STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175238	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LOUISBURG HEALTHCARE & REHAB CENTER	**1200 S BROADWAY LOUISBURG, KS 66053**

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 35 residents. The sample consisted of 16 residents, including one resident reviewed for choices. Based on observation, interview and record review, the facility failed to ensure that the one Resident (R) 7 received his choice of three showers a week to maintain his hygiene. Findings included: - The signed Physician order [REDACTED]. The Annual Minimum Data Set (MDS), dated [DATE], documented the resident admitted [DATE]. The MDS revealed the resident had a Brief Interview for Mental Status (BIMS) score of 14, indicating he had an intact cognition. It was documented to be very important to the resident to choose a bath, shower, bed bath or sponge bath. The resident needed limited assistance with personal hygiene. The Activity of Daily Living Functional/Rehabilitation Care Area Assessment (CAA), dated 07/21/2019, documented the resident continued to need help and supervision with his activities of daily living (ADLs). The resident still wanted to remain as independent as possible, but had poor insight/safety awareness due to dementia. The Quarterly MDS, dated [DATE], documented the resident had a BIMS score of seven, indicating he had severely impaired cognition. The resident required extensive assistance with personal hygiene. The resident's care plan, dated 02/10/2020, documented the resident preferred showers during the day shift on Mondays, Wednesdays and Fridays. The care plan directed staff to encourage him to bathe, change clothing and shave. The care plan documented, on 08/01/2017, the resident required assistance of one staff with showering and directed staff to provide a sponge bath when not given a full bath or shower. The facility's current Bath Schedule Sheet, documented the staff scheduled the resident's baths on Mondays, Wednesdays and Fridays. The facility bath sheets, from 02/01/2020 to 03/10/2020, documented the following: The week of February 2nd to 8th, the resident did not receive any baths. The week of February 9th to 15th, the resident was offered and marked as a refusal on 2/12/2020. The week of February 16th to 22nd, the resident had a bath/shower on [DATE], and marked as a refusal on 02/19/2020. The week of February 23rd to 29th, revealed a refusal on 2/24 and 2/28. The week of March 1st to 7th, was marked as a refusal on 03/04/2020. The week of March 8th to 14th, as of the 10th no shower documented. The electronic record in the computer, from 02/01/2020 to 03/10/2020, documented the followings: The week of February 2nd to 8th, no bath/shower documented. The week of February 9th to 15th, marked as a refusal on 2/10/2020. The week of February 16th to 22nd, the resident had a bed bath on [DATE], and documented as a refusal on 02/19/2020. The week of February 23rd to 29th, the resident was documented as a bath/shower on 0[DATE]20, and 02/26/2020. A refusal documented on 2/28/2020. The week of March 1st to 7th, was documented as a refusal on 03/06/2020, and a bed bath on 03/04/2020. The week of March 8th to 14th, as of the 10th, a refusal on 03/09/2020. Observation, on 03/09/2020 at 4:18 PM, revealed the resident in his wheelchair self-propelling. The resident's face contained whiskers and had on a teal plaid western shirt with a maroon jacket on. Observation, on 03/10/2020 at 10:08 AM, revealed the resident in his wheelchair with whiskers on face and the same plaid teal western shirt and maroon jacket on. On 03/05/2020 at 10:55 AM, License Nurse (LN) H confirmed the resident did have whiskers at this time and needed shaving. On 03/10/2020 at 11:02 AM, Certified Nurse Aide (CNA) M reported, giving the residents showers was everyone's responsibility. The showers are given or offered twice a week or more. When a resident refused a shower, the staff should offer a bed bath, if that was refused, then offer to shower the next bath day. CNA M further reported R7 was a limited one assistance with his showers and shaving. On 03/10/2020 at 3:00 PM, CNA O reported, when a resident refused a shower staff should try a couple times or at a different time. The shower sheets are completed when a resident received a shower or refused. CNA O further reported the resident was an extensive assist for showering. On 03/10/2020 at 4:22 PM, LN I reported, the resident would not say his wants or needs, but often says he was sick then not say what was wrong. He can be resistant at times, and he may refuse a bath due to his confusion. On 03/10/2020 at 10:57 AM, LN G reported the staff completes a bath sheet when a resident receives a bath or shower. On 03/11/2020 at 3:17 PM, Administrative Nurse B reported the resident's baths are scheduled on Monday, Wednesday and Fridays. The resident had dementia and would refuse to bath or shower at times. When a resident refused their shower/bath, then staff should try more than once, ask the next day and tell the charge nurse about the refusal. The policy titled, Activities of Daily Living, ADLs, dated 08/01/2019, documented a resident who was unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. The policy titled, ADL Care of Dementia Unit Residents, revised 10/05/2019, documented the policy stated the facility was to provide ADL care to residents on the dementia unit to ensure all ADL needs are met on a daily basis. A variety of approaches, such as task segmentation, will be utilized in assisting the dementia unit residents with their ADLs. The facility failed to promote and facilitate resident self-determination through support of the resident's choice for bathing, or for showers three times a week.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.** The facility reported census of 35 residents. Based on observation, interview and record review the facility failed to provide a system for the residents that wanted to file anonymous grievances in the facility. Findings included: - On 03/05/2020 at 02:53 PM, during the Resident Council meeting, Residents (R) 8, R18 and R25 reported they could not fill out a grievance form by themselves, they had to ask staff to assist them with the form. Observation, on 03/05/2020 at 03:30 PM, revealed the facility did not have grievance forms available in the common areas of the facility making them accessible to the residents. On 03/05/2020 at 03:00 PM, R8 reported residents could not fill out a grievance. The forms were kept put away, and the residents had to ask staff for the forms. The staff would fill out the grievance form for the residents. On 03/05/2020 at 03:00 PM, R8 and R25 reported that the facility does not always respond timely to the concerns they report. They stated they have complained about how noisy some people are. There were a few residents that holler all the time. When you have a concern there are no forms, you just have to tell someone. On 03/05/2020 at 03:01 PM, R8 reported he did not believe there were grievance forms and did not know if they would respond or not, because the residents did not have forms to report to them on. On 03/05/2020 at 03:02 PM, R25 reported we know how to do a grievance, but we don't have the forms. We have to tell the staff and they do it, you cannot do it anonymously. On 03/05/2020 at 03:35 PM, Administrative Staff A reported, we have the forms for grievances in my office. The residents do get one form on admission. If a resident needed a form they just needed to ask and then if they needed help filling it out we assist them. Any resident can go ask any employee to help them fill out a form or to give them a form. The facility does not have any way of grievances being anonymous with the filing of a grievance. Staff A further reported if a resident wanted to be anonymous they just tell the person filing out the form to write that on the form, but I would say that was not anonymous as the person filling out the

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 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) form knows. The policy titled, Resident and Family Grievances, dated 08/01/2019, documented it is the policy of this facility to support each resident's and family member's right to voice grievances without discrimination, reprisal or fear of discrimination of reprisal. Information on how to file a grievance or complaint will be available to the resident. A grievance may be filed anonymously. The facility failed to demonstrate responses and rationale to grievances in writing as required and failed to have forms assessable to residents of the facility making it unable for the residents to remain anonymous when filing a grievance.
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 35 residents. The sample included 24 residents with three reviewed for personal hygiene needs. Based on observation, record review and interview, the facility failed to provide adequate assistance for personal hygiene for the three sampled residents including; Resident (R) 34 with soiled and jagged fingernails, R20 with uncombed and unkempt hair, and R35 with unshaven facial hair. Findings included: - The signed Physician order [REDACTED]. body tissues), and diabetic (when the body cannot use glucose, not enough [MED] made or the body cannot respond to the [MED]). The admission Minimum Data Set (MDS), dated [DATE], revealed resident (34) had a Brief Interview for Mental Status (BIMS) score of 10, indicating moderately impaired cognition. The resident's functional status revealed the resident required two-person extensive assistance with bed mobility, transfer, toilet use, and ambulating. The resident required total assistance with bathing. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/17/2019, revealed moderate impaired cognition and that the resident did refuse showers. The quarterly MDS, dated , 02/12/2020, revealed no changes from the prior MDS. The current care plan directed the staff to assist the resident with activities of daily living (ADL's). The staff were to provide showers as scheduled on the shower sheet. The staff scheduled the resident to receive showers on Tuesdays and Thursdays, with the certified nurse aides and the charge nurses signing the resident's bath sheets. Review of the resident's bathing sheets, reviewed from 02/01/2019 through 03/07/2019, revealed the following; On 02/01/2020, the resident refused the shower. (Would attempt the next day.) On 02/04/2020, the resident waited on new clippers to shave him and then the staff ran out of time. On 02/08/2020, the resident lacked a shower sheet. On 02/11/2020, the resident refused. (Would attempt next day.) On 02/15/2020, lacked a shower sheet. On 0[DATE], the shower sheet noted the resident's fingernails were not cut or cleaned. On 02/22/2020, the resident received a bed bath and noted his fingernails not cut or cleaned. On 02/25/2020, the resident's fingernails were not cut or cleaned on the shower sheet. On 02/29/2020, the resident's fingernails were not cut or cleaned on the shower sheet. On 03/03/2020, the resident refused the shower. On 03/07/2020, the shower sheet documented the staff cleaned the resident's fingernails. On 03/10/2020 at 9:08 AM, Administrative Staff B, stated that the staff should be giving the residents showers as scheduled on the shower schedule, as well as shaving, clipping fingernails and cleaning under each of the residents' fingernails. As long as the resident was not diabetic, the staff could the clip and clean under the resident's fingernails. On 03/10/2020 at 04:28 PM, the resident's fingernails were jagged, long, and contained a brown unknown substance under each fingernail. On 03/10/2020 at 04:31 PM, upon further questioning of Administrative Staff B about the resident's soiled, jagged, and long fingernails, she clipped and then cleaned under each of the resident's fingernails. The facility's policy dated, 08/01/2019, and titled, Activities of Daily Living (ADL's) read: The facility will ensure a resident's abilities in ADLs do not deteriorate unless is unavoidable. The facility failed to provide adequate assistance with fingernail hygiene for this dependent resident. - The signed Physician order [REDACTED]. The annual Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 5, indicating severely impaired cognition. The resident required one staff with extensive assistance for bed mobility, dressing and toilet use, and required limited assistance with personal hygiene. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 10/31/2019, the resident was at risk for isolation, depression and further cognition decline. The Activity of Daily Living (ADL) Functional/Rehabilitation Care Area Assessment (CAA), dated 10/31/2019, revealed the resident required assistance with ADL's. The Quarterly MDS, dated [DATE], documented the resident's cognition remained severely impaired. The resident required setup help to limited assistance with ADL's. The care plan, dated 11/09/2019, directed the staff to provide extensive assistance for the dependent resident with grooming and hygiene. On 03/05/20 at 12:30 PM, the resident leaned forward in her wheelchair in the dining room. The resident's hair was unkempt and uncombed. On 03/09/20 at 01:30 PM, the resident was sitting in her wheelchair in the dining room. Her hair was uncombed and unkempt. The resident's hair was pulled back with a black ribbon and a blue bow. On 03/10/20 08:59 AM, the resident was sitting in the wheelchair at the dining table eating breakfast. The resident hair was uncombed and unkempt. On 03/10/2020 at 4:50 PM, the resident was sitting in the wheelchair at the dining table. Her hair was uncombed and unkempt. On 03/10/20 at 09:01 AM, Certified Nurse Aide (CNA) M, verified that the resident's hair was uncombed and unkempt. She stated that the staff did try to comb the resident's hair every morning, but the resident was not compliant with staff to comb her hair anytime. CNA M stated that she noticed that the resident's hair had not been combed for the past two days and she had not attempted to brush the resident's hair. On 03/10/20 at 03:25 PM, CNA N, stated that the resident's hair was messy and did not really allow anyone to comb her hair. She was very independent, putting the bows in her hair and not allowing the staff to assist her. 03/10/2020 at 9:08 AM, Administrative Staff B, stated that the staff should be completing grooming cares when a resident wakes up and that would include dressing and combing a resident's hair. There were other things that needed to be completed also such as washing the resident's face, oral care, washing hands, and toileting. If there was a problem with a resident, she expected the charge nurses to be identified, and if the charge nurse was unable to solve the issue than I expect to be called. The facility's policy, dated, 08/01/2019, titled, Activities of Daily Living ADLs) read: The facility will ensure a resident ability in ADL's do not deteriorate un deterioration is unavoidable. The facility failed to provide adequate grooming for this resident (R20), with the failure to adequately comb the resident's hair. - The signed Physician order [REDACTED]. (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness). The significant change of condition Minimum Data Set (MDS), dated [DATE], documented the resident had a Brief Interview for Mental Status (BIMS) score of 10, indicating he had moderately impaired cognition. The resident required two-person extensive assistance with bed mobility, transfer, and toilet use. He also required one-person assistance with personal hygiene. The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 06/17/2019, documented the resident indicated signs of decreased cognitive loss and dementia. The Activity of Daily Living Functional/Rehabilitation Care Area Assessment (CAA), dated 06/17/2019, documented the resident recently returned from the hospital with a pelvic fracture. The resident was requiring more help with activities of daily living (ADL's). The quarterly MDS, dated [DATE], documented the resident had a BIMS score of 07, indicating severely impaired cognition. The current care plan directed the staff the resident needed one-person extensive assistance with bathing. On 0[DATE]20 at 8:59 AM, Certified Nurse Aide (CNA) M, stated that the resident was non-compliant with taking showers and morning cares. CNA M verified the resident needed to be shaved and that CNA M would do that today. On 03/09/2020 at 11:28 AM, the resident was in the dining room during church service listening to music. The resident face was unshaved with long facial hairs noted. On 03/09/2020 at 12:10 PM, the resident was in the dining room eating lunch with the same unshaven facial hairs. On 03/09/2020 at 02:14 PM, the resident was in bed watching the television, with the same unshaven long facial hairs. On 03/10/2020 at 09:09 AM, the resident was resting in bed with the same long facial hairs unshaven. On 03/10/20 at 03:40 PM, CNA N stated that the resident was not always cooperative with his cares. It was hard to get him in the showers as he refused to take his weekly showers. He also would refuse to be shaved at times. On 03/10/20 at 03:53 PM, Licensed Nurse (LN) J reported not being sure about the resident's bathing habits as the aides had not advised LN J of him refusing showers. On 03/10/2020 at 09:08 AM, Administrative Staff B stated that the residents should be given showers as scheduled on the shower schedule as well as shaving. The facility's policy, dated 08/01/2019, and titled, Activities of Daily Living (ADL) read the facility would ensure a resident's abilities in ADLs do no deteriorate unless deterioration is unavoidable. The facility failed to provide adequate assistance for grooming with facial shaving when needed for this dependent resident.
F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Observe each nurse aide's job performance and give regular training.** The facility had a census of 35 residents. Based on record review and interview, the facility failed to conduct the required annual evaluations for six of six Certified Nurse Aides (CNA). The facility also failed to provide at least 12

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F 0730 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) hours of required training for the same six CNAs reviewed. Finding included: - Review of six CNA's employee records revealed the following: 1. CNA P, hired on 10/02/2018, without an annual evaluation completed. CNA P had only eight and 1/2 hours of training, without infection control training. 2. CNA Q, hired on 09/10/2018, without an annual evaluation completed. CNA Q had only ten hours of training, without infection control training. 3. CNA R, hired on 10/29/2018, without an annual evaluation completed. CNA R had only five hours of training, without abuse, neglect and exploitation (ANE) training. 4. CNA S, hired on 03/29/2017, without an annual evaluation completed. CNA S had only four and 1/2 hours of training, without dementia training. 5. CNA T, hired on 12/08/2017, without an annual evaluation completed. CNA T had only one and 3/4 hours of training, without ANE training, or infection control training. 6. CNA U, hired on 08/19/2018, without an annual evaluation completed. CNA U had only one and 1/4 hours of training, without ANE training, or infection control training. On 03/05/20 at 4:33 PM, Administrative Nurse B reported, the facility failed to complete the annual evaluations on any of the staff. The facility employed about seven CNA/CMA (Certified Medication Aide) employed over a year. On 03/11/2020 at 3:42 PM, Administrative Nurse B reported she was aware the staff needed the annual evaluations and training. The facility policy titled, Continuing Education, dated 12/01/2019, directed staff all levels of employees are expected to complete required training within designated time frames. It is the responsibility of each employee, volunteer, or contract staff to complete required training. If deadlines are missed by an employee, he or she may be removed from the work schedule until required training are completed. For training that is assigned as self-paced, the employee is responsible for completing the training by the deadline. The facility failed to complete yearly evaluations for six CNAs, who had been employed over a year to ensure adequate cares to the residents of the facility. The facility also failed to ensure the six CNAs received at least 12 hours of education as required, based on the completed evaluations to ensure competency in providing care to the residents of the facility.
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 reported a census of 35 residents. Based on observations and interview, the facility failed to maintain sanitary and proper storage and disposal of foods in a timely manner to prevent food-borne illness. Findings included: - During the initial tour of the kitchen areas, on 03/05/2020 at 09:17 AM, with Dietary Staff BB revealed the refrigerator in the kitchen contained the following: 1. A box containing eight wilted green peppers, not labeled or dated. 2. A box containing one stalk of wilted celery, dated 02/10/2020. The freezer in the kitchen contained the following: 1. Two one-gallon Ziploc baggies of unlabeled meat noted with excessive freezer burn. 2. A box containing 24 sausage patties was open and exposed the uncovered sausage patties. On 03/09/2020 at 04:34 PM, the kitchenette contained eight of ten cabinet drawer fronts with peeling/chipped paint, which exposed raw wood. On 03/12/2020 at 03:45 PM, Dietary Staff BB confirmed there were a few wilted vegetables in the refrigerator. The facility policy titled, Food Storage, undated, directed the staff to have sufficient storage and instructed the facility to keep foods, safe, wholesome and appetizing. Food will be stored at appropriate temperatures and by methods designed to prevent contamination. All stock must be rotated with each new order received. The facility failed to maintain sanitary and proper storage and disposal of foods in a timely manner to prevent food-borne illness to the residents of the facility.