STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. BUILDING _____ B. WING _____	**03/09/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ANDBE HOME, INC	**201 W CRANE STREET NORTON, KS 67654**

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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 61 residents. The sample included seven residents reviewed for falls. Based on observation, record review, and interview, the facility failed to provide adequate supervision and implement care plan interventions for four of seven sampled residents, Resident (R) 2, R3, R4, and R7. Findings included: - R2's physician's orders [REDACTED]. The Quarterly Minimum Data Set (MDS), dated [DATE], documented the resident alert and oriented, required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and did not ambulate. The MDS documented the resident's balance unsteady, no functional impairment, and two or more non injury falls during the look back period. The Fall Care Area Assessment (CAA), dated 05/20/19, documented the resident fell several times over the last year and tried to do tasks without asking for help. The Fall Care Plan, dated 11/30/19, directed staff to encourage the resident to sit in his recliner when in his room and sit in the hallway when he wanted to stay in his wheelchair due to multiple falls. The 12/02/19 update documented staff placed a silent alarm in the resident's recliner. The 0[DATE] update directed staff to place the resident's footrest in the up position due to a fall out of the wheelchair. The 02/20/2020 update directed staff to use a gait belt and two staff when transferring the resident. The Fall Risk Assessments, dated 0[DATE] and [DATE] documented the resident a high risk for falls. The Nurse's Note, dated 0[DATE] at 08:01 PM, documented staff observed the resident's wheelchair on its side and the resident sat on the floor at the foot of his bed. The resident had no injury and able to move his lower extremities without pain or discomfort. The resident stated he was trying to open his window shades. Review of the care plan directed staff to remind the resident to use his call light. The Nurse's Note, dated 0[DATE] at 12:10 AM, documented staff walked by the resident's room and noticed the resident lying on the floor with his shoes on. The resident's wheelchair was upright at the resident's feet and soda was spilled everywhere, including all over the resident. Two staff assisted the resident up with a gait belt and placed him into bed. The note documented the resident had a reddened area 0.75 inches (in) in diameter to the back of his head and a reddened area along his shoulder blades up to the back of his neck. The resident did not complaint of pain. The Nurse's Note, dated 01/30/2020 at 03:06 AM, documented the resident refused to go to bed and sat in his wheelchair in his room. The note documented the nurse walked by his room and saw the resident still in his wheelchair, and a few minutes later, staff observed the resident on the floor beside his wheelchair. Staff assisted the resident up, assessed him for injuries with none found, and assisted the resident to bed. The Nurse's Noted, dated [DATE] at 12:55 AM, documented staff observed the resident seated on the floor in his bathroom between the door and the toilet holding onto his wheelchair with one hand and the toilet with the other hand. The noted documented the resident denied pain or injury. On 03/05/2020 at 07:47 AM, observation revealed the resident sat in his wheelchair in the hallway. On 03/05/2020 at 12:10 PM, observation revealed the resident sat in his recliner with his feet down. Certified Nurse Aide (CNA) M and CNA N placed a gait belt around the resident's waist and CNA N instructed the resident to stand tall and turn to his left. The resident stood up and slowly pivot turned. CNA N instructed the resident to reach back to feel for the arms of the wheelchair and the resident sat down in his wheelchair. On 03/05/2020 at 12:10 PM, CNA M stated staff placed the resident in his recliner when he was in his room and out by the nurse's station when he wanted to be in his wheelchair because he previously fell out of his wheelchair. On 03/09/2020 at 01:18 PM, Licensed Nurse (LN) G stated staff encouraged the resident to stay out in the commons area when he was in his wheelchair but there were times he didn't want to, so staff placed him in his recliner. On 02/09/2020 at 03:20 PM, Administrative Nurse D stated she felt the resident's falls were behaviors and was unsure of new interventions to keep the resident from falling. The facility's Falls policy, dated 05/17/19, documented the policy was intended to reduce falls, and injuries from unexpected and unintended falls. The policy documented the care plan would be reviewed and the approach would be updated by the licensed nurse as needed after every fall and progress notes would be completed every shift for 72 hours. The policy documented a Fall Event would be completed after every fall. The facility failed to implement R2's care plan interventions to prevent further falls, placing the resident at risk for injury. - R3's POS, dated 02/04/2020, documented [DIAGNOSES REDACTED]. The Admission MDS, dated [DATE], documented the resident had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, ambulation on the unit, and toileting. The MDS documented the resident's balance unsteady, no functional impairment, and one fall prior to admission. The Fall CAA, dated [DATE], documented the resident used a wheelchair for distance, unsteady balance, and at risk for falls. The Fall Care Plan, dated 12/23/19 documented the resident had a pressure alarm on his bed and chair as he was unaware of safety issues of needing help with ambulation. The 01/28/2020 update directed staff to transfer the resident with two staff and a gait belt or a sit to stand lift (a lift used for resident's who can bear weight and can hold onto the handles) when behaviors dictated. The Fall Risk Assessments, dated 02/06/2020 and 02/08/2020 documented the resident at risk for falls. The Nurse's Note, dated 02/08/2020 at 03:59 AM, documented CMA OO stated she tried to stand the resident up to reposition him, their balance was off, and CMA OO lowered the resident to the floor. The note documented the resident denied pain or injury and was able to move all extremities as previous. On 03/05/2020 at 04:45 PM, observation revealed the resident sat in a recliner in the dining room of the Special Care Unit (SCU). CNA O lowered the footrest down on the recliner, placed a gait belt around the resident's waist, and with assistance from CNA MM transferred the resident to his wheelchair. CNA O took the resident to his room to transfer the resident to his bed for catheter care. CNA O obtained the sit to stand lift and stated, There is not enough staff so one of us stays in the dining room and I transfer the resident alone. CNA O placed the sit to stand sling around the resident, cued him to hold onto the handles, and raised the resident to a standing position. CNA O quickly took the resident to his bed, lowered him to a sitting position, unhooked the sling, and lifted the resident's legs into bed. On 03/05/2020 at 04:45 PM, CNA O stated the resident stayed out in a recliner in the dining room area because of falls. CNA O stated he was a two person assist for transfers with a gait belt and the sit to stand lift. On 03/09/2020 at 02:24 PM, LN H stated the resident was a two-person transfer with a gait belt and with the sit to stand lift. On 03/09/2020 at 03:09 PM, Administrative Nurse D stated if the resident could not transfer with two staff, they used the sit to stand lift and depending how the resident stood determined how many staff were needed to help with the sit to stand lift. The facility's Transferring Residents to and from the Wheelchair and Bed, policy dated 06/18/07, documented the facility was committed to the prevention of injuries to the resident and staff during the process of transferring residents to and from their wheelchairs and/or beds. These guidelines provide a mechanism for safe and efficient transfers of our residents while minimizing the risk of injuries to both our residents and staff members. The policy documented there are two different mechanical lifts available for use; the stand-up mechanical lift and the full body sling lift. If the resident can bear weight and able to grab onto the handles with their hands, the standup lifts the first choice. If a resident was unable to bear weight and cannot hang on with one or both of their hands, the full body lift would be used. The facility failed to

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** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) provide R3 adequate supervision to prevent falls with transfers, placing the resident at risk for injury. - R4's POS, dated 02/11/2020, documented [DIAGNOSES REDACTED]. The Quarterly MDS, dated [DATE], documented the resident had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS documented the resident's balance unsteady, no functional impairment, two or more non injury falls during the look back period. The Fall CAA, dated 09/16/19, documented the resident had numerous falls over the past year, poor cognition, and poor safety awareness. The Fall Care Plan, dated 10/18/19 directed staff to check the resident's alarms prior to starting their shift. The 01/02/2020 update directed staff to ensure the alarm was plugged in and working after the mat was placed at the beside following trips to the bathroom. The 0[DATE]20 update directed staff to check the bed alarm to make sure it was in working order. The Fall Risk Assessments, dated 01/02/2020, 02/07/2020, and [DATE] documented the resident at risk for falls. The Nurse's Note, dated 01/02/2020 at 02:15 AM, documented staff observed the resident sat on a pillow on the floor in his room with no injuries. The Nurse's Note, dated 02/07/2020 at 05:44 AM, documented a dayshift staff member reported to the night shift nurse that she observed R3 on the floor. The note documented the resident lying on the floor with his pants and incontinence brief off. Staff helped the resident up, dressed, and assessed with [REDACTED]. and found him lying on the bathroom floor. The resident denied pain or injury, staff assisted the resident off the floor and placed back into bed. The note documented the bed alarm was blinking green but did not sound when the resident got out of bed. On 03/04/2020 at 03:00 PM, observation revealed the resident in his recliner. CNA P and CNA Q placed a gait belt around the resident's waist and placed his walker in front of him. Observation revealed the resident stood up and independently transferred into his wheelchair. CNA P placed foot pedals on the resident's wheelchair and took him to the nurse's station. On 03/05/2020 at 01:11 PM, CNA M stated she checked the batteries in the alarms to make sure they were working every shift because the alarms have not worked in the past, and the resident had multiple falls. On 03/09/2020 at 01:18 PM, LN G stated staff checked the alarms to make sure they worked every shift because the alarms have not worked in the past and the resident had multiple falls. On 02/09/2020 at 03:09 PM, Administrative Nurse D stated staff should check to make sure the alarms are functioning properly at the start of the shift and verified there have been alarms that have not work and the resident had falls. The facility's Silent Alarm policy, dated 09/10/18, documented the alarms ensure the safety of resident who can no longer ambulate safely on their own and to alert staff the resident desires to get up. The nursing staff are to assess the history of falls and determine if a silent alarm is needed. All personal alarms will be set to silent and set up to alert staff through the call light system, and nursing staff will respond to a personal alarm when activated. The facility failed to ensure cognitively impaired R4's silent alarm functioned properly to prevent falls, placing the resident at risk for injury. - R7's POS, dated 01/27/2020, documented [DIAGNOSES REDACTED]. The Quarterly MDS, dated [DATE], documented the resident had severely impaired cognition and required extensive assistance of two staff for bed mobility, transfers, dressing, toileting, and personal hygiene. The MDS documented the resident's balance unsteady, no functional impairment, and two or more non injury falls during the look back period. The Fall CAA, dated 05/06/2020, documented the resident did not realize he could not walk by himself and often forgot to use his call light. The Fall Care Plan, dated 01/30/2020, documented the resident had a silent alarm in bed and recliner, a fall mat beside the bed, and a hoop on the right side of the bed to use for bed mobility and positioning. The 02/06/2020 update directed staff to check the resident's alarm to make sure it was working every time he was placed in bed. The 0[DATE]20 update directed staff to check the resident's pressure pad personal alarm each shift to ensure it was plugged in and worked correctly. The Fall Risk Assessments, dated 02/06/2020 and 02/23/2020 documented the residents a high risk for falls. The Nurse's Note, dated 02/06/2020 at 04:59 AM, documented staff walked by the resident's room and found the resident lying on his stomach on the fall mat. The note documented the resident's bed alarm was working but did not sound. Staff assessed the resident with no injury and placed back into bed. The Nurse's Note, dated 02/11/2020 at 03:20 AM, documented staff found the resident lying face down on the floor next to his bed. The resident's silent alarm did not sound over the monitor or the staff walkie tallies. Staff assess the resident with no injury and assisted the resident back to bed. The resident's silent alarm did not sound over the monitor or the staff walkie talkies. Staff assessed the resident with no injury found, and assisted the resident back to bed. The Nurse's Note, dated 02/23/2020 at 02:22 AM, documented staff observed the resident on the fall mat beside his bed, assessed the resident, no injury found, and placed the resident back in bed. The note documented the resident's bed alarm was blinking green but did not alert staff the resident attempted to get out of bed. On 03/09/2020 at 01:51 PM, observation revealed the resident sat in his wheelchair in his room with head down and eyes closed. CNA M and CNA MM placed the sit to stand sling around the resident's waist, cued the resident to hold onto the handles of the lift, stood the resident up, and transferred him to his bed. CNA M placed the resident's legs onto the bed, checked his personal alarm on the bed to make sure it worked and covered the resident with a blanket. On 03/09/2020 at 01:35 PM, LN H stated the resident had falls, his alarm wasn't working, and staff checked the alarm at the beginning of the shift to make sure it worked. On 03/09/2020 at 01:49 PM, CNA M stated the alarms were checked at the start of the shift to make sure they worked. CNA M stated the resident had a mattress and padded rug put into place because of his falls. On 03/09/2020 at 03:09 PM, Administrative Nurse D stated the alarms should be checked to make sure they are worked properly. The facility's Silent Alarm policy, dated 09/10/18, documented the alarms ensure the safety of residents who can no longer ambulate safely on their own and to alert staff the resident desires to get up. The nursing staff are to assess the history of falls and determine if a silent alarm is needed. All personal alarms will be set to silent and set up to alert staff through the call light system, and nursing staff will respond to a personal alarm when activated. The facility failed to ensure cognitively impaired R7's silent alarm functioned properly to prevent falls, placing the resident at risk for injury.