STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175373	A. BUILDING _____ B. WING _____	**04/21/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF BURLINGTON	**601 CROSS STREET BURLINGTON, KS 66839**

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to thoroughly investigate allegations of rape for two residents (R4, R5), a resident to resident altercation involving two residents (R6, R7), and a fall that resulted in a fracture for one resident (R3). R3 required hospitalization due to a fall with fracture of his cervical vertebra. R3 died as a result of the fracture. The facility failed to report the death of R3 to the State Agency (SA). The facility identified a census of 52 residents. Findings include: 1. R3's admission nursing assessment, dated [DATE], documented that the reason for his admission was increased weakness, requiring more assisted care. R3 required extensive assistance with locomotion, toileting, personal hygiene, transfers, and bed mobility. R3 experienced unsteady gait and balance issues and had poor trunk control. R3 was at risk for falls. Review of a nursing note, dated [DATE] at 6:56am, authored by Registered Nurse (RN1) documented that RN1 heard R3 yelling help me. R3 was found lying on his back on the floor, with his walker at his side. He wore shoes and socks, and his call light was on his bed. R3 repeated oh my, and was attempting to sit up. R3 complained of head pain, and was assisted to a sitting position before being moved to his bed. Facility staff notified R3's physician via fax, called R3's family, and notified emergency medical services (EMS). EMS arrived at 4:01am, and transferred R3 to the hospital. Review of a witness statement, dated [DATE], written by Medication Aide (MA1) documented that MA1 assisted R3 with toileting 45 minutes prior to the fall. MA3 documented that R3 was weak and shaky. No documentation could be located that indicated if MA1 notified the charge nurse on duty that R3 was weak and shaky prior to the fall occurring, or if facility staff implemented an intervention in response to R3's weak and shaky presentation. Further review of the facility's investigation revealed that the investigation lacked R3's hospital records from the hospital he transferred to following his emergency room visit. The investigation lacked any further witness statements other than MA1's statement. The investigation failed to note that R3 passed away five days after the fall occurred. As of [DATE] at 3:00pm, RN1 and MA1 failed to return calls. On [DATE] at 9:10am, the Administrator indicated that R3's investigation lacked information regarding his stay at the hospital he was transferred to following his emergency room visit, and indicated that the facility failed to notify the State agency that R3 expired after his fall occurred. The Administrator indicated that the investigation was not complete without the information. Review of the facility policy, dated ,[DATE], titled Protection of Residents: Reducing the Threat of Abuse & Neglect, documented that: It is the policy of this facility that reports of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. 7.The written summary of the investigation should include, but is not limited to: -A review of the Incident Report. -An interview with the person(s) reporting the incident. -Interviews with any witnesses to the incident. -An interview with the resident, if appropriate. -A review of the resident's medical record. -An interview with the employee(s), as needed. -A review of the employee's file, as needed. -Interviews with staff members on all shifts having contact with the resident at the time of the incident. -Interviews with the resident's roommate, family, and/or visitors who may have information regarding the incident. -Interviews other residents who received care or services from the alleged perpetrator. -A review all circumstances surrounding the incident. 2. R5 admitted to the facility on [DATE] for skilled care following a displaced [MEDICAL CONDITION]. R5 was assessed as alert and oriented. On [DATE] R5 had an overnight stay at the hospital for an elected surgical procedure and returned to the facility on [DATE]. The [DATE] at 5:33pm progress note recorded the resident left the facility against medical advice with her niece. The progress note indicated staff attempted to educate the resident and the niece but both refused to listen and left the facility. On [DATE] at 3:06pm the facility received the following text from R5's niece: my aunt is not being abused like she was allowed to be raped by your Niger male nurse Sat (Saturday). The facility immediately began an investigation. According to the investigation R5 reported to her niece that on Saturday [DATE], NA2 took her into the shower room and raped her while two other NAs stood at the door and watched. The investigation included interviews from multiple staff that observed R5 before and after the shower and included Resident Questionnaires. Resident Questionnaires were completed by unidentified staff for three residents (two female and one male) and dated [DATE]. The questionnaire consisted of seven questions related to possible abuse e.g. do you feel safe here? Are you afraid or scared of any staff members that work in this facility? The facility failed to obtain interviews from multiple residents in order to conduct a thorough investigation since NA2 had access to all residents in the facility. 3. R4's [DIAGNOSES REDACTED]. The [DATE] quarterly Minimum Data Set (MDS) assessment (federally mandated assessment tool required to be completed) recorded R4's Brief Interview for Mental Status (BIMS) score was 4 which indicated the resident was cognitively impaired. R4 required extensive assistance with activities of daily living (ADLs) for dressing, toilet use, and personal hygiene. According to the investigation, on [DATE] staff found R4 lying across her sister's bed crying. The resident and her sister were roommates. When asked what was wrong, R4's sister conveyed that R4 was raped last night. The facility immediately began an investigation which included completion of the Resident Questionnaire. The facility conducted three Resident Questionnaires dated [DATE] that were not signed by the staff member completing them. The facility failed to interview residents timely following the allegation and failed to interview multiple residents as staff had access to all residents. 4. Record review of a resident to resident altercation that occurred on [DATE] in the dining room, revealed R6 ran into R7 several times with her wheelchair. R7 grabbed R6's arm and shook her. R6 then hit R7 in the right arm. The investigation included the same three Resident Questionnaires dated [DATE] that were in R4's investigation. The facility failed to interview residents timely following the altercation and failed to include statements from multiple residents to ensure they felt safe and were free of abuse. During an interview on [DATE] at 8:47am, the Administrator indicated that investigations were started immediately following the allegations and typically interviewed a minimum of three residents following the State Agency checklist for complaint investigations. The Administrator indicated the checklist directive was to interview a minimum of three alert and oriented residents about then allegation. The Administrator was not aware the questionnaires were the same for both R4 and R6 and indicated different residents were interviewed for the allegation on [DATE] but she was unable to locate them. The facility's ,[DATE] Protection of Residents: Reducing the Threat of Abuse & Neglect Policy and Procedure under the title Investigation and Protection: It is the policy of this facility that reports of abuse (abuse, neglect, mistreatment, including injuries of unknown source, exploitation and misappropriation of property) are promptly and thoroughly investigated. Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported. Complaints and grievances will be investigated as outline in the Concern & Comment (Grievance) Program Policy and will be reported immediately if the investigation reveals any alleged violations involving neglect, abuse (including injuries of unknown source), and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law. Under the title Procedure: 7. The written summary of the investigation should include, but is not limited to: -Interviews with resident's roommate, family, and/or visitors who may have information regarding the incident. -Interviews with other residents who

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

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F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) received care or services from the alleged perpetrator.
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** Based on interview and record review, the facility failed to develop and implement individualized care plan interventions to prevent accidents from occurring for one of one cognitively impaired resident (R3), who had a history of [REDACTED]. R3 then experienced a fall with major injury on [DATE] (12 days after admission), and sustained a [MEDICAL CONDITION] cervical vertebrae. R3 required emergency transportation to a hospital, then to an intensive care unit at a different hospital. R3 discharged from the hospital on [DATE], and then passed away on [DATE], five days after the fall, and 17 days after his admission to the facility. The census included 52 residents. Findings include: R3's admission nursing assessment, dated [DATE], documented that the reason for his admission was increased weakness, requiring more assisted care. R3 required extensive assistance with locomotion, toileting, personal hygiene, transfers, and bed mobility. R3 experienced unsteady gait and balance issues and had poor trunk control. R3 was at risk for falls. R3's Fall Risk Evaluation assessment, dated [DATE], documented that he experienced one or two falls prior to admission. R3 experienced a change in his cognition over the last 90 days, and experienced behaviors such as distraction, wandering, altered perception, restlessness, lethargy (sleepiness), and/or a change in mental function throughout the day. The assessment documented that R3 walked with problems, and required the use of an assistive device. R3 required physical support during a balance test. R3 required at least three high-risk medications, and had three or more [DIAGNOSES REDACTED]. Review of R3's Elopement Risk Evaluation, dated [DATE], documented that he was cognitively impaired with poor decision making skills. Review of R3's baseline care plan, dated [DATE], documented that he was cognitively impaired, or experienced an impaired thought process. Staff must provide simple one to two step instructions and allow extra time to answer questions. The care plan further documented that R3 was at risk for falls. Facility staff must assist with activities of daily living (ADLs) as needed, keep his call light within reach, complete a fall risk assessment, and orient him to his room. There were no further individualized interventions to keep the cognitively impaired resident free of falls. No documentation could be reviewed that addressed how the cognitively-impaired resident would be able to remember to use his call light, or remember orientation to his room. Review of R3's [DATE] Minimum Data Set (MDS) assessment (a federally mandated assessment tool required to be completed) recorded under Section GG (Functional Status) that he required substantial to maximal assistance from caregivers to complete his ADLs, including but not limited to transfers and walking. Review of a nursing note, dated [DATE] at 6:56am, authored by Registered Nurse (RN1) recorded that RN1 heard R3 yelling help me. R3 was found lying on his back on the floor, with his walker at his side. He wore shoes and socks, and his call light was on his bed. R3 repeated oh my, and attempted to sit up. R3 complained of head pain, and was assisted to a sitting position before being moved to his bed. Facility staff notified R3's physician via fax, called R3's family, and notified emergency medical services (EMS). EMS arrived at 4:01am, and transferred R3 to the hospital. The facility's investigation summary documented the fall occurred at approximately 3:30am. Review of a witness statement, dated [DATE], written by Medication Aide (MA1) documented that MA1 assisted R3 with toileting 45 minutes prior to the fall. MA1 documented that R3 was weak and shaky. No documentation could be located that indicated if MA1 notified the charge nurse on duty that R3 was weak and shaky prior to the fall occurring, or if facility staff increased supervision in response to R3's weak and shaky presentation. Review of R3's emergency room Note-Final, dated [DATE] at 4:25am, documented that R3 sustained a C2 (second cervical vertebrae) traumatic spondylolisthesis fracture (hangman's fracture) as a result of the fall. The hospital transferred R3 to the intensive care unit (ICU) of another hospital. Review of R3's Case Management Progress Note, dated [DATE], recorded that the hospital social worker (SW) met with R3's family to discuss discharge. R3's family stated that they were concerned the facility would not be able to manage the pt's (patient's) care needs. The family was hesitant for pt to dc (discharge) back to this location (the facility) d/t (due to) his fall he had there. Review of R3's Case Management Progress Note, dated [DATE] documented that R3 would discharge to a different facility at 2:30pm on [DATE]. On [DATE] at 1:40pm, R3's family member stated that R3 moved to the facility because he required more care, and experienced a fall at his prior facility. The family member stated that R3 was at risk for falling, and that the facility failed to watch him as closely as he needed. Following the fall, R3 discharged to a different nursing facility, and died shortly after admission. The family member stated that R3 died as a result of the fall. On [DATE] at 12:00pm, the MDS coordinator indicated that baseline care plans were developed by the nurse on duty at the time of an admission. After this, the MDS coordinator would go in and finish up the care plan, based on physician's orders and what is going on with the resident. The MDS coordinator indicated that the baseline care plan intervention for R3's falls were universal interventions put into place for all residents. The MDS coordinator indicated that R3 was at high risk for falls. On [DATE] at 12:50pm, the Director of Nursing (DON) indicated that R3's fall care plan was not appropriate for him. The DON indicated that due to R3's impaired cognition, he would not have remembered to use his call light, or remember the layout of his room. The DON indicated that R3 discharged from the hospital to a different nursing facility because his family was concerned that the facility would not be able to meet his needs. As of [DATE] at 3:00pm, RN1 and MA1 failed to return calls. On [DATE] at 9:10am, the Administrator indicated that R3's investigation lacked information regarding his stay at the hospital he was transferred following his emergency room visit, and indicated that the facility failed to notify the State Agency that R3 expired after his fall occurred. The Administrator indicated that the investigation was not complete without the information. Review of the facility policy, dated [DATE], titled Event Management System Policy, documented that the facility would provide an environment that is free from accident hazards, over which the facility has control, and provides supervision and assistive devices to each resident to prevent avoidable accidents. The policy further documented that an avoidable accident was when an accident occurred because of the facility failed to . Implement interventions, including supervision and assistive devices, consistent with a resident's needs, goals, care plan and current professional standards of practice .
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to maintain an effective ongoing infection control program that identified, tracked, and trended infections including residents affected by COVID-19. Two residents (R1, R2) had elevated temperatures but were not included on the [DATE] infection control log. According to the facility, as of [DATE], 31 residents had tested positive for COVID-19 as well as multiple staff. Neither the residents nor staff were listed on the Infection Control Log. This failure had the potential to affect all 52 residents that resided in the facility. Findings include: 1. On [DATE] R1's electronic medical record recorded she had an elevated temperature of 99.6 degrees Fahrenheit (F) via oral route. The following highest temperatures recorded each day were as follows: [DATE] - 99.8 F oral [DATE] - 102.3 F oral [DATE] - 101.5 F axillary [DATE] - 100.8 F oral [DATE] - 99.6F oral [DATE] 101.3 F axillary On [DATE] at 3:28pm the nurse's note recorded an order to administer 2 liters (L) of oxygen (O2) via nasal cannula (N/C), [MEDICATION NAME] inhaler, and provide supplemental oxygen. R1's oxygen saturation level was 88 percent (%) on room air (normal range for older adults run between 95 and 99%). The nurse assessed R1's respiratory status and identified rubs (abnormal lung sounds) with diminished lung sounds in both lower lobes of the lungs. The note indicated the facility was still waiting the results of the respiratory [MEDICAL CONDITION] panel (a test for [MEDICAL CONDITION] infections). On [DATE] at 7:06am the nurse's note recorded the resident was admitted to the hospital. On [DATE] at 2:30pm, the nurse's note recorded the hospital notified the facility that R1 tested positive for COVID-19. R1 was not included on the [DATE] Infection Control Log. 2. On [DATE] at 9:06am, R2's recorded temperature was 100.0 F. At 5:11pm the nurse's note recorded staff attempted to contact the resident's family to inform them of the resident's condition, the isolation precautions and the [MEDICAL CONDITION] testing performed on the resident. On [DATE] at 4:25pm the nurse's note recorded R2 was sent to the emergency department with shortness of air, elevated temperature of 103.4 F, was progressively weaker, had difficulty with ambulation, transfers and toileting. Staff placed a urinary catheter in the resident. The [DATE] at 4:44pm nurse's note recorded the facility received the respiratory [MEDICAL CONDITION] panel results from the hospital. The note does not indicate what the results were. The [DATE] at 7:06am nurse's note recorded R2 admitted to the hospital and later expired at the hospital. The [DATE] Infection Control Log did not include R2. The facility utilized the Long Term Care (LTC) Respiratory Surveillance Line List form. The form included resident and staff names, symptoms displayed, and diagnostics that were completed for possible COVID-19 infection. The residents and/or staff listed on the forms were not included on

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 2) the Infection Control Logs for March or [DATE]. Residents were listed multiple times on several different forms. This made it difficult to identify exactly which residents tested positive or negative. Due to the lack of information on the Infection Control Logs and the LTC Respiratory Surveillance Line List form, it is not known if or when residents were placed on isolation precautions, where they resided, what medications if any, were used for treatment, or the date resolved, if applicable. The LTC Respiratory Surveillance Line List forms provided were completed as follows: -The [DATE] form recorded Nurse Aide (NA1) was listed as a resident, not as a staff member and had an elevated temperature on [DATE]. The surveillance list lacked any further information regarding NA1. This information was not included on the [DATE] Infection Control Log to be able to determine what the outcome was for NA1. -The [DATE] form recorded R1 had a fever and loss of appetite. The form lacked any additional information. This information was not included on the [DATE] Infection Control Log. -The [DATE] form recorded five residents and two staff members with symptoms of COVID-19. The form recorded one staff member received a nasopharyngeal swab test. This information was not included on the [DATE] Infection Control Log. -The [DATE] form recorded R1 with symptoms, received a nasopharyngeal swab, tested positive for COVID-19 and was hospitalized . This information was not included on the [DATE] Infection Control Log. -The [DATE] form listed seven staff members of which six tested positive for COVID-19. The form did not include any outcome information. A second form with the same date listed nine residents (new and previously listed on other forms) including R1 of which seven residents tested positive for COVID-19, including R1. One resident listed as hospitalized and one resident listed as expired. The form listed R2 tested positive for COVID-19 and was hospitalized . This information was not included on the [DATE] Infection Control Log. -The ,[DATE] - ,[DATE] form listed ten residents were tested for COVID-19. A second form with the same date listed six staff tested positive for COVID-19. A different form with the same date listed nine residents and one staff member. Six residents tested positive for COVID-19. A third form with the same date listed six staff members of which five tested positive for COVID-19. This information was not included on the March or [DATE] Infection Control Log. -Two undated forms listed 20 staff members of which seven tested positive for COVID-19 from ,[DATE] to [DATE]. This information was not included on the March or [DATE] Infection Control Log. -The ,[DATE] form listed ten residents of which five tested positive for COVID-19. A second form with the same date listed seven residents with five that tested positive for COVID-19. This information was not included on the [DATE] Infection Control Log. -The [DATE] form listed one staff member and one resident tested for COVID-19 but did not include results. This information was not included on the [DATE] Infection Control Log. -The ,[DATE]-,[DATE] form listed two staff and four residents. The four residents had symptom onset on [DATE] and were tested for COVID-19 on [DATE]. The [DATE] form listed the same four residents tested positive for COVID-19. This information was not included on the [DATE] Infection Control Log. On [DATE] at 11:30am, the Director of Nursing (DON) indicated R2 was tested for COVID-19 on [DATE] and was sent to the hospital. The DON confirmed R2 was not identified on the [DATE] Infection Control Log. The DON indicated R1 was tested for COVID-19 on [DATE] but did not receive the results until later after she was admitted to the hospital. The DON stated she did not include R1 on the log. The DON indicated that both residents resided on the West hall and were placed on droplet precautions. The DON indicated that she and the Assistant DON were off for several weeks at the end of March so the log had not been completed. The DON provided a list of residents and antibiotics ordered to date for [DATE] but did not develop an Infection Control Log for the month. The DON indicated the nurse consultant utilized the LTC Respiratory Surveillance Line List to keep a list of residents and staff that were tested for COVID-19. On [DATE] at 12:08pm, NA1 indicated she had an elevated temperature when she went to work on [DATE] and was sent home by the facility. NA1 indicated the elevated temperature returned to normal that evening. She indicated she was not tested for COVID-19 at that time and did not have any additional symptoms or elevated temperature. The [DATE] Infection Prevention and Control Program (IPCP) and Plan Policy and Procedure recorded the following under the title Scope of the Infection Prevention and Control Program: The organization-wide Infection Prevention and Control Program (IPCP) is comprehensive in that it addresses detection, prevention and control of infections among residents and personnel. The risk of development of a healthcare-associated infection (HAI) is minimized through an organization-wide IPCP including the implementation of antibiotic stewardship activities.