STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175470	A. BUILDING _____ B. WING _____	**10/15/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
QUAKER HILL MANOR	**8675 SE 72ND TERRACE BAXTER SPRINGS, KS 66713**

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 28 resident with 12 selected for review, including one resident reviewed for [MEDICAL TREATMENT] care. Based on interviews and record review, the facility failed to review and revise the care plan for Resident (R) 2 with interventions to monitor and assess for complications related to [MEDICAL TREATMENT] care. Findings Included: - Review of R2's physician orders, dated 09/05/2020, documented the resident admitted on [DATE], with the [DIAGNOSES REDACTED]. Review of R2's plan of care, dated 06/17/2020, lacked direction to staff regarding assessing the dressing every shift and/or when to remove the pressure dressing, no blood pressures, venipunctures (the puncture of a vein as part of a medical procedure, typically to withdraw a blood sample or for an intravenous injection), finger sticks, in left arm due to the [MEDICAL TREATMENT] fistula (a blood vessel made wider and stronger by a surgeon to handle the needles that allow blood flow out to and return from a [MEDICAL TREATMENT] machine). The care plan lacked instruction to include assessing thrill (a fine vibration felt which reflects the blood flow by a [MEDICAL TREATMENT] resident's shunt) or bruit (blowing or swishing sound heard which reflects the blood flow with a [MEDICAL TREATMENT] resident's shunt) to the fistula every shift or as needed. On 10/15/2020 at 10:40 AM, Administrative Nurse D verified the care plan was not updated to include interventions for the assessment and monitoring of the fistula site for this resident. On 10/1/2020 at 12:37 PM, Administrative Staff A, confirmed and verified the care plan lacked documentation to assess/monitor the fistula site. The facility's policy, Hemo-[MEDICAL TREATMENT], dated 04/02/2018, documentation included the management of the elder's overall comprehensive plan of care related to [MEDICAL TREATMENT] is the responsibility of the facility. The facility failed to review and revise R2's care plan with interventions to include the monitoring and assessment of the resident requiring [MEDICAL TREATMENT].
F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 28 residents with 12 residents selected for review including two residents reviewed for activities of daily living (ADL's). Based on observation, interview, and record review, the facility failed to ensure one of the two sampled residents, Resident (R)14, received appropriate personal hygiene assistance needed for trimming and cleaning of his fingernails. Findings included: - The physician orders, dated 09/29/20, for Resident (R)14, included [DIAGNOSES REDACTED]. The Admission Minimum Data Set (MDS), dated [DATE], assessed R14 as having a Brief Interview of Mental Status (BIMS) score of 8, indicating moderate cognitive impairment. He required limited assistance of one staff for personal hygiene. The ADL (activities of daily living) Care Area Assessment (CAA), dated 02/03/20, indicated R14 had physical deconditioning related to a recent hospitalization for [MEDICAL CONDITION] ([MEDICAL CONDITION]- a condition with low heart output and the body becomes congested with fluid). R14's daughter reported he was independent with ADL's except for bathing prior to his hospitalization . R14 required limited assistance with most ADL's except bathing. The quarterly MDS, dated [DATE], assessed R14 as having a BIMS score of 8 and was independent with personal hygiene without setup assistance required. The care plan, dated 07/28/20, indicated that R14 had difficulty with bathing/showering, bed mobility, toilet use, transfers, dressing, eating, ambulation, and locomotion related to decreased physical functioning from his recent hospitalization . An intervention, added 10/07/20, directed the staff that R14 required extensive assist of one with grooming. The electronic medical record (EMR), under the MDS tab, revealed R14 discharged from the facility with return anticipated on 10/02/20 and returned to the facility on [DATE]. On 10/12/20 at 02:14 PM, observation revealed R14's fingernails were long with some of his nails containing a dark substance underneath them. On 10/13/20 at 08:30 AM, observation revealed R14's fingernails continued to be long with a dark substance underneath some of his nails. On 10/14/20 at 08:13 AM, observation revealed R14's fingernails continued to be long with a dark substance underneath some of his nails. Review of the bathing schedule dated 10/11/20 through 10/17/20 indicated at the bottom of the schedule that R14 bathed himself. On 10/14/20 at 02:32 PM, Certified Nurse Aide (CNA) M revealed R14 liked to bathe every three to four days and staff should put him on the scheduled now since he required assistance. On 10/15/20 at 08:48 AM, R14 continued with long fingernails with some of them containing a dark substance underneath. On 10/15/20 at 08:49 AM, R14 revealed he did not know if the staff helped with nail care and he reported his fingernails needed trimmed and cleaned. On 10/15/20 at 09:29 AM, Administrative Staff A revealed that R14 had not been updated on the bathing schedule, since reentry into the facility on [DATE], and that a former employee updated and monitored those sheets. Physical therapy and occupational therapy worked together to give him a partial bath yesterday and on 10/13/20 CNA N attempted but the resident refused. On 10/15/20 at 09:40 AM, Administrative Staff A revealed that R14's nails needed trimmed and cleaned. The facility policy Cleaning and Trimming Nails, dated 03/08/19, directed that cleaned and trimmed fingernails were important for resident's overall health, bacteria often collect under and around nailbeds. Fingernails will be kept clean, neatly trimmed, and smooth to prevent injury to the resident's skin. The facility failed to ensure R14 received appropriate personal hygiene assistance needed for trimming and cleaning of his fingernails.
F 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Past noncompliance - remedy proposed** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 28 resident. The 12 selected included one resident reviewed for [MEDICAL TREATMENT] care. Based on interview and record review, the facility failed to ensure Resident (R) 2, sampled for [MEDICAL TREATMENT], received cares consistent with professional standards of practice. Findings included: - Review of R2's physician orders, dated 09/05/2020, documented the resident admitted on [DATE], with the [DIAGNOSES REDACTED]. Review of R2's plan of care, dated 06/17/2020, lacked direction to staff regarding post [MEDICAL TREATMENT] that included guidance for assessment of the dressing post [MEDICAL TREATMENT] and/or when staff should remove the pressure dressing, blood pressure monitoring, venipunctures (the puncture of a vein as part of a medical procedure, typically to withdraw a blood sample or for an intravenous injection), or finger sticks, in the left arm due to the [MEDICAL TREATMENT] fistula (a blood vessel made wider and stronger by a surgeon to handle the needles that allow blood flow out to and return from a [MEDICAL TREATMENT] machine). The care plan lacked instruction to include assessing thrill (a fine vibration felt which reflects the blood flow by a [MEDICAL TREATMENT] resident's shunt) or bruit (blowing or swishing sound heard which reflects the blood flow with a [MEDICAL TREATMENT] resident's shunt) to the fistula. The review of R2's medical record, July, August, and September2020, lacked documentation of assessment of the resident's fistula site, every shift. On 10/14/2020 at 02:34 PM, Certified Nurse Aide (CNA) O, reported the resident attends [MEDICAL TREATMENT] on Monday, Wednesday, and Friday. If there was bleeding

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 0698 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) from the site, she would notify the nurse to assess the resident. On 10/15/2020 at 09:40 AM, Certified Medication Aide (CMA) R, reported if the resident were to have bleeding from the site, the nurse would be notified. On 10/15/2020 at 10:35 AM, Licensed Nurse (LN) G, reported on [MEDICAL TREATMENT] days, staff should complete a Pre/Post Evaluation Assessment. The evening the resident returns from [MEDICAL TREATMENT], the site should be assessed several times. On 10/15/2020 at 10:40 AM, Administrative Nurse D verified the [MEDICAL TREATMENT] sites are assessed after treatment on Monday, Wednesday, and Friday, but should be assessed for thrill or bruit and bleeding every shift. She verified staff failed to provide proper assessment of the [MEDICAL TREATMENT] site. On 10/15/2020 at 12:37 PM, Administrative Staff A, verified expectations included staff monitoring the site every shift and monitor for thrill or bruit every shift. She verified that was not being completed. The facility policy, Hemo-[MEDICAL TREATMENT] Policy, dated 04/02/2018, documented for elders with fistulas and grafts, inform all staff of the following: No blood pressures, venipunctures, finger sticks, ABG's in the affected arm, assess thrill or bruit every shift and record, and assess for bleeding every shift; do not remove pressure dressings until bleeding has completely stopped and notify the [MEDICAL TREATMENT] center of any bleeding. The facility failed to ensure that this resident who required [MEDICAL TREATMENT] receive such monitoring and services, were consistent with the professional standards of practice.