STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E597	A. BUILDING _____ B. WING _____	08/18/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
KIOWA HOSPITAL DISTRICT MANOR	1020 MAIN STREET KIOWA, KS 67070

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 0689 **Level of harm -** 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 had a census of 21 residents. Based on observation, interview, and record review the facility failed to identify causal factors to develop interventions to prevent avoidable falls for Resident (R) 1 with a fracture to the femur (large bone of upper leg) and Resident (R) 2 with no injury. Findings included: - Review of R1's Physician order [REDACTED]. Review of the Significant Change Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 11 indicating moderate cognitive impairment. The resident required total care of 2 staff for transfers and extensive assistance of two staff for bed mobility. The resident had impaired range of motion (ROM) on both sides of the upper and lower extremities. The resident had balance problems and was only able to stabilize with assistance of staff. The resident had no falls since prior MDS dated [DATE]. The Cognition Care Area Assessment (CAA) dated 03/31/2020 revealed BIM score decreased to 11 from 15 since 12/2019. Care plan interventions focus towards helping the resident's memory improve now that she was back in the facility and her health was more stable. Familiar faces and visits with her daughter who worked in the facility will help assist with improving memory. Provide frequent reorientation during interactions. Other possible interventions to consider are memory games, calendar in room, daily orientation by staff, and encouraging her to come to the dining room for mealtimes. The Activities of Daily Living (ADL) CAA dated 03/31/20 revealed a decline in ADLs. The resident required a Hoyer lift (mechanical lift) for transfers, and assistance for all ADLs including assistance for bed mobility. The resident was non-ambulatory and required total assistance for locomotion, and extensive assistance for dressing. The Quarterly MDS dated [DATE] indicated the resident had a BIMS 15 which indicated intact cognition and had one fall with injury. No other significant changes since the previous MDS dated [DATE]. Review of the care plan dated 4/7/20 included: the following interventions: Resident required supervision to limited assistance of two staff to turn and reposition in bed every 2-3 hours and as necessary. The resident used a grab bar on her bed for repositioning purposes. (04/07/20) The resident required total assistance of two staff and a full Hoyer lift to move between surfaces when transferring. (04/10/2020) Keep the resident's bed in the lowest position and a fall mat beside her bed while she was in it. (07/20/2020) Hourly safety checks were implemented. Ensure personal items remain in reach and positioned safely in bed or recliner. (07/01/20) The resident is at risk for falls and has had actual falls with minor injuries related to poor balance and deconditioning. The resident rolled onto the floor out of bed when reaching for something in June 2020. (07/01/20) The care plan failed to include the safe use of the lift chair by the resident. Review of the Readmission assessment dated [DATE] revealed vital signs within normal range for the resident. She was alert and oriented with some forgetfulness, communicated verbally, speech was clear, can understand and be understood when speaking. Review of the nurse's Progress Notes dated 07/29/20 at 09:58 PM noted when resident the readmitted her [MEDICATION NAME] (diuretic medication that promotes excretion of urine) 1 milligram (mg) daily restarted. Review of the nurse's Progress Notes dated 07/31/20 06:35 PM revealed the nurse walked down the hallway, looked into the resident's room, and the resident was on the floor face down in front of her recliner. The resident denied hitting her head. The nurse assessed resident and she had a large skin tear on her right forearm, a bruise on right knee, and small cut on the bottom of the left foot. Vitals, neurological checks and ROMn WNL (within normal limits) for the resident. Staff lifted the resident with the Hoyer lift to her bed. Staff cleansed and dressed her wounds. Staff notified the physician with no new orders, and the Durable Power of Attorney (DPOA), Director of Nursing (DON), and Administrator notified. The nurse encouraged the resident to always use her call light for staff assistance. She stated she understood. Review of the nurse's Progress Notes dated 08/02/20 at 03:10 AM noted the resident neuro checks, grip and strength WNL for resident with stable vital signs Resident's affect was quite flat (without expression). Denied complaints or needs, but was very quiet. The nurse's Progress Notes dated 08/02/20 at 02:33 PM stated at 10:55 AM Certified Nurse Aide (CNA) D and this nurse (writer of note) went in to reposition the resident. The resident complained of leg pain. The resident requested to be sent to the emergency room (ER) for an x-ray of her right knee. Spoke with her Durable Power of Attorney (DPOA) and it was agreed to send her via ambulance. Left message with the Director of Nursing (DON). Emergency Medical Service (EMS) arrived and with assistance of 2 people and the Hoyer lift with her right leg supported by an EMS worker and transferred her to the gurney with no difficulty. The resident transferred via EMS to the ER at 11:35 AM. Review of the nurse's Progress Notes dated 08/02/20 at 08:52 PM revealed the resident transferred from the local ER to a larger hospital for more care via ambulance with a [DIAGNOSES REDACTED]. Review of the Fall Checklist dated 07/31/20 described a fall the resident had on 07/31/20 at 05:45 PM. The resident was found face down on the floor in front of her lift chair all the way lifted into the standing position. The resident had ROM within normal limits for her. A large skin tear on right forearm, wrist and bottom of left foot. A bruise on her right knee. The resident was alone at time of fall. The resident raised her lift chair up to standing position and fell forward. The fall investigation lacked causal factors or care plan review for new interventions. Review of the resident's electronic record lacked any safety assessment for the use of the lift chair. No observation of the resident obtained due to remaining in a hospital in another city. During an interview on 08/18/20 at 10:30 AM CNA D reported the resident frequently messed with her chair. She would go up and down and up and down. She could reach her controls, so she kept them on her lap most of the time. During an interview on 08/18/20 at 01:45 PM Licensed Nurse C reported she was the nurse on duty at the time of the resident's fall. She reported the resident adjusted her chair often moving her feet up and down. She did not know of any kind of assessment for the safety of using a lift chair and the resident had access to the remote. She reported she never updated the care plan and that was not her job. The DON updated the care plans. During an interview on 08/18/20 at 01:50 PM Administrative Nurse B reported the resident was clear and we go by the residents BIMS scores as to whether she was alert or not. She reported the nurses should be updating the care plans with interventions after falls, and if not them when the DON reviewed she should update it. During an interview on 08/18/20 at 02:00 PM Administrative Nurse A reported there was no assessment done on residents to determine who was safe with a lift chair. Staff tried to keep the controls in the pocket on the side of the chair, but the resident can reach the pocket and get to the controls. Nursing should be revising the care plans as falls happen. She reviewed all falls after they happen. Review of the facility's Falls policy with a revision date of 04/2017 revealed: Residents who have a history of frequent falls or have high risk factors for falling will be identified to prevent falls. If a resident has had a fall when applicable new interventions will be put into place to assist in trying to prevent further falls. Using the facility fall form assess resident to determine risk of falls, toileting habits, medications taken, weakness, confusion, or any other risk factor. Use the information obtained to make new care plan intervention which is related to the cause of that fall that is appropriate for the individual resident, and place on the plan of care. The facility failed to assess R1 for safe use of an electric lift chair. The resident fell from the chair after raising the chair to the high position and

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 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) sustained a broken leg. - Review of R2's signed Physician order [REDACTED]. The Annual Minimum Data Set ((MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13 indicating normal cognition. The resident required limited assistance of one staff for toileting. The resident had balance issues and was not steady only with staff assistance. The resident had 2 falls since prior MDS dated [DATE]. Review of the Fall Care Area Assessment (CAA) dated 03/10/20 revealedthe resident had two actual falls during the last quarter because she ambulated much better, was stronger, more confident, and now wanted to get up and ambulate without assistance from staff which was unsafe due to balance problems. Review of the Care Plan dated 07/20/20 revealed: The resident was at risk for falls related to impaired mobility and decreased safety awareness due to [MEDICAL CONDITION] and dementia. The resident had unwitnessed falls. (07/20/20) Maintain call light within reach. (03/15/19) Place resident's table in front of her rather than beside her while she is in the chair, so she has all her personal items in front of her and won't try to get up to look for them. (07/20/20) Re-direct and re-orient the resident to room and facility as needed. (03/15/19) Social Service Designee (SSD) will do 1:1 with resident 1-2 times weekly. (09/16/19) Ensure that resident's call light was in her lap rather than on her table, so she will remember to call before getting up. (04/27/20) Toileting - The resident was incontinent of urine at times, especially at night. Wears pull ups. Needed assist of 1 staff and limited to extensive to toilet due to transfers. Encourage toileting before meals and at bedtime. (12/19/19) Transfers - Required assistance of one staff with use of 4-wheel walker. The resident often required verbal cueing/commands, allow additional time, and resident was slow to respond at times. (09/19/19) No new interventions added to the care plan or evidence of review with falls that occurred on 07/30/20 and 08/01/20. The nurse's Progress Notes dated 06/28/20 at 04:00 PM revealed the resident was found up by herself several times this shift, without using the call light for assistance. Resident stated she needed to go home for different reasons. Staff encouraged the resident to use the call light and wait for staff assistance when wanting to get up. Resident stated, she knew that, but needed to go. Staff was unable to successfully redirect the resident. Review of the nurse's Progress Notes dated 07/01/20 at 03:21 AM stated that earlier in the shift, staff observed the resident attempting to get up out of her chair without calling for assistance. Reminded the resident to call before getting up, then assisted the resident to toilet, change clothes, and go to bed. No further behaviors noted or reported this shift. Review of the nurse's Progress Notes dated 07/05/20 at 04:13 AM stated that earlier this shift, the resident was found up ambulating in her room without assistance and without calling, two separate times. Both times, the resident toileted within an hour before, and she had her personal items and call light in reach. The resident denied needing to toilet again and stated she couldn't remember why she was up. Nurse's Progress Notes dated 07/07/20 at 04:57 AM revealed the resident ambulated with her walker from her room all the way to the living room area last evening. Staff assisted her back to her room without incident. Review of the nurse's Progress Notes dated 07/10/20 at 04:54 AM stated the day shift passed on in report that the resident was found up ambulating in hallway alone and without calling for assistance. Resident was found twice in the night, attempting to get up from her chair and up from her bed without calling for assistance. Review of the nurse's Progress Notes dated 07/17/20 at 05:11 AM noted the resident attempted ambulation independently last evening without using her call light. The nurse's Progress Notes dated 07/18/20 at 06:02 PM revealed a CNA called the nurse to the resident's room. Upon arrival found the resident sitting on the floor between her recliners up against the wall. Resident stated she was reaching for something and fell . Denied any pain currently. Assessment completed head to toe. No injuries noted. Vital signs taken and resident assisted up with gait belt to standing position. Resident ambulated with assist of 1 staff with gait belt to the lobby. Review of the Fall Checklist completed on 07/18/20 at 04:15 PM revealed the resident had an unwitnessed fall while reaching for something and fell . No injury noted. Care plan updated with new interventions to prevent another fall. Review of the nurse's Progress Notes dated 07/18/20 at 10:39 PM noted the resident had a small raised area on her occipital area (back of head). Vital signs and neurological checks within normal limits (wnl). No complaints related to fall. Review of the nurse's Progress Notes dated 07/22/20 at 05:03 AM indicated the resident was up ambulating last evening by herself with no other behaviors noted during the shift The nurse's Progress Notes dated 07/26/20 at 04:03 PM revealed the resident was ambulating in her room and pushing her walker out into the hallway without calling for staff assistance. When asked what she was doing she said she just wanted out of the entertainment. Staff assisted her to her recliner and educated her on use of her push button call light. She promptly used it, with staff in her room. When asked why she pushed it she said she guessed to let everyone know. Review of the nurse's Progress Notes dated 07/27/20 at 04:44 AM documented the resident attempted to get up on her own when her neighbor tried to help her, but otherwise no behaviors noted Review of the nurse's Progress Notes dated 07/30/20 at 05:56 PM stated on 7/30/20 at 03:30 PM staff called the nurse for an unwitnessed fall. Upon arriving the resident sat on the floor with her knees drawn up in between the recliners. Asked resident what happened, and she stated, I was plugging in the extension cords for the tv program. Assessed resident s vitals, neuros, and range of motion (ROM) wnl for the resident. Resident denied pain, but stated she hit her head. Palpated her head without resident distress. No redness, [MEDICAL CONDITION] or bruising noted. Placed gate belt on resident and with 2 staff assisted her to her feet and she used her walker to ambulate. to the living room. When sitting on the couch the resident stated her right knee hurt. Upon assessing, the right inner knee was found to be mildly tender, with no [MEDICAL CONDITION], redness or bruising noted. Notified the physician, Director of Nursing, Administrator, and Durable Power of Attorney. The Fall Checklist completed on 07/30/20 at 03:30 PM revealed the resident had an unwitnessed fall. Resident stated she was plugging in extension cords together for the TV show. The resident had no extension cords in her room. Resident had confusion and reported the inside of her right knee was tender. No injury found. The resident last toileted by staff at 3:00PM. No causal factors identified, and care plan not updated. Nurse's Progress Notes dated 07/30/20 at 05:57 PM stated the resident continued to have tenderness in the knee at dinner time. Staff administered ordered [MEDICATION NAME] (narcotic pain medication) for pain, and the resident stated that made it better. Denied further needs. Encouraged resident to always use call light for assistance. Review of the nurse's Progress Notes dated 08/01/20 at 03:59 PM revealed the nurse went to residents' room where she was found sitting on the floor in between her recliners. When asked what happened she stated she heard somebody yelling help, was getting up to help, lost balance, and fell . Denied hitting anything but her bottom. Assessment completed. Assisted up with gait belt and assist of 2 staff to standing position and the wheelchair. Resident denied any pain or discomfort. Educated the resident on the importance of using her call light when wanting to get up. Call lights were both in reach. Resident stated she would try to remember to use it next time. Review of the Fall Checklist completed on 08/01/20 at 03:05 PM revealed the resident had an unwitnessed fall in her room. She reported she thought she heard someone yell for help and she was getting up to go help them. Causal factors listed as increased confusion and disease process. The care plan failed to address the fall or plan any interventions to prevent her from falling again. Observation on 08/18/20 at 11:29 AM revealed the resident ambulated from the dining room accompanied by a staff member with use of a 4-wheel walker. The resident ambulated to the sofa in the TV area. The resident changed channels on the remote herself. Observation on 08/18/20 at 12:12 pm revealed the resident leaving the dining room following lunch ambulating with CNA E. The resident had a steady gait with walker and gait belt used. CNA E offered the bathroom when they entered the resident's room. Staff walked with the resident into the bathroom to toilet After using the toilet, the resident ambulated to her recliner and the call light placed on her lap. Staff placed the over bed table over the resident so she could easily reach it. During an interview on 08/18/20 at 11:30 AM CNA D reported the resident had falls. She tried to get up on her own. We have started checking her every 15 minutes. Our care guide stated every hour, but we do it more frequent. We make sure the resident had her call light in her lap or on the table by the resident. If the resident was restless staff offered walks down the hall. We also encouraged her to toilet every hour. During an interview on 08/18/20 at 02:16 PM CNA E reported the resident was a one-person assist, so she helped her with about everything. We check her frequently, whenever we walk past her door. To help keep her in bed without getting up we prop her legs up on pillows and she cannot sit up to get out of bed as easily as she is very impulsive. During an interview on 08/18/20 at 01:45 PM Licensed nurse C reported she assessed the resident after a fall, but she did not update the care plan with new interventions. During an interview on 08/18/20 at 01:50 PM administrative nurse B reported the resident was very impulsive and could not remember to use the call light. The nurses should be updating the care plan at the time of the fall. Review of the facility's Falls with a revision date of 04/2017 revealed: Residents who have a history of frequent falls or have high risk factors for falling will be identified to prevent falls. If a resident has had a fall when applicable new interventions will be put into place to assist in trying to prevent further falls. Using the facility fall form assess resident to determine risk of falls, toileting habits, medications taken, weakness, confusion, or any other risk factor. Use the information obtained to make New care plan intervention which is related to the cause of that fall that is appropriate for the individual resident, Place on Plan of Care. The facility failed to identify causal factors of the resident falls to plan new interventions to prevent the

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F 0689 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) resident from falling.