STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANKLIN HEALTHCARE OF PEABODY LLC	**500 PEABODY PEABODY, KS 66866**

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0561 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residen, with 19 residents selected for review. The sample included three residents for review of choices. Based on observation, interview and record review the facility failed to support the resident's choice to eat in his room for one of the three residents reviewed, Resident (R) 28. Findings included: - The signed Physician order [REDACTED]. The Annual Minimum Data Set, dated dated [DATE], documented the resident as cognitively intact. He performed activities of daily living independently and had occasional pain. On 08/09/20 at 03:38 PM, R28 stated he would like to eat in his room and that he was not allowed to have a room tray. On 08/10/2020 at 01:25 PM Certified Nursing Assistant (CNA) N stated if R28 doesn't come out to the dining we take him a room tray. We try to encourage him to come out so he won't isolate himself . On 08/11/2020 at 09:35 AM, R28 stated he talked with a dietary staff. He reported he was told if he doesn't go down to dining for supper that at 6:00 PM they would bring a tray to his room. For lunch he would get a tray at 12:15 PM. R28 was pleased with this arrangement. On 08/11/20 at 12:47 PM, R28 had not received a lunch tray yet and he was concerned. On 08/11/20 at 01:06 PM R28 had a room tray but stated he had to go get it. He reported he does not want to carry a meal tray because it hurts his back and that his anxiety increases when in the close crowd in the dining room. On 08/12/20 at 10:56 AM, Licensed Nurse G stated residents would ask the CNA or tell the kitchen to request a room tray. Unless they had a medical reason they could get a room tray. On 08/12/20 at 02:10 PM R28 reported he had not yet received a room tray. On 08/12/20 at 03:47 PM R28 reported he did not receive a meal tray for lunch and that he made his choice known to two CNAs. He stated he walked to the dining room and received a sandwich and piece of cake. On 08/12/20 at 03:49 PM Dietary BB was unaware that R28 did not receive lunch. Dietary BB stated the resident had back issues that make it impractical for him to carry a meal tray the distance back to his room. On 08/12/2020 at 05:15 PM Administrative Nurse D stated we try to keep people from eating in their rooms because they hoard food. The facility policy titled Meal Service, revised 03/09/15, evidenced room service trays will be delivered promptly upon reaching the floor. The facility failed to provide the resident with his choice to eat meals in his room.
F 0567 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to manage his or her financial affairs.** The facility had a census of 40 residents and identified 38 with deposited funds in Residents Accounts handled by the facility. Based on interview and record review, the facility failed to ensure availability of resident funds, on weekends, when requested for these 38 residents. Findings included- - On 08/09/20 at 4:10 PM, Resident (R) 26 stated he was unable to receive money on the weekends. I need to ask the for money during the week. On 08/10/20 at 10:11 am, R3 stated she was unable to receive money on the weekends. I do have access during the week. On 08/12/20 at 09:49 am, R6 stated she was able get money on Monday through Friday. She stated the residents do not have access to money on the weekends. On 08/12/20 at 10:56 am, R85 stated I can get money on weekdays, but I am not able to receive money on the weekends. On 08/10/20 at 12:48 PM, License Staff (LN) H stated previously there was petty cash in the treatment cart in the locked box but that had been quite some time ago. LN H stated she did not know why the petty cash was removed from the treatment cart for availability on the weekends. On 08/10/20 at 01:16 PM, Certified Medication Aide S stated that I do not believe the residents knew there was petty cash available. On 08/10/20 at 01:06 PM, Administrative Staff A stated the nurses have access to the petty cash during the evenings and weekends. The money is locked in the treatment cart. I was not aware the residents did not know the funds from their account were available on the weekends. On 08/10/2020 at 1:10 PM, Administrative Staff B stated that she did not know that residents were not aware that petty cash was available in the treatment cart during the evenings and weekends. I was not aware that the residents did not have access to their accounts during the weekends, but the residents should be able to. Staff should be aware of this also. The facility policy for Accounting and Records of Resident Funds, revised April 2017, lack documentation of the facility's plan to provide availability for petty cash for the residents on the weekends. The facility failed to ensure all residents aware of the availability of resident funds, on the weekends.
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.** The facility identified a census of 40 residents. Based on observation and interview, the facility failed to ensure a sanitary, orderly and comfortable environment for the residents in commons area, various halls, various resident's rooms and mowing the yard. Findings included: On 08/12/20 at 09:00 am, during the environmental tour with maintenance staff member U, Administrative Staff A, and Administrative Staff B, revealed the following; 1.) In the common's area, under the air conditioner/heater grates contained excessive debris. 2.) In the common's area the ceiling frame was bent, and tiles were hanging downward. 3.) On the women's hall in one resident's room, a 3-grate air conditioner/heater contained excessive rust. 4.) On the women's hall in one resident's bathroom, at the baseboard and threshold, the caulking was detached with excessive dirt. 5.) On the women's hall in one resident's bathroom, the shelf over the sink was detached from the wall. 6.) On the women's hall, at the fire doors, contained three chipped floor tiles as well as three ceiling tiles that appeared to be stained. 7.) On the women's hall in one resident's bathroom, the door frame was detached at the threshold. 8.) On the men's hall in the shower room, the shelf above the sink was detached from the wall. The paint was peeling from the wall and there was excessive black grime on the wall next to the sink. There was an opening in the wall behind the toilet at the baseboard. The air conditioner/heater grates contained excessive rust. 9.) On the men's hall, at the exit door, the air conditioner/heater grates contained excessive dust and the paint was peeling. 10.) On the men's hall in one resident's room, a brown recliner had approximately 4 hole. 11.) On both the women's and men's halls, several beds had headboards and footboards chipped at the corner edges. 12.) On the women's and men's halls, in several resident rooms, chipped and missing tiles in the ceilings. On 08/12/20 at 0:900 am, interview with maintenance staff member U, Administrative Staff A and Administrative Staff B, revealed the facility was looking to replace or paint the rusted grates. Staff members did confirm all areas reviewed in need of maintenance and repair. Also stated the facility will shampoo the carpet in the common living area. The facility lacked a policy regarding maintenance of the environment to ensure a sanitary, orderly and comfortable environment for the residents in the facility. The facility failed to ensure a sanitary, orderly and comfortable environment for the residents on two resident halls, the commons area, and multiple resident rooms.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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

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 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) The facility reported a census of 40 residents with 19 residents sampled. Based on interview, record review, and observation, the facility failed to complete an accurate comprehensive assessment for four of the sampled residents including Resident (R)1 and R17 regarding range of motion (ROM), R6 regarding dental and R9 regarding antipsychotic medications (medications used to treat [MEDICAL CONDITION] and other mental and emotional conditions). Findings included: - The Physician order [REDACTED]. The quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating she had intact cognition. The resident was independent with eating and had no weight gain or weight loss. Her weight at the time of the assessment was 188 pounds. The annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 15, indicating she had intact cognition. The resident was independent with eating, on a physician-prescribed weight gain regimen and had a weight of 206 pounds. She had no oral or dental issues. The Dental Care Care Area Assessment (CAA), dated 06/01/20, did not trigger. The nutrition care plan, dated 06/08/20, instructed staff the resident received a regular diet with ground meat upon request due to lack of teeth or dentures. Staff were to monitor the resident's meal intake during meals. Review of the resident's paper chart revealed a physician's orders [REDACTED]. On 08/09/20 at 02:07 PM, the resident stated, she had no teeth or dentures. On 08/10/12 at 03:04 PM, Certified Nurse Aide (CNA) O stated the resident did not have her natural teeth or dentures. On 08/12/20 at 02:21 PM, CNA M stated, the resident does not have teeth or dentures but is able to chew and swallow without difficulty. On 08/12/20 at 12:36 PM, Administrative Nurse E stated, the resident did not have natural teeth. He verified the annual assessment, dated 06/01/20, was inaccurate. Staff E stated he used the Resident Assessment Instrument (RAI) manual for completion of the MDS. On 08/12/20 at 05:05 PM, Administrative Nurse D stated, it was her expectation that the MDS would be completed correctly on all residents. The facility uses the RAI manual for accurate completion of the MDS. The facility failed to complete an accurate comprehensive assessment for this resident with no natural teeth or dentures. Furthermore, The Nutritional Care Area Assessment (CAA), dated 06/01/20, documented the resident ate her meals in the dining room and she was able to feed herself. The quarterly MDS, dated [DATE], documented the resident had a BIMS score of 15, indicating she had intact cognition. The resident was independent with eating and had no weight gain or weight loss. Her weight at the time of the assessment was 188 pounds. The nutrition care plan, dated 06/08/20, instructed staff to monitor the resident's meal intake during meals. Review of the resident's paper chart revealed a dietary assessment, dated 06/01/20, which documented the resident had a weight gain over the past year. On 08/11/20 at 07:30 AM, the resident ate breakfast which consisted of sausage and scrambled eggs. She had no difficulty chewing or swallowing her meal. On 08/10/20 at 03:04 PM, Certified Nurse Aide (CNA) O stated the resident was not on a physician-prescribed weight gain regimen. On 08/12/20 at 02:36 PM, Licensed Nurse (LN) G stated the resident had never been on a physician-prescribed weight gain regimen. On 08/12/20 at 12:36 PM, Administrative Nurse E stated the resident had not been on a physician-prescribed weight gain regimen. The annual assessment, dated 06/01/20, was inaccurate. Staff E stated he used the Resident Assessment Instrument (RAI) manual for completion of the MDS. On 08/12/20 at 05:05 PM, Administrative Nurse D stated, it was her expectation that the MDS would be completed correctly on all residents. The facility uses the RAI manual for accurate completion of the MDS. The facility failed to complete an accurate comprehensive assessment for this resident who was not on a physician-prescribed weight gain regimen. - The Physician order [REDACTED]. The admission Minimum Data Set (MDS), dated [DATE], documented a staff assessment for cognition which revealed the resident was independent with decision making. He had disorganized thinking continuously with delusions and daily rejection of care. He had not received antipsychotic medications (medications used to treat [MEDICAL CONDITION]). The [MEDICAL CONDITION] Drug Use Care Area Assessment (CAA), dated 06/25/20, documented he was currently on antipsychotic medications (which was inaccurate). The care plan addressing behaviors, dated 06/20/20, instructed staff to encourage the resident to do things which calm him when he was upset, nervous or anxious. The resident was at risk for constipation due to [MEDICAL CONDITION] medications (medication capable of affecting the mind, emotions, and behavior). Review of the resident's June, July and August 2020 Medication Administration Records (MARs) revealed the resident had not received antipsychotic medications while a resident at the facility. On 08/12/20 at 12:36 PM, Administrative Nurse E stated, the resident had not been on an antipsychotic medication. The [MEDICAL CONDITION] Drug CAA dated 06/25/20, was inaccurate. Staff E stated he used the Resident Assessment Instrument (RAI) manual for completion of the MDS. On 08/12/20 at 05:05 PM, Administrative Nurse D stated, it was her expectation that the MDS would be completed correctly on all residents. The facility uses the RAI manual for accurate completion of the MDS. The facility failed to complete an accurate comprehensive assessment related to the CAA portion of the MDS for this resident regarding antipsychotic medications. - The signed Physician order [REDACTED]./2020, documented the resident as cognitively intact, and as independent with bed mobility, transfer and walking with a walker and as having functional limitation in range of motion in one lower extremity. Questions assessing functional rehabilitation potential, by the resident himself and by staff, are unanswered. On 08/09/2020 at 05:10 PM, R17 walked using a walker. Both knees were bent. On 08/10/20 at 12:28 PM, as R17 walked to his room, knees bent and walker far in front of him. On 08/10/2020 at 01:45 PM, R17 walked with a walker, both knees bent and supported by staff. O 08/11/2020 at 08:42 AM R17 lay in bed, on his left side with both knees bent. On 08/11/20 at 12:31 PM, R17 walked to the dining room, knees bent and the walker far in front of him. On 08/12/20 at 08:05 AM, R17 lay in bed, on his right side with knees bent. On 08/12/20 at 12:02 PM, R17 sat on the edge of his bed. Both knees were bent, his legs suspended in the air. When he put his legs into the bed, his knees remained bent. On 08/12/2020 at 01:12 PM Administrative Nurse E stated the facility utilizes the Resident Assessment Instrument (RAI) Guidelines as policy governing the completion of the MDS. On 08/12/2020 at 05:15 PM Administrative Nurse D stated the resident had limited range of motion to both lower extremities and could benefit from restorative services . Administrative Nurse D verified that the MDS was inaccurate. The facility uses the RAI manual for guidance to complete the MDS. The facility failed to complete an accurate comprehensive assessment of R17's functional limitation in range of motion and functional rehabilitation potential.
F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents, with 19 residents sampled. Based on observation, interview and record review, the facility failed to develop an individualized baseline plan of care for 1 Resident (R)134 regarding falls. Findings included: - The Physician order [REDACTED]. The medical record for this resident lacked a Minimum Data Set (MDS), as he was a new admission to the facility and his MDS was not yet complete. The baseline care plan, dated 07/27/20, instructed staff the resident's goals were to maintain his current status. The baseline care plan lacked instructions on preventing falls for this resident. Review of the resident's paper chart revealed a fall assessment, dated 07/28/20, which placed the resident at a high risk for falls. On 08/09/20 at 01:32 PM, observation revealed the resident attempted to get out of bed. He had socked feet which were tangled in the blanket from his bed. On 08/10/20 at 01:40 PM, observation revealed the resident ambulated in the hallway. The resident walked on tip-toes of his left foot and normally on his right foot, with a shuffling gait. The esirdent lacked appropriate footwear and wore only socks on his feet. On 08/09/20 at 01:32 PM, Certified Nurse Aide (CNA) N stated the resident was unbalanced when standing and ambulating. CNA N was unaware of any fall interventions for the resident. On 08/12/20 at 02:21 PM, CNA M stated the resident shuffled his feet when he walked and did not always remember to wear his shoes. CNA M was unaware of any fall interventions for the resident. On 08/12/20 at 02:36 PM, Licensed Nurse (LN) G stated, the resident shuffled his feet when he walked. LN G did not know if the plan of care addressed falls or if the resident was a fall risk. On 08/12/20 at 05:05 PM, Administrative Nurse D stated the baseline care plan should include interventions to prevent falls since he was at a high risk for falls. The facility lacked a policy for completion of baseline care plans. The facility failed to develop an individualized baseline care plan for this resident who was at a high risk for falls.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 resident with 19 selected for review which included four residents reviewed for

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F 0656 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) restorative care. Based on observation, interview and record review, the facility failed to develop a comprehensive care plan for restorative services for these four residents which included Resident (R) 134 for need for staff assistance with ambulation, use of an over the bed trapeze and self-positioning, R1 for knee contractures and abnormal posture with a walker during ambulation, and R2 and R17 for abnormal posture with ambulation with a walker. Findings included: - Review of resident (R)1's Physician order [REDACTED]. and fragmentation of thought.) The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident had moderate cognitive limitations, independent with bed mobility, transfer, eating (set up) and ambulation. The resident required limited assistance of one person for dressing, toileting and personal hygiene. The resident was dependent on staff for bathing. This MDS assessed the resident had limitation in range of motion bilaterally (on both sides) in upper extremities. (Observation, on 08/11/20 at 12:00 PM, revealed the resident had contractures in bilateral knees and walked with knees flexed.) The resident's balance was unsteady, but he was able to stabilize without staff assistance. The resident used a walker for mobility. The resident sustained [REDACTED].) The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA,) dated 03/23/20, assessed the resident had two falls in the last 90 days, ambulated slowly but independently and can make his needs known with slow but understandable speech. The staff assessment of mental status indicated the resident had moderately impaired cognition. The resident required limited staff assistance with dressing, toileting and personal hygiene. The care plan, revised 07/15/20, instructed staff the resident was at risk for ADL self-care deficit related to [MEDICAL CONDITION] and [MEDICAL CONDITION], required assistance of one staff for bathing (the resident was dependent on staff for bathing) toileting and personal hygiene. The resident was independent with bed mobility and eating. The resident always required a walker to promote safe transfers. The care plan lacked staff instruction for restorative services. Observation, on 08/10/20 at 01:20 PM, revealed the resident unassisted in the bathroom attempting to wash his hands at the sink. The resident positioned the walker in front of himself and attempted to stand upright. The resident's knees were in a flexed position, as the resident gripped the walker and attempted to stand more upright, the resident's knees became more flexed and he was unable to hold himself in an upright position to wash his hands. The resident attempted this several times, then obtained several paper towels, placed them in his shirt pockets and slowly turned and walked back to his recliner, and transferred himself into the recliner by lunging backward using his right arm to steady himself. Observation, on 08/11/20 at 12:00 PM, revealed the resident seated in the dining room, attempting to arise unassisted from his seat (which was a fast food style table with attached seat). The resident attempted to push himself upright with one hand on the walker and one hand on the table. The resident's knees were in a flexed position and his head was bent downward. The resident made several attempts before arising and then began ambulating through the dining area. The resident's gait was slow, with knees flexed, and one foot in front of the other and head bent downward and arms outstretched. The resident stopped after 18 steps, then took another 11 steps, and stated his walker was not right. Social Service staff X, spoke to the resident and determined the resident required a wheelchair and transported the resident to his room. Certified Nurse Aide (CNA) P questioned the resident if he would like to use the bathroom, and the resident requested to continue using the wheelchair to the bathroom. Interview, on 08/11/20 at 01:30 PM, with CNA P, revealed staff did not provide restorative services to the resident. CNA P stated the activity director sometimes has exercise groups but did not think the resident participated. CNA P stated the resident used his call light for staff to assist him to the bathroom but did not always make it to the toilet in time. Interview, on 08/11/20 at 02:30 PM, with CNA MM, revealed the resident used his call light when he needed assistance to toilet. CNA MM stated the resident usually used his walker for mobility and did have an abnormal, slow gait, but did make it to the dining room unassisted. Observation, on 08/12/20 at 08:13 AM, revealed CNA N, assisted the resident transfer from his seat in the dining room to a wheelchair. CNA N wheeled the resident to his room and assisted him to transfer into his recliner. Interview, on 08/12/20 at 08:20 AM, with CNA N revealed the resident requested the wheelchair for mobility at times depending on how he feels. Interview, on 08/12/20 at 12:40 PM, with Licensed Nurse (LN) G, revealed the resident had always ambulated with an abnormal gait. LN G stated the resident received hospice services. LN G stated she did not think the facility had a restorative program. Interview, on 08/12/20 at 03:30 PM, with Administrative Nurse D, confirmed the facility lacked a restorative program, and the residents should have an assessment to determine their needs to maintain/improve functional range of motion. Administrative Nurse D verified the plan of care failed to evidence a plan to provide restorative nursing services to the resident. The facility policy Goals and Objectives, Restorative Services revised April 2013, instructed staff that specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessment and staff identify rehabilitative goals and objectives for each resident and outline them in the plan of care. The facility failed to develop a comprehensive plan of care for this resident with limitations functional range of motion in his bilateral lower extremities. - Review of resident (R) 134's Physician order [REDACTED].) The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a BIMS (Brief Interview for Mental Status) score of 13, indicating normal cognitive status. The resident had continuous disorganized thinking, hallucinations, delusions and no rejection of care. The resident required limited assistance of 1 person for bed mobility and personal hygiene, supervision for transfer, ambulation and toileting, and extensive assistance for dressing. The resident's balance was not steady, but he was able to stabilize without assistance. The resident used a walker for mobility. The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA,) dated 04/17/20, assessed the resident triggered due to the resident required assistance for bathing. The resident walked by himself with a walker and had a steady gait. The care plan, revised 01/14/20, instructed staff the resident required a walker and assistance of one staff with transfers and ambulation and used a walker. The resident uses a trapeze to turn and reposition when in bed. The care plan, revised 04/16/20, instructed staff the resident was at risk for a self-care performance deficit related to impaired mobility, noncompliance, and paranoid [MEDICAL CONDITION]. The resident required assistance of one staff for bathing, bed mobility, personal hygiene and toilet use. The resident required extensive assistance of one to two staff for transfer. The care plan lacked interventions for restorative services. A Physician Order, dated 05/21/20, instructed staff to discharge the resident to another facility for skilled nursing care related to generalized decline and increased need for assistance with ADL to ensure his needs were met. The Interdisciplinary Discharge Summary, dated 05/21/20, documented the residents had an increase in health problems during the past six months with increased [MEDICAL CONDITION], increased wounds and decreased mobility. The resident agreed to need for increased care and need for skilled therapy services to improve mobility. Interview, on 08/12/20 at 09:57 AM, with Social Service staff X, revealed the resident's medical needs outweighed his psychological needs. Staff X stated the resident had [MEDICAL CONDITION] in his lower extremities and declined in his ADL ability. Staff X stated the facility did not have restorative services to offer the resident. Interview, on 08/13/20 at 08:25 AM, with Administrative Nurse E, revealed the resident declined in ADL ability and then elected to receive services at another facility. Administrative Nurse E stated the facility lacked restorative services for approximately one year. Administrative Nurse E stated the resident sat in his recliner and did not/was not able to reposition himself. Administrative Nurse E stated the care plan did not include a plan to maintain/improve the resident's ability to perform ADL's. Interview, on 08/12/20 at 12:33 PM, with Licensed Nurse (LN) G, revealed the resident abilities decreased. LN G stated the facility did not have restorative service or a care plan to maintain/improve his abilities for ADL's. The facility policy Goals and Objectives, Restorative Services, revised April 2013, instructed staff that specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessment and staff identify rehabilitative goals and objectives for each resident and outline them in the plan of care. The facility failed to develop a comprehensive care plan for this resident's restorative needs to maintain/prevent decline in functional range of motion for this resident with [MEDICAL CONDITION], decreased ability for bed/chair repositioning and ambulation with a walker. - The Physician order [REDACTED]. The significant change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating she had moderately impaired cognition. Her balance was not stable, but she was able to stabilize without human assistance. She had no impairment of functional range of motion (ROM) and used a walker for ambulation, independently. She had not received any restorative services. The falls care plan, dated 05/28/20, instructed staff the resident had a history of [REDACTED]. Staff were to ensure she had her walker with her at all times. On 08/12/20 at 08:20 AM, the resident ambulated in the hallway with her walker. Her arms were fully extended, holding the walker approximately three feet in front of her (an unsafe distance) as she walked behind the walker with her head down. On 08/12/20 at 09:49 AM, the resident ambulated outside. Her arms were again fully extended holding onto the walker as she walked behind the walker with her head down. On 08/12/20 at 10:19 AM, Certified Nurse Aide (CNA) N stated the

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F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) resident was not receiving restorative services at that time. Currently the facility lacked a restorative program. On 08/12/20 at 02:21 PM, CNA M stated the facility lacked a restorative program at that time. On 08/12/20 at 02:36 PM, Licensed Staff (LN) G stated, the resident walked with her walker far out in front of her and staff try to remind her to walk closer to the walker. Currently, the facility did not have a restorative program and have not had a restorative program for a couple of years. On 08/12/20 at 05:05 PM, Administrative Nurse D stated, the facility lacked a restorative program but the facility was working on developing a program. The resident would benefit from a restorative program to address safe ambulation with a walker. Administrative Nurse D verified the plan of care failed to evidence a plan to provide restorative nursing services to the resident. The facility policy for Restorative Services, revised April 2013, included: Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. The facility failed to develop an individualized, comprehensive plan of care regarding restorative care for this resident to promote safe ambulation with a walker. - The signed Physician order [REDACTED]./2020, documented the resident as cognitively intact, and as independent with bed mobility, transfer and walking with a walker and as having functional limitation in range of motion in one lower extremity. Questions assessing functional rehabilitation potential, by the resident himself and by staff, are unanswered. The ADL (Activity of Daily Living) Functional / Rehabilitation Potential Care Area Assessment, dated 05/22/2020, evidenced high level of cognitive status and he was able to make decisions regarding his daily needs and wants but required guidance with all other decisions. He was currently on antipsychotic, antidepressant, and antianxiety medications. Resident walks with a walker, walks very fast and was reminded by staff to slow down when walking. Care Planning Decision indicated this would be care planned. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of 11. Review of the care plan on 08/10//2020 at 10:20 AM verified lack of a restorative care plan. On 08/10/20 at 12:28 PM, R17 walked with knees bent and walker positioned far in front of him On 08/11/20 12:31 PM, R17 walked with walker far in front of him, knees bent. On 08/11/20 at 03:48 PM Social Services X stated R17 got out of the van with his walker and just fell . On 08/12/20 at 02:26 PM, CNA M states R17 has no restorative because the facility currently does not have a restorative program CNA M has noticed the off position with walker and she tries to put a hand on his back to get him closer to his walker. On 08/12/2020 at 05:15 PM Administrative Nurse D stated the resident had limited range of motion to both lower extremities and could benefit from restorative services. Administrative Nurse D verified the facility does not currently have a restorative program. Administrative Nurse D also verified the plan of care failed to evidence a plan to provide restorative nursing services to the resident. The facility policy titled Goals and Objective, Restorative Services, revised April 2013 states, Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. The facility failed to develop a comprehensive care plan which includes restorative services for this resident for training for safe ambulation.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents with 19 selected for review which included four residents reviewed for restorative services. Based on observation, interview and record review, the facility failed to assess and provide restorative services to the four residents sampled, including Resident (R) 134 for increased need for staff assistance with ambulation and self-positioning, R1 for knee contractures and abnormal posture with a walker during ambulation, and R2 and R17 for abnormal posture with ambulation with a walker. Findings included: - Review of resident (R)1's Physician order [REDACTED]. and fragmentation of thought.) The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident had moderate cognitive limitations, independent with bed mobility, transfer, eating (set up) and ambulation. The resident required limited assistance of one person for dressing, toileting and personal hygiene. The resident was dependent on staff for bathing. This MDS assessed the resident had limitation in range of motion bilaterally in upper extremities. (Observation, on 08/11/20 at 12:00 PM, revealed the resident had contractures in bilateral knees and walked with knees flexed.) The resident's balance was unsteady, but he was able to stabilize without staff assistance. The resident used a walker for mobility. The resident sustained [REDACTED].) The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA,) dated 03/23/20, assessed the resident had two falls in the last 90 days, ambulated slowly but independently and can make his needs known with slow but understandable speech. The staff assessment of mental status indicated the resident had moderately impaired cognition. The resident required limited staff assistance with dressing, toileting and personal hygiene. The care plan, revised 07/15/20, instructed staff the resident was at risk for ADL self-care deficit related to [MEDICAL CONDITION] and [MEDICAL CONDITION], required assistance of one staff for bathing (the resident was dependent on staff for bathing) toileting and personal hygiene. The resident was independent with bed mobility and eating. The resident always required a walker to promote safe transfers. The care plan lacked staff instruction for restorative services. Observation, on 08/10/20 at 01:20 PM, revealed the resident unassisted in the bathroom attempting to wash his hands at the sink. The resident positioned the walker in front of himself and attempted to stand upright. The residents knees were in a flexed position, as the resident gripped the walker and attempted to stand more upright, the resident's knees became more flexed and he was unable to hold himself in an upright position to wash his hands. The resident attempted this several times, then obtained several paper towels, placed them in his shirt pockets and slowly turned and walked back to his recliner, and transferred himself into the recliner by lunging backward using his right arm to steady himself. Observation, on 08/11/20 at 12:00 PM, revealed the resident seated in the dining room, attempting to arise unassisted from his seat (which was a fast food style table with attached seat). The resident attempted to push himself upright with one hand on the walker and one hand on the table. The resident's knees were in a flexed position and his head was bent downward. The resident made several attempts before arising and then began ambulating through the dining area. The resident's gait was slow, with knees flexed, and one foot in front of the other and head bent downward and arms outstretched. The resident stopped after 18 steps, then took another 11 steps, and stated his walker was not right. Social Service staff X, spoke to the resident and determined the resident required a wheelchair and transported the resident to his room. Certified Nurse Aide (CNA) P questioned the resident if he would like to use the bathroom, and the resident requested to continue using the wheelchair to the bathroom. Interview, on 08/11/20 at 01:30 PM, with CNA P, revealed staff did not provide restorative services to the resident. CNA P stated the activity director sometimes has exercise groups but did not think the resident participated. CNA P stated the resident used his call light for staff to assist him to the bathroom but did not always make it to the toilet in time. Interview, on 08/11/20 at 02:30 PM, with CNA MM, revealed the resident used his call light when he needed assistance to toilet. CNA MM stated the resident usually used his walker for mobility and did have an abnormal, slow gait, but did make it to the dining room unassisted. Observation, on 08/12/20 at 08:13 AM, revealed CNA N, assisted the resident transfer from his seat in the dining room to a wheelchair. CNA N wheeled the resident to his room and assisted him to transfer into his recliner. Interview, on 08/12/20 at 08:20 AM, with CNA N revealed the resident requested the wheelchair for mobility at times depending on how he feels. Interview, on 08/12/20 at 12:40 PM, with Licensed Nurse (LN) G, revealed the resident had always ambulated with an abnormal gait. LN G stated the resident received hospice services. LN G stated she did not think the facility had a restorative program. Interview, on 08/12/20 at 03:30 PM, with Administrative Nurse E, revealed the facility had not had a restorative program for several months. Interview, on 08/12/20 at 03:30 PM, with Administrative Nurse D, confirmed the facility lacked a restorative program, and the residents should have an assessment to determine their needs to maintain/improve functional range of motion. Administrative Nurse D stated this was a PIP (Performance Improvement Plan). The facility policy Goals and Objectives, Restorative Services revised April 2013, instructed staff that specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessment and staff identify rehabilitative goals and objectives for each resident and outline them in the plan of care. The facility failed to provide restorative services to this resident with abnormal gait and bilateral knee flexion to maintain/improve his ambulation with a walker. - Review of resident (R) 134's Physician order [REDACTED].) The Annual Minimum Data Set (MDS), dated [DATE], assessed the resident with a BIMS (Brief Interview for Mental Status) score of 13, indicating normal cognitive status. The resident had continuous disorganized thinking, hallucinations, delusions and no rejection of care. The resident required limited assistance of 1 person for bed mobility and personal hygiene, supervision for transfer, ambulation and toileting, and

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	17E210	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANKLIN HEALTHCARE OF PEABODY LLC	500 PEABODY PEABODY, KS 66866

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F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) extensive assistance for dressing. The resident's balance was not steady, but he was able to stabilize without assistance. The resident used a walker for mobility. The resident was occasionally incontinent of urine and always continent of bowel. The ADL (Activity of Daily Living) Functional/Rehabilitation Potential Care Area Assessment (CAA,) dated 04/17/20, assessed the resident triggered due to the resident required assistance for bathing. The resident walked by himself with a walker and had a steady gait. The resident had episodes of urinary incontinence and no skin issues. The care plan, revised 01/14/20, instructed staff the resident required a walker and assistance of one staff with transfers and ambulation and used a walker. The resident uses a trapeze to turn and reposition when in bed. The care plan, revised 04/16/20, instructed staff the resident was at risk for a self-care performance deficit related to impaired mobility, noncompliance, and paranoid [MEDICAL CONDITION]. The resident required assistance of one staff for bathing, bed mobility, personal hygiene and toilet use. The resident required extensive assistance of one to two staff for transfer. The care plan, revised 05/01/20, instructed staff the resident was at risk for skin integrity impairment due to obesity. Staff instructed to elevate the resident's legs when seated in the recliner A Physician Order, dated 05/21/20, instructed staff to discharge the resident to another facility for skilled nursing care related to generalized decline and increased need for assistance with ADL to ensure his needs were met. The Interdisciplinary Discharge Summary, dated 05/21/20, documented the residents had an increase in health problems during the past six months with increased [MEDICAL CONDITION], increased wounds and decreased mobility. The resident agreed to need for increased care and need for skilled therapy services to improve mobility. Interview, on 08/12/20 at 09:57 AM, with Social Service staff X, revealed the resident's medical needs outweighed his psychological needs. Staff X stated the resident had [MEDICAL CONDITION] in his lower extremities and declined in his ADL ability. Staff X stated the facility did not have restorative services to offer the resident. Interview, on 08/13/20 at 08:25 AM, with Administrative Nurse E, revealed the resident declined in ADL ability and then elected to receive services at another facility. Administrative Nurse E stated the facility lacked restorative services for approximately one year. Administrative Nurse E stated the resident sat in his recliner and did not/was not able to reposition himself. Interview, on 08/12/20 at 12:33 PM, with Licensed Nurse (LN) G, revealed the resident abilities decreased and he needed skilled care. LN G stated the facility did not have restorative service. The facility policy Goals and Objectives, Restorative Services, revised April 2013, instructed staff that specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessment and staff identify rehabilitative goals and objectives for each resident and outline them in the plan of care. The facility failed to evaluate and provide restorative services for this resident with [MEDICAL CONDITION], decreased ability for bed/chair repositioning and ambulation with a walker. - The Physician order [REDACTED]. The significant change Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 11, indicating she had moderately impaired cognition. Her balance was not stable, but she was able to stabilize without human assistance. She had no impairment of functional range of motion (ROM) and used a walker for ambulation, independently. She had not received any restorative services. The [MEDICAL CONDITION] Drug Use Care Area Assessment, dated 11/20/19, documented the resident ambulated using a walker independently, but required staff to remind her to use it appropriately. The quarterly MDS, dated [DATE], documented the resident had a BIMS score of 11, indicating she had moderately impaired cognition. Her balance was not stable, but she was able to stabilize without human assistance. She had no impairment of functional ROM and used a walker for ambulation, independently. She had not received any restorative services. The falls care plan, dated 05/28/20, instructed staff the resident had a history of [REDACTED]. Staff were to ensure she had her walker with her at all times. On 08/12/20 at 08:20 AM, the resident ambulated in the hallway with her walker. Her arms were fully extending holding the walker approximately three feet in front of her (an unsafe distance) as she walked behind the walker with her head down. On 08/12/20 at 09:49 AM, the resident ambulated outside following a smoking break. Her arms were again full extending holding onto the walker as she walked behind the walker with her head down. On 08/12/20 at 10:19 AM, Certified Nurse Aide (CNA) N stated the resident was not receiving restorative care at this time. Currently the facility lacked a restorative program. On 08/12/20 at 02:21 PM, CNA M stated the facility lacked a restorative program at that time. On 08/12/20 at 02:36 PM, Licensed Staff (LN) G stated, the resident walked with her walker far in front of her and staff try to remind her walk closer to the walker. Currently, the facility did not have a restorative program and have not had a restorative program for a couple of years. On 08/12/20 at 05:05 PM, Administrative Nurse D stated, the facility lacked a restorative program but the facility was working on developing a program. The resident would benefit from a restorative program to address safe ambulation with a walker. The facility policy for Restorative Services, revised April 2013, included: Specialized rehabilitative service goals and objectives shall be developed for problems identified through resident assessments. Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. The facility failed to assess and provide restorative services for safe ambulation for this resident with abnormal posture while ambulating with a walker. - The signed Physician order [REDACTED]./2020, documented the resident as cognitively intact, and as having functional limitation in range of motion in one lower extremity. The ADL (Activity of Daily Living) Functional / Rehabilitation Potential Care Area Assessment, dated 05/22/2020, evidenced high level of cognitive status and he was able to make decisions regarding his daily needs and wants but required guidance with all other decisions. He was currently on antipsychotic, antidepressant, and antianxiety medications. Resident walks with a walker, walks very fast and was reminded by staff to slow down when walking. Care Planning Decision indicated this would be care planned. Review of the care plan, dated 5/1/2020, lacked a restorative care plan. Furthermore, the plan of care did not address the resident's need for training related to safe ambulation. On 08/10/20 at 12:28 PM, R17 walked with knees bent and walker far in front of him 08/11/2020 09:50 AM Review of R17 care plan in care plan book showed no restorative care plan On 08/11/20 12:31 PM, R17 walked with walker far in front of him, knees bent On 08/12/20 12:02 PM, R17 sat on edge of his bed, legs bent at knees and suspended in the air, not resting on bed or floor. He then put his legs/feet (still with his shoes) on the bed, knees remained bent. On 08/12/20 at 02:26 PM, CNA M stated R17 has no restorative nursing. CNA M has noticed the off position with walker and tried to put a hand on his back to get him closer to his walker, something CNA M thought of to do. On 08/12/2020 at 05:15 PM Administrative Nurse D stated the resident had limited range of motion to both lower extremities and could benefit from restorative services. The facility policy titled Goals and Objective, Restorative Services, revised April 2013 states, Rehabilitative goals and objectives are developed for each resident and are outlined in his/her plan of care relative to therapy services. The facility failed to provide restorative services to promote proper walker usage, safety, and to increase or maintain bilateral lower extremity mobility.
F 0689 **Level of harm -** Immediate jeopardy **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** The facility reported a census of 40 residents with 19 selected for review, which included three residents reviewed for elopement and one resident reviewed for choking accidents . Based on observation, interview and record review, the facility failed to assess for elopement risk and develop interventions for prevention of elopement for one resident (R) 86, who climbed over a fence in an unsupervised area, and was found 37 miles from the facility placing the resident in immediate jeopardy. Furthermore, the facility failed to ensure staff monitored resident R17 during meals, as care planned, to decrease the potential for choking. Findings included: - Review of resident (R) 86's Face Sheet, revealed the resident admitted to the facility on [DATE]. The unsigned, undated Physician order [REDACTED]. The Admission Minimum Data Set (MDS), was in progress. The Baseline Care Plan, dated 08/13/20, with a review date of 08/15/20 instructed staff the resident was alert and cognitively intact, with adequate vision and hearing, independent with bed mobility, transfer, and walking, and was continent of bowel and bladder. The resident was at risk for falls due to [MEDICAL CONDITION] drug use. The care plan indicated the resident was a smoker and at risk for smoking related injury. The care plan indicated the resident had a history of [REDACTED]. The resident admitted to the facility while on parole from prison. The Elopement Assessment, dated 08/15/20 (the resident admitted to the facility 08/13/20 and completed after the elopement), assessed the resident risk score of 24 (>10 at risk) and the resident ambulated independently. Review of a Nurses Note, dated 08/13/20 at 1:00 PM, revealed the resident arrived at the facility. A Nurses Note, dated 08/13/20 at 03:40 PM, revealed the resident borrowed a

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) cell phone to call 911. This nurses note indicated the resident's speech was unclear, and the resident thought she could leave the facility whenever she wanted to. The resident stated there was a war going on in the jail and she needed to help a friend. A Nurses Note, dated 08/13/20 at 09:35 PM, indicated the resident was anxious and frequently went outside to smoke. A Nurses Note, dated 08/15/20 at 4:38 PM, indicated at 12:00 PM, the Certified Nurse Aide (CNA) could not locate the resident. All staff (including ancillary staff - other department staff) on duty looked for the resident. Licensed Nurse (LN) H and Certified Nurse Aide (CNA) P were the only nursing personnel on duty). At 12:18 PM LN H called emergency services to report the elopement and called administrative staff. A Nurses Note, dated 08/15/20 at 01:37 PM, documented that the police called the facility to inform them the resident was found in a town 37 miles from the facility. A Nurses Note, dated 08/15/20 at 02:20 PM, documented the resident returned to the facility and staff placed a wander guard bracelet (a device that alarms when the resident enters an area around a door to alert staff of the resident's presence) on the resident. The resident had sunburn on her face, neck, and bilateral arms from the elbow down. Interview on 08/19/20 at 02:00 PM, with LN H, revealed the elopement assessment lacked completion upon admission, so she completed it on 08/15/20 after the resident eloped and the assessment indicated the resident was an elopement risk. LN H revealed she was the charge nurse and CNA P was the only other nursing staff who worked on 08/15/20 day shift. LN H revealed the resident frequently went outside to smoke. LN H stated CNA P notified her at approximately 12:00 PM that she could not find the resident. Dietary staff, housekeeping staff, and CNA P searched the facility and surrounding area. LN H notified the local police department and administrative staff of the elopement at approximately 12:15 PM. The police found the resident in a town 37 miles from the facility, and the resident returned to the facility at approximately 02:30 PM. The resident sustained [REDACTED]. LN H placed a wander guard on the resident. Interview on 08/19/20 at 02:00 PM with CNA P, revealed she completed every two hour checks of the residents, and used a flow sheet to document she saw the resident and thought the last time she saw her as 10:00 AM. CNA P stated the resident was a smoker and frequently went to the fenced yard area to smoke. Interview on 08/19/20 at 03:45 PM with Administrative Nurse E revealed he spoke to the resident on 08/14/20 and felt the resident had normal cognitive status. Administrative Nurse E stated the admitting nurse should complete an elopement assessment and then document interventions on the care plan. Interview on 08/19/20 at 05:07 PM with Administrative Staff B revealed prior to the resident's elopement, staff unlocked the door to the fenced smoking area in the morning and the residents could smoke and ambulate as they wanted within the fenced yard area. Administrative Staff B stated there were set times for smokers that needed assistance. Administrative Staff B stated the facility had cameras of the fenced area that the nursing staff could view on a monitor at the nurses' station. Administrative Staff B confirmed only two nursing staff worked on 08/15/20 at the time of the elopement. Administrative Staff B stated usually two CNAs and a Certified Medication Aide (CMA) were scheduled. Administrative Staff B stated now the door to the smoking area remained locked at all times, and staff will supervise residents during set smoking times and during recreational activities. Staff removed all moveable chairs from the area. Interview on 08/19/20 at 05:15 PM with Administrative Staff A revealed review of the camera footage revealed on 08/15/20 at approximately 09:45 AM, the resident moved a plastic chair from the picnic table area to the fence and climbed over the fence. A state trooper made contact with the resident at approximately 10:56 AM, on a gravel road (speed limit on this gravel road 55 mile per hour), but at that time the facility had not made the elopement report (the facility realized the resident was missing at 12:00 PM). Administrative Staff A confirmed the resident would have to cross railroad tracks, and a two lane highway to get to a gas station in a neighboring town (10 miles from the facility). Administrative Staff A, stated that the resident described the gas station during a post elopement interview. From this gas station the resident obtained a ride, and was next seen by video surveillance at a truck stop in another town which was approximately 16 miles from the facility. The resident paid an unknown person to drive her to Hutchinson. The police were able to identify the car in(NAME) Kansas, approximately 37 miles from the facility. Upon return to the facility, the resident was anxious and pacing. The resident sustained [REDACTED]. The resident declined screening by mental health on 08/15/20. The mental health services subsequently screened the resident and she transferred to an acute care mental health facility on 08/17/20. Interview on 08/20/20 at 11:16 AM, with Social Service X, revealed the resident was pacing, very anxious, seeking cigarettes and drugs when she spoke with her on 08/13/20. Interview, on 08/20/20 at 11:30 AM with LN G revealed she worked as charge nurse on 08/13/20 and admitted the resident to the facility. LN G stated the resident paced and was anxious. LN G stated staff should complete the elopement screen upon admission and thought if the admitting staff did not complete the screen, the next shift should complete it. LN G stated prior to the resident's elopement, residents could go out into the fenced courtyard from approximately 07:30 AM to 08:00 PM at which time staff locked the door. LN G stated the resident was an elopement risk, but she did not implement interventions. Per Wunderground.com, the weather on 08/15/20 at 10:00 AM was 85 degrees. The facility policy Safety and Supervision of Residents, revised December 2007, instructed staff to use various sources to identify risk factors for residents, including the information obtained from the medical history, physical exam, observation of the resident and the MDS. The car team shall analyze information obtained from assessments and observations to identify any specific accident hazards or risks for that resident. The facility failed to assess this resident's elopement risk upon admission and failed to develop interventions for the resident's behaviors. The resident eloped from the facility traveled on foot on rural roads/fields, obtained rides from unidentified motorists, and was found 37 miles from the facility approximately four hours after leaving the facility. The facility removed the immediate jeopardy on 08/15/20 at 01:45 PM by initiating the following: Elopement assessments will be completed at admission, quarterly, and as needed on all residents. The facility will complete an elopement assessment on all current residents by 8/27/2020. The Interdisciplinary team will audit new admission elopement assessment within 24 hours of admission/readmission. The Quality Assurance Performance Improvement Committee will review compliance of the elopement assessments on a monthly basis until February 2021. On 8/15/20 at approximately 12:30 PM All admissions/readmissions will have a wander guard for at minimum 30 days. This will be on the TAR for proper placement function/monitoring by nursing staff on each shift. The wander guard system will be checked each nursing shift. On 8/15/20 at 12:30 PM The decision was made for the outdoor courtyard secured by a door that has a mag-lock that you must use a keypad to release. Staff was posted in front of the door until maintenance arrived. The job was completed at 1900 by the maintenance tech and owner. The doors are checked by staff daily to ensure proper functioning. On 8/15/2020 at 12:30 PM the decision was made that the residents will be supervised by staff when in the back courtyard during smoking and recreational activity time. The residents were informed at supper time of the implementation of supervision by staff when utilizing the courtyard to included smoking and recreational time. A sign was made and given to each resident and posted throughout the facility. On 8/15/20 at 01:15 PM - Administrator gave direction to staff that chairs that were able to be moved easily be immediately removed from the courtyard even though residents were not allowed to be in the area without supervision. All other items were of significant weight and size and could not be moved easily. At approximately 1345- Administrator verified that this was completed. On 8/15/2020 at 01:45 PM, Staff that were on duty were educated by administrator that the courtyard had to be supervised by staff when residents were present. Staff will be present for smoking breaks and activities in the outdoor space. A sign was posted at the nurses station. All oncoming staff will be educated as they report to work. The immediate jeopardy was removed, on 08/15/20 at 01:45 PM, however the deficiency remained at a scope and severity of a D. - The signed Physician order [REDACTED]./2020, documented R17 as cognitively intact and requiring supervision during eating. The Nutrition Care Plan, dated 05/01/2019, instructed staff to sit with R17 at meals. On 08/12/20 09:32 AM n the dining room, R17 held a glass with both hands. He was tremulous and had difficulty obtaining liquid from the glass. He coughed repeatedly, and liquid flew from his mouth. There were no staff in the vicinity and no staff checked on the resident. Cameras in the nurses' station viewed the area. Licensed Nurse G, in the nurses' station, talked on the telephone and sat turned away from cameras. No other staff were present. On 08/12/20 at 12:15 PM Dietary Staff BB stated someone who needs more attention should not eat alone. Dietary BB specifically identified R17 as one such resident. On 08/12/20 at 02:26 PM Certified Nurse Aide M stated R17 had trouble controlling liquid in cups and spills liquids on his shirt. Someone should be in dining when residents are eating, and usually 2 aides are in the dining room. The facility policy titled Meal Service, revised 03/09/2015, instructs residents who require assistance with feeding will not have their trays delivered until a staff member is available to assist with feeding. Further instruction indicates that the Food Service Director will perform meal rounds in the dining room daily to observe for residents needing assistance. The facility failed to provide adequate supervision during meals as planned to monitor for potential aspiration and/or choking for this resident.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.**

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 6) The facility reported a census of 40 residents. Based on observation, interview and record review, the facility failed to ensure adequate staffing to meet the needs of the residents. Findings included: - Observation, on 08/09/20 at 12:30 PM, revealed one Licensed Nurse (LN) G and one Certified Nurse Aide (CNA) N working in the facility with a census of 40 residents, which included 15 residents required assistance of one or two staff for bathing, five residents required assistance with dressing, four resident required assistance with toilet use and two residents required assistance with eating. Review of the Staffing Schedules for June 2020, July 2020 and August 2020, provided by the facility, revealed the following days with one Certified Nurse Aide and one Licensed Nurse: Day shift on 07/26/20, 07/31/20, 08/09/20, and 08/15/20 Evening shift on 06/03/20 and 06/07/20. Night shift on 06/16/20 07/17/20, 08.13/20, 08/16/20, 08/17/20, and 08/18/20 The Facility Assessment Tool, dated 11/26/19, indicated the number/average or range of residents with behavioral health needs as 40. The types of cares the resident population required by specific care of practice documents general care as mobility and fall/fall with injury prevention with specific care of practices as transfers, ambulation, restorative nursing, contracture prevention/care: supporting resident independence in doing as much of these activities by himself/herself. This assessment documented the facility based staffing on current census, patient needs and providing a safe and homelike environment for those residing in the facility. The section Assistance with Activities of Daily Living lacked completion, with blank spaces under the Independent and Assist of 1-2 Staff. The Dependent column indicated 0. The Mobility section was blank. Interview, on 08/09/20 at 1:30 PM, with CNA N revealed she did get resident cares done but felt rushed to do so. Interview, on 08/09/20 at 1:35 PM, with LN G, revealed usually a Certified Medication Aide (CMA) worked with her and the CNA, but the CMA called in. LN G stated it could get hectic depending on resident behavior. Interview, on 08/11/20 at 12:00 PM, with Certified Nurse Aide (CNA) P, revealed the facility no longer had a Certified Nurse Aide that provided restorative services to the residents, and she was not trained to provide restorative services. Interview, on 08/11/20 at 12:45 PM, with CNA MM revealed she was not trained to provide restorative services. Interview, on 08/12/20 at 02:45 PM, with CNA M revealed she was not trained to provide restorative services. Interview, on 08/12/20 at 04:49 PM, with Administrative Nurse D, confirmed the facility lacked a restorative aide to provide restorative services to the residents. Interview, on 08/12/20 at 4:30 PM, with Administrative Nurse D, revealed the facility provided staff to the residents based on census and resident needs. Administrative Nurse D stated the facility had a census of around 30 residents in June 2020, and it rose to around 40 residents mid July 2020. Administrative Nurse D stated she often filled in to cover for staff on all shifts. Administrative Nurse D stated the facility staffed one to two Certified Nurse Aides and a Certified Medication Aide with a Licensed Nurse on the day and evening shift and one Certified Nurse Aide and one Licensed Nurse on the night shift . Interview, on 08/19/20 at 2:00 PM, with LN H confirmed on 08/15/20 day shift, she worked as the charge nurse and had one CNA to meet the needs of 40 residents. LN H confirmed resident (R) 237 and R 11 eloped from the facility on 08/15/20. Interview, on 08/19/20 at 05:00 PM, with LN I, confirmed on 08/13/20 night shift, she worked as charge nurse and had one CNA to meet the needs of 39 residents. LN I confirmed R11 and R25 had an altercation during this shift. The facility policy Staffing, revised April 2007, instructs staff to maintain adequate staffing on each shift to ensure that resident needs and services are met. Furthermore, the facility failed to provide adequate staffing to ensure quality of care for the residents as follows: Rrefer to F688: The facility failed to assess and provide restorative services to the four residents sampled, including Resident (R) 134 for increased need for staff assistance with ambulation and self-positioning, R1 for knee contractures and abnormal posture with a walker during ambulation, and R2 and R17 for abnormal posture with ambulation with a walker. Refer to F689: The facility failed to assess for elopement risk and develop interventions for prevention of elopement for one resident (R) 86, who climbed over a fence in an unsupervised area, and was found 37 miles from the facility placing the resident in immediate jeopardy. Furthermore, the facility failed to ensure staff monitored resident R17 during meals, as care planned, to decrease the potential for choking. The facility failed to provide adequate nursing staff to ensure quality of care and to meet the behavioral health needs of the residents of the facility.
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 40 residents. The sample included 19 residents for review of social services. Based on observation, interview and record review the facility failed to provide appropriate social services to meet the needs for one resident, Resident (R) 25, involved in a resident to resident altercation. Findings Included: - The signed Physician order [REDACTED]. The Psychosocial Well-Being Care Area Assessment (CAA), signed 03/19/2020, documents R25 as having a recent [DIAGNOSES REDACTED]. The behavioral care plan, dated 03/19/19, indicates that in the past R25 drank bleach, jumped off a bridge, stabbed himself with a fork, and ate non-food items, and as having anxiety around other people during meals. The care plan, dated 12/19/2019, identified R 25 as at risk for self-harm and instructed staff to assess and monitor the resident. On 08/19/2020 at 12:20 PM, R25's plan of care was without update since the review date of 06/18/2020. The Physician order [REDACTED]. The Psychiatry Note, dated 04/01/2020, documented R25 as still struggling with hopelessness and flat affect (diminished emotional expression). A Complaint Investigation documented that on Thursday, 08/13/2020 at approximately 03:15 AM, R25 was involved in a physical altercation with resident R11. Nurses Notes dated 08/13/2020 through 08/14/2020, documented the incident and revealed monitoring until 08/14/2020 at 08:00 PM, at which time R25 had less anxiety and the perpetrator came up and apologized. There were no Social Services notes regarding the incident in the chart. On 08/19/2020 at 02:20 PM R25 told the surveyor that until R11 left the facility he did not feel safe. He reported he had nightmares and staff did not offer him counseling. On 08/19/2020 at 06:22 PM Licensed Nurse I, who was present during the altercation, stated R25 was very upset as the perpetrator kept saying I'm gonna kill you. On 08/20/2020 at 10:55 AM, Licensed Nurse G stated that after the incident R25 spent the day in his room. Then he kind of went back to normal. We were monitoring R11 for behaviors but were not monitoring R25. On 08/20/2020 at 11:04 AM, Social Services (SS) X stated she talked to R25 on Monday (08/17/2020). R25 said his nose hurt and had an x-ray. SS X further stated R25 wasn't really upset about what happened, and that he usually talks to her if he is concerned about things. SS X verified this was the only social services follow up as of the time of the interview, and that R25 had not been offered counseling. The facility policy titled, Behavioral Assessment, Intervention and Monitoring instructs Interventions will be individualized and part of an overall care environment that supports physical, functional and psychosocial needs, and strives to understand, prevent or relieve the resident's distress or loss of abilities. The facility failed to provide medically-related social services to meet the needs of this resident following a physical altercation.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** The facility identified a census of 40 residents. Based on observations and interviews, the facility failed to store & prepare food under sanitary conditions in the kitchen for the residents in the facility. Findings included: - The kitchen environment tour observations, on 08/10/2020, at 3:07 pm, revealed the following areas of concern: 1.) Dietary Staff CC facial mask lacked covering her nose while loading dishwasher. 2.) The Artic Air Commercial Freezer contained a white sticky substance on the front of both doors in several places. 3.) There was excessive food and dirt noted on the floor under the white table next to the ice machine. 4.) Twenty-four spices containers, sitting on the shelf above the preparation area had a build-up of a sticky substance on the outside of the container. On 08/09/2020 at 1:00 pm, Dietary Staff DD stated they do not need to wear a mask while working in the kitchen. On 08/09/20 at 01:03 pm, Dietary Staff BB stated staff are encouraged to wear a mask in the kitchen. The mask should cover the mouth and the nose. On 8/10/2020 at 4:30 pm, Administrative Staff A stated she was not aware the staff were not wearing a mask in the kitchen. She stated the policy is for all staff to wear a mask in the facility and in the kitchen. She stated that she would discuss the above concerns in the kitchen with dietary staff. She stated that she would walk through the kitchen to review her concerns in the kitchen as well. The facility's Nutritional Services policy, dated 07/2014, failed to include to maintain a cleaning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E210	A. BUILDING _____ B. WING _____	08/20/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
FRANKLIN HEALTHCARE OF PEABODY LLC	500 PEABODY PEABODY, KS 66866

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 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 7) schedule to ensure the kitchen was clean and kept under sanitary condition for the residents in the facility. The facility failed to store and prepare food under sanitary conditions for the residents of the facility.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide and implement an infection prevention and control program.** The facility reported a census of 40 residents. Based on observation, interview and record review, the facility failed to follow the Center for Medicare and Medicaid Services (CMS) and Centers for Disease Control and Prevention (CDC) recommended practices to prevent transmission of COVID-19 when the facility failed to ensure social distancing in the common dining area for the residents of the facility. Findings included: - Observation, on 08/09/20 at 05:04 PM, as staff and residents prepared for evening meal. The dining room contained two to four seats attached to a table (fast food style). The tables had distance of approximately three feet between them. Residents sat diagonally from each other at the four seated table, but five residents sat within six feet of each other at a table beside them. One resident sat at a two seat table. Certified Nurse Aide CNA NN, directed residents to various seats in the dining room, within six feet of each other. Interview, on 08/09/20 at 05:38 PM, with CNA NN, confirmed the seating did not allow six feet social distancing for the residents. Interview, on 08/09/20 at 5:50 PM, with Dietary staff BB, revealed the residents should be social distancing in the dining area, and the tables were not fixed to the floor and could be moved apart. Dietary staff BB stated she would contact maintenance to move the tables to provide six foot social distance for the residents. Interview, on 08/09/20 at 06:06 PM, with Administrative Staff A, confirmed the current seating arrangement in the dining room did not accommodate six foot social distancing for the residents. The facility lacked a policy for social distancing in the dining room. The facility failed to ensure the seating arrangement in the common dining room accommodated six foot social distancing for the residents to prevent the potential spread of the Covid-19 virus.
F 0881 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Implement a program that monitors antibiotic use.** The facility reported a census of 40 residents. Based on interview and record review, the facility failed to ensure an effective antibiotic stewardship program which incorporated aa system to monitor the use of antibiotics. Findings included: Review of the June 2020 Infection Control Logs, revealed one resident with a urinary tract infection, and two residents with tooth infection with antibiotics prescribed. The log lacked indication of resolution of the infection and lacked indication of McGeers Criteria (an evidence based set of standards for assessment to determine appropriateness of antibiotic use.) Review of the July 2020 Infection Control Logs, revealed two residents with a urinary tract infection, four residents with tooth infections, one resident with an eye infection, one resident with an ear infection with antibiotics prescribed. The log lacked indication of resolution of the infections, tracking and trending and lack of McGeers Criteria to determine appropriateness of antibiotic use. Interview, on 08/12/20 at 4:49 PM, with Administrative Nurse D, confirmed lack of determination and staff use of the McGeers Criteria for assessment and appropriateness of antibiotic usage. Administrative Nurse D confirmed the Infection Control Logs lacked indication of infection resolution Interview, on 08/19/20 at 01:10 PM, with LN G revealed she did not fill out a McGeer's Criteria document for resident infections. LN G stated she documented in the Nurses' Notes pertinent information about a resident requiring an antibiotic. The facility failed to provide a policy for use of McGeers Criteria. The facility policy Antibiotic Stewardship policy, revised December 2016, instructed staff to monitor the use of antibiotic in the residents for appropriateness. The facility failed to ensure an effective antibiotic stewardship program which included a system to assess the appropriateness of antibiotic usage in the facility.
F 0947 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention.** The facility identified a census of 40 residents. Based on record review and interview, the facility failed to ensure the continuing competency training for Abuse, Neglect, and Exploitation for two of five certified nurse aides reviewed. Findings included: - On 08/09/20, the personnel record revealed staff member O lacked In-Service training for Abuse Investigation and Reporting, Abuse Prevention Program, Protection of Residents During Abuse Investigations, Recognizing Signs and Symptoms of Abuse/Neglect, Behavioral Assessment, Intervention and Monitoring, Unmanageable Residents On 08/09/20, the personnel record reviewed revealed staff member NN lacked In-Service training for Abuse Investigation and Reporting, Abuse Prevention Program, Protection of Residents During Abuse Investigations, Recognizing Signs and Symptoms of Abuse/Neglect, Behavioral Assessment, Intervention and Monitoring, Unmanageable Residents On 08/10/20 at 12:03 PM, Administrative Staff B stated we have not been able to get all staff in for In-Service. If the staff members signatures are not on the In-Service sign in sheet, then the two staff members have not completed the trainings. The facility lacked a policy to ensure annual in-service training for nurse aides for Abuse, Neglect and Exploitation. The facility failed to ensure these two nurse aides received annual training for Abuse, Neglect, and Exploitation.