STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E630	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANTHONY COMMUNITY CARE CENTER	**212 N 5TH AVE ANTHONY, KS 67003**

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 census totaled 23 with three residents included in the sample for lack of updating and revision of care plans. Based on observation, interview and record review the facility failed to update or revise care plans for Resident (R)5 regarding falls and for R16 regarding cast care. Findings included: - Review of R16's Physician Order dated 01/18/20 revealed the resident's [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. R16 has delusions and wandering at least one out of three days a week. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] revealed BIMS severe cognitive impairment. R16 received a non-injury fall no other changes since admission assessment dated [DATE]. Review of the Care Assessment Area (CAA) dated 04/23/19 revealed R16 has severe cognitive impairment due to dementia. R16 wanders, needs extensive assist with transfers due to weakness, poor balance, ad coordination. R 16 has history of fall and at risk for falls. Review of the Care Plan revealed on 08/25/19 staff initiated an intervention to provide a padded call light for easier use for R16. On 12/24/19, a Care Plan revision advised staff to remove the foot pedals to R16's wheelchair when she self-propelled. Review of the Nursing Facility Falls Investigation Form dated 11/03/19 revealed staff noted R16 seated on the floor on her buttocks. R16 reported she was getting up and staff noted no injuries. The intervention identified was for staff to assist her to bed between 7 PM and 9 PM nightly, while the Care Planned intervention was for staff to remove foot pedals off of the wheelchair when R16 was not propelling. Review of the Nursing Facility Falls Investigation Form dated 12/24/19 at 03:38 PM revealed unidentified staff found R16 on the floor on her right side with the wheelchair by R16's feet. R16 injuries included a large hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to right side of the forehead and skin tears (wounds, such as cuts, punctures, and scrapes). R16 complained of right forehead pain, pain with bending right knee, and right wrist and forearm pain below the elbow. The staff transferred R16 to the local emergency department for evaluation and treatment. Review of the Nurses Notes dated 12/30/19 at 06:19 PM revealed R 16 right wrist continues to be swollen, red, warm to touch and tender. Orders received to obtain x-ray (photographic or digital image of the internal composition) of right wrist. Report received from x-ray R16 right wrist has nondisplaced fracture will place cast to right wrist/arm. Cast on R16 for one month do not let right arm hang down and watch for swelling. Review of Nurse Notes dated 01/01/20 at 01:24 PM revealed R16 fingers below the cast were puffy and warm with good circulation. Review of Nurse Notes dated 02/06/20 revealed the local clinic saw R16 for a cast removal and applied a splint. The splint was to stay in place except for bathing until the x-ray's were completed on 02/06/20. Review of Nurse Notes dated 02/10/20 at 06:50 PM revealed staff noted R16's right hand as more swollen today and the x-ray report showed a fracture still there and a different splint was brought over from the clinic. Observation on 03/04/20 at 01:30 PM revealed R16 propelled herself in the hallway towards the activity room. The foot pedals were on the wheelchair, R16 passed unidentified staff members and conversed as she went by. Observation on 03/05/20 at 08:47 AM revealed R16 sat in her wheelchair with footrest on the wheelchair, and propelled herself around the room with no staff members on her hall. Interview with Certified Nurse Aide (CNA) N on 03/04/29 at 11:10 AM revealed CNA N had not looked at the care plan and was not aware of what to watch for regarding R16's cast. Interview with Licensed Nurse (LN) G on 03/05/20 at 09:10 AM revealed she expected the CNAs to know how to care for the residents and to look at the Care Plan if there were questions regarding interventions. Interview with Administration Nurse B on 03/04/20 at 01:30 PM revealed she did not know the cast care and interventions were not on the Care Plan. Review of the facility policy Care Plan and Revision effective 02/01/17 revealed all staff who used the plan of care were responsible for interdisciplinary collaboration to establish goals and appropriate interventions as well as on going evaluations and revisions. The facility failed to update and revise R16's care plan with interventions for her cast care/splint care. - Review of R5's pertinent [DIAGNOSES REDACTED]. of walking). Review of the 03/13/19 Annual Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of zero, indicating severely impaired cognition. The resident required extensive two-person assistance for transfers and toilet use and did not have a steady gait. R5 experienced two or more falls with no injury, two or more falls with minor injury noted, and used a chair/floor mat alarm less than daily during the seven-day review period. Review of the 12/03/19 Quarterly MDS revealed a BIMS of three, indicating severely impaired cognition. The resident required extensive two-person assistance for transfers and toilet use and did have a steady gait. R5 experienced two or more falls with no injury and two or more with minor injury noted. Review of the 03/13/19 Cognitive and Fall Care Area Assessment (CAA) revealed the resident did have dementia with a memory impairment. He needed extensive assistance with activities of daily living (ADLs) with a long history of multiple falls and continued to believe he could get up on his own and without assistance. Review of 02/21/17 ADL Care Plan, revised on 12/06/19, revealed R5 required one to two staff participation with transfers. He had impaired cognitive function related to dementia and a BIMS score of three on 12/03/19. R5 had trouble remembering to call for assistance. The staff were to not ask him yes/no questions like Do you need to go to the bathroom, but rather should have stated it is time to go to the bathroom and assist him every two hours. The resident experienced the following falls: 1. Review of Fall Investigations dated 11/04/19 at 02:08 PM indicated the resident had agitation and restlessness and fell out of his wheelchair, and the last toileted time was not filled out. The root cause was agitation and restlessness. The fall investigation intervention was staff were to complete a one-on-one with the resident when he had agitation. The care plan lacked an associated intervention. 2. Review of Fall Investigations dated 12/06/19 at 01:55 PM indicated the resident had agitation, dementia and that staffed failed to notify the nurse or provide further interventions resulting in a skin tear to his right forearm and abrasion to his right-side neck below the ear. The root cause was R5 was agitated when staff put him in his recliner, and then staff failed to notify nurse or provide further interventions. The intervention was that staff were re-educated to notify nurse of R5's agitation. The conclusion and action plan were not filled out. The associated care plan intervention identified reeducation of staff since the nurse was not notified of agitation prior to the fall and staff were not to leave the elder alone in his chair when agitated. 3. Review of 02/26/20 Nursing Facility Investigation Form for a left forehead bruise that occurred on 02/26/19 revealed no injury sustained, and there were no staff noted for the incident. The fall investigation lacked an intervention (not completed), lacked notifications to appropriate staff/family, and the care plan was not updated. Observation of R5 on 03/05/20 at 11:01 AM revealed the resident slept in his recliner with no shoes on, his personal socks in place, and no gripper socks noted. Interview with Certified Nurse Aide (CNA) C on 03/03/20 at 09:37 AM revealed R5 tended to be upset when his wife was out of the room, so staff made sure to take him with her when she leaves the room, they were always together. Interview with CNA D on 03/03/20 at 03:33 PM revealed staff assist him to his recliner and put

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 0657 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) his feet up and check on him frequently. He has an anti-skid material in his recliner too. We can take his wife somewhere without him, he did not try to get up when she was gone. Staff can take her out of the room without him coming. Interview with CNA E on 03/04/20 at 10:11 AM revealed the footrest on his recliner cannot be put up because it would trip him up. Interview with Licensed Nurse (LN) F on 03/05/20 at 11:09 AM revealed R5 would kick his shoes off, so staff do take them off when he was in his recliner. He should have gripper socks on too when we take his shoes off sitting in his recliner. Interview with Administrative Nurse B on 03/03/20 at 04:08 PM revealed the CNAs carried a pocket care plan which contained a synopsis of cares and interventions, and the staff should be following the interventions. The root causes and interventions should be tailored to the resident. Review of 02/01/17 Elder Directed Care Plans policy revealed all staff using the plan of care is responsible for interdisciplinary collaboration to establish goals and appropriate interventions, as well as ongoing evaluations and revisions. The care plan may be amended at any time the team determines it is necessary to ensure the elder receives appropriate care and services. Review of 02/01/17 Care Plan Revisions policy revealed changes in an elder's condition often require changes to be made in the plan of care either by change in individual approaches or by the addition of new problems to the plan of care. The care plan will be revised after every fall to include specific instructions to staff based on the causal factors identified at the time of the occurrence and during the fall investigatory process to prevent or reduce the possibility for recurrence of a fall. Revisions to the care plan will be the responsibility of a Registered or Licensed Nurse in collaboration with the elder, the responsible party/family, direct care staff, and the entire interdisciplinary team and changes will be communicated with all staff, all shifts. The facility failed to update the resident's care plan with resident specific fall prevention interventions.
F 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 23 with three residents included in the sample for falls. Based on observation, interview, and record review the facility failed to monitor Resident (R)16, R2, and R5 for falls. Findings included: - Review of R16's Physician Order dated 01/18/20 revealed the resident's [DIAGNOSES REDACTED]. Review of the Admission Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of three indicating severe cognitive impairment. R16 has delusions and wandering at least one out of three days a week. Review of the Quarterly Minimum Data Set ((MDS) dated [DATE] revealed BIMS severe cognitive impairment. R16 received a non-injury fall no other changes since admission assessment dated [DATE]. Review of the Care Assessment Area (CAA) dated 04/23/19 revealed R16 has severe cognitive impairment due to dementia. R16 wanders, needs extensive assist with transfers due to weakness, poor balance, ad coordination. R 16 has history of fall and at risk for falls. Review of the Care Plan revealed on 08/25/19 the intervention to provide a padded call light for easier use was initiated. On 12/24/19, the Care Plan was revised to advise staff to remove the foot pedals to R16's wheelchair when she self-propelled. Review of the Fall Risk assessment dated [DATE] and on 01/20/20 indicated R16 as a high risk for fall. Review of the Nursing Facility Falls Investigation Form dated 11/03/19 revealed the R16 noted to be sitting on the floor on her buttocks. The R16 reported she was getting up no injuries noted, intervention was to assist to bed between 7 PM and 9 PM nightly, while the Care Planned intervention was for staff to remove foot pedal off the wheelchair when not propelling R16. Review of the Nursing Facility Falls Investigation Form dated 12/24/19 at 03:38 PM revealed R16 found on the floor by unidentified staff member on right side with wheelchair by R16's feet. R16 injuries included large hematoma (collection of blood trapped in the tissues of the skin or in an organ, resulting from trauma) to right side of the forehead and skin tears (wounds, such as cuts, punctures, and scrapes). R16 complained of right forehead pain, pain with bending right knee, and right wrist and forearm pain below the elbow. R16 was transferred to local emergency department for evaluation and treatment. Review of the Nurses Notes dated 12/29/19 at 07:56 PM revealed R16 kept her right wrist lying in her lap and did not use it today with warmth and swelling noted from fall last week. Review of the Nurses Notes dated 12/30/19 at 06:19 PM revealed R 16 right wrist continues to be swollen, red, warm to touch and tender. Orders received to obtain x-ray (photographic or digital image of the internal composition) of right wrist. Report received from x-ray R16 right wrist has nondisplaced fracture. Observation on 03/04/20 at 01:30 PM revealed R16 propelling self in hallway towards the activity room. Foot pedals on the on the wheelchair, R16 passed unidentified staff members and have a conversation with the unidentified staff members. Observation on 03/05/20 at 08:47 AM revealed R16 sat in her wheelchair with footrest on the w/c, R16 was propelling self around the room with no staff members on R16's hall. Interview with Certified Nurse Aide (CNA) N on 03/04/29 at 11:10 AM revealed (CNA) N had not looked at the care plan and was not aware that the foot pedals were to be removed when the R16 was self-propelling in the hallways. Interview with Certified Medication Aide (CMA) O on 03/05/20 at 08:45 AM revealed (CMA) O was not aware of the intervention to remove the R16 foot pedals. Interview with Licensed Nurse (LN) G on 03/05/20 at 09:10 AM revealed she would expect the CNAs to know how to care for the residents and to look at the Care Plan if there were questions regarding interventions. Review of the facility policy Accident, Incident Unusual Occurrence Documentation effective date 03/15/18 revealed along with the fall investigation a root cause analysis will be turned in so that the root cause can be found in the fall. A new fall risk assessment should be done unless elder is already a high fall risk. Once a root cause has been determined the nurse needs to decide what interventions can be added to prevent further occurrences and maintain elder's safety. The elder's care plan will be updated within 24 hours and staff will be notified immediately to put interventions into action. The facility failed to monitor and implement interventions for R16 to prevent continued falls. - Review of R5's pertinent [DIAGNOSES REDACTED]. of walking). Review of the 03/13/19 Annual Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of zero, indicating severely impaired cognition. The resident required extensive two-person assistance for transfers and toilet use and did not have a steady gait. R5 experienced two or more falls with no injury, two or more falls with minor injury noted, and used a chair/floor mat alarm less than daily during the seven-day review period. Review of the 12/03/19 Quarterly MDS revealed a BIMS of three, indicating severely impaired cognition. The resident required extensive two-person assistance for transfers and toilet use and did have a steady gait. R5 experienced two or more falls with no injury and two or more with minor injury noted. Review of the 03/13/19 Cognitive and Fall Care Area Assessment (CAA) revealed the resident did have dementia with a memory impairment. He needed extensive assistance with activities of daily living (ADLs) with a long history of multiple falls and continued to believe he could get up on his own and without assistance. Review of 02/21/17 ADL Care Plan, revised on 12/06/19, revealed R5 required one to two staff participation with transfers. He had impaired cognitive function related to dementia and a BIMS score of three on 12/03/19. R5 had trouble remembering to call for assistance. The staff were to not ask him yes/no questions like Do you need to go to the bathroom, but rather should have stated it is time to go to the bathroom and assist him every two hours. The resident experienced the following falls: 1. Review of Fall Investigation dated 10/03/19 at 07:00 PM the resident fell /slid out of his wheelchair, was restless and had a skin tear, but cognition was not indicated as a factor for the fall. The root cause of the fall was indicated as the resident propelled in his wheelchair and could have slid out when the wheelchair did not move, he was restless and had dementia. The intervention on the fall investigation instructed the staff to place a non-skid sheet under the resident. The associated care planned intervention was to take the elder to the toilet after lunch prior to getting in his recliner. 2. Review of Fall Investigations dated 11/04/19 at 02:08 PM indicated the resident had agitation and restlessness and fell out of his wheelchair, and the last toileted time was not filled out. The root cause was agitation and restlessness. The fall investigation intervention was staff were to complete a one-on-one with the resident when he had agitation. The care plan lacked an associated intervention. 3. Review of Fall Investigation dated 11/05/19 at 02:32 PM indicated R5 was restless, wanted to go home, and slid out of his recliner and obtained a small skin tear back of left thigh. The root cause was that R5 had an increase in agitation after lunch for no reason. The intervention was a change to R5's medication times. The associated care planned intervention instructed the charge nurse to administer R5's [MEDICATION NAME] earlier in the day at 06:00 AM, 11:00 AM, and 04:00 PM. 4. Review of Fall Investigation dated 11/17/19 at 03:55 PM indicated R5 had dementia and wanted to go to his car. He fell out of his recliner, had right shoulder pain, and two bruises to his right hand. The root cause identified him as confused and tried to get up. The intervention was that staff should not put R5's feet up when he was seated in his recliner, at 11:00 AM staff were to ask if he was in pain, and the Certified Medication Adie (CMA) was to spend 15-20 minutes with him after lunch. The associated care plan intervention instructed the staff to put the foot up on the recliner and at 11:00 AM

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) daily the nurses were instructed to ask if the resident had pain. The care plan further instructed the certified medication aide (CMA) to do a 15-20-minute activity daily after lunch with R5. 5. Review of Fall Investigation dated 11/18/19 at 11:23 AM indicated R5 had dementia, was trying to go to lunch and fell out of his recliner and had a knot to his left forehead above his left eye. The root cause was that the elder used to go to the grocery store daily to get food for lunch per his family member, he had dementia and was bored/restless. The intervention was to try old country music when he was restless. The associated care plan intervention instructed the staff to try old country music on R5's iPod when he was agitated/restless. 6. Review of Fall Investigation dated 11/20/19 at 12:03 PM indicated R5 had dementia, agitation and was climbing out of his recliner. The root cause was that the elder was woken up for lunch, got agitated and tried to get up on his own. The intervention was that if R5 was asleep, staff were not to wake the elder for meals/toileting, and the hospice nurse was called, and a medication review was requested. The associated care plan intervention instructed the staff to not wake the resident for toileting and meals if the resident were resting comfortably, and report to the charge nurse and monitor him. 7. Review of Fall Investigation dated 11/25/19 at 07:00 AM indicated R5 crawled out of his bed to go to bathroom, staff last toileted R5 when he was incontinent at 01:00 AM. The root cause was noted as dementia, confusion, and he rolled out of the bed. The associated care plan intervention identified a scoop mattress supplied by Hospice and placed on his bed. 8. Review of Fall Investigations dated 11/28/19 at 02:23 PM indicated the resident reached in the trash can and he fell out of his chair, and his wife had been taken out of the room to the shower. The root cause was that his wife was taken to the shower and the elder was left alone in their room. The intervention stated that the care plan was not followed by staff and to place the trash can on other side of his wife's chair. The associated care plan intervention instructed the staff to place the trash cans out of the resident's sight on the other side of his wife's chair. The bedside care plan was updated, and the staff were educated to follow the bedside care plan. 9. Review of Fall Investigations dated 12/06/19 at 01:55 PM indicated the resident had agitation, dementia and that staffed failed to notify the nurse or provide further interventions resulting in a skin tear to his right forearm and abrasion to his right-side neck below the ear. The root cause was R5 was agitated when staff put him in his recliner, and then staff failed to notify nurse or provide further interventions. The intervention was that staff were re-educated to notify nurse of R5's agitation. The conclusion and action plan were not filled out. The associated care plan intervention identified reeducation of staff since the nurse was not notified of agitation prior to the fall and staff were not to leave the elder alone in his chair when agitated. 10. Review of Fall Investigations dated 01/07/20 at 06:31 PM indicated R5 was restless and agitated, fell out of his wheelchair, and resulted in an abrasion to his mid forehead/hairline. The root cause was that the care plan not being followed by staff and the non-skid material was not in his wheelchair, and the elder was agitated. The intervention was that the administration times of [MEDICATION NAME] and [MEDICATION NAME] changed in an attempt to cover the time when the elder was agitated. The Durable Power of Attorney (DPOA) was not notified of this fall. The associated care plan intervention identified a medication time change due to agitation. The staff were to administer R5's [MEDICATION NAME] (antianxiety medication) at 07:00 AM and 03:00 PM, and [MEDICATION NAME] 10:00 AM and 08:00 PM. 11. Review of Fall Investigations dated 02/11/20 at 06:54 AM indicated the resident's brief was wet, he attempted to climb out of bed and fell . The bed controls were within reach, and the last toileted time was noted as on the night shift. The root cause was that the resident was ready to get up because he had spent all yesterday in bed. The intervention was a fall mat beside his bed. The root causes and interventions for R5's falls were repeated for falls, not followed per the care plan, and fall investigations were not completely filled out with information and notifications. The associated care plan intervention identified a fall mat to be placed beside the bed. 12. Review of 02/26/20 Nursing Facility Investigation Form for a left forehead bruise that occurred on 02/26/19 revealed no injury sustained, and there were no staff noted for the incident. The fall investigation lacked an intervention (not completed), lacked notifications to appropriate staff/family, and the care plan was not updated. Observation of R5 on 03/02/20 at approximately 08:15 AM revealed the resident sat in his recliner with the legs elevated, and his wife sat next to him in her recliner. Observation of R5 on 03/05/20 at 11:01 AM revealed the resident slept in his recliner with no shoes on, his personal socks in place, and no gripper socks noted. Interview with Certified Nurse Aide (CNA) C on 03/03/20 at 09:37 AM revealed R5 tended to be upset when his wife was out of the room, so staff made sure to take him with her when she leaves the room, they were always together. Interview with CNA D on 03/03/20 at 03:33 PM revealed staff assist him to his recliner and put his feet up and check on him frequently. He has an anti-skid material in his recliner too. We can take his wife somewhere without him, he did not try to get up when she was gone. Staff can take her out of the room without him coming. Interview with CNA E on 03/04/20 at 10:11 AM revealed the footrest on his recliner cannot be put up because it would trip him up. Interview with Licensed Nurse (LN) F on 03/05/20 at 11:09 AM revealed R5 would kick his shoes off, so staff do take them off when he was in his recliner. He should have gripper socks on too when we take his shoes off sitting in his recliner. Interview with Administrative Nurse B on 03/03/20 at 04:08 PM revealed the root causes and interventions should be tailored to the resident, and the fall investigations should be filled out completely. Review of 03/15/18 Accident, Incident, Unusual Occurrence Documentation policy revealed along with the fall investigation a root cause analysis will be turned in so the root cause can be found in the fall. A new fall assessment should be done unless elder is already a high fall risk. Once a root cause has been determined the nurse needs to decide what intervention can be added to prevent further occurrences and maintain elder's safety. Elder's care plan would be updated within 24 hours and staff would be notified immediately to put the intervention into action. The facility failed to ensure fall investigations were completed and failed to ensure the staff implemented the care planned interventions which resulted in further falls for R5. - Review of R2's pertinent [DIAGNOSES REDACTED]. Review of the 11/18/19 Quarterly Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of 11, indicating moderately impaired cognition. The resident required extensive one-person assistance for transfers and toileting, was not steady with gait and used a walker/wheelchair for mobility. Review of the 02/18/20 Significant Change MDS revealed a BIMS of 15, indicating intact cognition. The resident required limited one-person assistance for transfers and extensive one-person assistance for toileting, was not steady with gait, and used a walker/wheelchair. She was occasionally incontinent of bowel/bladder and had one fall with minor injury noted. Review of the 02/18/20 Activities of Daily Living (ADL) Care Area Assessment (CAA) revealed R2 needed limited assistance with transfers and ambulation with her walker, and extensive assistance with toileting because she was unsteady with ambulation and needed staff assistance. She had [MEDICAL CONDITION] and impaired vision, and needed ADL assistance due to vision impairment, weakness, poor coordination and balance. She had occasional bowel and bladder incontinence and was at risk for falls. Review of the 02/18/20 Falls Care Area Assessment (CAA) revealed the elder was unsteady with transitions and ambulation and needed staff assistance to stabilize. She fell on [DATE] with a minor injury noted, when she self-transferred and stumbled. Review of 02/18/19 with revision dated 01/15/20 Psychosocial Care Plan revealed R2 hallucinated at times and she saw a neurologist for her [DIAGNOSES REDACTED]. When R2 required extensive assistance, she called for assistance. She could walk independently in her room and move herself into a wheelchair as well. R2 fell on [DATE] and the nurse discussed with the elder to transfer slowly to ensure safe transfer. The identified intervention was not an appropriate intervention due to R2 required one assistance for transfers and was also noted at times to hallucinate. Review of 01/20/20 Fall Investigation Form revealed R2 fell (non-injury fall) when she self-transferred from her wheelchair to her chair and caught her foot on the carpet. The resident had her shoes off. The intervention was noted as the nurse discussed with elder to transfer slowly to ensure safe transfers. The fall risk assessment was indicated as completed, but the record lacked an associated and completed fall risk assessment. R2's cognition was marked as not a factor to the fall. The nursing staff were notified of the action plan implementation with a root cause noted as stumbling while trying to transfer. Review of chart for Fall Risk Assessment for fall on 01/20/20 revealed lack of a fall assessment completed. The resident was considered a moderate risk for falls prior to 01/20/20 fall. Observation of R2 on 03/04/20 at 07:40 AM revealed the resident in her bed, Bilevel Positive Airway Pressure ([MEDICAL CONDITION], non-invasive form of therapy for patients suffering from sleep apnea) in place, resident appeared restless, had legs up/bent and slowly swayed back and forth while she laid in bed. Interview with R2 on 03/03/20 at 03:18 PM revealed she had [DIAGNOSES REDACTED] and did get tired. She could do some things by herself, like get up, but the staff instructed her to use the call light. R2 said sometimes she thought she had more strength than she did. Interview with Certified Nurse Aide (CNA) D on 03/03/20 at 03:33 PM revealed R2 always appeared sleepy and wore her [MEDICAL CONDITION] often. The staff checked on her every two hours and would make sure she was not up walking by herself, R2 knew to call for assistance. Interview with CNA O on 03/04/20 at 01:38 PM revealed R2 repeated herself sometimes, and she did sleep a lot with her [MEDICAL CONDITION] because she tired easily. Interview with CNA E on 03/04/20 at 10:11 AM revealed R2 required one-person assistance for transfers before her fall and currently, and her dizziness had always been

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F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) an issue with her [DIAGNOSES REDACTED]. Interview with Licensed Nurse F on 03/04/20 at 08:38 AM revealed she completed fall risk assessments quarterly and with the Minimum Data Set (MDS) completions, but not after a fall occurred. Interview with Administrative Nurse B on 03/04/20 at 09:00 AM revealed the nurses were to complete a fall risk assessment quarterly/annually, but if the resident was not a high risk for falls before the fall, staff were to complete one. The fall assessment should be completed the same day as the fall investigation. Administrative Nurse B stated the intervention for R2's fall on 01/20/20 was not appropriate; a more appropriate intervention would have been to encourage her to use her call light and do one-to-one checks every two hours to see if she needed anything. R2 had dementia so there were some cognition issues, and staff checking on her more frequently would have been more appropriate. Review of 03/15/18 Accident, Incident, Unusual Occurrence Documentation policy revealed along with the fall investigation a root cause analysis will be turned in so the root cause can be found in the fall. A new fall assessment should be done unless elder is already a high fall risk. Once a root cause has been determined the nurse needs to decide what intervention can be added to prevent further occurrences and maintain elder's safety. Elder's care plan will be updated within 24 hours and staff will be notified immediately to put the intervention into action. The facility failed to ensure appropriate interventions were implemented to prevent a fall for R2.
F 0693 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 23 residents with 12 residents in the sample. Based on observation, interview, and record review the facility failed to ensure the facilty staff administered the correct amount of tap water to resident (R) 20's feeding tube, as per the physician orders. Findings included: - Review of R20 pertinent [DIAGNOSES REDACTED]. Review of the 11/04/19 Quarterly Minimum Data Set (MDS) revealed a brief interview for mental status (BIMS) of 99, indicating severe impaired cognition. The resident required total dependence assistance of one person for eating with a feeding tube that provided 51% of R20's total calories daily and 501 cubic centimeters (cc) of displacement or more of fluid intake a day. Review of the 02/03/20 Annual MDS revealed severely impaired cognition. The resident required total dependence assistance of one person for eating with a feeding tube that provided 51% of R20's total calories daily and 501 cubic centimeters or more of fluid intake a day. Review of the 02/03/20 Feeding Tube Care Area Assessment (CAA) revealed R20 had dysphagia due to a [MEDICAL CONDITION] ([MEDICAL CONDITION], stroke). He was to have nothing by mouth (NPO) with enteral feedings (food or drug administration via the human gastrointestinal tract). The dietitian had evaluated him. Review of 05/17/17 Activities of Daily Living (ADL) Care Plan revealed R20 had tube feedings of [MEDICATION NAME] 1.2 cal (nutritional supplement) and tap water flushes of 75 cc before and after each feeding. Review of Physician order [REDACTED]. 01/08/18 Medication per tube must be crushed separately and dissolve each pill with 20 cc water with a flush of 10 cc water between the medications. Review of November 2019 to (NAME)2020 Treatment Administration Record (TAR) revealed the enteral feeding every 4 hours with 75 cc tap water. Documentation was missing for 11:00 AM feeding on 01/15/20 and 01/19/20, and on 03/03/20 for the 07:00 PM and 10:00 PM feedings. Observation of R20 on 03/03/20 at 11:20 AM revealed Licensed Nurse (LN) F brought in [MEDICATION NAME] 1.2 cal 8 fluid ounces, set clean paper towels on side table. She then filled tap water in the container and syringe dated 03/03/20 and administered 50 cc of tap water through tube before and after feeding. Interview with LN F on 03/03/20 at 11:20 AM revealed the staff fed R20 every 4 hours around the clock and verified there was a 10 cc tap water flush with each medication too. She was not sure why she did not check the orders before she gave the feeding, but the order did in fact say 75 cc tap water before and after the feeding. She said she thought it was 50 cc before and after the feeding and indicated she did not usually work the floor. Interview with Administrative Nurse B on 03/03/20 at 12:01 PM revealed the amount of tap water before and after a feeding for this resident was 75 cc. Administrative Nurse B said she expected the nurses to read the order before completing the feeding. Review of 02/01/17 Enteral Feeding Tube policy revealed that an elder who is fed by an enteral feeding tube receives the appropriate treatment and services. For bolus supplementation, the facility will encode orders into the computer under the medication order entry program. Labeling and dispensing will be as with unit dose medications. The facility failed to ensure staff administered the correct amount of water to R20's feeding tube as per physician orders.
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 22 residents, with one kitchen which included a low temperature dishwasher and a compartment sink for manual dishwashing, in which both required the use of sanitizing solution. Based on observation, interview, and record review the facility failed to maintain sanitizer solution concentration levels when they did not document or maintain logs of the sanitizer concentration levels for the dishwasher sanitizer and the Quat (a surfactant cleaning chemical that is typically used in hospitals and food processing plants) sanitizer solutions. Findings included: - Review of the logbook and records in the kitchen lacked evidence of a log for dishwasher sanitizer of the Quat sanitizing solution. An observation on 03/04/20 at 10:35 AM of Dietary Staff (DS) I checked the sanitizer in dishwasher and used improper strips and could not determine why the color was splotchy. After obtaining proper test strips, she tested the dishwasher sanitizer solution, which resulted at less than 10 parts per million (ppm). An observation on 03/04/20 at 10:45 AM of DS I revealed she did not know how to test the Quat sanitizer solution and reported she did not test or maintain logs of the Quat sanitizer. An observation on 03/04/20 at 02:08 PM revealed Eco Lab (company that maintenance the sanitizer solutions) Representative K in the kitchen with DS I, who tested the dishwasher sanitizer which resulted at 100 ppm and the Quat sanitizer resulted at 300 ppm. An interview on 03/04/20 at 10:42 AM with DS J revealed she documented dishwasher temperatures only and did not document dishwasher sanitizer levels. An interview on 03/04/20 at 10:43 AM with Dietary Manager (DM) H revealed she did not know how to test the sanitizer solutions. She stated eco lab company went to the facility on ce per month to maintain the sanitizer. An interview on 03/04/20 at 10:45 AM with DS I stated the facility used the Quat sanitizer solution for manual dishwashing and to sanitize kitchen counter and dining room table surfaces and did not test the Quat sanitizer solution. An interview on 03/04/19 at 10:45 AM with DM H, DS I, and DS J revealed the staff did not log dishwasher or Quat sanitizer concentration levels and reported they did know what effective sanitizer concentration levels were. An interview on 03/04/20 at 11:15 AM with DM H stated she did not have expectations of the dietary staff to monitor the dishwasher and Quat sanitizer solutions in the kitchen. An interview on 03/04/20 at 11:18 AM with DM H revealed she contacted an Eco Lab representative who informed her of proper dishwasher sanitizer results were 100 ppm and requested new test strips for the sanitizer. An interview on 03/04/20 at 02:05 PM with DM H stated Eco Lab Representative K arrived at the facility and tested the dishwasher sanitizer with new strips, which resulted at 100 ppm and confirmed the old test strips were bad. An interview on 03/05/20 at 12:17 PM with Administrative Staff A stated she expected dietary staff to test and log the sanitizer results at least daily and expected dietary staff to know effective sanitizer concentration levels for both the dishwasher and Quat sanitizer solutions. The facility's policy titled, Dishwashing Protocol, dated 0[DATE]16 documented, All staff members will follow accepted practices in washing dishes that will prevent food borne illnesses. The policy instructed staff to check dishwasher sanitizer levels prior to the beginning of dishwashing, ensure concentration levels of a minimum of 50 ppm, and to document the results. The policy lacked information or instructions for manual dishwashing. The policy lacked information and instructions for the use and/or maintenance of the Quat sanitizer solution. The facility's policy titled, Sanitation, revised on 07/21/14 ensured the proper dishwashing procedures would be followed and lacked information or instructions for the use of Quat sanitizer solution. The facility did not provide a policy for the Quat sanitizer solution. The facility failed to maintain sanitizer solution concentration levels when they did not document and/or maintain logs of dishwasher sanitizer and the Quat sanitizer concentration level results. This had the ability to affect all residents.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility census totaled 23 residents with 12 included in the sample. Based on observation, interview and record review the facility failed to develop an infection control program to track and trend infections in the facility and to place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E630	A. BUILDING _____ B. WING _____	**03/05/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANTHONY COMMUNITY CARE CENTER	**212 N 5TH AVE ANTHONY, KS 67003**

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 4) Resident (R) 4 with a [MEDICAL CONDITION] Resistant Staph Areaus infection (MRSA - a type of bacteria resistant to many antibiotics) in her urine. Findings Included: - Review of Resident (R)4's signed physician orders dated 01/18/2020 revealed the following Diagnoses: [REDACTED]. Review of the annual Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3 indicating severe cognitive impairment. The resident required supervision of one staff for toileting, and personal hygiene. The resident was occasionally incontinent. The resident received a diuretic (medication to promote the formation and excretion of urine) seven days of the seven-day observation period. Review of the Quarterly MDS dated [DATE] revealed no changes since the annual assessment dated [DATE] Review of the Urinary Incontinence Care Area Assessment (CAA) dated 06/10/19 revealed R4 had occasional stress incontinence. She wore a pad and was able to manage, change, and clean herself. She needed cuing at times to not use dietary napkins. She takes diuretics for [MEDICAL CONDITION] (swelling). She was at risk for a urinary tract infection [MEDICAL CONDITION]. Review of the Care Plan dated 01/12/2020 revealed: Resident had occasional stress bladder incontinence related to diuretic use and cognitive impairment. The resident wore pads in her underwear and could change them and clean herself. Staff were to monitor/document for symptoms of UTI. Update to the Care Plan dated 03/03/2020 included: Resident [MEDICAL CONDITION] in urine. Resident placed on contact isolation until urine clear of infection. Resident to have food in room on paper or foam disposable and plastic ware. Review of the Nurse's Progress Notes, dated: 0[DATE]20 at 09:30 AM Infection Note Call from Medical Staff L revealed the urinary culture [MEDICAL CONDITION]. 03/3/2020 at 01:20 PM Infection Note Text: Elder moved to different room due to being on isolation. Medical Staff L gave order to send urinalysis (UA) to see if free from bacteria after completion of the antibiotics. Observation on 03/03/20 at 11:00 AM resident was relocated to another room and placed on contact precautions due [MEDICAL CONDITION] in her urine. Staff assisted the resident to relocate. During an interview on 03/03/2020 at 10:00 AM Certified Nursing Aide (CNA) M reported the facility had no residents in isolation or having precautions. During an interview on 03/03/2020 at 01:30 PM CNA C, reported the resident required more assistance with her care. The resident had a UTI and was more incontinent lately probably from the infection. She reported finding out today that the resident was supposed to be on precautions for her UTI. She has had it for a while and did not know why they had to gown up now, but she would do it to be safe. During an interview on 03/4/2020 at 11:25 AM CNA N reported she did not know the resident [MEDICAL CONDITION] in her urine. The resident should have been in a room with a private bathroom that no one else shared the restroom. She would make sure she protected herself by wearing gloves and gown. The resident was clear now and she wished she would have known before today. During an interview on 3/3/2020 at 11:45 AM Licensed Nurse (LN) F reported she did not know what to do in the event of a resident being incontinent and [MEDICAL CONDITION] and directed surveyor to talk to the Director of Nurses. During an interview on 3/3/2020 Administrative Nurse B reported she was just made aware of the resident being incontinent. The resident will now be put on contact precautions. During an interview on 03/05/20 11:57 AM LN F revealed she logged into the dashboard on Point Click Care (PCC) electronic charting program) and had an antibiotic edited view. She then wrote the antibiotics onto a log. The charge nurse was responsible to makes sure cultures were returned. LN F reported she did not track infections by location or type of infection. She also reported any nurse can make the decision to put a resident in isolation. Two residents were missed when cultures came back [MEDICAL CONDITION]. She was unsure if nurses had been in-serviced in when residents should have been on isolation, but they will plan an in-service to inform nurses. Review of the facility policy for Infection Control dated 02/01/2017 revealed the a system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility. Standard and transmission-based precautions to be followed to prevent the spread of infections. Nursing personnel may initiate precautions for residents whose infectious disease are detected by laboratory results including the resident with positive cultures for resistive microorganisms. The facility failed to develop an infection control program to track and trend infections in the facility and to place R4 with a [MEDICAL CONDITION]-resistant staphylococcus aureus (MRSA) in her urine in isolation.