk investigation for this fall.

The facility was unable to provide evidence of neurological checks performed after the unwitnessed fall on 07/23/22.

The "Nursing Note" dated 07/23/22 at 06:18 PM documented an unidentified nursing staff found R1 on the fall mat next to her bed lying in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 17	F 689		

supine position on her back.

The EMR lacked a risk investigation for this fall.

The facility was unable to provide evidence of neurological checks performed after the unwitnessed fall on 07/23/22.

The "Nursing Note" dated 07/24/22 at 11:59 PM documented R1 "migrated" from her low bed to sit on the perimeter mattress on the floor.

The EMR lacked a risk investigation for this fall.

The facility was unable to provide evidence of neurological checks performed after the unwitnessed fall on 07/24/22.

The "Weekly Skilled Review Note" dated 07/28/22 at 09:38 AM documented R1 had frequent falls, decreased safety, advanced dementia, decreased insight, a left humeral neck fracture with decreased compliance with sling. R1 had an appointment scheduled with orthopedics (bone doctor), but due to R1 tested positive for COVID (highly contagious respiratory virus), the appointment needed rescheduled.

The "Nurse Practitioner Physician Assistant Progress Note" dated 08/01/22 at 10:41 AM documented R1 laid on her floor mat and R1 reported that she wanted to get up for the day. Unidentified nursing staff reported that therapy would get her up. The plan of care for R1 was frequent rounding.

The EMR lacked a risk investigation for this fall.

The facility was unable to provide evidence of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 18	F 689		

neurological checks performed after the unwitnessed fall on 08/01/22.

On 08/02/22 at 02:45 PM Administrative Nurse D stated R1 had five falls total and that two did not make it into the risk system for investigation.

Observation on 08/02/22 at 02:28 PM revealed R1 laid on the floor with her head facing the windows and her feet towards the doorway. R1 laid on her right side, parallel with the bed on the floor mat next to her bed. R1 hollered out "come here, come here."

On 08/02/22 at 02:30 PM Licensed Nurse (LN) G looked at R1 on the floor/mat and stated R1 was care planned to lay on the floor mat by her bed. Another[unidentified] nurse who stood at the medication cart stated, "yes, she is care planned to be on the floor" and neither nurse assessed R1 or assisted R1 off the floor.

On 08/02/22 at 02:38 PM LN H stated R1 was very confused and was constantly up and down. LN H revealed when she worked, R1 would sit in a wheelchair at the nurse's station. LN H further revealed staff would do one on one with her when it was viewed as needed, in that moment, but one-to-one was not ordered. LN H stated when a resident fell, the resident was assessed, vital signs were checked, and staff attempted to figure out what happened or caused the fall. Staff completed the risk investigation paperwork, notified the appropriate individuals, and started neurological checks if the fall was unwitnessed, or the resident was confused. LN H stated she expected to see some type of intervention put into place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 19	F 689		

On 08/02/22 at 03:35 PM Certified Nurse Aide (CNA) M stated she picked R1 up from the floor/mat, and placed R1 back into her bed. She stated she did this at different times throughout her shifts as well. CNA M reported she picked R1 up from the floor/mat twice already that shift. She stated on 07/29/22, she picked R1 up from the floor/mat two or three times. CNA M further stated that she tells the charge nurse on duty about R1's falls. CNA M revealed she got R1 up off the floor mat without an assessment completed. CNA M further revealed R1 was restless and fidgeted frequently and would "throw herself" on the floor. CNA M doubted R1 could walk without assistance related to R1's fractured arm.

On 08/03/22 at 11:05 AM Certified Medication Aide (CMA) R stated she know how to provide cares for R1 based on the care plan on the Kardex (a medical-patient information system). CMA R stated that when a resident fell, CMA R reported the fall to the nurse and CMA R sat with the resident until the nurse was able to assess the resident. CMA R further stated that interventions put into place related to a fall would go on the Kardex to alert floor staff.

On 08/03/22 at 11:55 AM Administrative Nurse D stated she expected nursing staff to have the baseline care plan completed within 12 hours, but nursing staff had 24 hours to complete it. CNA/CMAs knew there was a JOT sheet (quickly written sheet of what the residents needed for cares) that was handed out for staff when a resident admitted and that initially told the staff how to care for the resident while staff completed the baseline care plan. Administrative Nurse D revealed without a Kardex or JOT sheet to direct cares, staff would not know how to keep R1 safe.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 20	F 689		

The "Fall Management System" policy revised 06/2018 documented the facility would provide each resident with appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurred. It further documented residents with high risk factors identified on the Fall Risk Evaluation would have an individualized care plan developed to prevent falls by addressing the risk factors and would consider elements of the evaluation that put the resident at risk. When a resident sustained a fall, a physical assessment would be completed by a nurse, with results documented in the medical record, follow-up documentation would be completed for a minimum of 72 hours following the incident. The policy documented review of the fall incident would include an investigation to determine probable cause factors, a summary of the investigation and recommendations would be documented in the resident's clinical record and the residents care plan would be updated.

The facility failed to provide adequate supervision and implement interventions aimed to prevent falls for R1, who was at high risk for falls and was cognitively impaired. The facility failed to identify and implement preventative measures to address falls, safety and supervision needs for R1 who had multiple falls including one which resulted in a fracture. The facility failed to assess R1's physical and neurological status after unwitnessed falls though R1 had a fall related head injury and fracture. These deficient practices placed R1 in immediate jeopardy.

On 08/02/22 the facility implemented the following corrective actions to address the immediate jeopardy (IJ):

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 21	F 689		

The Medical Director was notified of IJ at 06:12 pm on August 2, 2022.

R1 incidents were reviewed.
Root cause was established, and interventions and care plan updated for R1 to include the following:
Immediate 1:1 24/7 to ensure residents safety
Perimeter Mattress
Non-Skid Socks
Fall mats to be placed at bedside at all times
Comfort measures -repositioning
Assessment of sling to ensure that arm is positioned comfortably
Anticipate residents needs and offer foods/fluids frequently.
Resident is always to be transferred with a gait belt.
Bed at lowest position.
Nursing staff has been in serviced on these interventions.
Director of Nursing verified that the resident's interventions were in place.

An Interdisciplinary Team (IDT) review of residents with frequent falls was completed 08/02/22. Interventions and care plans were updated as necessary.
Review of all resident fall assessments was completed on 08/02/22. Resident designated as being at high risk for falls had their falls and plan of care reviewed for intervention effectiveness and care plan updated as necessary. DON and designees verified that interventions were in place.
Education with floor staff regarding fall prevention, interventions and Resident specific education on plan of care for Resident #1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175548	A. BUILDING _____ B. WING _____	C 08/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTHCARE RESORT OF KANSAS CITY	8900 PARALLEL PARKWAY KANSAS CITY, KS 66112

(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 689	Continued From page 22 initiated 08/02/22. After removal of the immediacy was verified, the deficient practice remained at a scope and severity of a "G"	F 689		